CHAPTER

3

Organizations: Surviving Within a Chaotic, Complex, Value-Based Environment

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OBJECTIVES

- Describe how communication, collaboration, and autonomy impact the organization.
- Understand how chaos and complexity affect organizations.
- Identify ways that nursing can impact the value-based environment (the second curve).
- Describe organizational competence.
- Identify evidence that impacts organizations.
- Understand the soul and spirit in an organization.
- Assess the healthcare organization.

Organizational Evidence

> The United States has the highest health care costs in the world, *with third world outcomes.*
>
> — J. Storfjell, O. Omoike, and S. Ohlson, *The Balancing Act: Patient Care Time Versus Cost*

> The real voyage of discovery is not in seeking new landscapes but in having new eyes.
>
> —M. Proust

Healthcare organizations are in the midst of a major change in design. In this past century, we were in a volume-based, tertiary system. However, that perspective will no longer survive. In this new century, a value-based thrust in health care has emerged. *To meet that value-based perspective, healthcare organizations must change drastically to survive*. Consider the following evidence and observations:

> Hospitals and health systems in the U.S. face unparalleled pressures to change in the future. Industry experts have projected that multiple intersecting environmental forces will drive the transformation of health care delivery and financing from volume-based to value-based payments over the next decade. These influences include everything from the aging population to the unsustainable rise in health care spending as a percentage of national gross domestic product.
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> Economic futurist Ian Morrison believes that as the payment incentives shift, health care providers will go through a classic modification in their core models for business and service delivery. He refers to the volume-based environment hospitals currently face as the *first curve* and the future value-based marker dynamic as the *second curve*. Progressing from the *first curve* to the *second curve* is a vital transition for hospitals. This is analogous to having one foot on the dock and one foot on the boat—at the right point, the management of that shift is essential to future success. (American Hospital Association 2011 Committee on Performance Improvement [AHA], 2011)
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> Half the decisions in organizations fail. Studies of 356 decisions in medium to large organizations in the U.S. and Canada reveal that these failures can be traced to managers who impose solutions, limit the search for alternatives, and use power to implement their plans. Managers who make the need for action clear at the outset, set objectives, carry out an unrestricted search for solutions, and get key people to participate are more apt to be successful. Tactics prone to fail were used in two of every three decisions that were studied. (Nutt, 1999, p. 75)
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> Even the best concepts or strategies tend to develop incrementally. They rarely ever work the first time out or unfold just as they were planned. (Pearson, 2002, p. 122)
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> In Honda plants, . . . even relatively routine . . . problems are solved by rapidly created, temporary teams assembled when needed from people who come from throughout the [facility]—not just from the specific area where the problem was first observed. The roots of even seemingly straightforward problems can be far-flung and thus require a surprisingly broad range of institutional knowledge to be resolved. (Watts, 2003, p. 17)

Evidence is all around us. We have been using evidence to identify best practices for the last decade. But best practice goes beyond patient care. It also applies to management practices and organizational improvement. The American Organization of Nurse Executives (AONE)

> has taken the strongest possible position on the importance of using best evidence in leadership and management practices. Leadership's use of best evidence in making organizational decisions has potential to impact patient care to a greater extent than does a single clinician using best practices at the bedside. (Marshall, 2008, p. 205)

What we thought worked before (such as the importance of transparency) now often has empirical evidence to support it. It is so important for nurse administrators to keep up-to-date on management and organizational evidence.

The Second Curve of Health Care

One important major shift in health care, supported by the evidence, is the change from a *volume-based environment* (the *first curve*) to a *value-based environment* (the *second curve*). The American Hospital Association (AHA) published two special reports on the major change (AHA, 2011, 2013). In the past century (Industrial Age—first curve), reimbursement was based on volume of insured patients, patriarchal systems and authoritarian leadership abounded, the bottom line was often first priority, and patients were told what to do. Now evidence shows that a major shift has occurred as we enter this new century (Information Age—second curve) that has eroded the old Industrial Age practices.

A number of changes have occurred together (*complexity*), necessitating that we change course in health care. Currently, more information than any one person can possibly know is available. This results in evidence-based care, in evidence that the old patriarchal and authoritarian systems are ineffective and lose money, in research that shows that a bottom-line orientation loses money, and in proof that reimbursement is related to quality and the continuum of care, not just volume (value-based reimbursement). We are realizing that we need to pay attention to what the patient wants and values. This is in the midst of appalling reports that show how many patients are injured or killed because of our poor healthcare practices. Patients have access to a lot of information. Physicians (and nurses) need to listen to patients and work more closely with them so they can make decisions about their care. (*Note:* Although the term *health care* is used throughout this book, in reality *tertiary illness care* is primarily being discussed. This is because historically tertiary illness care was given most of the "healthcare" dollars.)

A review of leadership development—for both staff and patients—at the point of care highlights its importance. The AHA 2011 report agrees with this assessment.

> Several of the interviewees relayed that the power and success of their organization is completely based on the culture, desire, and dedication of their employees. To thrive in a second-curve market, every clinical and administrative employee must be involved in initiatives to control expenses, improve efficiency, increase quality, and understand the new accountability that hospitals have to overall population health. Interviewees emphasized that change is going to happen, and that their respective organizations must train a new breed of administrative and clinical leadership to manage that change effectively. This can be accomplished with a variety of educational and involvement strategies. Organizations noted that even small engagement in employee health and wellness programs positively impacted turnover rates. As physicians continue to become better aligned with the interests of acute-care facilities, it is a necessity to provide leadership training to clinicians who may be able to guide the integration process. (AHA, 2011, p. 18, in reference to Strategy 6 discussed later)

To survive in this new value-based environment, the AHA (2013) recommends 10 *must-do strategies* for hospitals:

1. Aligning hospitals, physicians, and other providers across the continuum of care (p. 3)
2. Utilizing evidence-based practices to improve quality and patient safety (pp. 5–6)

- Effective measurement and management of care transitions
  Fully implemented clinical integration strategy across the entire continuum of care to ensure seamless transitions and clear handoffs

Fully implemented use of multidisciplinary teams, case managers, health coaches, and nurse care coordinators for chronic disease cases and follow-up care after transitions [Teams, interdisciplinary *shared governance*, and collaboration are discussed later in this chapter.]

Measurement of all care transition data elements. Data are used to implement and evaluate interventions that improve transitions.

- Management of utilization variation

  Regular measurement and analysis of utilization variances, steps employed to address variation, and intervention effectiveness analyzed on a regular basis

  Providing completely transparent, physician-specific reports on utilization variation [Transparency is encouraged throughout this text.]

  Regular use of evidence-based care pathways and/or standardized clinical protocols on a systemwide basis for at least 60% of patients

- Reducing preventable admissions, readmissions, emergency department (ED) visits, complications, and mortality

  Regular use of patient-engagement strategies such as shared decision-making aids, shift-change reports at the bedside, patient and family advisory councils, and health and wellness programs [Interdisciplinary shared governance and rounds are discussed later in this chapter.]

  Regular measurement or reporting on patient and family engagement, with positive results

- Active patient engagement in design and improvement

3. Improving efficiency through productivity and financial management (p. 6)

- Expense-per-episode of care

  Tracking expense-per-episode data across every care setting and a broad range of episodes to understand the true cost of care for each episode of care

- Shared savings, financial gains, or risk-bearing arrangements from performance-based contracts

  Measuring, managing, modeling, and predicting risk using a broad set of historical data across multiple data sources (e.g., clinical and cost metrics, acute and nonacute settings)

  Implementing a financial risk-bearing arrangement for a specific population (either as a payer or in partnership with a payer)

- Targeted cost-reduction and risk-management goals

  Implementation of targeted cost-reduction or risk-management goals for the organization

  Institution of process reengineering and/or continuous quality improvement initiatives broadly across the organization and demonstrated measurable results

- Management to Medicare payment levels

  Projected financial impact of managing to future Medicare payment levels for the entire organization; cost cuts to successfully manage at that payment level for all patients

4. Developing integrated information systems (p. 6)

- Integrated data warehouse

  Fully integrated and interoperable data warehouse, incorporating multiple data types for all care settings (clinical, financial, demographic, patient experience, participating and nonparticipating providers)

- Lag time between analysis and availability of results

  Real-time availability for all data and reports through an easy-to-use interface, based on user needs

  Advanced data mining capabilities with the ability to provide real-time insights to support clinical and business decisions across the population

Advanced capabilities for prospective and predictive modeling to support clinical and business decisions across the population

Ability to measure and demonstrate value and results, based on comprehensive data across the care continuum (both acute and nonacute care)

- Understanding of population disease patterns
  Robust data warehouse, including disease registries and population disease patterns, to identify high-risk patients and determine intervention opportunities
  Thorough population data warehouse that measures the impact of population health interventions
- Use of electronic health information across the continuum of care and community
  Fully integrated data warehouse with advanced data mining capabilities that provides real-time information to identify effective health interventions and the impact on the population
- Real-time information exchange
  Full participation in a health information exchange and use of the data for quality improvement, population health interventions, and results measurement

5. Joining and growing integrated provider networks and care systems (p. 4) [Usually this is not something that nurse managers are involved with very much, although nurse administrators at higher levels in the organization may participate. Once mergers and alliances have happened, nurse administrators are more involved with the issues of aligning different systems in the care experience.]
6. Educating and engaging employees and physicians to create leaders (p. 4)
7. Strengthening finances to facilitate reinvestment and innovation (p. 4) [This topic is discussed later in this chapter.]
8. Partnering with payers (p. 4) [The 2011 AHA report observes that "payers are increasingly rewarding clinical integration and high-quality care" [p. 20]. A lot of this will fall to the finance department in negotiating with payers. However, nursing has a key role in achieving quality/safety goals that are far better than what we have presently achieved.]
9. Advancing an organization through scenario-based strategic, financial, and operational planning (p. 4)
10. Seeking population health improvement through pursuit of the "triple aim" (p. 4)

> The "triple aim" is an initiative launched by the Institute for Healthcare Improvement in 2007 to encourage hospitals to simultaneously focus on population health, increased quality, and reduction in health care cost per capita. The pursuit of these three goals permits organizations to identify and fix a wide range of problems, but most importantly, it allows them to redirect resources to activities that will have the greatest impact on overall health. For the organizations interviewed, these activities included community-wide education and wellness projects, disease screening initiatives, and chronic disease management programs. (AHA, 2011, p. 22)

Generally hospitals have not been concerned with health promotion and disease prevention, leaving this to public health. However, in a value-based environment—the second curve—it becomes more important to integrate health promotion and disease prevention into planning for the future. Another difference is the need to pay more attention to the continuum of care, especially with chronic illness. With an increasing aged population, this becomes important and is why the Centers for Medicare and Medicaid Services (CMS) is beginning to attend to these aspects in an attempt not to spend all the healthcare dollars on tertiary care.

In Strategy 7 in the list of must-do strategies, the AHA Committee on Performance Improvement (AHA, 2011) states:

> Hospitals must prepare for tightening margins. The future of decreased reimbursement and a more severe case-mix commands today's organizations to find the means to cut costs and improve their operating margin without sacrificing any quality in the care provided. Simultaneously, technologies are being designed that significantly improve outcomes but are also a huge financial investment for the majority of institutions. Interviewees commented that without maintaining or improving current operating margins, they would not have the financial resources to perform any of the other must-do strategies such as focusing on quality and patient safety, creating strategic alliances with physicians and other providers, or engaging employees. To achieve the financial status desired for future innovation, organizations will have to fix their current service offerings, capital, and management structure to meet the needs of their population and reduce fixed costs throughout their budget. (p. 19)

In this text, written by a nurse administrator and CFO, we have stressed the importance of nursing and finance working together. People from both areas must understand the issues inherent in this relationship, such as speaking different languages (*linear* versus *relationship* perspectives), not understanding the other's worldview (financial people not understanding the care side; nursing not understanding the financial side), and possible male–female differences. To work together more effectively we need to develop a broader perspective in both professions because it is critical in this environment that frequent communication occurs.

Also, because we anticipate fewer dollars for care, this necessitates an interdisciplinary focus in dealing with this problem. If the administrative leadership is ineffective or stuck in the old authoritarian model, the organization will decline and, if not corrected, eventually fail. Achieving success in this arena depends on having second-curve administrative leadership in place. This chapter focuses on organizations. Evidence shows that a positive organizational culture makes money; achieves patient, staff, and physician satisfaction; allows fewer errors; and provides better quality care. To achieve a positive culture, it is important for everyone in the organization to support the mission and core values in their every action.

In this chapter, first we explore complexity issues that have brought about the need for second-wave organizations. Then, we examine components of a second-wave organization to help ensure that we leave behind first-wave mentality and make the necessary changes to move deeper into a second-wave organization. We define *organizational competence* and discuss how to assess organizations, including the importance of everyone doing regular rounds, to have a better idea of how to best make continuous second-wave changes.

Change Is All Around Us

Presently, we are at an interesting juncture in time because healthcare organizations are changing very significantly.

> Leaders must develop affection for risk and for the edges of agreement and understanding. They must be able to [meander like the river] so that the mental models people bring to the resolution of concerns or the determination of strategies and actions are shifted or even fundamentally altered. There is nothing worse in deliberation than using a mental model or frame of reference that does not fit the circumstances. As we move inexorably into the new age, we must try to understand its characteristics within the context of its becoming rather than of the past. Peter Drucker said it best when he suggested that we must all close the door on the Industrial Age and simply turn around. (Porter-O'Grady & Malloch, 2011, p. 28)

The old model was either based on who had authority (physicians or the executive group) or the location of the service (nursing, laboratory, radiology). As this old model crumbles (including many of the buildings), healthcare leaders are being called into the *chaos* of creativity to produce a good fit between the new framework demanded and the infrastructure that needs to be constructed to support it.[1]

> Changes in technology, service structure, clinical models, consumer demand, and healthcare economics are conspiring to create a need for healthcare organizations that possess the same fluidity and nimbleness required of [other] businesses. The chaos currently being experienced in the system arises from the conflict between the requirement for a radical shift in design and service and the continuing infrastructure. The myriad stakeholders—nurses, doctors, hospitals, pharmacists, etc.—are struggling to hold onto their piece of the healthcare pie without realizing the pie is now being sliced in an entirely different way. (Porter-O'Grady & Malloch, 2011, pp. 33–34)

As we examine organizations, it is important that we understand what is going on around us. A chaotic, complex process has been occurring, not only on the earth (just look at the weather), but within healthcare organizations. *To survive, it is important to be constantly aware of possibilities and find vastly different ways to better serve clients—most of the service will not be in hospitals.*

Consider the following:

- Time is becoming more compressed.
- Change is happening more frequently.
- The unexpected will happen.
- Medical practices continue to become less invasive.
- Eastern and Western medicine are merging.
- Healthcare (a misnomer because it has focused on illness care) is shifting from medical care to genomics integrated with other alternative options.
- Information (including general health information) is instantly available to everyone.
- The hospital bed has ceased to be the main point of service and services will increasingly move out of the hospital. During the next two decades, the number of hospital beds will decline by about 50%. By the end of this decade, more than 70% of the medical services currently provided in hospitals will be provided in clinics and doctors' offices.
- The service structure is more decentralized, more fluid, and more highly mobilized (with service being delivered in small, broadly dispersed units of service).
- Healthcare providers (including physicians and nurses) must be aware of current evidence and change their practices accordingly.
- Core practices of the health professions are being substantially altered.
- Insurers base payment on patient outcomes rather than delivered services.
- The middle class continues to be eroded so fewer people can afford health insurance.
- The Affordable Care Act of 2010 brings healthcare services to many who cannot afford it, and/or who may not want to purchase it. It brings increased taxes for everyone to pay for this, and yet this may not be enough money to provide this service.
- People who can afford it and who value it, are reaching outside the traditional medical focus for alternative, holistic care.
- The locus of control continues to shift from the provider to the user—emphasis has changed from simply rendering services the patient may not want or services not linked with good patient outcomes to what the patient values/wants.

- Patients need to partner with providers to understand options available to them as they undergo care.
- The numbers of elderly people are increasing, many of whom have multiple chronic illnesses.
- There are not enough long-term care facilities to meet the increased needs of elderly adults.
- Better case management is needed to keep patients out of hospitals and long-term care facilities; most patients prefer to be at home.
- Technology continues to proliferate.
- Social media, when misused, can easily violate Health Insurance Portability and Accountability Act (HIPAA).
- Connection between providers and patients (telemedicine) will increasingly be virtual, with supporting technology making clinical services possible without bringing patients to the provider.

In *The New Health Age*, Houle and Fleece (2011) define three forces driving health care: (1) the flow to global—patients can fly anywhere for needed health care and can find it less expensively outside the United States; (2) the flow to the individual—patients have more information available to them to make better healthcare choices; and (3) accelerated connectedness—we can communicate anywhere, anytime, meaning that we can communicate and share new medical treatments and research from various locations around the world.

Houle and Fleece (2011) identify nine dynamic flows operating in the present healthcare environment:

How we think about health care

- Sickness → Wellness
  Currently, health care is about curing sickness. Our current model does not encourage patients to learn how to stay healthy and prevent disease. Yet incentives are increasing to encourage wellness. For example, Knutson and colleagues (2013) describe one model that includes alternative health options.
- Ignorance → Awareness/Understanding
  There is employer recognition that good employee health is critical for business success as well as decreasing health costs.
- Opposition → Alliance
  Currently, there is opposition among patients, payers, and providers. Yet new models (such as accountable care organizations, or ACOs) are encouraging these groups to work *together* to achieve the highest quality at the lowest costs.

How we deliver health care

- Treatment → Prevention
  Increased focus on prevention will decrease costs of care over time.
- Reactive → Proactive
  Patients with chronic illnesses are expensive. Better ways of monitoring and controlling their illnesses need to be found that cost less money.
- Episodic → Holistic
  Payment will be for preventing illness, including lifestyle changes, rather than treating every episode of illness.

The economics of health care

- Procedure → Performance
  Now payment is by procedure, but employers can no longer afford this. New payment models [such as ACOs, which could fail] will not only cover necessary care but will reduce coverage and costs. Employees will have to pay more for care.

- Isolation → Integration
  Today care is delivered in silos (hospitals, doctors' offices) with communication and linkages among silos not always effective. More integration is needed between providers and information systems.
- Passive → Active
  Services and insurance claims need to be linked and at lower costs (Mauck & Breitinger, 2012, pp. 8–9).

This environment is complicated by four *financial issues that affect health care*. First, unlike other industries, our customers generally do *not* save up their money because they *want* our services. Instead, they often are vulnerable when they need our services, are afraid of many of the services we offer, and dread that the illness event might deplete their life savings. However, when they experience an illness crisis, they desperately want our services.

Second, the economy is troubled. The middle class is dwindling. Jobs are not plentiful. Inflation has increased costs so that someone who retired 10 years ago can no longer buy as much today, and children are returning to parents' homes because they cannot afford to live on their own.

Third, even when people do not have money to pay for illness services, they still need care. In a retail store they would be told, "No money. No merchandise." In health care, people have indeed been turned away in greater numbers, yet hospital and long-term care providers are forced by law to treat people who cannot pay as specified by federal regulations in the Affordable Care Act of 2010, and to do so in such a way that all providers work together to achieve better outcomes—keeping people in their homes longer. This means that a hospital can no longer be a stand-alone entity but must now pay attention to the *continuum of care* and *prevention*. To keep patients from being readmitted, hospitals must plan for better home care services for their patients, work more effectively with physician offices, and link more closely with long-term care. Accountable care organizations are an initial attempt to achieve this goal, which really affects the bottom line not only of organizations but of the public, who must pay additional taxes.

Fourth, insurance companies continue to cut percentages given to providers for reimbursement. For example, Medicare, which covers the majority of the U.S. population, continues to cut back payments to pennies on the dollar even when positive outcomes are achieved. With pay for performance, reimbursement is taken away when negative patient outcomes occur. In this case, healthcare organizations are left with the additional financial burden of having to pay for the care patients received. In addition, we are now being asked to achieve better coordination of care. In the midst of this environment, healthcare personnel grapple with how to provide quality service, yet make ends meet financially. It is a complicated dilemma fraught with many challenges.

Environmental Chaos and Complexity

Amid all of these changes, what are we supposed to do? Why can't things stay the same? These are good questions.

This complicated group of changes is too much for the old, linear, authoritarian systems to deal with effectively. In the past, we have used a linear *open systems model* to describe organizations:

> The inputs, throughputs, outputs, and feedback loops in a basic system exist in an environment that is influenced by economic, political, social, and cultural factors.

- The *inputs* include the resources, human and nonhuman (materials, equipment, buildings), that come together to provide the desired service. In health care, inputs might be staff labor hours, number and skill mix of nursing staff, other staff needed for various services, technology, equipment, supplies used, and remodeling or building expense.

- *Throughputs* are the processes or work that people do to achieve the output, the final product, or service. In the healthcare system, throughputs are the patient care services provided to the patient and family. Throughput processes use the available inputs to create work processes.
- *Output* results from the interaction of inputs in the throughput process. The output is the material, goods and/or services, produced. Outputs can be both qualitative and quantitative in health care. Reimbursement in health care is driven by the quantitative outputs or documented services produced by the system, regardless of the quality of the output or errors that might have occurred.
- *Feedback* is derived from both the outputs and throughput processes. Feedback is information about the effectiveness of the system and provides support for system changes. When outputs are positive, the system inputs and throughputs are reinforced and supported to continue. When the outputs are less than desired, modifications based on the feedback from the system are made to the throughputs. Similarly, when outputs are not what was expected, modifications to throughputs are considered. (Kathy Malloch, personal communication, June 25, 2012)

Although this linear open systems model is a useful starting point when discussing organizations, actually organizations are complex systems. The dynamic interactions and activities of the system must be considered. For example, Tortorella and colleagues (2013) give an example of improving *throughput* by starting a bed management system. However, as they describe how they did this and how they arrived at this solution, they accounted for the complexity within the system.

Healthcare organizations must be able to change quickly and be more effective. Healthcare administrators *and* workers must continually invent newer, better, more effective and efficient ways to offer services to clients. This is absolutely imperative for survival. We all have to shift our paradigms about how organizations operate. Some chaos and complexity knowledge can help us better understand what is happening and help guide us to change direction in organizations. This complex model better captures what is actually happening. To start with, consider the following statement by Henry Adams, an American journalist and historian born in the 1830s:

Chaos often breeds life, when order breeds habit.

Think about this statement. Chaos and order are opposites. Both are happening at the same time. Too much of either one creates total disruption and death. Both are natural processes. Life is always a dance between the two. As we deal with chaos and order, we need to work continually to balance them.

The linear view of the world—always viewing it the same way, holding accepted values without questioning them—does not capture the complexity of what is happening around us. We professionals can get stuck grasping at sacred cows—"we have always done it that way"—that are now outdated. Evidence supports a better, different way of doing. The linear view can get us stuck when the world is complex and changing. Quantum science provides evidence *that our world is chaotic and complex and ever changing*.

In the midst of the changes, there are some constants (**Exhibit 3–1**). Knowing these helps us deal more effectively with change.

First, *change is constant*. As our Earth changes, so do we. What is orderly at one time or place is chaotic at another time or place.

Change happens all around us and *more quickly than it did in the past*. Yet we don't always perceive change occurring because it happens incrementally outside our field of vision. Changes have a profound impact on us and affect our administrative role in health care. We need to keep abreast of the pulse of this energy and be open to it even though we don't know what is going to happen next.

Hints of changes are all around us. It is important to be on the lookout for these and to encourage staff to look for them as well. As we communicate with each other, together we can better identify what

Exhibit 3–1 Constants in the Midst of Change

- Change is constant, and is happening more quickly.
- Time is compressed and is gaining momentum.
- We are all different and very complex.
- Duality will always be present. Paradoxes reveal that where things seem contradictory, at a deeper level they are complementary.
- Chaos happens but we are attached to stasis. Our choice is how to respond to it.
- There is order within the chaos.
- "Living systems continually seek to renew and reinvent themselves, yet maintain their core integrity" (*autopoiesis*).
- New information enters into a system "in small fluctuations that continually grow in strength, interacting with the system and feeding back upon itself" (*autocatalysis*).
- At times we choose to create chaos—cause disorder (*dissipative structures)*.
- In the midst of chaos and change, there are some things we cannot explain (*strange attractor).*
- We are all interconnected.
- We are all interdependent.
- Organizations become increasingly more complex over time.
- Unexpected events occur "that have a significant and disproportionate impact on a system" (Clancy, 2008a, p. 273). These are called *black swans*. The more complex a system is, the more frequently these events occur. The vast majority are positive.
- As above, so below (fractals). Example: The patterns in a leaf have the same form as the tree that contains the leaves. "The smallest level of a single organization and the most complex array of the large aggregated system containing the organization are connected inexorably through the power of fractals."
- "At every level of the organization there exists a self-organizing capacity and this capacity maintains a balance and harmony even in the midst of the most chaotic processes. To the extent the balance and harmony are sustained, the organization's life is advanced. To the extent that they are upset or cannot be articulated, visualized, and acted on at every level of leadership, the organization's actions tend to impede its integrity and effectiveness."
- "No decision, action, or undertaking can occur any place in the organization without ultimately having an impact on every other action, decision, and undertaking."
- Quoted material, except where indicated, from Porter-O'Grady and Malloch, 2011, p. 14.

Source: Porter-O'Grady, T., & Malloch, K. *Quantum Leadership: Advancing Innovation, Transforming Health Care,* 3rd ed. Sudbury, MA: Jones and Bartlett, p. 167.

is changing. It is important to be open to the possibilities. Change happens throughout our lives, although here we focus on healthcare organizations.

The fact that everything is complex, ever changing, and seemingly chaotic can lead us to question what we see. So, when we see something that does not make sense, we must be open to it and think about possibilities. A quantum perspective better explains what is happening and what we might expect to happen. Linear ways of thinking do not capture or explain complexity.

As change happens, healthcare organizations need to continue to adapt (change) to this new environment by *de*constructing health services and changing to newer models of service. For instance, Ackman and associates (2012) found that better information was obtained from nurses who used a trial admission assessment and referral sheet than those who used a nursing history. Clavelle (2012) got better patient services in a small rural hospital in Idaho using a collaborative team effort with physicians expanding advanced practice RN privileges.

Change is not just a one-time event; it is a *journey*.

> It is premature to claim victory or arrival. Every arrival point is also a debarking point. There really is no permanent point of respite from change. Since everything in life is a journey, it is important for the nurse leader to keep an honest perspective. The arrival points are merely points of demarcation, of momentary rest. The wise leader carefully balances the moments of rest and celebration with those of effort and action. Depending upon the demand, the timeframe, and the circumstances, leaders choose the moments of marking success carefully so that they can serve to reenergize when necessary, refresh when possible, and challenge when appropriate. (Porter-O'Grady, 2003, p. 64)

Part of the journey involves the death of what we have gotten used to. At first, we mourn this loss. However, something better is replacing it, so there is hope along with the loss. Death is part of the cycle of life. We cannot avoid it. "Not everything in the universe that thrives will continue to do so. When circumstances change radically, some formerly vigorous systems fail" (Porter-O'Grady & Malloch, 2011, p. 35).

So, change is happening all around us.

A second constant is *compressed time*. Since the earth was formed, time has continued to become more compressed. This was not as noticeable 100 years ago, but we feel it today because it is happening more rapidly than in the past and is gaining momentum. Have you noticed how quickly time is passing? Today what had been measured as 24 hours has been compressed into 18 or 19 hours. Scientific evidence supports your thoughts about not having as much time!

A third constant is that *we are all different and very complex*, like snowflakes and organizations. This is why what works in one workplace does not work in another. This is because the people are different, the environments are different, and so forth. Because we are all different it is not right to superimpose our beliefs on others. Each person must decide what is best for himself or herself. It is important to respect every person for his or her differences. In fact, in an effective team, members celebrate their differences, knowing that these differences make the team more effective.

Imagine how boring this world would be if everyone was exactly like us! Our definitions about the world create different pictures. Think of what we view as "perfect." In actuality, when we want things to be perfect, the problem is that (1) nothing is perfect because it is ever changing, and (2) what is considered perfect to one person is not by another.

When we apply this concept to organizations, no organization is perfect, and what is perfect for one organization probably will not be for the next. It also means that as we make changes and choose strategies, *there is no one best way,* even within the same organization, and no one best way to structure organizations (Clancy, 2007a, p. 535).

A fourth constant is that we live in a *world of duality*—positive and negative, good and evil, male and female, and so on. We cannot control this. Duality complicates the situations we face each day. Our only choice is what we do, how we respond to it, and how we treat others around us. We can react positively or negatively. The choice is ours. *The only choice each of us has in this world is to choose how to respond to our environment*.

Most of us, deep down inside, want harmony and usually make positive choices. "Happy, well rested, and inspired people will perform better work" (Douglas, 2012, pp. 117, 119). However, duality is present. Some people delight in it or, out of frustration, cause chaos and negativity. They have gotten stuck in negativity as the most effective way to respond to the world.

How do we deal with this? Negativity needs to be dealt with by mentoring and counseling. But negativity can bring about good changes. Let's explain. Sometimes in duality, *paradox* is involved. This is where things are *seemingly contradictory*. For instance, data and intuition seem to be opposites. Other examples are as follows:

- We want things to be simple. Yet we experience complexity.
- We want to change something, be a risk taker, and push beyond the limits of our comfort zone. Yet we continue to need status quo for comfort and stability.
- We want to be able to change instantly, try things, improvise, experiment. Yet we want order, neatness, and consistency following procedures for patient safety.

However, in paradoxes, the things that seem contradictory may actually be *complementary at a deeper level*. Let's examine a few instances where this is true:

- **Creativity and tension:** Tension leads to creativity, and creativity causes tension.
- **Difference and similarity:** Difference seen from a great distance appears as an integrated whole.
- **Complexity and simplicity:** Complexity is simply the visible connection between aligned simplicities.
- **Chaos and order:** There is order in all chaos and vice versa.
- **Conflict and peace:** Conflict is necessary to peacemaking, containing in it the elements upon which peace must be built. (Porter-O'Grady & Malloch, 2011, p. 27)

What is harmony at this instant will not remain harmonious because of change. Conflict, a normal element in any environment, helps us to get to *something better,* a ***potential reality***.

> The techniques for finding common ground, for sorting through the various landscapes representing the diversity inherent in each issue, are now required by every leader. [Thus it is important to] get people to come together around issues helping them determine appropriate responses within the context of their own roles. This is a challenge that cannot be met by establishing standardized job procedures or rules. (Porter-O'Grady & Malloch, 2011, p. 28)

It is precisely these opposing concepts that provide us with grist for the mill. When we think *linearly*, these opposing concepts present sources of conflict. However, if we can realize that our responsibility is to rise above the seeming differences and find ways to combine the opposing forces, we can resolve these conflicts to create a better workplace.

New tensions that need resolution always exist. It is like the piece of sand in the oyster that creates friction that eventually results in a perfect pearl. Right now we cannot see the pearl, but it is there, and as we work through the tensions, the pearl manifests. We can choose to remain in our linear world where the pearl will never manifest and we continue to feel the frustrations—or we can build toward a better future.

The fourth paradox, chaos and order, is another constant: *We are attached to order, but chaos happens*. Our linear beliefs can help us as we move through our daily routines (habits); this is stasis. But our habits also get in our way. Our daily routines gradually need to change. Stasis, over time, leads to death if we choose not to change. Enter chaos.

What is chaos? Generally, it is perceived as something unpredictable or random. Chaos happens whether we want it to happen or not. Chaos helps us change—*even when we do not choose to do so*. Our only positive choice is to see chaos as a positive force that gets us out of our habits and brings about a better reality. Of course, in a world of duality, another choice is to view chaos as a force to be dreaded. Someone who chooses a negative way of dealing with the world may cause chaos to disrupt the environment and achieve negative goals.

We do *not* have a choice about whether chaos will occur. *Our only choice is how we respond to chaos*.

However, take heart. Quantum scientists have found that *there is order in the chaos*. When looking at a situation overall across time, *chaos leads us to a better reality*. "Chaos is a class of system behavior that appears random but has underlying structure and is deterministic" (Clancy, 2007b, p. 436).

> Even at the fundamental levels of life, chaos is hard at work. Creatures as small as one cell are constantly undergoing accidental modifications that give them a better chance of thriving. It is a basic requisite of all life to adapt to changing conditions. The demise of the dinosaur is a good example of what happens when living beings fail to adapt. (Porter-O'Grady & Malloch, 2011, p. 27)

The scientific word for chaos happening is *autopoiesis*. This is the process where "living systems continually seek to renew and reinvent themselves, yet maintain their core integrity" (p. 14). Chaos is a renewal process. As chaos happens sometimes we like it and sometimes we do not. As we wonder why chaos is occurring, or why we are changing the way we do something, this is autopoiesis working to renew and reinvent us—to improve!

This concept also applies to organizations. Let's use technology as an example. Gradually, more and more technology has been introduced into our lives—and into the organization. In the last two decades, we changed from not having much technology available to being confronted with technology at every turn. We have truly entered the Information Age. In chaos theory, this process is called *autocatalysis,* where new information enters a system "in small fluctuations that continually grow in strength, interacting with the system and feeding back upon itself" (p. 14). This is what has happened with technology.

These small fluctuations cause disruptions in the workplace. We have not anticipated them. They threaten our reality. They change our roles and the way we do our work. They are going to happen whether we want them to or not. They break down old structures that are not working anymore. For instance, think about the old patriarchal, authoritarian systems in health care. Gradually, this has eroded as patients have gotten more involved in their own care, as the Internet has made information widely available, and as our patients became involved in decisions about what actions to take. Employees have gotten more assertive, and we have begun to recognize that we need each employee doing his or her best to achieve organizational goals. Chaos happened and continues to happen. It is leading us to the realization that everyone in an organization is valuable and is part of a team that can more effectively serve our patients and accomplish the work, if we work together.

Chaos is pulling us (kicking and screaming sometimes!) in a different, better direction. Understanding this process helps us be better administrators. And, if we can share all of this with staff, and be aware of it ourselves, as the little disruptions occur, each person can respond positively, thinking, "Well, this is one of those little disruptions. What should we change?" Encourage everyone to share their perceptions because this can lead to better patient care and a better workplace.

Sometimes we choose a chaotic way of doing something (to help us get out of old habits) *to achieve positive final outcomes*. For instance, in the book, *On the Mend*, the authors created chaos as they worked to improve patient outcomes, save money, and give the patients what they valued (Toussaint & Gerard with Adams, 2010). The chaos created treaded upon some interdisciplinary sacred cows yet achieved better patient outcomes and reimbursement at a lower cost.

When we choose to create chaos—cause disorder—we are choosing to use *dissipative structures*. Here "disorder is the source of order and vice versa to this 'dance' between order and disorder, old form ends and new form begins" (Porter-O'Grady & Malloch, 2011, p. 14). Sometimes we can get things back in order (the old way), and sometimes we cannot and have to create a new way.

Using a sentinel event as an example, the event causes disorder. Then, as we do a root cause analysis, we get back to order, *but hopefully with some small incremental change or changes in the way we go about our work*. We are making progress and are ahead of where we were before the sentinel event happened. *The dance continues back and forth between disorder and new order being established.* Our choice is whether to recognize it and deal with it or continue to let the chaos spread, which will cause greater disorder later.

Amid chaos and change, some things we cannot explain. People react unexpectedly in support of or against a change. This is called a *strange attractor* and it happens when "the activity of a chaotic system composed in interactive feedback between and among its various 'parts' [results in] 'attraction' to the pattern of behavior" (p. 14). It was not expected.

There are more constants in chaos. For instance, we are all *interconnected*. Elsewhere in this text we have discussed the silo problem. The reality is very different. We work with different patients and families, across disciplines, and with other departments and different physicians. All of this is necessary to provide

services for our patients. We are all interconnected, within the organization and within the environment outside the organization. All the people within the system are *interdependent* upon one another.

Connectedness means that we have shared goals. For instance, what is best for the patient? We cooperate. We help each other. We share knowledge with each other. There is an element of shared meaning within the group. We create group synergy in the pursuit of collective goals. We make sacrifices to achieve these goals. Connectedness means that we do not judge. Remember the saying about walking in another's shoes? This is why cultural diversity is so important (Kersey-Matusiak, 2012).

Can you see how *love one another* expands to include everyone and makes this world a better place? It has a ripple effect. In fact, we may only do one small, loving action, but if it is done at just the right moment, it expands. The ripple can span the whole pond.

The same is true of negative stuff—anger, greed, jealousy—all of this goes out to everyone else too. The choice is always up to each of us.

This process happens in the larger community surrounding the organization, and throughout the world. Our actions affect all living things on this earth and beyond. *It is reciprocal*.

Within this interdependent environment another thing happens. Over time, *organizations* (and the communities surrounding them) *become increasingly complex*. As things change within organizations, as organizations compete in the marketplace and meet accreditation and funding guidelines, they change. As one change after another occurs, the complexity increases. Eventually, "man-made systems grow far beyond their benefits" (Clancy, 2008b, p. 510). They create bureaucracies that spawn more errors.

One way to deal with this issue is to evaluate systems in use and simplify them. This is why the *lean* movement in business and manufacturing has gained momentum because it aims to eliminate any practices or processes that fail to create value for the client. In health care, all stakeholders—including physicians and patients (some facilities leave these two out so the changes only create more complexity)—get together to identify what they do in a process and why it is needed. Many items in the process do not seem to accomplish anything, so they are removed. Yet many times these changes do not work because certain things were not considered when making the change. In this case, the new change created more complexity. This is supported by evidence: "Research suggests that such interventions often fail to achieve the proposed efficiencies and in fact often bring about unintended and often negative consequences" (Clancy, 2012, p. 78). This occurs for several reasons.

First, even the process is a complex event that spirals into more complex events. Second, all stakeholders may not have been identified and included in the process. Third, it is most important while changing systems to keep in mind the overall goal—giving the patient what the patient values. And, fourth, workflows also experience unexpected events. Perhaps a more effective example than the lean technique is what is described in *On the Mend* (Toussaint & Gerard with Adams, 2010).

It is easy to go overboard with systems changes and create more problems unintentionally. First, it is difficult to predict future events. Add to this the fact that organizational and community complexity changes daily. Peter Senge (2006) identified 11 laws in *The Fifth Discipline—highly recommended reading*—when he describes "learning disabilities" that occur within organizations that threaten viability and productivity:

1. *Today's problems can come from yesterday's solutions* describes what it is like when one has to deal with a quick-fix solution that was made in the past but did not work in the long run. Quick-fix solutions may seem best at the time but can actually create more problems and may not even fix the original problem. They create more complexity.
2. *The harder you push, the harder the system pushes back* discusses the phenomenon of *compensating feedback*. This occurs when the more personal effort you exert to improve or change matters, the more effort seems to be required. Instead, it is better when a larger group has been involved and has decided to make the change.

3. *Behavior grows better before it grows worse* talks about systems that may make things look better in the short run, only to return in 2 or 3 years to haunt you.
4. *The easy way out usually leads back in* discusses how we often apply familiar solutions to problems. This idea of sticking to what we know best is comforting, but very often the real solution is not obvious and the answer is hiding somewhere in the darkness, so we create more complexity by keeping with the familiar.
5. *The cure can be worse than the disease* is seen when familiar solutions are not only ineffective but sometimes addictive and dangerous. For instance, many organizations become dependent on consultants, instead of training their own staff and solving problems themselves.
6. *Faster is slower* comes from the old story of the tortoise and the hare. Making a change quickly without involving all the players results in many unanticipated problems that could have been avoided with more dialogue between all the players in the first place, and with making a change more incrementally.
7. *Cause and effect are not closely related in time and space* uses the example where there are sagging profits and unemployment in the nation. The "cause," which happened earlier, is that companies have moved beyond our borders seeking cheaper labor.
8. *Small changes can produce big results—but the areas of highest leverage are often the least obvious.* Large changes often have the least effect. How easy it is for people to go back to the status quo after a large change, especially when they were not involved in planning it. Smaller, incremental changes involving many stakeholders are better.
9. *You can have your cake and eat it too—but not at once*. For instance, organizations can improve on processes and achieve better quality (the cake) that in the long run result in lower costs (eat it too).
10. *Dividing an elephant in half does not produce two small elephants* describes how many organizations can see problems within individual departments but do not realize how they interconnect with the "whole" organization.
11. *There is no blame* indicates that the real problem probably involves a complicated group of processes that occurred.

This list shows how important it is to have dialogue with all those involved in the change before implementation.

Quick fixes can easily occur. Clancy (2010, 2011a) gives two quick-fix examples with preventing medication errors and MRSA. When we experience similar situations, we implement quick fixes that actually make things worse because other factors or stakeholders affecting the process were not identified. The quick fixes add to the complexity instead of decreasing it.

"It is rare that a project unfolds in the precise manner it was planned. . . . *Intensely prescriptive plans have a higher likelihood of leading to unexpected outcomes*" (Clancy, 2011b, p. 340). It is better to use a trial-and-error process that tests new ideas in small increments and to throw away the unsuccessful ones while only keeping the ideas that are successful. This method achieves the best result.

Clancy (2010) suggests a *positive deviance (PD) method* as a better way to deal with making improvements in organizations:

> In most organizations there are individuals and groups whose different (deviant) practices or strategies produce better (positive) outcomes than do colleagues who have access to the same resources. The PD process helps members of the community uncover the positive deviants in their midst and identify their successful practices and then, through widespread engagement, amplify and spread these practices. . . . One of the mantras of PD is: "Who else needs to be here?" (p. 152)

The PD process brings about new connections within the organization as those who did something successfully share what they did with others. As a result of the increased communication and collaboration occurring among diverse individuals in different roles and different places, a new self-organizing process is created that results in better outcomes.

In addition, unexpected events occur "that have a significant and disproportionate impact on a system" (Clancy, 2008a, p. 273). These are called *black swans*. In actuality, most black swans are often *positive* improbable events—when we think, This is a *miracle!* However, negative events can happen too. "The death of a patient from a medication error is a black swan, and *the more complex a system is, the more frequently these events occur*" (p. 273). *Black swans occur even when the procedures have been followed to the letter*. It is *so* important to treat the information discovered from a sentinel event (or any outlier) as *valuable* information. We need to pay attention to these outcomes and immediately implement changes based on the results. Usually, several systems processes have caused the error. So, instead of doing a quick fix that increases complexity, we can take actions that decrease complexity. The main issue is to recognize black swans, be adaptable, and make changes accordingly.

As chaos happens we often do not appreciate the complexity involved. Yet there is another concept or constant that helps us understand. Consider the saying, *As above, so below*. For instance, the veining patterns in a leaf have the same format as the tree that contains the leaves. We can look at any leaf on the tree and see the same pattern. Same with holograms. This is the nature of *fractals*. "The smallest level of a single organization and the most complex array of the large aggregated system containing the organization are connected inexorably through the power of fractals" (Porter-O'Grady & Malloch, 2011, p. 13). Fractals occur within our own bodies, within organizations, and throughout the world.

> Fractals have tremendous implications for organizations. From the smallest structural elements to the very complex patterns of behavior existing throughout an organization, the same patterns appear and are played out in precise detail. This fact implies that *at every level of the organization there exists a self-organizing capacity and that this capacity maintains a balance and harmony even in the midst of the most chaotic processes*. To the extent that the balance and harmony are sustained, the organization's life is advanced. To the extent that they are upset or cannot be articulated, visualized, and acted on at every level of leadership, the organization's actions tend to impede its integrity and effectiveness. It is important, therefore, that the leaders of the organization be aware of the continuous and dynamic action of fractals in all organizational behavior and structure so that they can advance the consonance and value of the employees' activities and enhance the organization's ability to fulfill its mission.
>
> ***Perhaps it is even more important for leaders to recognize that, within the context of the fractals' dynamic action, their own actions have cascading and rippling implications in every other part of the organization. In fact, they should understand that no decision, action, or undertaking can occur any place in the organization without ultimately having an impact on every other action, decision, and undertaking. In addition, once they are cognizant of the web of interaction and interdependence that exists in the organization, the leaders will approach deliberation and decision making only with extreme care, caution, and thoroughness.*** (Porter-O'Grady & Malloch, 2011, p. 14)

This concept is so important. Please reread the quote. We must understand how this concept is critical to being an effective administrator and why, if things are broken, it takes time to fix them. The entire contents of this text are interrelated—just as all contents within an organization are interrelated.

Some excellent resources on chaos and complexity include *Resilience: Why Things Bounce Back* (Zolli & Healy, 2012), *On the Edge: Nursing in the Age of Complexity* (Lindberg, Nash, & Lindberg, 2008), *Edgeware: Lessons from Complexity Science for Health Care Leaders* (Zimmerman, Lindberg, & Plsek, 2008),

and *Inviting Everyone: Healing Health Care Through Positive Deviance* (Singhai, Buscell, & Lindberg, 2010). Many of these are sponsored by Plexus Institute (www.plexusinstitute.org). In addition, *Nursing Economic$* has a regular column on managing organizational complexity.

> Organizations—Living Ever-Changing Systems
>
> Our concept of organizations is moving away from the mechanistic creations that flourished in the age of bureaucracy. We now speak in earnest of more fluid, organic structures, of boundaryless and seamless organizations. We are beginning to recognize organizations as whole systems, construing them as "learning organizations" or as "organic" and noticing that people exhibit self-organizing capacity. These are our first journeys that signal a growing appreciation for the changes required in today's organizations. . . . We can forgo the despair created by such common organizational events as change, chaos, information overload, and entrenched behaviors if we recognize that *organizations are living systems, possessing the same capacity to adapt and grow that is common to all life.*
>
> What is it that [rivers] can teach me about organizations? . . . The stream has an impressive ability to adapt, to change the configurations, to let the power shift, to create new structures. But behind this adaptability, making it all happen, is the water's need to flow. Water answers to gravity, to downhill, to the call of ocean. The forms change, but the mission remains clear. Structures emerge, but only as temporary solutions that facilitate rather than interfere. There is none of the rigid reliance . . . in organizations on single forms, on true answers, on past practices. [Rivers] have more than one response to rocks; otherwise, there'd be no Grand Canyon. Or Grand Canyons everywhere. The Colorado River realized there were many ways to find ocean other than by staying broad and expansive. . . .
>
> Organizations lack this kind of faith, faith that they can accomplish their purposes in varied ways and that they do best when they focus on intent and vision, letting forms emerge and disappear. We seem hypnotized by structures, and we build them strong and complex because they must, we believe, hold back the dark forces that threaten to destroy us. . . . [Rivers] have a different relationship with natural forces. With sparkling confidence, they know that their intense yearning for ocean will be fulfilled, that nature creates not only the call, but the answer. (Wheatley, 1999, pp. 15, 17–18)

Where Are We Headed? Determining Purpose

What is a healthcare organization's ocean? Where are we headed? And, the greater question is, How do we get to that ocean? It is important to understand this organizational perspective to survive in the value-based (second-curve) environment.

The ocean is the organization's primary purpose. *Purpose* remains unchanged for years. It needs to be aimed at achieving what patients' value. It may be similar to the purpose of other healthcare organizations. Purpose is similar to quality, where one is always working toward achieving it, but it is never totally accomplished. The purpose statements *do not* give a specific description of the various services (products). Nor do they specifically define the customer.

Purpose helps to give clarity and direction to all in an organization.

> When leaders make their strategic intent abundantly clear—as Wal-Mart's management has in proclaiming its strategy of "low prices, every day"—employees know what to do without requiring myriad further instructions. Achieving that clarity, however, is often far more difficult than managers appreciate. (Useem, 2001, p. 57)

We are mistaken if we believe that our ocean, our primary purpose, is making money. Many healthcare organizations are run by administrators who believe that the bottom line runs the organization, the antithesis to the mission statement above their entrance that defines various values. When we make the bottom

line first, finances plummet, whereas *when purpose is the first priority, with the bottom line in second place, finances are sustained or improved*.

This is not to say that revenue is unimportant. We still need money to operate. The money simply must remain *secondary* to the primary goal. Money is part of the meandering that the stream does while looking for the ocean. If revenues are unavailable from one source or service, they might be available elsewhere. *The primary issue is, Which services does the patient want or need?* Then, we go from there to determine what we do. The research shows this to be true:

> Profitability is a necessary condition for existence and a means to more important ends, but it is not the end in itself. . . . Profit is like oxygen, food, water, and blood for the body; they are not the point of life, but without them, there is no life. (Collins & Porras, 1994, p. 55)

If the CFO, and perhaps most of the executive team, really believes that the bottom line is the ocean, conflict and frustration occur for others in the organization who believe the patient comes first. What is important to workers, *what makes the work worth doing,* are the outcomes achieved—not the bottom line. (Just like being paid is important but not the most important aspect of the work.)

Stewardship

We discussed *as above, so below.* The organization must be considered within its larger community. It is important to consider the facility's obligations to and interactions with the community.

Walter Gast rightly claimed that to be successful in the long term:

> A business has to follow six laws: 1) provide a just return on capital; 2) produce a useful commodity or service; 3) increase the wealth or quality of society; 4) provide productive employment opportunities; 5) help employees find satisfying work; and 6) pay fair wages. (O'Hallaron, 2002, p. 125)

If the community flounders, the organization could be at risk, or vice versa. Just as all departments need to be integrated and working together within an organization, all organizations are better off if they are integrated and working effectively with others in the community, helping the community to better serve its citizens. This is called *stewardship*.

The concept of stewardship is discussed in Magnet Force 10: Community and the Healthcare Organization: "Relationships are established within and among all types of health care organizations and other community organizations, to develop strong partnerships that support improved client outcomes and the health of the communities they serve" (American Nurses Credentialing Center [ANCC], 2013b).

In a discussion of second-wave strategies, the AHA's (2013) first must-do strategy supports community involvement: "Aligning hospitals, physicians, and other providers across the continuum of care" (p. 3). Within the community all need to work together to improve prevention as well as provide a seamless continuum of care.

The Soul and Spirit of the Organization

For organizations, two energies are necessary to navigate the meandering river to the ocean successfully: *soul* and *spirit*. Understanding and believing in the ocean (giving patients what they value—the purpose) is the soul. Spirit comes from doing meaningful work. We feel it very deeply. Spirit is the energy that fuels getting to the ocean. Our relationships with each other reflect soul and spirit. We need to understand and feel these to be successful in the value-based (second-curve) environment. If relationships are not good, chances are we have lost touch with the soul part of our business and the spirit is not strong.

If relationships are collaborative and positive, chances are the soul and spirit are present, alive, and well. Remember this Chinese proverb:

> If there is light in the soul, there will be beauty in the person.
> If there is beauty in the person, there will be harmony in the house.
> If there is harmony in the house, there will be order in the nation.
> If there is order in the nation, there will be peace in the world.

Let's start with defining the importance of the *soul* part—understanding and believing in the purpose. This is where the spirit gets its energy. Collins and Porras (1994) reported an enormous research project that lasted 50 to 100 years with premier companies that are known for excellence and yet have experienced multiple leaders and different product lines through the years. They report:

> A visionary company almost religiously preserves its core ideology—changing it seldom, if ever. Core values in a visionary company form a rock-solid foundation and do not drift with the trends and fashions of the day; in some cases, the core values have remained intact for well over one hundred years. And the basic purpose of a visionary company—its reason for being—can serve as a guiding beacon for centuries, like an enduring star on the horizon. Yet, while keeping their core ideologies tightly fixed, visionary companies display a powerful drive for progress that enables them to change and adapt without compromising their cherished core ideals.
>
> There is no "right" set of core values. . . . Indeed, two companies can have radically different ideologies, yet both be visionary. . . . The crucial variable is not the content of a company's ideology, but how deeply it believes its ideology and how consistently it lives, breathes, and expresses it in all that it does. Visionary companies do not ask, "What should we value?" They ask, "What do we actually value deep down to our toes?" (pp. 8–9)

The *core value,* or belief, is described in a sentence or two that capture the general guiding principle of the organization. It can provide a common cause for people who work in the organization. (It can be useful for nurse managers to identify core values with staff for a unit or department as well.) When sound, *these beliefs provide the backbone of every policy or action people within the organization take*. The core values come first, before goals, policies, or procedures. If a goal, policy, or procedure violates a core value, then it must be changed. Generally, one core value will remain unchanged for many years. An example of a core value is *To treat the patient the way we would want a family member to be treated.*

Examples of core values from other businesses are as follows:

- **Sam Walton's value for Wal-Mart:** "[We put] the customer ahead of everything else. . . . If you're not serving the customer, or supporting the folks who do, then we don't need you."
- **John Young's core value for Hewlett-Packard:** "The HP Way basically means respect and concern for the individual; it says 'Do unto others as you would have them do unto you.' That's really what it's all about." (quoted material p. 74)

The core value must be authentically identified by people in the organization, not copied from some other organization (even though it is possible that a core value for one company is the same as for another). The core value does not have to be unique, but it is imperative that all within an organization support it with words, actions, and goals.

Core values are extremely important. In premier companies, as described in *Built to Last,* ***one becomes an outcast if one does not support the values***:

> A visionary company creates a total environment that envelops employees, bombarding them with a set of signals so consistent and mutually reinforcing that it's virtually impossible to misunderstand the company's ideology and ambitions. . . . Because the visionary companies have such clarity about

> who they are, what they're all about, and what they're trying to achieve, they tend to not have much room for people unwilling or unsuited to their demanding standards, both in terms of performance and congruence. (Collins & Porras, 1994, p. 121)

These companies promote from within, encouraging managers to immerse themselves in the company ideology for several years to make sure they understand what is expected from them, before being promoted.

We are most successful in defining our core values when they go *deeper* than just surface direction. Consider how people accomplish the impossible for a cause.

> Shared values are the primary vehicle through which people experience the highest form of trust in one another and their leader. A clear vision and mission can unify the values of external and internal stakeholders. In a study of 418 project teams, a clearly stated vision and mission was the only factor that predicted collaborative teamwork and success.
>
> The vision and mission can also be a springboard for personal values examination and a means to build a stronger organizational culture with shared values and a collective identity. (MacPhee, 2007, p. 408)

Several authors discuss the importance of core values in rallying staff but stress the difficulties of really living by the core values. For instance, Lencioni (2002a) observes:

> Coming up with strong values—and sticking to them—requires real guts. Indeed, an organization considering a values initiative must first come to terms with the fact that, when properly practiced, values inflict pain. They make some employees feel like outcasts. They limit an organization's strategic and operational freedom and constrain the behavior of its people. They leave executives open to heavy criticism for even minor violations. And they demand constant vigilance. (p. 114)

When the bottom line has the greatest importance, facilities lose the *soul* of the organization. Morale and job satisfaction of staff plunge. As budget cuts occur, workers feel depersonalized and suffer from battle fatigue and survivor guilt (Tuazon, 2008). The problem is that staff do not feel valued, and they will turn around and not treat patients well. Problems spiral because clients coming for care sense that they are not important, that staff do not care. Any organization using this approach cannot survive in the long run.

Shared vision arises from the core values. There continue to be new ways to operationalize the core values in the changing environment.

> With a quantum sensibility, there are new possibilities for how to create order. Organizational behavior is influenced by the invisible. If we attend to the fields we create, if we help them shine clear with coherence, then we can clean up some of the waste of organizational life. . . . In a field view of organizations, we attend first to clarity. We must say what we mean and seek for a much deeper level of integrity in our words and acts than ever before. And then we must make certain that everyone has access to this field, that the information is available everywhere. Vision statements move off the walls and into the corridors, seeking out every employee, every recess in the organization. . . . We need to imagine ourselves as beacon towers of information, standing tall in the integrity of what we say, pulsing out congruent messages everywhere. We need all of us out there, stating, clarifying, reflecting, modeling, filling all of space with the messages we care about. If we do that, a powerful field develops—and with it, the wondrous capacity to organize into coherent, capable form. Let us remember that space is never empty. If it is filled with harmonious voices, a song arises that is strong and potent. If it is filled with conflict, the dissonance drives us away and we don't want to be there. When we pretend that it doesn't matter whether there is harmony, when we believe we don't have to "walk our talk," we lose far more than personal integrity. We lose the partnership of a field-rich space that can help bring order to our lives. (Wheatley, 2006, pp. 56–57)

The *spirit* is the energy that fuels getting to the ocean. Spirit comes from our belief that we are doing meaningful work. It is the "radical loving care" that is given (Chapman, 2004). Work becomes meaningful when we strongly believe in, and are committed to giving, what our patients value. It is the synergy that exists between team members, physicians, suppliers, patients, families, and the community as what the patient values is realized. Spirit is the energy that works to achieve getting to the ocean.

Spirit is enhanced by Magnet Model Component II: Exemplary Professional Practice:

> The true essence of a Magnet organization stems from exemplary professional practice within nursing. This entails a comprehensive understanding of the role of nursing; the application of that role with patients, families, communities, and the interdisciplinary team; and the application of new knowledge and evidence. The goal of this Component is more than the establishment of strong professional practice; it is what that professional practice can achieve. (ANCC, 2013c)

Magnet Force 5 further defines professional models of care:

> There are models of care that give nurses responsibility and authority for the provision of direct patient care. Nurses are accountable for their own practice as well as the coordination of care. The models of care (i.e., primary nursing, case management, family-centered, district, and wholistic) provide for the continuity of care across the continuum. The models take into consideration patients' unique needs and provide skilled nurses and adequate resources to accomplish desired outcomes. (ANCC, 2013b)

Spirit is so important. Evidence supports this:

> As nurses became more involved in testing and implementing changes in care on their units, vitality increased. . . . It is also supported by previous research on magnet hospitals that have demonstrated a relationship between the level of nurse job satisfaction and access to empowering factors in the workplace and the ability to exercise judgment and implement changes related to their work environment. (Upenieks, Needleman, & Soban, 2008, p. 393)

Nurse engagement (spirit) is linked with patient satisfaction (Bacon & Mark, 2009).

Throughout this discussion of spirit, money is not mentioned. A theme we pursue is that *if we do what the patient values, the money will follow*. This discussion follows on that theme. This intrinsic motivator is more important than pay to nurses. First, nurses have to find their work meaningful. Research shows this. Still, we continue to get tripped up believing that paying bonuses, or some other payment scheme, will achieve success with employees. Just like the bottom line, the pay helps but is not the most important factor.

Magnet Force 4: Personnel Policies and Programs states that "salaries and benefits are competitive," but mostly support professional nursing practice:

> Creative and flexible staffing models that support a safe and healthy work environment are used. Personnel policies are created with direct care nurse involvement. Significant opportunities for professional growth exist in administrative and clinical tracks. Personnel policies and programs support professional nursing practice, work/life balance, and the delivery of quality care. (ANCC, 2013b)

Spirit, or motivation, comes from within. There is not a magic wand we can wave to achieve a motivated workforce. Instead, in the right environment, under the right conditions, the opportunity is there for personnel to be motivated about their work. But remember, duality is present, so whether someone is motivated remains that person's choice. Motivation is an intrinsic factor that comes from within.

Trust is an important factor that relates to our spirit. It is important for all in an organization to trust each other. This contributes to more effective teamwork, and getting what the patient values delivered. Trust is important between nurse administrators and finance people who know that the nurse

administrator is being honest about financial issues, and vice versa. Employees trust administrators when administrators have integrity, believe in and live by the core values. Any achievement is possible in a trusting environment. Trust is something to value very highly because it is not lightly given and, once lost, can probably never be regained.

When an organization derails and administrators want to fix the problems, it is important they start with the core values. Can administrators live by the core values and support the core values in all their actions? (Or, if core values have not been identified, can administrators and staff dialogue about—and agree on—core values?) Next, administrators must talk about the core values with all employees. Can everyone support them? If all believe and live by the core values, *their beliefs will provide the energy, or spirit, to achieve success*. If an administrator cannot support the core values in his or her words and actions, that person may need to be dismissed. It takes time and commitment to recover from this change because the trust has been lost. Trust must be earned again, or new administrators will have to prove they can be trusted, before the situation can be turned around.

The *soul* provides meaning for the *spirit* to remain alive and well. It permeates our feelings of belonging and engagement. It is the heart of teamwork and connectedness within an organization. "Courage comes from the French word which means heart. Once our heart is engaged, we operate with passion, and not power, and we can find ways to transform our world together" (Kerfoot, 2002, p. 298).

When soul is there but the spirit is missing, we need to question within ourselves whether we are doing something to cause this problem. Curran (2000) reports that the Gallup organization, after doing 25 years of research on 400 companies with 80,000 managers, concluded that one could measure the strength of the workplace using 12 simple questions. *Spirit* is more likely to be energized when these 12 aspects are present in the workplace:

1. Do I know what is expected of me at work?
2. Do I have the materials and equipment I need to do my work right?
3. At work, do I have the opportunity to do what I do best every day?
4. In the last 7 days, have I received recognition or praise for doing good work?
5. Does my supervisor, or someone at work, care about me as a person?
6. Is there someone at work who encourages my development?
7. At work, do my opinions seem to count?
8. Does the mission/purpose of my company make me feel my job is important?
9. Are my co-workers committed to doing quality work?
10. Do I have a best friend at work?
11. In the last 6 months, has someone talked to me about my progress?
12. This last year, have I had opportunities at work to learn and grow?

> Buckingham and Coffman . . . demonstrated that these 12 questions separate great organizations from average ones. . . . Individuals may join organizations, but it is their immediate manager who directly influences how long they stay and how productive they are. Employees do not leave organizations, they leave managers. (Curran, 2000, p. 277)

This is really what patient satisfaction is all about. In "Serving Up Uncommon Service," Doucette (2003) points out the difference between quality, the "measurement of outcomes," and service, "a measure of perception of what matters to the patient." "Quality outcomes are a baseline. The one feature that units demonstrating consistently high-ranking customer satisfaction scores share is satisfied employees. The conclusion seems clear: To improve patient satisfaction, improve staff satisfaction" (Doucette, 2003, pp. 26–27).

It is easy to diagnose whether spirit is present. It is reflected in productivity—or the lack of it. You can also see spirit in workers' eyes: Their eyes shine. Or, if lacking, they look overwhelmed and discouraged, even depressed. Employees want to be a part of important work that is accomplished through collective effort. *Soul* and *spirit* are not management techniques. They are available to us through personal commitment to values. They are intangible things surrounding us when we have a healthy workplace. They energize us.

The Nursing Organizations Alliance™ believes that a healthful practice/work environment is supported by the presence of the following elements:

1. ***Collaborative Practice Culture***
   Respectful collegial communication and behavior
   Team orientation
   Presence of trust
   Respect for diversity
2. ***Communication Rich Culture***
   Clear and respectful
   Open and trusting
3. ***A Culture of Accountability***
   Role expectations are clearly defined
   Everyone is accountable
4. ***The Presence of Adequate Numbers of Qualified Nurses***
   Ability to provide quality care to meet client/patient's needs
   Work/home life balance
5. ***The Presence of Expert, Competent, Credible, Visible Leadership***
   Serve as an advocate for nursing practice
   Support shared decision-making
   Allocate resources to support nursing
6. ***Shared Decision-Making at All Levels***
   Nurses participate in system, organizational, and process decisions
   Formal structure exists to support shared decision-making
   Nurses have control over their practice
7. ***The Encouragement of Professional Practice and Continued Growth/Development***
   Continuing education/certification is supported/encouraged
   Participation in professional associations encouraged
   An information-rich environment is supported
8. ***Recognition of the Value of Nursing's Contribution***
   Reward and pay for performance
   Career mobility and expansion
9. ***Recognition by Nurses for Their Meaningful Contribution to Practice***
   These nine elements will be fostered and promoted, as best fits, into the work of individual member organizations of the Alliance

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Nobre (2001) suggests that "*Soul* + *Spirit* + *Resources* + *Leadership* = *Results*. The fruits of spirit are enthusiasm, motivation, and performance" (pp. 287–288).

The key to an effective organization is that *the goals, organizational strategies, policies, and administrators—along with staff—support the purpose and core values.* This gives life to the soul and spirit and helps us to know how to meander along as we head toward the ocean. It varies from organization to organization, from one healthcare worker/administrator to another, and from patient to patient because we are all different.

We provide some possible strategies, processes, or landmarks throughout this chapter, but because each organization is different and serves a different community, there will be differences in the strategies used as well as outcomes achieved. Just as no river is the same, no organization is the same. *There are an infinite number of possibilities of how to more effectively reach our ocean and how to keep the spirit energized. There is no one best way to achieve any of this*.

The Power of Meaningful Work

When we discuss spirit, we need to better define *meaningful work*. Work is meaningful when we give our patients what they value. This is why most of us became nurses. This is the goal in a second-wave healthcare organization.

However, sometimes people get confused about the importance of the work outcome versus the organizational processes. The processes can be in place, yet patient outcomes can be negative. The processes are not the most important thing. Processes only become important, or have value, when they are directed toward specific outcomes. *Outcomes give processes their value*.

This concept can also be applied to work. The work itself is not valuable. It is the *outcome* of the work that makes the work fulfilling. When burnout occurs, it is not the work itself, but the outcomes of the work that have not occurred. Nurses can become burned out when their workplace is understaffed and patient outcomes suffer. *Outcomes not occurring causes burnout, not the work itself.*

This is currently an issue in healthcare organizations. We become focused on the processes, forgetting that the most important issue is a good patient outcome. If our processes do not achieve the outcome, we need to change the processes—*always focusing on the outcome we want to achieve*.

To improve patient outcomes sometimes it is necessary to change care delivery models. These changes can be major and critical to achieving better patient-centered care, better patient and staff outcomes, physician satisfaction, lower costs, and better reimbursement (Cropley, 2012; DiGioia, Bertoty, Lorenz, Rocks, & Greenhouse, 2010; Mellott, Richards, Tonry, Bularzik, & Palmer, 2012; Morjikian, Kimball, & Joynt, 2007; Novak, Dooley, & Clark, 2008; Reineck, 2007; Storey, Linden, & Fisher, 2008; Thompson et al., 2011; Tonges & Ray, 2011).

Vestal (2012) gives one example when she suggests ways to make a quick turnaround. First, it is important for the nurse executive to get an honest, objective assessment of the issues by obtaining *feedback* from a number of sources. Then, based on that feedback, the nurse manager develops a plan to improve along with a timeline in 100-day increments, making sure that key managers, educators, clinical leaders, and mentors all agree with the issues and the plan.

> The plan should be detailed, have timeframes, and establish outcome measurement points and goals. Share the plan widely to make it clear what will be expected throughout the process and how the benefits will accrue to everyone. Ensure the necessary resources are committed. (p. 11)

The nurse executive should be sure that key staff are involved. For instance, if there has been staff turnover, it may be necessary to replace and orient staff as the first part of the plan. Or an expert may be brought in to ensure proper care is given to meet different patient population needs. "Lead the process

with quality and safety as the first focus" (Vestal, 2012, p. 11). Sometimes that is all that is needed. For instance, if staff learn how to better care for a new patient population, their confidence and capability will increase. "Post and constantly review progress and results" (p. 11). It is important, when implementing a change, not to lose interest in it partway through.

> Additionally, it was noted that organizational culture is an essential foundation to the success of the strategy execution. A culture of performance improvement, accountability, and high-performance focus is critical to enhancing the organization's ability to implement strategies successfully. The right culture will enable the transformation to the hospital and care system of the future. (AHA, 2011)

Each person must tweak the processes as he or she perceives the individual nuances in what patients value and need. It is important to keep the outcome in mind and then determine the next action that will best achieve this outcome. This is supported by evidence that stresses the importance of nurse engagement and identifies factors that decrease engagement, such as having too many patients and not enough support services/equipment—these diminish the possibility of nurses achieving the outcome.

In this text, we keep coming back to what the patient values. As we consider care delivery models, it is important to first get the *patient perspective*. DiGioia and associates (2010) suggest shadowing and care flow mapping to be sure we understand in detail what patients and families are actually experiencing. To accomplish this, we can select a care experience and define the beginning and end points. Then, we establish a care experience guiding council. Council members can be anyone who touches patients' care experiences, such as nurses, physicians, therapists, technicians, dietitians, appointment schedulers, parking attendants, and janitors, as well as hospital leaders, purchase and supply chain employees, and financial representatives whom patients may never see. Next, a tool kit that includes patient shadowing, care flow mapping, patient storytelling, and patient surveys is used. This is followed by developing a work group that creates a shared vision of the ideal patient and family care experience. Last, we can identify improvement projects and project teams and implement the changes. In a surgical experience, the authors thought their ideal experience seemed impossible in 2007, and by 2010 they had realized the goal. Viewing a care experience through the eyes of the patient and family resulted in excellent outcomes.

When asked how they make sure best practices are used at the bedside, *staff nurses*

> emphasized the need to begin with building clear understandings as to how best practice actually resonates at the bedside. Moreover, nurses need to clearly establish and make visible a lived philosophy of care that embraces a priority for best practices. (Novak et al., 2008, p. 452)

They suggested the following strategies to achieve this:

1. Develop a clear grassroots understanding of the current state of affairs and degree of readiness for practice changes.
2. Start the dialogue by gauging the degree of staff commitment and soliciting ideas about how to make it happen.
3. Appraise to what extent nurses take ownership and responsibility for continuously updating clinical practices.
4. Solicit focused unit-based ideas for examining care efficiencies and/or effectiveness.
5. Establish performance review recognition and systemwide reward mechanisms for organizing and implementing clinical best practices.
6. Allocate budgetary resources to directly support the development of best practices through equipment and/or clinical nurse leader positions. (Novak et al., 2008, p. 452)

Clinical shift leader influence is important when making practice changes. Clinical shift leaders need to support the practice changes with each staff member and on each shift (Storey et al., 2008).

As new care delivery models are implemented, the *CNO role* is critical. "Executive leadership selects the [larger] change initiatives for the organization. Success is promoted by crafting change initiatives that are realistic, valued, manageable, and locally applicable to employees" (MacPhee, 2007, p. 405). Morjikian and colleagues (2007) completed interviews with CNOs who had successfully implemented changed delivery models. They identified four challenges:

1. The first challenge was the importance of completing a rigorous, formal business planning process for the implementation of the new care delivery model that includes formulation and analysis of key assumptions; strategy; operating plan and tactics; resource requirements; financial plan/analysis identifying costs and benefits as well as revenues and expenses; evaluation/measurement plan (including measurable benefits such as fewer readmissions, lower rates of complications and mortality, lower inpatient costs, patient and physician satisfaction, staff retention); and contingency plans.
2. The second challenge was communication effectiveness, internally (in an interactive way with the care team, the nursing department, physicians, senior executives, and board members) and externally (with other hospitals, the broader nursing profession, relevant professional associations, policy makers, consumers, and other community leaders). This included providing information people needed to know to do their jobs, and providing information in a timely manner so that individuals could make accurate decisions. CNP approachability was important—they could be easily approached, built rapport, put others at ease, and listen. This meant having the patience to hear people out and being able to accurately restate the opinions of others even when the CNP did not agree. They identified a set of core values that were the basis for the change.
3. Resistance to change was the greatest obstacle. Communicating the need for the change and persuading experienced nurses to accept the change were critical. Dealing with this early is important.
4. Communicating expectations around the change process, that it is a journey. (pp. 400-401)

When implementing the change Morjikian and colleagues (2007) found that: (1) Using patient care facilitators was a cornerstone because the new model would change how all clinicians worked together to provide the care. (2) It was important that physicians recognized and valued the facilitators as well as the change. (3) It was important that other stakeholders were involved in the change, such as the executive group as well as other disciplines. (4) Having at least one nursing champion who had credibility and respect across the organization was critical. This person could energize the group (pp. 402–403).

Change fatigue is an issue to be reckoned with when implementing any new procedures and can derail a change. Reineck (2007) identifies six signs of change fatigue:

1. The value and objectives of the change effort are increasingly questioned.
2. Resources become diverted to other strategic initiatives.
3. Impatience with the duration of the change effort.
4. Data and results of the change are shared with hesitation.
5. Key leaders no longer attend status updates about the change project.
6. Change leaders become stressed and often leave. (p. 389)

"Traditional models of change are often linear and, unfortunately, do not account for the circular, chaotic change experienced today" (p. 389). Reineck recommends using six change strategies that are more successful in complex environments.

1. Change through Power—empowering others to build the change
2. Change through Reason—appealing to logic and rationale
3. Change through Reeducation—providing information, knowledge, and skills
4. Structural Approach—altering structures or processes
5. Behavioral Approach—developing new communication and collaboration patterns
6. Technological Approach—harnessing the power of computers and automation (p. 389)

Promoting Clinical Autonomy

Work is meaningful when staff autonomy is promoted. This is a must in a second-wave environment. Ditomassi (2012) identified organizational characteristics that are highly correlated with RN work satisfaction: autonomy, control over practice, and internal work motivation. The ANCC Forces of Magnetism Force 9 is Autonomy:

> Autonomous nursing care is the ability of a nurse to assess and provide nursing actions as appropriate for patient care based on competence, professional expertise and knowledge. The nurse is expected to practice autonomously, consistent with professional standards. Independent judgment is expected within the context of interdisciplinary and multidisciplinary approaches to patient/resident/client care. (ANCC, 2013b)

For nurses to have autonomy they need to be valued. Joseph (2007) recommends specific measurements that can be identified within an organization that portray the impact of nurses on patient and organizational outcomes.

One seminal research study by Kramer and associates (2007) examines "structures, practices, elements in the environment, and interventions that nurses, nurse managers, and physicians identify as promoting staff nurse clinical autonomy" (p. 41).

The first issue they identified revolves around *renegotiation of scope of practice*.

> Doing something that the patient needs right now without an order is not buried under a bushel basket or whispered about in the dark. We openly talk about it and what is the best way to handle the situation and whether that activity should be added to our scope of practice. (p. 44)

It is helpful to discuss this regular meeting of physicians and nurses (some places have designated rapid response teams for this function) (Gibson, 2011). As treatment evidence changes, these groups renegotiate and evaluate, or create, critical pathways or protocols based on best practice evidence. (Note that this can actually impede nurse autonomy when it reflects physician preferences instead of best practices.) "Renegotiating scope of practice enables autonomy by lessening feelings of risk and providing sanctioned power and authority for staff nurses to make decisions in the best interests of patients" (Kramer et al., 2007, p. 44).

The second issue identified in the study was *administrative/departmental sanction,* which was important to both nurses and physicians.

> [Each] hospital had a council structure designed to foster organizational autonomy, that is, formulation, regulation, and standardization of policies and practice across clinical services; guidance and development of educational, recruitment, and retention activities; and design of mechanisms to evaluate practice. Councils vary in goals, but all have one in common that is related to autonomy, that is, the promotion, regulation, and implementation of research and EBP initiatives. (Kramer et al., 2007, p. 44)

This was sanctioned in shared governance councils (discussed later in this chapter), department documents (such as scope of practice, definitions of nursing, or models of professional practice), performance appraisals, and career ladders documents.

A third element the study identified was the importance of a *cohesive, supportive peer group*. Effectiveness of teams and a culture of "helping one another without having to ask" were important to nurses. They trusted each other and worked well together.

A fourth element was *physician trust, respect, and support*. This mutual trust and respect create a synergistic, interdependent alliance based on recognition of each other's competencies. "Trust and support are based on meeting mutual expectations: the nurse will do what needs to be done for the patient; the physician will provide feedback and will cover with an order" (Kramer et al., 2007, p. 45). This is supported by the third point in the Institute of Medicine report *The Future of Nursing: Leading Change, Advancing Health*: "Nurses should be full partners with physicians and others in redesigning U.S. healthcare" (Cadmus, 2011, p. 34).

A fifth element supporting nurse autonomy was *specialization, focus, and mission*. The specialized, focused body of knowledge helped to create autonomy among nurses and physicians. "Focus or mission also promotes a distinct and constant group of nurses and physicians working together where . . . trust earned by some group members is extended to others who are new to the team" (Kramer et al., 2007, p. 46). The unit culture also promotes this.

Not surprisingly, *nurse manager support* was another factor. In the Magnet precepts, control over nursing practice is essential. Nurse managers supported positive clinical autonomy, promoted staff cohesiveness, supported a positive unit culture, and wanted "staff to function autonomously in scheduling, assignments, organizing tasks, and direct patient care" (Kramer et al., 2007, p. 46). The group worked together "to select equipment, review policies/practices, and manage scheduling" (p. 47). In this study, unit culture was identified as being more important than organizational culture. A cultural premise was being dedicated to the patient. Nurse manager support was particularly important with new employees.

Physicians and nurses identified combined, interdisciplinary evidence-based practice activities that promoted autonomy and teamwork. Various educational programs were cited as essential, including certification review sessions.

Lastly, in this study two nurse attributes were important: (1) "that the nurse is experienced, knowledgeable, and smart [learns from experience, and even applies for certification]; and (2) nurses must want, desire, and enjoy autonomous practice and have confidence in their ability to make decisions" (Kramer et al., 2007, p. 48).

Culture

Culture reflects the way people work together, the spirit that moves the organization forward. Weiss (2001) defines an organization's culture as "shared values, beliefs, norms, expectations, and assumptions that bind people and systems" (p. 348). Culture is a pattern of assumptions or behaviors, often implied and not formally recognized, that are indirectly taught to new members as they enter an organization. A strong culture (such as the expectation that all will give 200% effort, or that each staff member helps other staff complete the work when help is needed) has great impact on team members and results in effective teams, goal fulfillment, innovations, and a strategic capacity (Gordon, 2002). In the most effective cultures, self-management can flourish. In this environment, nurses can make critical decisions with minimal supervision. "Nurses are actually self-managing themselves" just as chaos and complexity are self-managing. "Although implicit, each nurse follows a set of social rules or norms that stress the importance

of cooperation. . . . Just provide the right mix of rules (policies and procedures) and let self-management emerge spontaneously" (Clancy, 2009b, p. 106). *This type of positive culture is a necessity in a value-based environment to achieve the second curve.*

> Shared values and group behavior norms are building blocks of corporate culture. . . . [For example,] does the group reward tardiness or positively reinforce timeliness? . . . The organization's culture is learned through the connection between behaviors and their consequences. Changing the culture means changing behaviors. Behaviors must match values. For instance, a hospital that values career progression, quality, and excellence will shift cultures from pay by seniority to pay according to performance and development. (Sherwood, 2003, p. 37)

Within the culture, *rituals* exist—such as always doing things the same way; *unwritten norms* are present—such as having every staff member work every other weekend, or enforcing that everyone works 12-hour shifts; and *beliefs* can influence the culture—such as never talking about the Q word (quiet) because then something will happen. *Myths* or *stories* can also be important. Stories can be a powerful way to describe actions that are sanctioned—either positively or negatively—within the work environment.

A positive culture supports and encourages social interaction, achieves social cohesion, and produces positive workplace morale. Generally, it is accompanied by administrators whose communication is open and honest. The work teams are usually efficient and effective.

> One of the most fundamental predictors of success with patient safety initiatives is the state of the current organizational culture. How open are people to discussing their views on patient safety with their colleagues and the organization? How safe do they feel about speaking out? How serious do they think the organization is about acting on their input? Is there reason for cynicism? (Smetzer & Navarra, 2007, p. 49)

Shared responsibility is another important aspect of culture. Here "caregivers feel accountable not only to assigned patients but also to all patients and outcomes across the unit or institution as a whole" (Berkow, Workman, & Aronson, 2012, p. 167). This is more likely to be achieved when staff are asked for input on organizational goals, specific targets, and solutions. "Likewise, embedding formal opportunities for peer feedback and coaching may result in increased peer-to-peer accountability, with nurses more likely to 'manage' each other and address observed performance shortfalls" (p. 167). Rewards and recognition can take place both informally, and formally in performance evaluations and bonuses when organizational goals are met.

"In contrast, control-oriented cultures, with an emphasis on productivity and cost savings, are likely to be more expensive to organizations" (MacPhee, 2007, pp. 407–408). Blame is also a part of a negative culture.

To assess the culture, Curran (2002) suggests answering the following question:

> Where does your organization [nursing department/unit] spend its time and money? . . . When I see a physician's parking lot, a physician's lounge, and a physician's dining room, I conclude, "this place values physicians." I have never seen a nurse's parking lot or a nurse's dining room. . . . Things like meeting agendas and minutes tell a great deal about values. Most health care "board packets" that I have seen are filled with financial information, and a long list of physician names for credentialing, but there is little about human resources and patient care. (p. 257)

King and Byers (2007) identify different research instruments for measuring organizational culture.

Casida (2008) suggests the Denison Organizational Culture Model. He identifies four organizational traits—mission, adaptability, involvement, and consistency—and links them to organizational effectiveness. *Mission* is actually an effective organizational purpose (the soul part discussed earlier) and provides the direction for goals. Employees internalize and identify with this mission. Evidence shows that this is significant for effective organizations. *Adaptability* "refers to the organization's ability to translate the demands of the business environment into action" (p. 107).

> [*Involvement*] is a characteristic of a "highly involved" culture, in which employee involvement is strongly encouraged and where a sense of ownership and responsibility exists. In such a culture, employees rely on informal, voluntary, and implied control systems rather than on formal, explicit, bureaucratic control systems. Out of this sense of ownership grows a greater commitment to the organization and an increasing capacity for autonomy. Employees tend to be more involved and dedicated to positive organizational outcomes. Managers who solicit input from organizational members increase the quality of the management decisions and heighten members' participation in their implementation because of increased collaboration and leveraging of broader operational knowledge. Thus, this cultural trait focuses on employee participation and empowerment as a response to rapidly changing conditions in the external environment of the organization. Employee satisfaction, commitment, and morale are key aspects of organizations with strong involvement culture. (Casida, 2008, pp. 107–108)
>
> [*Consistency*] defines the values and systems that are the basis of a strong culture. . . . Organizations characterized by consistency tend to create internal systems of governance based on consensual support. Such organizations have highly committed employees, key central values, a distinct method of doing business, a tendency to promote from within, and a clear set of appropriate behaviors. [Their beliefs and values] enable individuals to react in a predictable way to an unpredictable environment by emphasizing a few general, value-based principles upon which actions can be grounded. (Casida, 2008, p. 108)

These four traits enable organizations to achieve a balance between stability and flexibility.

Smetzer and Navarra (2007) choose to measure the following domains to examine patient safety, but these domains are useful for cultural assessment as well:

> **Leadership:** Are board members, executives, managers, and medical staff committed to patient safety?
>
> **Empowerment:** Are frontline caregivers empowered to "stop the line" or otherwise take action to put patient safety first?
>
> **Communication:** Is there an assumption of clinical competence in interactions between every doctor and every nurse? Ancillary staff?
>
> **Commitment:** Is patient safety just the "flavor of the month" or ingrained in your long-term strategic plan?
>
> **Teamwork:** Do care team members act as individual agents or embrace the concept of "we"?
>
> **Transparency:** Does a culture of secrecy prevail or one of transparency, where information is shared openly among clinicians and with patients and families?
>
> **Risk tolerance:** Do individuals engage in at-risk behavior based on habit or pressure, or are they coached to make safe behavioral choices every time once the system-based causes of the at-risk behaviors are resolved?
>
> **Justice/accountability:** Does the organization encourage individual accountability by distinguishing between human error, at-risk behavior, and reckless actions? (p. 50)

Some additional domains may need to be examined for further insights:

> **Learning/mentoring:** Is learning from one another encouraged, and are new staff mentored?
> **Patient-centered involvement:** Are patients and their families treated as part of the care team? Are the risks and benefits of care fully disclosed to patients? Are the decisions about care by an informed patient respected and supported?
> **Resources/staffing:** Patient deaths are associated with fewer nurses. [It is also important] that nurses *perceive* that staffing is adequate. Education and skill level of resources are also factors.
> **Mindfulness:** Is situational awareness always paramount, and is deference given to expertise depending on environment and circumstance?
> **Job design:** Are pains taken to support the needs of caregivers who work in a highly fragmented environment fraught with latent conditions that can undermine [what patients value/safety]?
> **Change:** Are management and staff open to incorporating [best practices]? (p. 50)

The authors suggest that other ways to measure culture include "recent hire and exit interviews, executive rounding, focus groups, staff satisfaction and turnover rate, performance evaluations, and testing of [best practice] knowledge" (Smetzer & Navarra, 2007, p. 51).

An example of an organizational culture in which nursing practice is valued is when nurses have the option to close units to new patients—and physicians and administrators *cannot override this decision*. The most important thing to remember is to model the behavior that one wants to promote. Actions speak louder than words.

> Two factors contribute to a deeply satisfying work culture. The quality of worker engagement at the point of service, the first factor, is similar to the caring concept of presence with the patient, which nurses find deeply satisfying. The second factor is the ability of front-line leaders to move out of supervision to focus on motivating and enabling workers to do their work effectively. These factors are challenged by emphases on efficiency and economics, such that employees often feel depersonalized as an expense item. (Sherwood, 2003, p. 37)

Nurse manager leadership is a key factor in achieving a strong culture. Laschinger and colleagues (2009) cite the importance of unit leadership in creating empowering work environments that increase nurses' commitment to the organization. Thompson and associates (2011) found nurse managers who were higher on leader–member exchange had higher supervisor safety expectations, were more committed to organizational learning and continuous improvement, had better total communication, gave more feedback and communication about errors, and had a nonpunitive response to errors. Warshawski and colleagues (2012) found that interpersonal relationships with the people nurse managers reported to were most predictive of nurse managers' work engagement:

> [Evidence shows that] the driving force behind top performance is an engaged workforce. Engaged employees are energized, dedicated, and motivated to persevere and complete their work. Managers are critical for creating environments fostering employee engagement. Managers must be engaged in their own work to create these stimulating work environments. (p. 423)

In a study with 323 nurse managers, Warshawski and colleagues (2012) found that nurse managers were highly engaged in their work. They felt their work was meaningful. They had access to sufficient job and personal resources to mitigate job demands. These findings support the importance of both supervisor and coworker relationships as key in building work engagement.

The organizational culture is enhanced when nurse executives support and communicate the importance of collaborative interpersonal relationships and mentor nurse managers to achieve this on their units.

> Organizational designs, such as reduced spans of control for nurse managers, promote the development of quality interpersonal relationships with staff nurses by having time to coach and build connections.
>
> Organizational designs may also improve nurse manager relationships with physicians. For example, employing physicians as hospitalists encourages physicians to align their goals with the organization. By creating partnerships of nurse managers and physicians, responsibility for achieving quality patient outcomes can be shared. (Warshawski et al., 2012, pp. 423–424)

The authors suggest that staff, physicians, and nurse administrators are all involved in interviewing potential nurse managers. This achieves support of the new candidate by all involved in the interviews and sends the message to staff and physicians that interdisciplinary teamwork is valued.

"Recognition and rewards need to be based on team performance and achievement of shared goals. . . . Shared rewards for exemplary team performance reinforce team behaviors" (Warshawski et al., 2012, p. 424).

The evidence shows that culture is influenced from the top down. When nurse managers are supported by their supervisors, they become more engaged. Then, the nurse managers can support staff on the unit to become more engaged.

Now let's turn to *negative cultures*. "Culture can kill the best strategic plan" (Curran, 2002, p. 257). Evidence shows negativity is most often caused by

> (1) an excessive workload; (2) concerns about management's ability to lead the company forward successfully; (3) anxiety about the future, particularly longer-term jobs, income, and retirement security; (4) lack of challenge in their work, with boredom intensifying existing frustration about workload; and (5) insufficient recognition for the level of contribution and effort provided, and concerns that pay isn't commensurate with performance. (Huseman, 2009, p. 61)

Bohn (2000, p. 84) warns that if at least three of the following symptoms are present, the organization is in trouble, productivity will suffer, and everyone will burn out rushing from crisis to crisis:

1. There isn't enough time to solve all the problems. (Not enough nurses are present for the current number of patients.)
2. Solutions are incomplete. (As nurses try to deal with everything, they patch the present problem but do not fix it.)
3. Problems recur and cascade. (The same problems come up again or are even worse because they were not dealt with properly in the first place.)
4. Urgency supersedes importance. (There is never any time to examine processes or work on improvements because of all the crises the nurses are dealing with.)
5. Many problems become crises. (Smaller problems flare up to larger ones that may require heroic efforts on the part of the nurses.)
6. Performance drops.

To understand how powerful negativity is, Huseman (2009) observes:

1. We tend to remember failures more vividly than success.
2. We tend to react more strongly to negative stimuli than we do positive.
3. We tend to trust negative information more than we do positive.
4. When we experience joy it is short lived and then we start taking what caused the joy for granted. (pp. 60–61)

In the workplace:

> Negativity is contagious and spreads quickly [like a virus], especially within an organizational culture. . . .[one large study] found that, on average, more than half of workers' current emotion is negative at work and a third is intensely negative. (Huseman, 2009, p. 61)

Negative emotions at work affect productivity, performance, and retention. The problem is that it also spreads to patients and can affect patient outcomes. For instance, Huseman (2009) cites a study where nurses' general mood on certain cardiac care units was "depressed," and the death rate was four times higher than on other similar units.

How can we make the workplace more positive? Studies show that satisfying three strong needs of nurses brings about a positive culture; the needs are as follows: "(1) the need to feel connected to and competent in their work; (2) the need to strengthen/develop their capabilities and build their careers; and (3) the need for recognition" (Huseman, 2009, p. 63). The immediate engaged supervisor is key here. "Having leaders at every level of a hospital adopt a leadership style using praise and recognition is one of the quickest ways to counteract negativity" (p. 63).

Once the causes of negativity are identified, they need to be fixed. For instance, if staffing is inadequate, problems will continue until the administration increases staffing. The nurse administrator may need to emphasize that evidence shows that negative cultures result in higher nurse turnover, more patient safety issues, more potential lawsuits, and less reimbursement. If administrators are using linear thinking, the nurse administrator can supply numbers for all of these points.

Sometimes the issue can be the nurse manager (or higher levels of administrators). Is this person effective in the role? If not, this must be dealt with. The person may need mentoring, or perhaps the person does not like the administrative role and would prefer to do something else. The person may need to be counseled and, if changes do not occur, may need to be terminated or asked to step down from the role. Leadership issues must be fixed before the culture can change.

Once any leadership issues are fixed, correcting the issues on a unit (or in the organization) takes time and consistent, positive leadership by administrators. Often the culture gets worse as the manager begins work to change it because the behaviors are static and employees do not want to change—even though many hate the culture! Having support from the top down and having support of informal leaders really help the nurse manager turn this around.

Within a positive, empowering culture, some individuals do not fit. Sometimes this results from a style difference or is an example of the Pygmalion effect. Moving to another work area with a different supervisor may better suit these individuals. It may be necessary for certain people to leave, if they decide not to support the changes.

If an individual has a negative effect on the culture and needs to be counseled, the best way to counsel is to recognize that it is an individual's personal responsibility to change negative behaviors. Campbell, Fleming, and Grote (1985) published a classic on disciplinary action that *involves the employee in solving the problem*. This includes the use of reminders rather than warnings and actually gives the employee a paid leave day to decide whether (1) to change, specifying how behaviors will change, or (2) to quit and submit his or her resignation. This method of disciplinary action is preferable to action where the supervisor *tells* the employee what to do.

Bates (2003, p. 38) gives five tips for building a credible culture:

- Reward people who communicate openly and build trust in the workplace; counsel those who don't.
- Talk about the values of your organization from the top down and encourage conversation about issues.
- Build your own credibility bank by practicing open communication; if you make a mistake, you will get the benefit of the doubt.

- Encourage questions. Trust thrives on open lines of communication. The people who work for you know it's okay to question a decision or priority.
- Don't assume people know what is expected; be clear about the kind of behavior and communication you expect and find acceptable.

Organizational Design: Shifting to Complexity

Now let's turn to organizational design because it is needed for best outcomes in this value-based environment (the second curve). As we examine design, it is important to shift our linear views to *relational and whole systems thinking* that incorporates complexity and chaos. As previously discussed, the mission and core values are important underpinnings—as long as they support what patients value.

> Organizations are like icebergs. They float above the water with characteristics that are easily visible. Characteristics and events tell the story. Often we make the mistake of reacting to events without considering what is lying below the water line: patterns behind those events and system structures that support those patterns. Patterns tell you what has been happening over time and allow you to predict or anticipate what is likely to occur in the future. Structures, both tangible and intangible, drive those patterns and support those events. Tangible system structures include organizational structures, policies, and procedures. Intangible structures include culture, beliefs, and mental models. (Wolf, 2012, p. 309)

For an organization to be viable, everyone must be flexible and adapt in ways that better achieve patient outcomes. As problems occur, each person must figure out how to change to better achieve what patients value. *Administrators and staff need to work together to achieve this.*

Organizationally, the design needs to be the best way to accomplish this goal. At this point, some terms need clarification. *Structure* in linear language refers to the way an organization delineates jobs and reporting relationships. The arrangement of roles within an organization is portrayed in the organizational chart. Structure is needed to provide a starting place to organize the work, yet it must be ever changing. It is a linear picture that does not capture all the complexity of relationships within the organization as people (regardless of placement on the chart) interact to achieve what the patient values. It also does not capture group effectiveness. Porter-O'Grady and Malloch (2011) warn:

> When any system has too much structure, it begins to support the structure rather than accomplishing its objectives. Unnecessary structure draws resources away from the system's services and interferes with its ability to do its work. Structure drains the energy and creativity out of a system and obstructs relationships and interactions necessary for the system's function. The same holds true for unnecessary management. (pp. 25, 69)

The *design* of an organization describes the process of "setting up" or the "appearance" of the organization. Though the terms *structure* and *design* are closely related, there is a lack of consistency and clarity in the use of these words. Many times these terms are used interchangeably. *Design* goes beyond structure to include the identified work units and how they are interconnected internally and externally. Design reflects the relationships and processes used (the complexity) within an organization.

> The design that best coordinates resources to achieve [patient outcomes] should be contingent on the evolving environment. For example, an organization competing in an externally complex environment must match that complexity internally to remain viable. A complex environment means that there are multiple states the overall system could evolve to. (Clancy, 2007a, p. 535)

Earlier we discussed, *As above, so below*. This also applies to design. Organizational design must match the complexity in the greater community, and individuals in the organization need to match the complexity found in the overall organization. Each worker in an organization must own his/her work processes and take part in bringing about the necessary changes because chaos happens in incremental bits. It takes each person in the organization doing his/her best to give patients what they value and support others to give their best.

> By focusing on different descriptors in portraying how human dynamic systems work and how processes get sustained, we have created a new framework for considering design and function within the workplace and within the entire human community—and for considering what is and is not effective in the workplace and in relationships between people, as well as for looking at issues of accountability, productivity, and value.
>
> For example, no longer is it enough for leaders to assess the functional proficiency of individual workers as a way of determining whether a work process is fully effective and sustainable. Instead, they must also examine whether each worker's competence fits with the competence of the other workers. "*Goodness of fit," not the individual proficiency of any single participant, leads to effectiveness and sustainability*. (Porter-O'Grady & Malloch, 2011, pp. 14–15)

In organizational design, Senge (2006) suggests we create a *learning organization*. He refers to five disciplines that build the learning organization:

1. **Building shared vision:** The practice of unearthing shared "pictures of the future" that foster genuine commitment
2. **Personal mastery:** The skill of continually clarifying and deepening our personal vision
3. **Mental models:** The ability to unearth our internal pictures of the world, to scrutinize them, and to make them open to the influence of others

   Mental models are the beliefs and assumptions that we have about almost everything—the lens through which we view the world. They are usually unconscious and yet have a very powerful effect on our behavior. Often they act as a filter, limiting the information we are able to absorb. . . . The culture of an organization has a strong impact on the mental models of employees. (Wolf, 2012, p. 310)
4. **Team learning:** The capacity to "think together" that is gained by mastering the practice of dialogue and discussion
5. **Systems thinking:** The discipline that integrates the others, fusing them into a coherent body of theory and practice

Senge coined the term *systems thinking*, describing it as a framework for seeing interrelationships. Systems thinking "lies in a shift of mind: seeing interrelationships rather than linear cause and effect and seeing processes of change rather than snapshots" (p. 73). As thinkers we often see things in straight lines, whereas reality is actually made up of circles.[2]

By using systems thinking, we can picture the entire organization and how it functions, not just our own department. It is dynamic (ever changing). How will people across the organization, and even in the community, respond to a change? What outcomes might result if a decision is implemented?

When decisions are made using systems thinking, the decisions are carefully crafted to include dialogue by all who would be affected by a change and incorporate issues they identify. This achieves the best result and avoids possible pitfalls that could actually worsen the situation. Without using systems thinking, it is easy to implement quick-fix solutions that actually generate more problems and result in other unanticipated effects because they did not account for the entire system response to the change. In today's complex organizations, *systems thinking is a necessary administrative competency*.

Understanding systems thinking begins with understanding the concept of feedback. The word *feedback* can be used in many different ways. When we ask for feedback, we are often asking for someone's opinion, encouraging both positive and negative remarks. Systems thinkers use feedback as a broader concept. Senge (2006) describes feedback as any "reciprocal flow of influence," an "axiom that every influence is both cause and effect," and that "nothing is influenced in just one direction" (p. 75). Ongoing dialogue helps us better understand what is going on by providing feedback in this circular process.

In systems thinking, we need to understand feedback issues. According to Senge (2006), there are two types of feedback: reinforcing and balancing. *Reinforcement feedback* (the "engine of growth") occurs in many ways throughout the organization, such as when leaders or team members praise those who have done well (positive) or when low performers are ignored (negative). When feedback is negative, reinforcing processes may become vicious cycles. For example, if a person is interfering with other team members' work and this behavior is allowed to continue, another more positive team member may leave for a healthier work environment.

The second type of feedback in systems thinking is *balancing feedback* (or goal-oriented behavior). This occurs as we encounter limits or boundaries. A classic example is when managers, under budgetary constraints, cut team members to help meet or decrease the budget. In turn, the remaining team members become overworked, and the budget does not improve because of an increase in turnover and required overtime. If the managers had used systems thinking, they would have anticipated this result and would have met the budget constraints in other ways.

Balancing feedback is often difficult to manage because the goals are implicit and go unrecognized. No one realizes that they even exist. One example that Senge uses is the leader who tries relentlessly to decrease burnout among professionals by decreasing work hours and locking offices so that people stop working late. This backfires when professionals start taking work home because the offices are locked. Balancing processes are more difficult to handle than reinforcing processes; we often do not see change occurring because of an actual balancing process.

The issue of responsibility often complicates the concept of feedback. Linear thinkers always search for someone or something to blame, for instance, in regard to patient safety issues. When we become accomplished systems thinkers, we renounce the idea that one individual is responsible and begin to realize that responsibility is shared; it is interconnected.

Everyone in an organization needs to use systems thinking. Work teams are more effective when the entire team can view the organization as a whole. Unfortunately, team members' confidence and responsibility can be undermined by the complexity of a situation. How often do we hear team members and front-line leaders comment, "You can't change the system?" Systems thinking can drastically help to change this helpless feeling.

Senge (2006) lists several qualities that are apparent in most successful change initiatives:

- They are connected with real work goals and processes.
- They are connected with improving performance.
- They involve people who have the power to take action regarding these goals.
- They seek to balance action and reflection, connecting inquiry and experimentation.
- They afford people an increased amount of "white space," opportunities for people to think and reflect without pressure to make decisions.
- They are intended to increase people's capacity, individually and collectively.
- They focus on learning about learning in settings that matter. (p. 43)

Formal Organization

Two forms of organizational structure and design are usually described: formal and informal. The *formal* organization, or "official" structure, is described by the organizational chart. The organizational chart displays the chain of command, or the relationship of authority. The solid lines that connect the boxes show the formal channels of communication and reporting relationships; the dotted lines show an informal reporting relationship. Doesn't this sound linear?

Most often the *organizational chart* has the board and the CEO, or president, at the top of the chart. (Some suggest that this chart should be inverted, with the patient at the top and the president and board at the bottom.) The organizational chart provides clarity and specifies areas of responsibility, which are needed for stability. However, an organizational chart is a very *imperfect* linear picture because it does not capture the relationships (complexity) that exist. Relationships are more important to getting the work accomplished. Therefore, the chart must be taken in context with the actual workings of the organization.

In authoritarian linear structures, the organizational chart is tall, meaning that there are many layers in the hierarchy. This is a centralized model. In this text, we advocate a decentralized organizational model, which works much better because everyone is interconnected and communication occurs throughout the organization. In decentralized models,

> Organizational structures are generally flat, rather than tall, and decentralized decision-making prevails. The organizational structure is dynamic and responsive to change. Strong nursing representation is evident in the organizational committee structure. Executive-level nursing leaders serve at the executive level of the organization. The Chief Nursing Officer typically reports directly to the Chief Executive Officer. The organization has a functioning and productive system of shared decision-making. (ANCC, 2013b)

This is the second Force of Magnetism.

The formal structure also includes the regularly scheduled meetings that take place within the organization. Hopefully, these meetings aid those in the organization to function more effectively. However, there is great divergence in actual meeting effectiveness. Some organizations have so many meetings the administrators cannot get their work done or do not do regular rounds! Often the meetings have a more linear focus. In a complex environment, better information can actually be obtained from rounds (discussed later in this chapter).

In nursing, staff are generally expected to attend and participate in certain meetings. The problem becomes finding a way to relieve staff of patient care responsibilities long enough to attend and participate in meetings. In an authoritarian environment, meetings might not be considered as important, and other issues might easily interfere with staff being able to attend these meetings. Meetings are linear, just giving information.

In a participative, value-based environment, release times for meetings have more importance because administrators realize the complex nature of important functions and the need for transparency. A shared governance model encourages everyone to deal with issues that staff face every day. Meetings, when functioning well, more than pay for the release time needed.

Informal Organization

> In every organization there is a formal structure and process and an informal network. This network is primarily relational and carries most of the information about how people in the organization think or feel and what their sentiments are regarding almost anything in the system. It is as vital and valid a part of the system as any other, and it requires attention because, among other things, it

> typically contains essential pieces of the dynamic that have been overlooked or missed as well as the "undiscussables," and opinions that do not reflect the prevailing point of view. Embedded here too are some of the most dynamic notions of what should happen or what should be done.
>
> All elements of the system, whether formal or informal, are a part of the dynamic of change in the organization. Each can be a vehicle for action and even transformation. Leaders need to pay notice to all the informal pathways and networks of communication and relationship, from hallway conversations to lunchtime discussions, from whispered comments to sarcastic asides—each plays a role in the complex web of interactions necessary for sustaining the organization. Taking an opportunity to hear, communicate, or join with the others, contributes to discovering the state of the organization and determining the proper actions to take to strengthen it. (Porter-O'Grady & Malloch, 2011, pp. 28–29)

The informal organization reflects all the interpersonal relationships among people that are not reflected on the organizational chart but that affect operations. For instance, a nurse manager may value the unit secretary's informal leadership, which might really enhance the nurse manager's effectiveness and help the unit to function much more efficiently. If the nurse manager chooses to ignore or suppress this person's leadership capabilities, unnecessary conflicts can result, patient care may suffer, and the dysfunctional situation spirals downward from there.

When there are flaws or inefficiencies in the administrative leadership, such as when a nurse administrator is secretive or does not share information, the informal information network runs rampant. When most information is shared (transparency) and nurses trust administrators, the informal network becomes relatively inactive.

In the informal organizational structure, free-flowing communication is known as "the grapevine." This type of communication reaches every corner and level of the organization, introducing complexity. When team members do not receive credible information from administrators, the grapevine takes over. Generally, information spread through the grapevine is about 75% correct. Leadership can use the grapevine to gauge employee responses by allowing new ideas and policies to be spread through the grapevine. Although it is critical for nurses to learn formal channels of communication, the informal communication networks cannot be ignored.

Increased Communication in a Value-Based Environment

In the past, three common types of communication patterns prevailed in a formal organization: downward, upward, and lateral. Presently, we realize there is another communication pattern that is most effective: It is *circular and messy*—the most appropriate kind of communication in a value-based environment. People at all levels talk with one another. They talk with those within and those who touch the organization. For instance, we have open-door policies that break the rigid barriers of the protected office with a secretary out front to prevent others from reaching the administrator, and we do regular rounds (discussed later in this chapter).

This circular communication pattern is messy because it opens up the realization that we may have misperceptions about a situation (in an authoritarian system we were not aware of this). It *changes our judgmental attitude to one of curiosity*. At the same time, it *creates synergy and belonging.*

This brings about another change in the value-based environment—we need to *increase* the information flow within the organization. Studies in the field of social network theory demonstrate that *by increasing the number of communication links among individuals, an organization can generate more solutions to environmental threats* (Clancy, 2007a, p. 535). Communication among all stakeholders (including physicians and patients) is paramount.

Ideally, there is *transparency*. "Transparency is about being open about what you do and how you do it" (Scalise, 2006, p. 35). This not only takes place within the organization but also in the greater community. For instance, quality, charity care, and/or financial data can be shared openly with others. Many states have passed transparency laws requiring healthcare organizations to report sentinel events, nurse staffing levels, and/or hospital charges/payment rates. Obviously, risks are involved. Sometimes administrators fear that other similar entities will look better, or that competitors will exploit their weaknesses. Physicians may fear that published mortality rates will give them a bad reputation. But secrets have a way of eventually becoming public knowledge. All of this is chaos and complexity at work.

In today's explosion of information technology, communication has become even more complex. Misunderstandings, misreadings, and unclear or selective hearing all play into faulty communication exchanges within an organization.

> The most powerful way to make a significant change is to convene a conversation. But we know that often that is the most difficult thing to do. It is easier to talk about the person than to the person, but no progress is made toward solving a particular problem or learning about new ways to interact to make a real change.
>
> A sign of professional maturity is a person's capacity and appreciation for conversation. Our world and our organization's world would be in a much more peaceful state if the capacity for conversation between the parts were more mature.
>
> The art and science of focused conversation [is] . . . a collaborative dialogue of discovery where you invite others to share differing views and you test your thinking and understanding in the context of this dialogue so you can hear in a different manner . . . trusting the wisdom of the person or group and believing that this is the right person or group to solve the problem. . . . The leader will only succeed if he/she truly believes in the group's wisdom and does not come armed with solutions. . . .
>
> We must be open to seeing the issues in a much more messy context than our little world of making judgments has allowed us. When you open yourself to a conversation among equals, you open yourself to the necessity of questioning your positions and the "truths" from which you operate. The only way to enter a productive conversation is to give yourself permission and willingness to be disturbed. . . . Real conversations change you and the people/groups you are talking to. That is the whole point: to make new relationships and synergies out of old dysfunctional patterns of parts interacting with each other. To have a conversation, you must allow for messiness and for being disturbed and confused as a way to make new growth.
>
> The only way to improve the world is through relationships, and conversations are the prelude to creating that change. (Kerfoot, 2002, pp. 298–299)

Pilette (2006) cites a study where *60% of U.S. hospital deaths each year can be attributed to poor, faulty, or absent communication*. "Participants acknowledged their inability to structure and handle the conversation as the most frequent reason for not addressing faulty behaviors" (p. 26). Honesty is important here, but the first issue is that people may not realize that they are not communicating appropriately. She recommends doing a 360-degree evaluation or having an executive coach. This provides feedback for each administrator.

> Some experts believe that we're frequently defending against fears or concerns about our own significance, competence, and likability. They further distinguish that we're not defending ourselves from other people, but from painful feelings inside us that we don't want to experience. For example, if we feel we're not competent, we may be very critical of others, try to shame them, use sarcasm to berate them, treat them with indifference, or bully them.
>
> Now the good news. With genuine introspection, defensiveness is advantageous as "an early internal warning system," which can be used to consciously shift us out of a conflict-generating posture to

> one of relationship building. Knowing our trigger points for defensiveness makes it easier to recognize similarities in another's response, thereby affording us an opportunity to step out of an emotional discussion and rebuild safety into the conversation. (Pilette, 2006, pp. 26–27)

Faulty communication on the part of administrators is only part of the problem.

> The communication skills of the physician, nurse, and hospital staff topped the list as the most critical to positive patient satisfaction scores. Physicians are charged with not taking the time to really listen to patients. Meetings with physicians are usually hurried and impersonal. The patient isn't included in the care decisions about his or her health and lacks the knowledge on how to proceed with treatment options and medication regimens. Poor communication with patients can result in dangerous situations, noncompliant patients with prescribed treatment regimens, negative outcomes, and patient dissatisfaction. (Squires, 2012, p. 28)

Ajeigbe and associates (2013) found that when a teamwork intervention was completed with nurses and physicians in EDs, it enhanced autonomy and control over practice for both nurses and physicians. Participants felt it was a more positive work environment.

Nurses can help the faulty communication issue by treating the patient with respect, listening to the patient, paying attention to nonverbal clues, explaining what the physician wants, giving the patient helpful suggestions in discharge information, as well as managing pain and protecting the safety of the patient.

> Physicians and nurses communicate with patients differently. Physicians usually speak to patients from a medical point of view using technical terms. . . . Nurses explain how behavior patterns determine health conditions and the importance of taking responsibility to improve health status. (Porter-O'Grady & Malloch, 2011, p. 28)

Physician communication can cause other issues. Physicians sometimes exhibit abusive behavior toward nurses.

> Doctors commonly get frustrated when nurses present information differently than they would or provide more detail than they believe necessary. Nurses get frustrated when doctors seem uninterested in information nurses deem essential to their patients' health and well-being. Of course, these differences in communication styles don't justify disruptive outbursts—but understanding them can help nurses and doctors avoid them.
>
> Power dynamics within healthcare organizations may contribute too. Even as nurses are poised to take on a greater role as health care turns to a more team-based care model, physicians still cling to traditional positions and roles. Also, physicians remain central to revenue models, perpetuating traditional hierarchies. And while the problem of nursing shortages waxes and wanes, universal agreement exists that physicians are in short supply and will be for decades to come.
>
> For most nurses, the first step in addressing disruptive physician behavior is internal. It starts with an absolute belief that nobody deserves to be yelled at for making or witnessing a mistake, much less while doing their job correctly and competently. . . .The best approach is to be assertive and confront the physician directly at the time of the occurrence. How this is done marks the difference between a healthy workplace culture and a toxic one. (Gessler, Rosenstein, & Ferron, 2012, p. 9)

When inappropriate physician behavior is not dealt with by administrators and by the medical staff it results in negative patient outcomes, errors, and adverse events. This behavior also causes nurses to leave positions (Squires, 2012). Education can help nurses and administrators better deal with this issue and can help physicians to learn how to deal with conflict more appropriately (Casanova et al., 2007; Crawford, Omery, & Seago, 2012; Rosenthal, 2013; Squires, 2012).

Many issues contribute to this communication problem—variance in knowledge, differing educational perspectives, stereotypes, language/cultural issues, and organizational culture issues (Crawford et al., 2012). Both physicians and nursing professionals work in a stressful environment with frequent interruptions. Physicians value rounding, whereas nurses do not always believe they have the time. Some physicians continue to think that nurses' main function is to follow MD orders. Both types of professionals are pressed for time. When nurses ask for clarification of orders, physicians can perceive this as "undermining their authority." Another challenge is "coordination between multiple patients with multiple physicians" (Casanova et al., 2007, p. 69). Lastly, some are still caught up in the doctor–nurse game involving "passive communication structures and male–female autonomy issues." The rules of this game:

> Nurses are required to be bold, take initiative, and make significant recommendations while appearing to be passive and submissive. Properly done, the recommendations appear physician-initiated. In return, physicians request a recommendation from nurses without appearing to ask for it. The avoidance of open disagreement is a key game feature. Mutual dialogue must be established in order to achieve interdisciplinary collaboration and overcome this cumbersome milieu. (Crawford et al., 2012, p. 549)

In an integrated review of the evidence on nurse–physician communication, Crawford and associates (2012) suggest the following evidence-based recommendations for both physicians and nurses:

- Respectfully greet each other and introduce new staff members to other care providers.
- Establish a nonhierarchical and collaborative communication structure emphasizing respect, openness, active listening, and a free flow of patient-centered information.
- Use a structured tool to focus communication on patient care needs.
- Increase opportunities for sharing about the differences between the work of the nurse and the physician, using that knowledge to create a collaborative common ground meeting patient needs.
- Encourage active participation among the team involving all disciplines in programs such as multidisciplinary rounds or care conferences.
- Nurses should be timely and prepared with accurate and relevant patient information when communicating with physicians and other team members. Succinct communication needs to be refined. This is particularly relevant when communicating condition changes and patient care needs over the phone.
- Establish specific procedures to eliminate unnecessary telephone calls, such as bundling redundant phone calls and the development of clinical algorithms when appropriate.
- Implement effective strategies that support chain-of-command procedures and enforcement of disruptive behavior policies.

Manojlovich and Antonakos (2008) found that "openness, understanding, and accuracy of communication are important communication satisfiers for nurses" (p. 241).

Pilette (2006) suggests that we can help ourselves if we learn to dissect a conversation into *content*, *pattern*, and *relationship*. It is relatively easy to recognize *content*. This is the subject of the conversation (problem, event, person, or idea). *Patterns* reflect "habits, which affect *relationship* predictability. Good habits foster dependability and reliability, while a string of bad habits erode interpersonal trust" (p. 27). To determine if habits are good or need improving, consider the consequences of the conversation. Is that what you really wanted or intended?

If the subject is the issue, Pillette (2006) advocates using a *Ladder of Inference*:

1. Observe "data" (information, evidence, etc.).
2. Select specific data from what you've observed.
3. Add meaning to the data from a personal and cultural perspective.
4. Make assumptions based on the meaning.
5. Draw conclusions based on assumptions.
6. Adopt beliefs based on conclusions.
7. Take action based on conclusions. (p. 27)

Using this model, think about these in the order given. If someone says something that we think is inappropriate or harmful, instead of emotionally reacting to this (because we are drawing conclusions about how bad this is), we can take a breather, if necessary, and then go through the seven steps. We can ask for clarification (What are the assumptions you used to determine this?). Then, we use active listening with the goal of understanding the other person's perspective. The same process can be used with problematic patterns: What are the consequences of the actions? Is this what we intended and really wanted?

Communication is also complex because of gender differences and the ways men and women do work. Rutan (2003) reports that female nurse managers discuss "domestic, family, personal, and social issues before the meetings" and sometimes these issues are interwoven in meeting discussions, whereas male leaders stick to business and work-related subjects. On the other hand, male leaders discussed meeting agenda items before the meeting in various locations, and, in one example, once a meeting started,

> The male [leader] acted as a coach in charge of a team, with the other males helping him carry out the play. Female team members were never part of this "meeting before the meeting." . . . [During the meeting] the male participants communicated more actively, asking more questions, contributing information and data, and making frequent recommendations and suggestions. Males avoided both eye contact and exchanging personal thoughts and feelings. They were interested in getting to the point of issues by being assertive, dominant, competitive, independent, and aggressive. (p. 184)

Females often do not understand this dynamic and, instead, would bring ideas up in the meeting:

> Women see the leader's competence, respect, and fairness as significantly more important to team effectiveness than men do. Women see the team members' knowledge of their jobs as significantly more important to team effectiveness than men do. Women see the team members' liking, trusting, and helping each other as significantly more important to team effectiveness than men do. (p. 184)

A nurse manager is more effective if he or she understands these differences. For women, it is important not only to be attentive to nurturing and socializing roles but to be task oriented with well-developed business and financial skills. For men, it is important to incorporate more of the interpersonal skills and be open to changes occurring during the meeting. Rutan (2003) suggests that the following learning needs to take place:

> Females must understand that males do not share personal experiences primarily because they do not want to appear vulnerable. Nurse leaders should . . . devote time prior to a formal meeting for idea generation, problem solving, and information sharing, just as the . . . male administrators . . . need to concentrate on being more open to new ideas as they are proposed or be prepared to present ideas and work out solutions while team meetings are in session. (p. 185)

Staff development activities that identify gender differences and encourage everyone (regardless of gender) to understand and use the positive aspects of both perspectives go a long way to achieve better teamwork. We recommend the Pat Heim tapes (1996) as a helpful tool to accomplish this goal.

Some organizations have used *scripting*, where people say prescribed words in certain situations. This can be helpful for employees. Be aware that if the underlying emotion is negative, actions speak louder than words, and in such cases, the scripted response is not effective. A second issue is that workers can resent having to use scripting, and the resentment builds.

Collaboration: The Key to the Future

Collaboration is the glue that holds together the relationships, the teamwork, and the communication among everyone involved in the organization. It incrementally increases horizontal, messy communication. It is presented as a separate category here in this chapter, but in reality it is interwoven with teamwork, giving care the patient values, meeting reimbursement requirements, and so forth. The better the glue, the more effective the organization in this value-based environment.

This is magic, dynamic glue. It is not permanently adhesive, but, when needed, it is removable. The bond is strong, yet ever changing. The bond forms between people who know and trust each other. Magic happens within a messy process when people work effectively together. Everyone respects each other, communicates with one another, and works together in ways that will best serve patients. Evidence shows that everyone, including the patients (residents, clients), staff, and physicians, fares better when collaboration is present. Laschinger and Smith (2013) found that as much as *70% of adverse events occur because of a lack of communication and collaboration among healthcare team members*.

> Collaboration focuses on trying to reach agreement among divergent opinions to accomplish mutual goals. Weiss suggests that the conflicts between nurses and physicians are due to the overlapping nature of their domains and the lack of clarification between their roles. Adding to the difficulty of achieving agreement, doctors and nurses use different methods of conflict resolution. When resolving differences, physicians tend to bargain or negotiate while nurses avoid, accommodate, or compete.
>
> Collaboration . . . involves a high level of concern for others (cooperativeness), as well as a high concern for self (assertiveness). . . . Dechairo . . . found that self-confidence was a predictor of nurse case manager satisfaction with nurse/physician collaboration.
>
> The Thomas and Kilman model of conflict resolution is one of problem solving, and it is useful in complex situations where parties have common interests and the stakes are high. Inherent in this model is the assumption that conflict resolution [and mediation tools] can be taught and that effective collaboration will be the outcome. Using this model, willing participants can overcome the handicaps of a history of competition and style of avoidance or dominance. (Dechairo-Marino, Jordan-Marsh, Traiger, & Saulo, 2001, p. 225)

Sometimes collaboration does not happen even though it would have been a better approach. For instance, some use *competition,* thinking it is all important to win, regardless of the cost. Eventually, everyone loses in this situation, even the person who wins. Another approach that is not as effective is *compromise*, where each person gives up something but agrees on the best alternative. Even worse, one could *accommodate,* where one concedes to others, letting them get their way. The most ineffective approach is to *avoid situations* and not take any action.

Collaboration is most effective. When individuals collaborate, they work together to come up with a mutually acceptable solution. Although this takes more time, no one loses. This results in higher nurse satisfaction and better patient outcomes (Houser, Ricker, ErkenBrack, Stroup, & Handberry, 2012).

Collegiality, or collaboration between nurses and physicians, when effective, affects patient outcomes. Kramer and Schmalenberg (2003) cite lower mortality rates in intensive care units when collaboration

is achieved. In their research, they came up with a five-category scale describing nurse–physician relationships:

> **Category 1: Collegial.** Described as excellent, the essential ingredient in these relationships is equality based on "different but equal" power and knowledge.
> **Category 2: Collaborative.** In these "good" or "great" relationships, staff work together very well. Nurses describe mutuality but not equality of power.
> **Category 3: Student–Teacher.** Physicians are willing to discuss, explain, and teach. Power is unequal, but outcomes are beneficial. Either nurse or physician acts as the teacher.
> **Category 4: Neutral.** A near absence of feeling marks this relationship. Often, there's only information exchange. But physicians frequently fail to acknowledge receiving the information, which leaves the nurses feeling they aren't contributing much.
> **Category 5: Negative.** Frustration, hostility, and resignation characterize this relationship. Power is unequal and outcomes are negative because of their reactions to power plays. (pp. 36–37)

From this research, they suggest it is important to plant and nurture the "equal but different" seed: Create a culture that values, expects, and rewards collegial nurse–physician relationships and fosters, supports, and encourages education programs of all types (so that all stay clinically competent). This collegiality improves with ongoing relationships over time.

The Magnet approach supports this equal but different seed. Forces of Magnetism Force 13: Interdisciplinary Relationships states:

> Collaborative working relationships within and among the disciplines are valued. Mutual respect is based on the premise that all members of the health care team make essential and meaningful contributions in the achievement of clinical outcomes. Conflict management strategies are in place and are used effectively, when indicated. (ANCC, 2013b)

Magnet Force 12: Image of Nursing discusses the importance of respect for nurses:

> The services provided by nurses are characterized as essential by other members of the health care team. Nurses are viewed as integral to the health care organization's ability to provide patient care. Nursing effectively influences system-wide processes. (ANCC, 2013b)

Collaboration is a competency (Hill, 2006). When we have a competent organization, collaboration occurs everywhere—millions of times—as work gets done. It is messy. It is something that each person in the organization understands and works to achieve.

> Collaboration among disciplines, particularly among medical staff members, is one of the most challenging and often daunting tasks for the nurse leader. In today's pay-for-performance environment, collaboration between disciplines, particularly medicine, nursing, nutrition services, respiratory, radiology, and pharmacy, is essential to produce top-tier performance and, thus, optimal patient outcomes. (Hill, 2006, p. 390).

Collaboration occurs when we realize that we need to be true to ourselves and to others equally. Conflicts arise because we do not recognize that another person's perspective is different from ours. Neither perspective is wrong—each is just different from the other. Fisher and associates (1991) found that it is best to "separate the people from the problem; focus on interests, not positions; generate a variety of possibilities before deciding what to do; and insist that the result be based on some objective standard" (p. 11). It is always best to base this on giving the patient what is valued.

A must-read book, *Peace and Power: New Directions for Building Community,* by Chinn (2013), provides ways to facilitate collaboration.

> When your group uses Peace and Power to its fullest extent, you do not have a structure of elected officers in the same way that many groups do. Instead, leaders emerge based on the needs of the group at any one time, and needs and leaders can shift at any time.
>
> For example, group meetings are led by a convener, and the responsibility to convene a meeting shifts in a rotation that is agreed upon by the group. The more the group values everyone learning to be a leader, the more often they will rotate convening to make sure that every member of the group gains this important skill.
>
> When a task requires specific knowledge, people in the group who have the knowledge or experience to do the task assume responsibility for it initially, but they gradually orient others to the task so that others can learn and assume the responsibility. . . . [This includes finances.]
>
> When your group needs to make a decision, you can take "straw votes" to get a sense of the whole, but your decisions are made using a process of value-based decision making. This is similar to what is commonly understood as "consensus," but differs dramatically in that rather than getting everyone to agree, you make sure that everyone appreciates why one option is better than others. And most important, this process ensures that everyone is able to fully support the decision of the group even if it is not their personal preference. (p. 44)

Chinn's approach to collaboration supports the quantum view of complexity and chaos. We are all interconnected, and we all have responsibility to work together effectively so we can best give the patient what the patient values. This results in, and continues to result in, a positive environment as well as positive outcomes. Conflict happens. Diversity is present. The environment is chaotic and complex. As collaboration transpires, the ultimate value question is, *What does the patient value and need*? Members of the group *may not agree with the patient's decisions*, yet these decisions *are the all-important basis and goal* of interdisciplinary groups involved in the collaborative process.

> Peace and Power decision-building focuses on the quality of the process that you use to get there, and in the end ensures the best possible decision that everyone understands. It also ensures that what you do is the same as what you value.
>
> Peace and Power decision-building combines individual preferences (as in voting), hearing all points of view (as in consensus), and brainstorming all possibilities (as in creative problem solving). In addition, Peace and Power decision-building incorporates processes of values clarification, conflict mediation, and critical thinking.
>
> Peace and Power decision-building is always grounded in your group's purpose [what the patient values], and is built consciously to be consistent with the group's values—your principles of solidarity. At the same time, decision-making processes contribute to clarifying and revising your group's purposes and your principles of solidarity.
>
> A common concern when you first consider Peace and Power decision-building is that the process will be time consuming and inefficient. It sometimes does take more time to reach a decision using Peace and Power decision-building. However, groups that shift to this approach almost never have to retrace their decision, nor do they have to spend time later making sure that everyone is on the same page. It is not possible to determine the time and effort saved when everyone understands and supports the decision while you are making the decision. But to take shortcuts in building a decision is a sure setup for wasted time and frustration later. The overall benefits of cohesiveness, acting in accord rather than at cross-purposes, and mutual understanding more than compensate for the time invested in reaching a decision using Peace and Power. (Chinn, 2013, p. 70)

The Peace and Power approach to making decisions can be found in **Exhibit 3–2**. This may seem very simple, but it captures the complexity and keeps everyone interconnected at the same time. The first step, *Define the Question*, also seems simple. Yet, does everyone truly know what the patient values—not what we *think* the patient values, but what he or she actually wants? This means that we have to involve the patient and the family in this process and get their perspective(s). We have to *listen* and actually hear what is important to them. It often is not what we think but instead is their perspective(s). It can be complicated in that the family may want something different from what the patient wants, so, in such cases, the patient may need some support in dealing with the family.

The second step, *Identify Your Key Principles of Solidarity*, also can seem deceptively simple. The group needs to first identify the basic value(s) they will work by, and support those values. "*Principles of solidarity* express the values and ideals that everyone in the group shares. They form your common ground that you intend to remain constant regardless of whatever happens in the group" (Chinn, 2013, p. 31). After finding what the patient values, it is important to think about resources that will be necessary to supply this. "The group may come to realize that they need to stretch the limits of what might be possible beyond the constraints of the budget as they now see it in order to achieve certain goals that they also value highly" (p. 72). But it always comes back to the basic value(s) identified, and agreed upon, by the group.

The third step, *List the Benefits You Seek*, "describe[s] the benefits that your group envisions for any decision that arises from this process" (Chinn, 2013, p. 72). However, the benefits need to support the underlying value(s).

> In typical decision-making, people who favor a certain decision use benefits that can come from the decision they prefer as a way to convince the group to go along with what they want. When you use Peace and Power, you identify the benefits you want from any decision *in advance* of considering possible options. Then when you know what the options are, you compare how each one measures in bringing the benefits your group seeks. (p. 73)

The fourth step, *Brainstorm the Options*, then follows. Here, everyone thinks of as many options as possible. The sky is the limit. Even when something seems impossible or ludicrous, it is brought to the table and listed as an option.

In the fifth step, *Gather Information You Need and Compare the Options*, the group revisits each option and gathers as much information as possible about it. A group member may have the expertise needed in a specific area, or the group may need to go to someone else for consultation and expertise. Gathering information can involve going into the community to find knowledge.

Exhibit 3–2 Approach to Making Decisions

1. ***Define the Question***
2. ***Identify Your Key Principles of Solidarity***
3. ***List the Benefits You Seek***
4. ***Brainstorm the Options***
5. ***Gather Information You Need and Compare the Options***
6. ***Make Your Decision***

Source: Data from Chinn, P. (2013). *Peace and Power: New Directions for Building Community,* 8th ed. Burlington, MA: Jones & Bartlett Learning.

> If at any time the group wants to know how many people prefer one option over others, pause to take a straw vote that gives everyone information about where people stand on the issue at this point in time. Votes are not taken to decide an issue, but rather to inform the deliberation. After the group votes, take the time to have people speak to why they favor one option over others.
>
> As you reach a point where you have considered many possibilities and you have before you all the information you can gather, begin to weigh the most viable options seriously against the benefits you set forth early in the process. Narrow the possibilities to those options that are most congruent with these benefits. (p. 73)

The last step is *Make Your Decision*. When everyone is in agreement about an option that seems best, the decision is made. But often everyone is not in agreement.

> If this is the case, take a deep breath and decide how urgent this decision is. If it is truly not urgent, or if you can make an interim decision, the group leaves the matter open and places it on the agenda for the next gathering.
>
> If the decision is urgent, then your group must focus on the necessity of reaching a decision that everyone can live with for now, and plan for more discussion of the issues involved. Even in this circumstance, the more that the group is able to identify the values upon which the decision is built and select the option that best expresses your values, the more satisfactory the decision will be in the long run. (Chinn, 2013, pp. 73–74)

This process is so valuable and results in much better patient outcomes and staff satisfaction. Each person and his or her knowledge, experience, and perspectives are given significance. If anyone disagrees, that person is encouraged to express his or her views. Dissenting views are valued, which means that people need to be within an environment where this perspective is encouraged. This decision-making process must be accepted and supported by each person in the group as the best method to use.

In the Information Age, collaboration must happen in different ways. Richards (2001) suggests that "collaborative practice involves a community of electronically connected practitioners providing a richer and more scientific foundation for practice" (p. 6). Chinn's method can also occur using technology. It is best if people can actually see each other as they interact.

Erickson and colleagues (2012) advocate creating a new role: attending registered nurse. This person coordinates the work of the interdisciplinary team in addressing overuse, underuse, and misuse of services.

In the hospital setting, Hill (2006) recommends that it is particularly positive when both a physician and a nurse can provide leadership for the interdisciplinary process on a unit, with the goal of giving patients what they value. Hill discusses how each profession can be more effective with each other and the team by using executive coaches who facilitate discussions between physicians and nurses "to verify the importance of accountability within the organization and to explore the notion of shared and independent domains of practice" (p. 391). Coaching can also help each discipline deal with the politics involved and, in such cases, help them (1) develop a joint strategy before meetings, and (2) deal with issues that come up in large meetings.

One nurse executive stated:

> I have found that the best decisions are supported through the informal communications before and after the meeting, where issues and political landmines can be more informally addressed and where a constituent can influence the outcome of a process or decision before it is presented. (Hill, 2006, p. 391)

It was important for nurse executives to mentor others in their profession so that they can more effectively work together.

This nurse executive recommended the following:

> (1) be inclusive in groups; (2) be transparent in your ideas. Often, the best ideas come from an open discussion on the issues. Leaders need to be open to input from multiple perspectives; (3) attainment of doctoral education created a level field for credibility with physicians as peers; (4) participate in a 360-degree evaluation so one is aware of one's own "blind spots"; (5) be explicit about what you want. (Hill, 2006, p. 392)

Collaboration is most effective with different professionals in an organization. We are educated differently from each other. We do not use the same terminology. Plus, we are all learning how to move away from the old frameworks when what the physician wanted was key. Now, we are on a more even playing field, although this is not always recognized. Our challenge is to work out ways to collaborate more effectively with each other, valuing each other's contributions.

> Interprofessional collaboration is essential to deliver unified, cohesive, patient care; yet our work in evidence-based practice is often profession-specific, without exchange of theories, models, or tools in a unified approach focusing on a specific patient outcome. Efforts of each individual profession are grounded in specific knowledge, value, and belief systems, with resulting variations in forms of and values for specific types of evidence. Social boundaries result in poor diffusion across professions. This status quo is intolerable if we are to advance the quality of care for patients in all settings. (Newhouse, 2008, p. 414)

Bleich and associates (2009) recommend that we restructure some of the common meetings, such as staff meetings, patient huddles, and rounds, to include other departments and services. We also need to create more feedback loops among staff, patients, families, and other caregivers, examining clinical problems in context.

With these new decision-making models at the point of service, team effectiveness or relationship building is enhanced when *collaboration* occurs. When we collaborate, we are working with others to achieve shared goals. We are proactive; that is, a person does not just complain about problems but thinks of ways to solve them. We cooperate and share knowledge with each other. There is an element of shared meaning within the group. We create group synergy in the pursuit of collective goals. We make sacrifices to achieve the group goals. Group energy is harnessed. Different views are encouraged and it is safe to express these views.

Work Teams

Work teams help us to better achieve what the patient values in a second-curve environment. Work teams are necessary because we are all interconnected and interdependent with one another. Although many times patients are not included in team efforts, the team is most effective when the patient is a valued member. Work teams may include just nursing staff and patients, but it is best when work teams are interdisciplinary to achieve what each patient values.

> Very few people work by themselves and achieve results by themselves. . . . Most people work with others and are effective with other people. . . . Managing yourself requires taking responsibility for relationships. This has two parts. The first is to accept the fact that other people are as much individuals as you yourself are. They perversely insist on behaving like human beings. This means that they too have their strengths; they too have their ways of getting things done; they too have their values. To be effective, therefore, you have to know the strengths, the performance modes, and the values of your coworkers. . . . Each [coworker] works his or her way, not your way. And each is entitled to work in

> his or her way. What matters is whether they perform and what their values are. . . . The first secret of effectiveness is to understand the people you work with and depend on so that you can make use of their strengths, their ways of working, and their values. Working relationships are as much based on the people as they are on the work.
>
> The second part of relationship responsibility is taking responsibility for communication. . . . Personality conflicts . . . arise from the fact that people do not know what other people are doing and how they do their work, or what contribution the other people are concentrating on and what results they expect. And the reason they do not know is that they have not been asked and therefore have not been told. . . . Even people who understand the importance of taking responsibility for relationships often do not communicate sufficiently with their associates. They are afraid of being thought presumptuous or inquisitive or stupid. They are wrong. Whenever someone goes to his or her associates and says, "This is what I am good at. This is how I work. These are my values. This is the contribution I plan to concentrate on and the results I should be expected to deliver," the response is always, "This is most helpful. But why didn't you tell me earlier?" [It is important for the leader to ask,] "What do I need to know about your strengths, how you perform, your values, and your proposed contribution?" . . . Trust . . . means that they understand one another. (Drucker, 1999, pp. 71–72)

Does this sound familiar? It is what we explored in the chaos/complexity section of this chapter. We are all interconnected and interdependent with one another. Yet each person has different perspectives and different ways of going about work that can cause conflict. This conflict, if recognized, can be used to foster a better understanding of each other's perspectives and can help to lead us to make needed changes. It is very valuable information. If we pay attention to this, patients are more likely to receive what they value.

The team involves all stakeholders who communicate with each other and who are committed to solving problems. If possible, it is best if all involved can remain unattached to current paradigms. The ultimate goal is providing what will better achieve what patients value. The team needs to build consensus around goals, realizing that changing one component of a system generally affects another part of the system. All of this needs to be coordinated. This is why making small, incremental changes is a good way to fix a problem. Then, if something that is tried only creates more problems, it can be changed or stopped until another process can facilitate the change successfully.

Systems dynamics is now an important concept for all in an organization to understand. In complexity science, we recognize that a large number of people/objects have many connections in different spaces and at different times. This approach is "used to model processes over time. [It] focuses on the information-feedback characteristics of a process or activity" (Clancy, 2009a, p. 251). The author explains complexity by using a social network example where physician consultation referral patterns are examined as one way to decrease length of stay.

Benham-Hutchins and Clancy (2010) further explain social network analysis.

> Social network analysis is a set of methods and analytical concepts that focuses on the structure and pattern of relations in a social network. Social network analysis is beneficial in workflow analysis because it can uncover explanatory factors or variables that influence individual and group behavior. (Clancy, 2009a, p. 251)

"Effective teamwork depends on leadership clarity, role clarity, shared goals, and frequent communication" (MacPhee, 2007, p. 407). "Leadership is a catalyst for teamwork" (Castner, Schwartz, Foltz-Ramos, & Cervolo, 2012, p. 470). The catalyst is not only the nurse manager, but we must include the charge nurse. Leaders "must encourage participation, mobilization, and innovation" (Smith, 2012, p. 46). Evidence shows that ambiguous leadership roles and responsibilities result in low levels of team support for innovation. We do not always discuss the importance of teams with staff, let alone have expectations

that each worker is an effective team member. Evidence shows that when team roles and expectations are not clarified, there is more conflict and outcomes/reimbursements plummet.

To gauge how effective a team is, MacPhee (2007, p. 410) recommends the following checklist for assessment:

Communications

1. Is there sufficient vertical (formal) team communication?
2. Is there sufficient horizontal (informal) team communication?

Coordination and mutual support

3. Are individual efforts assimilated into team efforts?
4. Do team members help and support each other to achieve team goals?

Contributions

5. Is each team member maximizing his or her contributions?
6. Is the team taking full advantage of each member's expertise?
7. Is the team acknowledging the contributions of its members in an equitable or balanced fashion?

Cohesion

8. Are there team spirit and a collective identity?
9. Are team members focused and motivated to achieve the team goals?

"An important personality trait of people who enjoy working with others and who are team players is agreeableness, which helps form social cohesion" (MacPhee, 2007, p. 407). Nurse managers can expect and mentor these behaviors, and these behaviors can be specified in performance evaluations.

Each team member brings certain gifts to the team that, when valued, are instrumental in achieving team effectiveness. Gifts can be clinical expertise, or certain people work better with certain kinds of patients. Gifts also include team roles. A few will be innovators.

> Innovators (about 2.5% of a group) are well connected to outside knowledge sources and recognize innovation opportunities, such as cutting-edge technologies and best-practice approaches. Innovators, however, are not always well connected within their organization. Their ideas need to be championed by the "early adopters" or opinion leaders, who comprise about 13.5% of a group. These transformational leaders inspire others to follow the new idea, and they have the power to make things happen. Although they have earned the trust of others, not everybody will immediately follow them. Their immediate audience consists of the "early majority," another 34% of the group. These followers are comfortable taking a new idea, adopting it to their local environment, and conducting small-scale pilots. Their successes pave the way for more innovation diffusion. The "late majority" followers, another 34% of the group, watch and see what happens among the early majority. They change when successful outcomes are more certain. The last 16% consists of "traditionalists." These individuals are rooted in habits and routines; "We've always done it this way." They eventually convert, but not until the innovation has become the new status quo. There needs to be a 15% to 20% critical mass of innovators, adopters, and early majority personalities to tip the scale toward innovative change. (MacPhee, 2007, p. 407)

The best way to achieve *innovation* within a team is to have a diverse team mix. Low-diversity group members are homogenous. They tend to keep on with the status quo. However, if diversity is too high, members often cannot develop shared goals and objectives. "The right mix consists of people with diverse but overlapping knowledge domains and skills" (MacPhee, 2007, p. 407). This is why a group of nurses needs other professionals (physicians, therapists, pharmacists, dietitians, etc.) on the work team and vice versa.

Educational programs can teach about role clarity, the importance of functioning as a team member (both with unit staff and with other disciplines), and teamwork expectations. Providing practice opportunities is important.

Frequent communication is needed because we don't know what each patient values until we talk with that person. If all on the team share what they find, the patient is more likely to receive what he or she values. This process of communication has different nuances for each patient situation.

Communication is complicated by needing to continually improve the care given. Current evidence specifies changes in the way we actually perform care. For instance, Shermont and colleagues (2008) suggest the importance of 10-minute huddles in the middle of a shift, for example, when suddenly several nurses have fallen behind, a patient takes a turn for the worse, another patient needs to be taken for an emergency magnetic resonance imaging scan, and the charge nurse finds out there will be another admission. By calling a huddle, the charge nurse, along with the rest of the nursing staff, can quickly get updated on what is happening and make more effective decisions on who will do what.

The huddle is a good example because, while the team is dealing with the patient situations, they need to be aware of the strategic plan goals and achieve pay-for-performance goals. This is further complicated because change is always occurring. Thus, each member of the team must help identify incremental changes that are necessary to better achieve what patients value. And this needs to be communicated to the rest of the team.

Another issue with teams can involve *delegation*. For instance, when care omissions occur (with ambulation, turning, delayed or missed feedings, patient teaching, discharge planning, emotional support, hygiene, intake and output documentation, and surveillance), evidence showed that nurses inconsistently or inappropriately delegated tasks to nursing assistants (NAs). This is a messy problem because reasons for these occurrences often are intertwined. There is

> inconsistency in the nature of the tasks delegated, a possible knowledge deficit in expectations by the nurse regarding the capability and functioning of NA, tension in the nurse and NA relationship, role confusion between practitioners, poor communication, and insufficient system support. (Bittner, Gravlin, Hansten, & Kalisch, 2011, p. 510)

To fix this problem, nurses and NAs may need to learn better communication techniques. Promoting positive relationships can also be helpful. Positive relationships occur when a team regularly works together and team members develop trust so that when things get busy good teamwork happens and the care continues to be delivered.

The delegation problem is affected by other factors—workload and NA competence. When nurses (and NAs—although this has been reported less frequently) are overwhelmed, even if for only part of a shift, they may not have time to make sure all the necessary care is occurring. Evidence also shows that NAs can become complacent about performing care, and nurses need to be more vigilant in making sure the care is given. This type of situation is often complex with intertwined causes.

Having *continual team dialogue* helps to determine what is happening and how best to deal with these changes. Each member brings small changes he or she is experiencing, and by having continual dialogue with other team members and communicating these changes, the team comes closer to achieving what the patient values. In addition, the workplace is a better environment for employees and physicians. Everyone wins.

We must realize that when team dialogue is working well, it is messy, but the energy is positive. Something is always happening, and something is always changing. It is worth experiencing this messiness because of the outcome achieved with the patient.

Group energy can increase or decrease what is accomplished. When teamwork is excellent, outcomes are very positive. Magic happens. We advocate that self-managed teams be used as much as possible because *90% of the decisions need to be made at the point of service.*

There are several reasons why using the team approach to decision making is advantageous in organizations. First, the knowledge and skills that each individual brings to the group create synergy. Second, an increase in creativity occurs, often as a result of the diversity of multidisciplinary teams and the different worldviews that each team member brings to the group. The whole is greater than the sum of the parts. *Most organizations experience a 20% to 40% increase in productivity when employees are deeply involved in their work* (Porter-O'Grady & Malloch, 2011, p. 341).

Teamwork is not as effective as it can be unless the leaders share power and foster interdependence. To be most effective teams need to have shared goals and, of course, support the core values.

Efforts to improve teamwork have positive effects. Kalisch and associates (2007) used a team enhancement and engagement intervention (that unit staff chose) to achieve a lower patient fall rate and lower turnover and vacancy rates. Staff reported better teamwork. Hall and colleagues (2008) designed a workplace intervention to improve resource availability on patient care units. "After participation in the intervention, nurses in this study reported higher perceptions of their work and work environment" (pp. 43–44).

Sometimes trained group facilitators are needed to help team members achieve better working relationships and more effective teamwork. Once the team functions effectively, the group facilitator may no longer be needed. Further education of team members and facilitation of their work can save countless hours of wasted time and advance the team toward successful completion of the goal.

According to Wellins, Byham, and Wilson (1991), there are six key factors in team development: commitment, trust, purpose, communication, involvement, and process orientation. All of these occur as a team evolves. In the first stage of team development, *getting started*, the purpose, or goal, of the group needs to be clearly defined, and all members need to get acquainted with it.

In the second stage, *going in circles,* team members know who they are and where they are going and need to decide how to get there. They often feel an urge to pull out of the team to work alone or to work in subgroups. Members sort out whom they do and do not trust and those they are unsure of at this point. The team has a better understanding of its purpose but still requires reassurance and guidance. Often, much time is spent on describing how meetings will be conducted, setting agendas, and setting up ground rules with task completion as the goal.

In this stage, conflict begins to arise, especially if certain members attempt to dominate the team. This conflict is disturbing to members who want the team to succeed. It is important for the team to keep returning to the group goal. Power moves tend to decline as more effective group process develops, feedback occurs, and members begin to identify specific gifts each member brings. However, if this does not occur, the team will be stuck and probably not accomplish the original purpose.

The third stage of team development, *getting on course*, is focused on achieving the goal. Team members are more comfortable with each other, more comfortable with their roles in the group, and are committed to getting the job done. The group process is more natural because members understand the team's purpose, are beginning to know and appreciate each other, and can begin to explore solutions different from the status quo.

The final stage, *full speed ahead*, is when teams are more comfortable with the benefits of being empowered. They are committed to both the team and the organization at this stage. Trust is a stable commodity and extended openly. A clear sense of mission and vision is maintained, and the team becomes more flexible. Changes in meeting frequency and communication occur at this level. Members are constantly involved and accept new roles and responsibilities. The team focuses on quality and continuous improvement.

Porter-O'Grady and Malloch (2011) have divided this stage into three substages: competent, proficient, and expert. At the *competent* stage, team members want to hear each other's concerns and ideas and integrate this information into a cohesive group collective. The members have established an effective set of ground rules. They may mentor and coach each other for increased effectiveness. They may find solutions that challenge the status quo.

> Teams at the competent stage can meet the requirements for standard success but find it impossible to become passionately optimistic while recreating the future or to maintain resilience in the face of negative events. They accomplish the assigned work but seldom move beyond the assigned boundaries. (p. 348)

At the *proficient* stage, team members are more likely to have a total organizational assessment, be passionately optimistic, be aware of individual differences, and can arrive at consensus decisions, not just saying that the majority rules. They honestly recognize team member limitations and give emotional support to help the person deal with personal failings. They consider the emotional components of the conflicts and work through them, supporting both the emotions and the actual work that needs to be accomplished. Relationships stay intact and are based on honesty.

At the *expert* stage, all the healthy internal group work occurs, and the group recognizes the organizational issues and culture making sure that the proposed solutions fit within the existing organizational components. The group is proactive and affirmative, recognizing and dealing effectively with each member's emotional needs and undercurrents and arriving at effective solutions for the individuals, the group, and the organization. At times, this could extend to the community as well.

Teams develop over time and progress through the stages of team development at different rates, depending on internal and external influences. In fact, if team membership changes or goals are not well defined or change, the group may revert to a previous stage or may never resolve the ensuing conflicts, thus never achieving the goal.

Team development is not a linear process. Often teams are composed of very diverse members with a variety of values and backgrounds. Some members may be into negative, selfish behaviors. The team will probably fail unless it can reach such individuals and pull them into the team or these individuals are effectively dealt with, asked to leave the team, or asked to leave the organization. Team development takes time, patience, and effort.

In *The Five Dysfunctions of a Team,* Lencioni (2002a) identifies other issues that surface. The book is written as a novel, presents some individual issues that can lead a team astray, and presents how to fix the problems. The five dysfunctions are invulnerability (absence of trust), artificial harmony (fear of conflict), ambiguity (lack of commitment), low standards (avoidance of accountability), and status and ego (inattention to results). These barriers create tremendous costs to the organization. First, there is the cost of everyone's salaries that are wasted, but there are many larger costs: This lack of teamwork will occur in other work areas, unresolved conflicts will resurface, administration will be viewed as ineffective, patient care and patient outcomes/reimbursements will suffer, physicians will prefer to be somewhere else, and legal issues will result. The higher the level of dysfunction, the more it permeates the entire organization.

As conflicts occur, if the team is able to resolve the conflict without decimating members and use the situation as an opportunity for learning, the team is more likely to make good progress with group development. They begin to develop a group identity and a feeling that they are making a difference. The *spirit* increases because of each person's involvement and commitment to the goals of the group. The team can become *self-actualized and believe they can make things happen*.

> Self-actualized teams . . . use the whole potential of each team member to remain incredibly focused on "their" work, and they use skepticism in a healthy and productive way. They are willing to live at the border and do not eliminate ideas, no matter how outrageous. All ideas are reviewed with the typical constraints

> of finance, practicality, time, and ethics. More importantly, self-actualized teams effectively deal with members who are congenital victims and continually tell us that this and that will not work now because it didn't work in 1947. Self-actualized teams regulate behavior and focus it toward innovation and away from the troubles of the day. They are able to be in the moment and image the future simultaneously, rearranging existing patterns into new and innovative strategies that will solve problems. (Crow, 2003, p. 35)

The leader is only as effective as the team, and the team only as effective as the leader. Part of leadership effectiveness is recognizing the individual differences in team members:

> Some people work best as team members. Others work best alone. Some are exceptionally talented as coaches and mentors; others are simply incompetent as mentors. . . . A great many people perform best as advisers but cannot take the burden and pressure of making the decision. A good many other people, by contrast, need an adviser to force themselves to think; then they can make decisions and act on them with speed, self-confidence, and courage. This is the reason, by the way, that the number two person in an organization often fails when promoted to the number one position. The top spot requires a decision maker. Strong decision makers often put somebody they trust into the number two spot as their adviser—and in that position the person is outstanding. But in the number one spot, the same person fails. He or she knows what the decision should be but cannot accept the responsibility of actually making it. (Drucker, 1999, pp. 68–69)

Magnet Force 8: Consultation and Resources discusses the importance of having experts available for staff. This is a critical component of organizational competence:

> The health care organization provides adequate resources, support and opportunities for the utilization of experts, particularly advanced practice nurses. The organization promotes involvement of nurses in professional organizations and among peers in the community.

Shared Governance: A Collaborative Model

Interdisciplinary shared governance is a necessity in the value-based environment. If it does not exist in the organization, it is important to at least start with nursing shared governance. Remember that in the second-curve environment, administrators serve the leaders who are at the point of care, and it is those leaders who need to make 90% of the decisions about their work environment.

Shared governance (**Exhibit 3–3**) is a structural team framework that affords nursing professional autonomy at the point of care (Brody, Ruble, Barnes, & Sakowski, 2012; Church, Baker, & Berry, 2008; Dunbar, Park, Berger-Wesley, & Cameron, 2007; Gokenbach, 2007; Johnson et al., 2012; Kear, Duncan, Fansler, & Hunt, 2012; Moore & Hutchison, 2007; Moore & Wells, 2010; Nolan, Laam, Wary, Hallick, & King, 2011). This is where staff members make decisions about their work. "Shared governance is not a democracy. It is an accountability-based approach to structure in which there is a clear expectation that all members of a system participate in its work" (Porter-O'Grady, 2009, p. 45). Costs and time allotments for staff to participate in shared governance are spelled out by Rundquist and Givens (2013).

> Shared governance isn't an end-point but a journey with continual "mile markers." It is based on two expectations: First, previous governance will be redistributed from managers to staff following implementation of shared governance. (So administrators need to release control and transition previous authority roles into educator, advocate, and coach roles.) Second, nurses want to be active participants in decision making. (So staff need to learn how to work out practice issues—not just have gripe sessions—yet still have a relationship with the administrators). (Church et al., 2008, pp. 36–38)

Outcomes are better with shared governance. This includes higher RN satisfaction scores, higher patient satisfaction scores, lower mortality and healthcare-acquired infection rates, and lower RN turnover and vacancy rates (Church et al., 2008).

Exhibit 3–3 Principles of Shared Governance

Partnership
- Role expectations are negotiated.
- Equality exists between the players.
- Relationships are founded upon shared risk.
- Expectations and contributions are clear.
- Solid measure of contribution to outcomes is established.
- Horizontal linkages are well defined.

Equity
- Each player's contribution is understood.
- Payment reflects value of contribution to outcomes.
- Role is based on relationship, not status.
- Team defines service roles, relationships, and outcomes.
- Methodology is defined for team conflict and service issues.
- Evaluation assesses team's outcomes and contributions.

Accountability
- Accountability is internally defined by person in the role.
- Accountability defines roles, not jobs.
- Accountability is based on outcomes, not process.
- Accountability is defined in advance of performance.
- Accountability leads to desired and defined results.
- Performance is validated by the results achieved.
- Processes are generally loud and noisy.

Ownership
- All workers are invested in the enterprise.
- Every role has a stake in the outcome.
- Rewards are directly related to outcomes.
- All members are associated with a team.
- Processes support relationships.
- Opportunity is based on competence.

Source: Porter-O'Grady, T. (2009). *Interdisciplinary shared governance: Integrating practice, transforming health care*. Sudbury, MA: Jones and Bartlett.

Shared governance operates in a true *environment of empowerment*. Empowerment does not even happen until a leader is at least at stage 4 of Hagberg's power model (Hagberg, 2003). With shared governance, staff and leaders are empowered to contribute collectively to the decision-making process related to clinical practice, standards, and procedures. Shared governance also provides the organization with a mechanism to make decisions that improve patient care and the workplace environment. For example, nurses know how processes can be improved, so the nurses who deliver the care can directly make the decisions to do so.

Shared governance benefits an organization because staff members (all staff members, not just nurses) are involved in the design of their work. Authoritarian environments are not effective. If there is an ideal time for shared governance and true empowerment, it is now. This is the only way to achieve positive patient outcomes and better reimbursement and, for that matter, organizational longevity.

Creating an empowering environment is hard work, meaning that *decision making is increased at the point of service*. It takes constant effort. It can be painful. It means staff should be making 90% of the decisions and may choose directions that never occurred to us. Staff need to be involved in the decision making with hiring, budgeting, allocating, discipline, and policy. An empowering environment is time consuming to maintain, but the time taken is well worth the outcomes achieved. As staff become used to working effectively with shared governance, the process becomes more automatic and takes less time.

Not all shared governance efforts are successful. Ballard (2010) discusses factors that lead to success and failure:

> Successful ventures happen when there is successful communication of a vision by senior nursing leaders, along with support of managers. It is helpful if both these groups along with staff nurses plan together, and continue this process as the governance model gets off the ground. One issue is that some managers have difficulty giving up authority patterns, rather than becoming a coach/mentor. Managers need a lot of mentoring before implementation can be successful. Another barrier to success can be staff apathy. It is better to start with staff that really believe in it, and then mentor them for the new role. This may involve their learning how to read and interpret various data reports, how to run meetings, set agendas, "shepherd" discussion, and reach consensus. It is important to be clear on boundaries—what kinds of decisions can be made by the group, other types of decisions will be recommendations to administrators or other departments, and certain organizational boundaries cannot be changed. Gradual transition is helpful using transition teams. Then it is trial and error. As they begin to function they need to learn how to substantiate need for changes, the timing of requests, and how to initiate changes. For first efforts it is probably best to do so with 3 guidelines: 1) must be congruent with hospital policies and procedures; 2) proposed changes must improve patient care/quality outcomes/work environment; and 3) financial outcome must be budget neutral or justified. Staff must have support to attend meetings; also, attendance is an expectation from the administrative team. (pp. 411–415)

Today, many nurse managers feel overwhelmed, especially when they are in environments where they are not empowered and not supported by supervisors. This leads to higher nurse manager (and nurse executive) turnover. So, in this chaotic time, it is time to support each other as we create this new reality.

In a *whole-systems shared governance model*, each member has equal power and responsibilities in the decision-making process, giving first priority to what the patient values. Porter-O'Grady (2009) advocates having an *operations council* (concerned with resources, linkage, planning, market strategy, implementation, and compliance), a *patient care council* (concerned with service delivery, system models, disciplines, service design, roles, quality, and process), and a *governance council* (concerned with mission, strategy, priorities, policy, and integration). Physicians have had a medical staff organization historically, but Porter-O'Grady advocates that

> many of the current separate functions of the medical staff will disappear as they become more integrated within the system. . . . The real struggle for physicians is seeing themselves as partners in the health system rather than the controllers of it. (pp. 264–265)

In this model, a shared governance steering group shares information and integrates decisions among the three councils. It is important that "every key role in the system, staff or management, should be represented in the steering group. The majority of planners, however, should be from the staff, not from management" (Porter-O'Grady, 2009, p. 80). "Integration is evidence of the attempt to configure services around the point of care and to bring providers together in a service partnership. . . . Compartmentalization is the death of integration" (p. 40).

To make all of this work effectively, caregivers who are at the point of service need access to accurate information, need to tune in to what the patient values, need administrative support from the top down to make these decisions, and need to feel accountable for their decisions. Shared governance structure ensures "that the decisions made there are correct, implementable, and do not require broad organizational approval or a long decision making process (which might reduce the efficiency and effectiveness of the clinical delivery system)" (Porter-O'Grady, 2009, pp. 77–78). It is a system based on accountability of staff who want to give their best effort to their work.

Professional Development

Keeping up with the latest clinical, educational, and administrative evidence requires time and commitment. Yet, this is a key necessity in a value-based environment.

Knowledge management "addresses how organizations leverage their knowledge or intellectual assets" (MacPhee, 2007, p. 408). There are three kinds of knowledge: "human knowledge or expertise, social knowledge or collective knowledge that develops as a result of people working together, and structured knowledge or the knowledge embedded in an organization's policies, procedures, and routines." (MacPhee, 2007, p. 408).

All are necessary for organizational competency. Sharing this knowledge is important.

Human knowledge includes the expertise of various employees of different disciplines. For instance, nursing work teams are enhanced when a nurse has expert knowledge as defined by Benner. Educational/orientation/mentoring programs usually exist to expand the expertise of employees. *Social knowledge* is about what happens in the organization as various teams work to provide care for patients, or do their work. Social networks exist, including who goes to lunch with whom. *Structured knowledge* is fairly standardized knowledge, which is shared and can be used repeatedly. Generally, this is codified data that can be stored in and retrieved from computer databases. Organizations tend to favor one of these three types of knowledge. If an organization emphasizes one strategy over the others, it will not be successful.

Often social knowledge is not as fully developed as it needs to be.

> Most healthcare organizations require viable social networks to effectively manage/share expertise and collective wisdom. Berwick describes the importance of "spannable social distance," where each person hears the news from someone socially familiar and credible to them. Networking opportunities among employees require organizational investment, such as meeting spaces and time away from work responsibilities to generate discussion.
>
> What are the outward signs of an organizational culture that supports social networking? Vertical interactions between different lines of authority are known for leaders' approachability and willingness to discuss all kinds of topics, even sensitive ones, openly and honestly. Horizontal interactions among individuals at the same organizational level support seeking out existing expertise versus "reinventing the wheel." High levels of interaction and collaborative problem solving are organizational norms. This is a high-trust organizational culture: Where trust exists among the organization, its leadership, and their followers. (MacPhee, 2007, p. 408)

The goals and objectives of the organization often give clues as to which knowledge strategy is favored. Organizations must learn to balance all three types of knowledge (another change).

The Magnet Recognition Program recognizes the importance of education of employees. Magnet Force 14: Professional Development follows:

> The health care organization values and supports the personal and professional growth and development of staff. In addition to quality orientation and in-service education addressed earlier in Force 11, Nurses as Teachers, emphasis is placed on career development services. Programs that promote formal education, professional certification, and career development are evident. Competency-based clinical and leadership/management development is promoted and adequate human and fiscal resources for all professional development programs are provided. (ANCC, 2013b)

Professional education is an important organizational strategy that enhances staff capabilities to better understand what is coming in the future. It helps everyone to stretch and grow. Every member of the organization—from housekeeping to board members—can benefit from additional learning opportunities. Generally, every staff member should experience learning opportunities both within and outside the organization. Because we learn differently—some by seeing, some by hearing, some by experiencing—we need to provide various opportunities that correspond to a person's learning style. And sometimes we learn

best when we have to teach someone else. The sky is the limit here because there is an infinite number of possibilities.

Unfortunately, often the education budget gets cut. This is a major error. In the current environment, which is constantly changing, educational offerings provide effective strategies for remaining viable, as well as meeting generational needs. If no educational opportunities are available, this ignores the fact that we all need to do meaningful work and have opportunities to continue to grow. Scott (2002) makes the following observation:

> When learning and professional development are viewed only in terms of an optional opportunity for improvement—rather than as *a threat to your organization's survival if ignored*—the commitment to sustain successful change will be missing. Thus, look at professional development from two angles: what you and your team will gain if everyone worked differently, and what you and your team will lose by simply maintaining the status quo. Bottom line, will you achieve your strategic goals if you and your staff continue to lead the way you are leading today? (p. 17)

We have discussed the shifts that all of us need to be living in this new Information Age. Scott (2002) names 10:

> From a provider orientation to customer obsession; from silo thinking to an organizational perspective; from directing to coaching; from status quo to courage, risk, and change; from busyness to results; from telling to facilitating dialogue; from protecting turf to building relationships; from a function manager to a business leader; from the employee as expendable to the employee as precious; and from pressure and overwork to perspective and balance. (p. 18)

There are many more examples of needed shifts sprinkled throughout this text. The exciting thing is that there is so much more to learn, which is true of the nurse aide all the way to the board members.

Another educational aspect cannot be forgotten in organizations. By providing organizational learning opportunities for students, we are facilitating future potential or current employees' knowledge base. The magnet program recognizes the importance of providing organizational opportunities for students. Magnet Force 11: Nurses as Teachers states:

> Professional nurses are involved in educational activities within the organization and community. Students from a variety of academic programs are welcomed and supported in the organization; contractual arrangements are mutually beneficial. (ANCC, 2013b)

It is important to have a development and mentoring program for providing staff preceptors for levels of students (students, new graduates, experienced nurses, and so forth. In all positions, staff serve as faculty and preceptors for students from a variety of academic programs. There is a patient education program that meets the diverse needs of patients in all of the care settings of the organization.

Organizational Competence

Now we turn to organizational competence in the (second-curve) value-based environment. In fact, there are *organizational competencies* that are necessary for survival (Gibson, 2011):

> A competent institution is characterized by individual and collective knowledge, skills, and attitudes that enable an organization to operate effectively. In the context of patient safety, a competent organization is one whose structures and processes enable care that is safe, effective, patient centered, timely, efficient, and equitable. Nurses and all health care professionals function best when the systems in which they work are competent and enable them to provide high-quality care. It's time hospitals and other organizations are held accountable for being competent in quality and patient safety, when nurses and other health care professionals are being called upon to do the same. (p. 46)

Part of our administrative responsibility is to build a competent organization. *However, even if achieved, it is only at one point of time, and then, because life is dynamic, it will need to continue to change or become obsolete.* Because the world is ever changing, achieving and keeping organizational competency take constant work. The organization, like us, needs to keep on changing with the times to survive.

What is a competent healthcare organization? First, we need to make sure all are aware of, and support, the purpose and mission or values of the organization. If this is not the case, we need to pay attention because it is important that everyone's actions always support the purpose and values. This is hard but always supplies our direction.

Second, it is important to *stay current with the evidence and with all the changes taking place in our healthcare environment* (external environments). This means that all staff, including staff nurses, physicians, and administrators, stay updated and practice accordingly. Because it is important to stay current with the surrounding environments, make needed incremental changes hourly (to keep re-creating the potential reality) to stay viable. This includes paying attention to

> Providers (healthcare institutions), payers (federal, state, private, and managed care insurers), individuals (patients, physicians, nurses, support staff, and educators), and technology (the Internet, information systems, medical equipment, and pharmaceuticals). Collectively, the interactions of these parts converge and create the emergence of a dynamic, highly complex state space. . . . Eventually, the environment will favor those institutions that are creative, robust, adaptable, and able to solve an ever-changing set of problems. (Clancy, 2007a, p. 535)

Administrators must also update their views of reality. For instance, in school we were taught to pay attention to the competition (note that part of this word is *compete*), which is what we needed to do to stay viable. Business journals discuss the importance of the competition. However, the competition really is not important.

> Capitalism treats competition as fundamentally a personal exercise—a contest between oneself and others for profitability and success. What it does not always recognize is that whether success is achieved has less to do with one's competitors than with one's adaptability, creativity, energy, and commitment to succeed. In other words, the pursuit of success should not be viewed as a contest with others but as a personal effort to give one's best and to thrive in the environment one has chosen to live in. (Porter-O'Grady & Malloch, 2011, p. 31)

The issue is not what the competition is doing; the issue is survival. It is giving it our best effort. All of us need to change, but this starts at home. The key is *survival and adaptability*. This is why it is so important to pay attention to the internal and external environments and look to the evidence for clues as to what we need to do next (new potential realities) to survive. It is not competition but *innovation* that is needed so that we can thrive.

> All living systems seek to thrive. At a fundamental level, they are not concerned with each other's survival unless it is somehow related to their need to thrive. Adaptation is not about competition between the fittest but about survival of the fittest, and the survival of the system is more dependent on its inherent adaptability to its environment than on anything else. To thrive, the system must have beneficial interactions with its environment and must also have the capacity to adjust to the prevailing conditions quickly and effectively. A system is fundamentally in competition with *itself*, not with anyone or anything else. (Porter-O'Grady & Malloch, 2011, p. 32)

The AHA (2011) suggests seven competencies for healthcare organizations:

1. Design and implementation of patient-centered, integrated care
2. Creation of accountable governance and leadership
3. Strategic planning in an unstable environment

4. Internal and external collaboration
5. Financial stewardship and enterprise risk management
6. Engagement of employees' full potential
7. Collection and utilization of electronic data for performance improvement (p. 23)

The AHA accompanies these competencies with competency questions in each category.

For the nursing profession and nurse administrators, perhaps the Magnet/Excellence precepts for internal organizational competencies are the best defined. These precepts continue to evolve. (There is a pattern here: They continue to evolve, too, to keep up with potential reality.) We need to keep *improving our internal environment so that we can best achieve what patients value*.

Magnet/Excellence Precepts

Both the Magnet Recognition Program and the Pathway to Excellence Program provide wonderful resources for nurse administrators, *whether one has applied for Magnet status or not*. Evidence supports this. Ulrich and associates (2007) found in a national sample of 1,783 nurses that *those in magnet organizations and those in organizations in the process of applying for magnet status had significantly better results when asked about characteristics of the work environment and professional relationships. Magnet hospitals enjoy higher percentages of satisfied RNs, lower RN turnover and vacancy, improved clinical outcomes, and improved patient satisfaction.*

In a four-state survey of 26,276 nurses, Kelly, McHigh, and Aiken (2011) reported:

> Magnet hospitals have better work environments and a more highly educated nurse workforce. Outside of California where nurse staffing mandates decrease variation in staffing, Magnet hospitals have significantly better nurse staffing reflected in nurses caring for fewer patients each. Nurses in Magnet hospitals are significantly less likely to experience high burnout or be dissatisfied with their jobs than nurses in non-Magnet hospitals. Our results are consistent with a substantial and growing research base on Magnet hospitals that has accumulated over several decades showing significantly better work environments in Magnet hospitals and better nurse outcomes. (p. 432)

Houston and colleagues (2012) found that decisional involvement is higher among Magnet-designed than non-magnet facilities. Kovner and associates (2009) reported that it is not Magnet status per se, "but rather common characteristics of Magnet hospitals such as autonomy and lower organizational constraints . . . that are related to satisfaction and organizational commitment" (p. 90). Trinkoff and colleagues (2010) found that "nurses who worked in Magnet hospitals were less likely to report having mandatory overtime and on-call as part of their jobs, although 'reported hours worked' did not differ" (p. 313). Kelly and associates (2011) found that magnet hospital nurses were 18% less likely to be dissatisfied with their job and 13% less likely to report high burnout. Vartanian and colleagues (2013) found that nurses' perceptions of their workplace were more positive in magnet environments. Boyle and colleagues (2012) found that magnet recognition is associated with increases in nursing specialty certification rates.

Although most of the evidence is positive, there are some exceptions. Goode and colleagues (2011), in a study of 19 magnet hospitals and 35 non-magnet hospitals, found that the magnet hospitals had fewer total staff and a lower RN skill mix compared with non-magnet hospitals. The non-magnet hospitals had better patient outcomes, except that the magnet hospitals had slightly better outcomes for pressure ulcers.

Higdon and colleagues (2012) advocate magnet designation in small hospitals with fewer than 100 beds, presenting a business plan (cost-benefit analysis, outcome measures, and financial impact data) to support this. Small hospitals can apply for the Pathway to Excellence Program® instead of the larger magnet Recognition Program®.

> The Pathway to Excellence program focuses on the quality of the nursing practice environment, whereas the Magnet program focuses not only on the practice environment, but also on research, outcomes, and innovation. According to the ANCC, the Pathway program is appropriate for facilities of all sizes where nurses work, but, in particular, it's viewed as a way for small- and medium-sized facilities (clinics, long-term-care facilities, and critical access hospitals) to demonstrate their commitment to excellent nursing practice environments. (Shaffer, Parker, Kantz, & Havens, 2013, p. 27)

The Pathway to Excellence Program has 12 standards:

1. Nurses control the practice of nursing.
2. The work environment is safe and healthy.
3. Systems are in place to address patient care and practice concerns.
4. Orientation prepares new nurses.
5. The CNO is qualified and participates in all levels of the facility.
6. Professional development is provided and utilized.
7. Competitive wages/salaries are in place.
8. Nurses are recognized for achievements.
9. A balanced lifestyle is encouraged.
10. Collaborative interdisciplinary relationships are valued and supported.
11. Nurse managers are competent and accountable.
12. A quality program and evidence-based practices are utilized.

The Excellence program is intended for small, rural hospitals, which comprise 41% of U.S. community hospitals. Havens and associates (2012) found that rural nurses viewed their work environments as favorable. Newhouse and colleagues (2009) found that 280 nurse executives in small, rural hospitals actually scored lower total Essentials of Magnet scores. "As a smaller system entity, nurse executives may perceive higher system oversight, control, and a lower level of influence" (p. 194). One hospital, working through the Excellence process stated:

> After a careful self-assessment, you may be pleasantly surprised to learn that many of the standards are already met in your organization. However, if your assessment reveals that the standards aren't in place, the Pathway program provides a framework to guide development of an excellent nursing practice environment. Involve as many staff members, disciplines, and departments as possible. Assign sections of the application and documentation of standards to staff and leaders from different disciplines. Inclusion of ideas from nonnursing colleagues contributes important perspectives and shows an appreciation for nursing's contribution to patient care across the organization.
>
> Communication is critical throughout the process. . . .
>
> Appreciative inquiry (AI), a method that focuses on increasing what works within an organization and removing what doesn't work, [was used]. (Shaffer et al., 2013, p. 31)

Appreciative inquiry was also used by Havens and colleagues (2006) to improve communication and collaboration, to increase nurse involvement in decision making, and to enhance cultural awareness and sensitivity. Appreciative inquiry is when a group completes the following cycle in this order: (1) discovery—appreciate "what works"; (2) dream—imagine "what might be"; (3) design—determine what "should be"; and (4) delivery/destiny—create "what will be" (p. 464).

Meraviglia and associates (2009) worked with 30 rural or small hospitals, providing consultation visits and ongoing support on strategies to achieve the 12 criteria. There was "significant improvement in nurses' appraisal of their work environment" (p. 70). Reineck (2007) suggests strategies for building

capacity for magnetism (Havens et al., 2012, p. 390). In non-magnet rural hospitals, Newhouse and colleagues (2011) found:

> Larger rural hospitals are more likely than small hospitals to have a clinical ladder, more baccalaureate-prepared RNs, greater perceived economic and external influences, lower shared vision among hospital staff, and higher levels of quality and safety engagement. Most nurses employed in rural hospitals are educated at the associate degree level. (p. 129)

The Magnet Recognition Program is a credentialing process that has been awarded to approximately 6.78% of all registered hospitals in the United States. The application process is extensive and fairly expensive. Often, a project director within an organization is designated to work on this (Lavin, 2013). The term *Magnet hospital* is equated with excellence.

Magnet criteria value further education, supporting the Institute of Medicine's *Future of Nursing* report. The second recommendation in the report focuses on increasing the proportion of registered nurses with baccalaureate degrees to 80% by 2020. Although the evidence is mixed on this issue, many studies have linked higher education with better patient outcomes. Blegan and associates (2013) found that "hospitals with a higher percentage of RNs with baccalaureate or higher degrees had lower congestive heart failure mortality, decubitus ulcers, failure to rescue, and postoperative deep vein thrombosis or pulmonary embolism, and shorter length of stay" (p. 89).

The Magnet Recognition Program was started 30 years ago by the American Nurses Credentialing Center (ANCC) for healthcare organizations that provide the services of registered nurses. The ANCC has continued to refine and improve the Magnet program. The program identified 14 common components, or Forces of Magnetism (FOM), in the 1980s, and in the late 1990s expanded this program to include long-term care facilities and international healthcare organizations, as well as hospitals.

The 14 Forces of Magnetism are as follows:

Force 1: Quality of Nursing Leadership
Force 2: Organizational Structure
Force 3: Management Style
Force 4: Personnel Policies and Programs
Force 5: Professional Models of Care
Force 6: Quality of Care
Force 7: Quality Improvement
Force 8: Consultation and Resources
Force 9: Autonomy
Force 10: Community and the Health Care Organization
Force 11: Nurses as Teachers
Force 12: Image of Nursing
Force 13: Interdisciplinary Relationships
Force 14: Professional Development

(These can be found at www.nursecredentialing.org/Magnet/ProgramOverview/HistoryoftheMagnetProgram/ForcesofMagnetism.)

After conducting several studies on the organizational culture of Magnet facilities, Kramer and Schmalenburg (2003) identified eight essentials of magnetism, now called the Nursing Work Index:

1. Working with other nurses who are clinically competent
2. Good nurse–physician relationships and communication
3. Nurse autonomy and accountability

4. Supportive nurse manager–supervisor
5. Control over nursing practice and practice environment
6. Support for education (inservice, continuing education, etc.)
7. Adequate nurse staffing
8. Paramount concern for the patient

As research continued on Magnet facilities, in 2008 a panel of experts examined the evidence from magnet facilities and reconfigured the 14 Forces of Magnetism into 5 model components. These make up the Magnet Model:

- Transformational Leadership
- Structural Empowerment
- Exemplary Professional Practice
- New Knowledge, Innovation, and Improvements
- Empirical Quality Results

The following subsections provide the Magnet definitions of these components and some additional helpful evidence to further explain how organizations can achieve each component.

I. Transformational Leadership

Today's health care environment is experiencing unprecedented, intense reformation. Unlike yesterday's leadership requirement for stabilization and growth, today's leaders are required to transform their organization's values, beliefs, and behaviors. It is relatively easy to lead people where they want to go; the transformational leader must lead people to where they need to be in order to meet the demands of the future.

This requires vision, influence, clinical knowledge, and a strong expertise relating to professional nursing practice. It also acknowledges that transformation may create turbulence and involve atypical approaches to solutions.

The organization's senior leadership team creates the vision for the future, and the systems and environment necessary to achieve that vision. They must enlighten the organization as to why change is necessary, and communicate each department's part in achieving that change. They must listen, challenge, influence, and affirm as the organization makes its way into the future.

Gradually, this transformational way of thinking should take root in the organization and become even stronger as other leaders adapt to this way of thinking.

The intent of this Model Component is no longer just to solve problems, fix broken systems, and empower staff, but to actually transform the organizations to meet the future. Magnet-recognized organizations today strive for stabilization; however, healthcare reformation calls for a type of controlled destabilization that births new ideas and innovations.

Forces of Magnetism Represented

- Quality of Nursing Leadership (Force #1)
- Management Style (Force #3) (ANCC, 2013c)

This component supports the previous material in this chapter. This type of leadership constantly transforms the organization, recognizing the chaos/complexity issues and the potential realities. Throughout the organization, it is important to have organizational advocacy and support for giving patients what they value from housekeeping to board members. This is an important model for all administrators within an organization.

II. Structural Empowerment

Solid structures and processes developed by influential leadership provide an innovative environment where strong professional practice flourishes and where the mission, vision, and values come to life to achieve the outcomes believed to be important for the organization.

Further strengthening practice are the strong relationships and partnerships developed among all types of community organizations to improve patient outcomes and the health of the communities they serve. This is accomplished through the organization's strategic plan, structure, systems, policies, and programs.

Staff need to be developed, directed, and empowered to find the best way to accomplish the organizational goals and achieve desired outcomes. This may be accomplished through a variety of structures and programs; one size does not fit all.

Forces of Magnetism Represented

- Organizational Structure (Force #2)
- Personnel Policies and Programs (Force #4)
- Community and the Healthcare Organization (Force #10)
- Image of Nursing (Force #12)
- Professional Development (Force #14) (ANCC, 2013c)

Elements of structural empowerment are discussed later in this chapter.

This criterion includes Magnet Force 4: Personnel Policies and Programs that states:

> Creative and flexible staffing models that support a safe and healthy work environment are used. Personnel policies are created with direct care nurse involvement. Significant opportunities for professional growth exist in administrative and clinical tracks. Personnel policies and programs support professional nursing practice, work/life balance, and the delivery of quality care. (ANCC, 2013b)

III. Exemplary Professional Practice

The true essence of a Magnet organization stems from exemplary professional practice within nursing. This entails a comprehensive understanding of the role of nursing; the application of that role with patients, families, communities, and the interdisciplinary team; and the application of new knowledge and evidence. The goal of this Component is more than the establishment of strong professional practice; it is what that professional practice can achieve.

Forces of Magnetism Represented

- Professional Models of Care (Force #5)
- Consultation and Resources (Force #8)
- Autonomy (Force #9)
- Nurses as Teachers (Force #11)
- Interdisciplinary Relationships (Force #13) (ANCC, 2013c)

Exemplary professional practice is emphasized throughout this text, and autonomy and interdisciplinary relationships are discussed in this chapter.

IV. New Knowledge, Innovation, and Improvements

Strong leadership, empowered professionals, and exemplary practice are essential building blocks for Magnet-recognized organizations, but they are not the final goals. Magnet organizations have an ethical and professional responsibility to contribute to patient care, the organization, and the profession in terms of new knowledge, innovations, and improvements.

Our current systems and practices need to be redesigned and redefined if we are to be successful in the future. This Component includes new models of care, application of existing evidence, new evidence, and visible contributions to the science of nursing.

Forces of Magnetism Represented

- Quality Improvement (Force #7)

This book helps to give readers new knowledge, as well as ideas for innovation and improvements. As Magnet Force 7: Quality Improvement states: "The organization possesses structures and processes for the measurement of quality and programs for improving the quality of care and services within the organization" (ANCC, 2013b).

V. Empirical Quality Results

Today's Magnet recognition process primarily focuses on structure and processes, with an assumption that good outcomes will follow. Currently, outcomes are not specified, and are minimally weighted. There are no quantitative outcome requirements for ANCC Magnet Recognition®. Recently lacking were benchmark data that would allow comparisons with best practices. This area is where the greatest changes need to occur. Data of this caliber will spur needed changes.

In the future, having a strong structure and processes are the first steps. In other words, the question for the future is not "What do you do?" or "How do you do it?" but rather, "What difference have you made?" Magnet-recognized organizations are in a unique position to become pioneers of the future and to demonstrate solutions to numerous problems inherent in our healthcare systems today. They may do this in a variety of ways through innovative structure and various processes, and they ought to be recognized, not penalized, for their inventiveness.

Outcomes need to be categorized in terms of clinical outcomes related to nursing; workforce outcomes; patient and consumer outcomes; and organizational outcomes. When possible, outcomes data that the organization already collects should be utilized. Quantitative benchmarks should be established. These outcomes will represent the "report card" of a Magnet-recognized organization, and a simple way of demonstrating excellence.

Forces of Magnetism Represented

- Quality of Care (Force #6) (ANCC, 2013c)

Strategic planning identifies the process needed to move forward into potential reality. Magnet Force 6: Quality of Care states:

> Quality is the systematic driving force for nursing and the organization. Nurses serving in leadership positions are responsible for providing an environment that positively influences patient outcomes. There is a pervasive perception among nurses that they provide high quality care to patients. (ANCC, 2013b)

Organizational Assessment: An Administrative Competency

Now we turn to an administrative competency: organizational assessment. Organizational assessment is the ability to have a fairly accurate, dynamic picture of the total organization, such as how various people work together, which departments are more effective, how different departments have different cultures, how clients perceive the organization, and how the organization fits within the community that surrounds it. This picture is dynamic, meaning that it changes constantly as various components, relationships, and people change within and outside the organization.

> Organizational agility exemplifies knowing and understanding how the organization works; knowing how to get things done both through formal channels and informal networks; understanding the origin and reasoning behind key policies, practices, and procedures; and especially critical, understanding the organizational culture. (Morjikian et al., 2007, p. 401)

This organizational assessment capability helps the administrator to know, with fair accuracy, how different individuals and departments might respond to situations. No matter how well we know an organization, we still experience surprises, but this organizational assessment capability is a key factor for effectiveness.

Assessment is a lived experience that takes time and effort. The resulting picture is never totally accurate because there are always hidden factors that we do not know, both about ourselves and about others, and because everyone in the organization is constantly changing.

Porter-O'Grady and Malloch (2009) suggest that it is necessary for the nurse administrator to possess synthesis and contextual capacity.

> *Synthesis*, the ability to "see" flow, movement, connection, and integration, is becoming an essential skill for both leader and innovator. The ability to articulate the product of the creative effort and the value of the innovation process and to know when to move with it has become an important competence for the leader. The ability to distinguish between emergent properties and coalescence is critical to the viability and sustainability of the products of innovation.
>
> *Contextual capacity* is critical if leaders of innovation are to enable the financial, strategic, and process viability of the innovation dynamic: facilitating proposal rendering for innovation, critically appraising innovation and the diffusion processes, assess the evidence-driven constructs underpinning an innovation, enabling successful diffusion and adoption of innovations, and evaluating innovation feasibility and sustainability. The 7 areas of content capacity essential to this approach are concept, evidence, policy, finance, technology, communication, infrastructure, and outcomes. (p. 246)

Organizing the Assessment Data

As part of the organizational assessment process, it is important to discuss the various components of an organization. If we use linear thinking, we can look at each component as a separate entity. *Yet we must remember that all of these components are actually intertwined and interconnected to make the whole.*

An organizational assessment is like describing a person. We cannot take a person apart and look at each separate body system or organ to get a true description of that person. We can only describe how the whole person seems to operate. At each moment, this whole person is changing as events happen and he or she responds. Similarly, although we can describe the components of an organization, we must go beyond linear thinking and see the organization as a *whole, ever-changing, dynamic entity.*

As we assess an organization, we need to define not only our own department but the overall organization, which could be a single facility or a larger corporate healthcare system. Large corporate systems have their own dynamic, as do individual facilities. For instance, the corporate system might have one culture, the individual facility another, and the specific department or unit yet another.

Collins and Porras (1994, pp. 259–260) defined nine organizational categories that are helpful to use when assessing an organization:

- **Category 1: Organizing Arrangements.** "Hard" items, such as organization structure, policies and procedures, systems, rewards and incentives, ownership structure, and general business strategies and activities of the company (e.g., acquisitions, significant changes in strategy, going public).

  When considering *rewards and incentives*, if not carefully thought out, they can produce negative results. For example, one incentive for an executive team might be a bonus if they can keep costs below a certain level for the quarter or for the year (a linear model). But this has significant downsides. First, bonuses are not linked with a quality dimension and so encourage executives to save money even when patient outcomes may worsen as a result of their decisions—in the long run costing more money, not to mention patients' lives. Second, these bonuses reward only executive-level administrators, yet the people doing the everyday work with patients are not rewarded. Bonuses are more effective when given to everyone in the organization.

  Another disincentive for nurses is that they are professionals, yet we make them use time cards to clock in and out. What if their patients need care beyond their shift time? Some organizations have chosen to pay nurses annual salaries rather than hourly rates. (Sometimes salaries have been abused by administrators as a way to avoid paying for overtime. That is not the intent here. Salaries should pay a fair wage.) This can have *positive results when nurses are given the freedom to work when their patients need them.* In inpatient settings, nurses could choose their hours while others cover actual shift times. The main idea is that nurses accomplish meaningful work—satisfying experiences with patients and families that enhance nurse retention and better serve the patients.

  Another disincentive in some organizations is the high amount of money paid for traveler nurses, which ignores our best and loyal workforce already present day after day working for us and costing less money. By hiring traveler nurses, we send the message that this loyal group is not as important as the traveler nurses. Who deserves the higher salary? Surely the loyal workforce!

  It is important to give careful thought to the rewards and incentives provided in an organization because they must support desired behaviors. For instance, employee performance evaluations have no clout if they are not used to determine merit increases. And organizational performance evaluations are worthless if not everyone in the workplace is rewarded for meeting performance standards. When incentives are used to reward certain behaviors, it is important to provide the staff with educational activities that teach them the specific behaviors. For instance, if rewards are given for being patient centered, it is important to supply educational activities to teach everyone what *patient centered* actually means in daily behaviors, including the thinking and decision-making processes to be used. In addition, it is helpful if all, including top-level administrators, model and support the desired behaviors.

  Another important incentive is to pay for staff to attend conferences. During budget meetings, conference monies are often cut—a short-sighted decision—yet sometimes executive travel expenses for national conferences remain fully paid. This sends a message to staff that they are not valued (actions speak louder than words). It is important that all staff, including aides and housekeeping staff, are up-to-date doing meaningful work.

- **Category 2: Social Factors.** "Soft" items, such as the company's cultural practices, atmosphere, norms, rituals, mythology and stories, group dynamics, and management style. (Collins & Porras, 1994, pp. 259–260)

  Social factors are discussed earlier in this chapter.
- **Category 3: Physical Setting.** Significant aspects of the way the company handled physical space, such as plant and office layout or new facilities. This included any significant decisions regarding the geographic location of key parts of the company. (Collins & Porras, 1994, pp. 259–260)

  The physical setting can be a significant factor and can use many budget dollars. For instance, as more elderly people navigate our health systems, it is important for them to have easy access to services (i.e., not having to walk long distances). The physical setting can also affect how well we can accomplish our work. If the environment is always too hot or too cold, or we have only double rooms available, or we have to go to different locations for equipment, supplies, and so forth, we are less effective. Many older work settings are not adequate to handle the newer technology necessary for care. One goal in many healthcare organizations is to have everything the healthcare worker needs present at the point of care. Pati and colleagues (2012) found this reduced total walking time on a 12-hour shift by 67.9%. Fixing physical setting factors can create considerable expense, but these factors are very important.
- **Category 4: Technology.** How the company used technology: information technology, state-of-the-art processes and equipment, advanced job configurations, and related items. (Collins & Porras, 1994, pp. 259–260)

  We are in the Information Age. Technology has exploded across the healthcare landscape. Healthcare organizations, if they are not keeping up with state-of-the-art processes and equipment, are becoming obsolete. Yet technology is a huge expense. Is it worth the cost, not only of the initial purchase but implementation, regular updates, and so forth? This is a big issue that looms larger as reimbursements continue to decline. At the same time, organizations are faced with how to keep confidential information safe (meeting HIPAA laws).
- **Category 5: Leadership.** Leadership of the firm since its inception: the transition between key early shapers of the organization and later generations, leadership tenure, the length of time the leaders were with the organization before becoming CEO (Were they brought in from the outside or grown from within? When did they join?), and leadership selection processes and criteria. (Collins & Porras, 1994, pp. 259–260)

  Leadership can make or break organizational effectiveness. It is so important that when a work group is dysfunctional, the first place to look to resolve the problem is the administrative leadership. Most likely, the administrator is ineffective, which leads to more and more dysfunction in the group.

  Currently, there is a high level of turnover in the nurse manager group. Many experience feelings of overwhelm about their role. They are caught in the middle: expected to "keep staff happy"; do what the administration wants them to do even when administrators do not understand how their decisions affect staff; keep patient satisfaction scores up; maintain quality in a safe environment; keep budgets balanced; and keep up with current technology, not only for patient treatments, administering medications, and documentation but to understand administrative systems and respond to data using these systems. A big issue is that the administrators they report to may need to grow themselves. We are all in this dance together.
- **Category 6: Products and Services.** Significant products and services in the company's history. How did the product or service ideas come about? What guided their selection and development? Did the company have any product failures, and how did it deal with them? Did the company lead with new products or follow in the marketplace? (Collins & Porras, 1994, pp. 259–260)

Products and services, such as oncology or cardiology services, are a key factor to organizational success. As we serve clients, it is important to pay attention to what our healthcare clients value and want. This is what we need to provide rather than what we personally might like if we were the patients. As services are delivered, an organization needs to pay attention to ethical and legal issues as well.

As organizations examine which services to offer, it is important for them to assess the local community to identify what is already available and what is needed. For example, with baby boomers approaching retirement, managing chronic illnesses is a huge issue in health care. As healthcare services are delivered, case management is critically needed for better management of the patient and better reimbursement. More attention needs to be given to develop a seamless continuum of care. The AHA (2013) must-do strategies focus on these issues for survival in a value-based environment.

- **Category 7: Vision: Core Values, Purpose, and Visionary Goals.** Were these variables present? If yes, how did they come into being? Did the organization have them at certain points in its history and not others? What role did they play? If it had strong values and purpose, did they remain intact or become diluted? Why? (Collins & Porras, 1994, pp. 259–260)

  The first part of this chapter is devoted to core values and organizational purpose—these are so important that we started the chapter discussing them. Vision and goals support the must-do strategies the AHA (2013) has identified.
- **Category 8: Financial Analysis.** Ratio and spreadsheet analysis of all income statements and balance sheets for every year going back to the date when the company became public: sales and profit growth, gross margins, return on assets, return on sales, return on equity, debt to equity ratio, cash flow and working capital, liquidity ratios, dividend payout ratio, increase in gross property plant and equipment as a percentage of sales, asset turnover. Also examine stock returns and overall stock performance relative to the market (if applicable). (Collins & Porras, 1994, pp. 259–260)

  Although most of this is the purview of the finance department, it is important for nurse administrators to understand ratio and spreadsheet analysis. Nursing personnel are most concerned with budgets; developing and analyzing budgets and understanding how to compare reimbursements with the costs of services provided—important mandates in the value-based environment.
- **Category 9: Markets/Environment.** Significant aspects of the company's external environment: major market shifts, dramatic national or international events, government regulations, industry structural issues, dramatic technology changes, and related items. (Collins & Porras, 1994, pp. 259–260)

The micro- and macroeconomic environments contribute significantly to our present illness care system.

Moving Toward Decision Making at the Point of Care

As one assesses an organization, Likert's (1973) model (**Exhibit 3–4**) continues to be useful to show how organizational variables interact with one another at different stages.

System 1 represents a very authoritarian system. Here, there is little dialogue, communication occurs only in a downward direction (assuming the CEO is at the top—an authoritarian model), the informal rumor mill is rampant and needed because it is the best source of information for staff, decisions are made at the top, orders are given, no one dares to question the orders, staff often resist the orders covertly, and control is all important. Linear thinking is rampant.

Exhibit 3–4 Likert's Organizational Systems

Organizational Variables	SYSTEM 1	SYSTEM 2	SYSTEM 3	SYSTEM 4
Leadership				
How much confidence and trust is shown in staff?	Virtually none	Some	Substantial amount	Great deal
How free do staff feel to talk to supervisors about job?	Not very free	Somewhat free	Quite free	Very free
How often are staff's ideas sought and used constructively?	Seldom	Sometimes	Often	Very frequently
Motivation				
Is predominant use made of (1) fear, (2) threats, (3) punishment, (4) rewards, and/or (5) involvement?	1, 2, 3, occasionally 4	4, some 3	4, some 3 and 5	5, 4, based on group
Where is responsibility felt for achieving the organization's goals?	Mostly at top	Top and middle	Fairly general	At all levels
How much cooperative teamwork exists?	Very little	Relatively little	Moderate amount	Great deal
Communications				
What is the usual direction of information flow?	Downward	Mostly downward	Down and up	Down, up, and sideways
How is downward communication accepted?	With suspicion	Possibly with suspicion	With caution	With a receptive mind
How accurate is upward communication?	Usually inaccurate	Often inaccurate	Often accurate	Almost always accurate
How well do administrators know the problems faced by staff?	Not very well	Rather well	Quite well	Very well
Decisions				
At what level are decisions made?	Mostly at top	Policy at top, some delegation	Broad policy at top, more delegation	Throughout but well-integrated
Are staff involved in decisions related to their work?	Almost never	Occasionally consulted	Generally consulted	Fully involved
What does the decision-making process contribute to motivation?	Not very much	Relatively little	Some contribution	Substantial contribution
Goals				
How are organizational goals established?	Orders issued	Orders, some comments invited	After discussion, by orders	By group action (except in crisis)
How much covert resistance to goals is present?	Strong resistance	Moderate resistance	Some resistance at times	Little or none

(*continues*)

Exhibit 3–4 Likert's Organizational Systems (*continued*)

Organizational Variables	SYSTEM 1	SYSTEM 2	SYSTEM 3	SYSTEM 4
Evaluation				
How concentrated are review and evaluation functions?	Very highly at top	Quite highly at top	Moderate delegation to lower levels	Widely shared
Is there an informal organization resisting the formal one?	Yes	Usually	Sometimes	No—same goals as formal
What are cost, productivity, and other evaluation data used for?	Policing, punishment	Reward and punishment	Reward, some self-guidance	Self-guidance, problem solving

Source: Adapted from *The Human Organization: Its Management and Value* by Rensis Likert. Copyright 1967 by McGraw-Hill, Inc.

Compare this to a system 4 model, which is participative, reflecting complexity. Here, matrices exist where communication occurs between and within all levels, communication is open and shared, dialogue occurs, decisions are made at the appropriate level, the organization consists of well-integrated staff, goals are determined by group action except in crisis, there is no need for an informal organization because information is transparent, and productivity is enhanced by each person, with everyone doing their own problem solving. Circular thinking exists here with people understanding the inner connectivity of everyone in the system. Systems 2 and 3 fall between these two extremes, with system 2 being slightly authoritarian whereas system 3 starts to become more participative.

Using Likert's model, we need to assess where our organization currently is and base our actions on this assessment. For instance, if we are a transformational leader who believes in a system 4 yet we are in a system 2, we become very frustrated and staff do not understand our leadership style if we interact with them as though we were in a system 4. Instead, we must respond based on the current system level and gradually move toward the desired system. So, in a staff meeting, when we want to get information from staff on an issue or a piece of equipment and we ask for feedback, we might not get much response. It is easy to wonder what we have done wrong. (This is internalizing the problem. Try not to do this.) Instead, realize that staff are suspicious of us, thinking, "What does she want from me? I'm not going to stick my neck out." Continue forward with transparency; it may take repeated meetings before staff begin to trust enough to start offering suggestions. Even then, it occurs only on issues that are perceived to be safe or not as emotionally laden. When this breakthrough happens, the group starts to move to a more participative model.

When we want to move an organization, department, or floor from a system 2 to a system 3, it takes repeated, consistent efforts for a year or two before we begin to see movement in the desired direction. This cultural change is enormous and particularly hard if administrators at the executive level are still authoritarian. We must not get impatient and must look for small changes. Maybe a staff member starts to give honest feedback in private, even though in meetings this person remains silent. This is an important breakthrough; it means that this staff member is starting to trust and starting to move to the next level.

When we are looking for a job, identifying the organization's system level is an important factor to assess in the interview process. Nurse administrators can assess the system level of the overall organization and the workgroup where he or she will be working.

Movement in the opposite direction is also possible, for example, nurse executives operating at a system 4 level could move to a system 2 organization. This can work but most often presents many problems.

In such cases, it is especially important to know what the nurse executive's boss is like. If the boss functions as a system 2 administrator and likes this system, this boss will not understand the nurse executive's leadership style and might even believe that the nurse executive is incompetent! System 4 characteristics can seem like a foreign language to those who operate in systems 1 or 2. When the new nurse executive asks staff what they think about issues, the system 2 boss might think, "Isn't the new nurse executive able to make his/her own decisions?" In other words, "Doesn't this nurse executive know what to do? Is this person incompetent? Why doesn't this person just tell staff what to do?" The boss operates in a system 2 mode by issuing edicts. Staff members are to follow the edicts, and there is no room for questions or dialogue. This approach can be very frustrating for the system 4 nurse executive unless the executive understands this systems model and deals with the boss on a system 2 level. Unfortunately, in this situation, most often the nurse executive is fired within a year.

This model can also help explain why a successful program in one facility will not work in another. Perhaps the successful strategy worked in a system 3 environment. Is it any wonder that it will not work in a system 2 setting?

Rounds

Another way to assess organizations is by doing *rounds*. In this value-based environment, this is the best way to stay in tune with what is actually happening with patients—the primary purpose of our business. This is important for everyone from board members and executives to floor nurses and nurse aides. It is the best way to discover the small, incremental changes that are around us every day. The focus is the patient and what the patient values. Frequent *administrative rounding* provides valuable information about organizational dynamics. It enables nurse administrators to get to know employees, see how organizational processes are actually working—or not, hear concerns from everyone—at all points of service, note physical environment issues, and more. *It is critical that administrators at all levels of management, as well as nursing staff, do frequent rounds.*

Rounds are times to share information, be open to questions and concerns, eliminate or reduce barriers to care, and have roundtable gatherings around issues. We can get a feel for the total organization, and an additional bonus is that many issues can be resolved on the spot. This also means that when there is full census, or a unit or department needs help, the administrators are empathetic to the situation and pitch in.

Nurse administrators can find out all sorts of helpful information by visiting staff, physicians, patients and families, and other interdisciplinary staff while doing rounds. Rounds allow feedback to be gained from and given to staff without having too many meetings. This is greatly facilitated when all administrators—from board members and the president to the nurse manager—do rounds *daily*, being visible for the sake of more effective communication as well as giving support and living the core values. In a value-based environment, this is a much more productive way to spend administrative time than many of the meetings are.

Rounds provide opportunities for regular dialogue with the people at the point of service about major issues that need to be fixed. During rounds, nurse administrators can identify the appropriate individuals to work on and discern solutions to fix the problem issues, and then continue to involve appropriate people to implement the chosen solution, to tweak it when needed, and to evaluate the effectiveness of what occurred to make sure the desired outcomes were achieved.

In fact, an *administrative competency* is *the ability to sense the atmosphere* in a department or on a unit when coming to round. Sometimes it is quiet or involves the usual hustle and bustle, but sometimes one can sense that something is wrong—or that magic is happening. Duality again. It may be time to celebrate

when magic is happening. But it may be necessary to intervene and help if something is wrong. This competency of being aware of the energy (atmosphere) as one rounds is something that develops over time.

Evidence supports the importance of doing rounds. Lee and Manley (2008) and Rondinelli and colleagues (2012) share how nurse director rounds support patient-centered care, and how nurse administrators who value staff rounding support this concept in meetings, staffing decisions, and so forth. Rondinelli and colleagues (2012) and Tonges and Ray (2011) describe nurse manager rounding, which includes whether staff have rounded on patients. Setia and Meade (2009) bundled nurse manager rounding with discharge telephone calls. This significantly raised patient satisfaction. They found that nurse manager rounds identified "many outcomes including identification of service recovery opportunities, setting expectations about the care that the patient will receive, and building confidence in the team of nurses who will care for the patient" (p. 140). Interestingly, they found that when the nurse manager rounds with patients, the patients "feel better about the nurses taking care of them."

There are fewer lawsuits when the patient and family perceive that the caregivers—and administrators—care. A healthcare administrator is always more effective when doing rounds because the real patient issues are more likely to be identified earlier and many can be addressed on the spot.

While doing rounds, it is important for nurse administrators to coach and mentor staff, rather than be too task oriented. We want staff to think, make decisions, and take actions, not depend on someone else, such as the administrator, the physician, or the nurse manager, for all the answers. The goal is to encourage and empower staff as much as possible to deal with issues as they arise.

There are some potential traps to avoid. First, the administrator needs to exhibit certain behaviors. While walking down the hall of an inpatient unit, if the administrator does not pay attention to call lights or patients/families that are having obvious problems, the message the administrator sends is that patient issues are not important. If the administrator does not greet staff but just goes to find the manager, staff get the message they are not valued. They can view the administrator as not caring about them.

Second, it is best not to be Attila the Hun. If one reacts to a situation and heads roll, everyone becomes afraid of the administrator, hides information from the administrator, resents the administrator, and does not actually change behavior—unless the administrator is around. It is more advantageous to converse with staff and to help staff explore more effective options.

A third trap to avoid is micromanaging. When an administrator micromanages, the message is that staff members, or the manager, are not capable of doing the job right. However, the real problem is that the administrator has not learned to delegate effectively.

The most effective way to do rounds is to pay attention to everyone present, talk with people, demonstrate caring, and use rounds as a learning process. All actions support the core values and the purpose. As crises occur, remain calm and decisive and, when necessary, pitch in and help resolve the situation. As problems become evident, talk with those involved to explore how best to handle a situation, or get into a dialogue about what happened and determine what could have been done to more effectively deal with the problem.

Round-the-clock meetings enable everyone, regardless of shift or work schedule, to learn what is important from other perspectives. This way the midnight or weekend personnel do not feel as isolated. Administrators at all levels should hold these meetings regularly.

Roundtable gatherings can be a helpful way to deal with the many issues that staff experience as they do their work. It is best if all attend a gathering based on interest in the topic to be discussed. It is especially helpful if those attending from administration represent various levels, and depending on the topic to be discussed, special invitations should go out to departments that deal with the issue being discussed.

An *open-door policy* means that someone who has an important issue is welcome to share it with any administrator at any level in the organization. An open door does not mean that a secretary intercedes, although, if the secretary is empowered, this person is invaluable to an administrator and actually deals with many issues directly, saving the administrator time.

Multidisciplinary rounds range from daily to biweekly or weekly, often led by a physician and/or nurse (Squires, 2012). Case managers are included. Geary and colleagues (2009) found daily rapid rounds to be most effective and decreased length of stay.

Many advocate hourly *staff nurse rounds* where nurses talk with patients about current issues patients are concerned with and make sure all patients' needs are met (pain medications, repositioning, patient and environmental assessment). Rondinelli and associates (2012) advocate: "A—activity, B—bathroom, C—comfort, D—dietary, and E—environment" (p. 328).

Sherrod and colleagues (2012) and Tonges and Ray (2011) advocate "purposeful" hourly rounding. This allows "nurses to spend more time with their patients addressing care needs. By increasing care quality, patient satisfaction improves, positively affecting the image of a facility for patients and families" (p. 37). Tonges and Ray (2011) advocate staff nurses and nursing assistants round on alternative hours. Both Neville and colleagues (2012) and Bourgault and colleagues (2008) advocate involving patient care technicians (PCTs) in rounding so that when a nurse needs to spend more time with one patient, the PCT can visit the other patients.

Rounds shows patients that someone cares about them. Rounds might be done by the primary nurse or by a nurse/PCT team, and frequently charge nurses assist in rounding (Minnier et al., 2012). Rounds needs to vary in certain areas, for example, in postpartum it may be to help with feeding the baby, and in the OR it may be to talk with relatives waiting during the patient's procedure.

> Routine patient [rounds], once considered a standard of care in the nursing profession, has recently reemerged with a twist. New research shows that hourly patient rounding increases patient satisfaction and decreases patient falls and call-light usage when performed in a standardized and consistent manner. (Bourgault et al., 2008, p. 18)

Berkow and associates (2012) advocate that nurses who are not assigned to certain patients round on similar patients for about 5 minutes. This gives the nurses more of an organizational team experience/picture than just being caught up with their own patients.

There are issues, however. Shepard (2013) discusses barriers to rounds. "Nurses described how complex patients, necessitating additional and prolonged time, frequently altered their rounds protocol, leaving them concerned and frustrated about caring and rounding for other patients" (Neville et al., 2012, p. 87).

> Although the findings support the practice of rounding, thematic analysis revealed that nurses' strong sense of professional autonomy and identification of patient needs through assessment were the most important factors in determining the frequency and duration of time spent with patients. Findings revealed that a mandated [rounds] protocol minimized the sense of professional autonomy and self-directed practice. It was felt that their presence at the bedside was oftentimes far more frequent than every 1 hour. Nurses reported challenges in the provision of rounding due to increased patient acuity levels, time constraints, and the nurses' awareness of their need to be physically present. (Neville et al., 2012, p. 86)

Other issues included documentation of the rounds—another task to do that takes more time; inadequate workloads and skill mix are barriers; and interruptions that interfere with rounds being completed.

Rounds work best when staffing is adequate; when technology is available, such as computerized physician order entry (CPOE), electronic medical records (EMRs), and Vocera; when the staff involved have good communication skills; and when there is a collaborative relationship between staff so that, as one nurse has to spend more time with one patient, someone else helps to cover the rest of the patients.

Education is needed. There is a "need for stronger delegation, [time management,] collaboration, team building, and role clarity between nurses and ancillary personnel" (Neville, et al., 2012, p. 86), as well as a stronger formal orientation to rounds. As rounds are implemented, it can be helpful to have each work group work out how to accomplish it, and then have project leaders/staff be available to share best practices and tools as others start the process. The project leaders can also identify barriers, which can be worked out for each area. During implementation, a collaborative phone call where anyone can call in to discuss the rounds process can be helpful (Rondinelli et al., 2012). Generally, some customized tool is developed to show that rounds are occurring every hour. Flexibility is important in determining the process and changes to this process. Rounds can also be tied in with performance evaluations and can be added to questions asked of patients when assessing their healthcare experience. Patient feedback is also helpful and can provide additional ideas.

Some aspects of physical design may be issues that need to be resolved as well. It is best if all the equipment and supplies needed are located right by the patient room. Charting can be done as nurses see patients in the room. All of this saves valuable nurse time.

The improved outcomes from rounds can also help to get staff and manager buy-in to the rounds concept. Rondinelli and associates (2012) found that outcomes included fewer patient falls, fewer hospital-acquired pressure ulcers, increased patient satisfaction scores, lower number of patient call lights, better pain management, increased number of patient compliments versus complaints, staff satisfaction, less staff turnover, fewer sitters, less restraint use, and fewer patient requests made at the nurses' station. They also identified some unintended positive outcomes: patients' perception of being well cared for, efficient nursing practice, expert nursing practice, and realization of both unit and individual practice culture (p. 330).

Conclusion

This chapter is only the beginning. As we head toward the ocean, we take various paths. Some meander here and there. Some get there successfully despite many obstacles. Many experience temporary setbacks but know that sometimes setbacks lead in a better direction. The charted course is different for each organization. Money can continue to be adequate or, if bottom-line thinking prevails, will be scarce. We continue to evolve, either into better systems that run closer to the mission or as antiquated relics of days gone by, floundering and disappearing midstream. The choice is ours.

Notes

1. A helpful resource on tearing down the old structure and replacing it with something healthier is Lencioni's *Silos, Politics and Turf Wars: A Leadership Fable About Destroying the Barriers That Turn Colleagues into Competitors* (2006).
2. To explore thinking patterns, see de Bono (1976, 1994).

Discussion Questions

1. Identify changes in the healthcare environment that affect you at work.
2. What actions can a healthcare organization take to increase reimbursement?
3. Why is it important for an administrator to understand chaos and complexity?
4. What are some ways that chaos and complexity could be used to achieve change in a healthcare organization?
5. Why do many changes result in more complexity, and not actually fix the problem?
6. Is the purpose in your facility an effective one? Is it followed by everyone in the organization as they work?
7. How can nursing help to achieve the 10 must-do strategies the AHA has identified to be most successful in the value-based (second-curve) environment?
8. From your perspective, what is the most important core value in a healthcare organization? What are the core values at work?
9. As a nurse manager, what actions can you take to facilitate more meaningful work for each staff member?
10. Assess the spirit within your organization. How can this be increased?
11. How much autonomy do staff nurses have in your organization? How could this be improved?
12. Assess the culture where you work. What would you do to make it even better?
13. Describe the design of your organization. Is this the best design to achieve what patients value? To achieve reimbursement?
14. Why is it important for administrators to use systems thinking?
15. What would improve communication in your work setting?
16. How does evidence affect your role as an administrator?
17. How can collaboration be improved within your department and across the organization?
18. What measures can a nurse manager take to increase team effectiveness?
19. How can a nurse manager increase staff decision making at the point of service?
20. Give an example where shared governance could improve the work setting.
21. What professional development changes would you make for your work setting?
22. How could the Magnet/Excellence precepts be useful in your organization?
23. Assess your organization. As you assess it, start with the corporate organization, and then the facility, and then the unit/department where you work.
24. Why is it so important for everyone from the CEO to the nurse aide to do rounds? Give examples of what can be accomplished during rounds.
25. What are five major organizational competence issues that need to be dealt with more effectively in your organization? How would you resolve them?

Glossary of Terms

Appreciative Inquiry—"a method that focuses on increasing what works within an organization and removing what doesn't work (Shaffer et al., 2013, p. 31).

Autocatalysis—"a process in which information enters into a system in small fluctuations continually grow in strength, interacting with the system and feeding back upon itself" (Porter-O'Grady & Malloch, 2011, p. 14).

Autopoiesis—"the process by which living systems continually seek to renew and reinvent themselves, yet maintain their core integrity" (Porter-O'Grady & Malloch, 2011, p. 14).

Black Swans—unexpected events that occur "that have a significant and disproportionate impact on a system" (Clancy, 2008a, p. 273).

Chaos—forces that work to unbundle attachment to whatever is impeding movement. Chaos challenges us to simultaneously let go and to take on. It reminds us that life is a journey of constant creation (Porter-O'Grady & Malloch, 2011, p. 22).

Complexity—dynamic, interactive, nonlinear systems that adapt to changing environments. When many different interconnected agents interact at all levels to affect each other. Has a self-organizing structure that is spontaneous, adapts, and is flexible. Finds order within seemingly random complexities. Recognizes that actions are reciprocal.

Dissipative Structures—"Structures in which disorder is the source of order and vice versa. In this 'dance' between order and disorder, old form ends and new form begins" (Porter-O'Grady & Malloch, 2011, p. 14).

Feedback—is derived from both the output and throughput processes. Feedback is information about the effectiveness of the system and provides support for system changes. When outputs are positive, the system inputs and throughputs are reinforced and supported to continue. When the outputs are less than desired, modifications based on the feedback from the system are made to the throughputs. Similarly, when outputs are not what was expected, modifications to throughputs are considered (Porter-O'Grady & Malloch, 2011).

Fractals—"the smallest level of a single organization and the most complex array of the large aggregated system containing the organization are connected inexorably through the power of fractals" (Porter-O'Grady & Malloch, 2011, p. 13).

Inputs—the resources, human and nonhuman (materials, equipment, buildings), that come together to provide the desired service. In health care, inputs might be staff labor hours, number and skill mix of nursing staff, other staff needed for various services, technology, equipment, supplies used, and remodeling or building expenses (Porter-O'Grady & Malloch, 2011).

Linear—processes based on Newton's theory in which the environment is viewed as mechanistic and events are vertical and linear, compartmental, hierarchical, reductionistic, and controlling.

Outputs—result from the interaction of inputs in the throughput process. The output is the material, goods, and/or services produced. Outputs can be both qualitative and quantitative in health care. Reimbursement in health care is driven by the quantitative outputs or documented services produced by the system, regardless of the quality of the output or errors that might have occurred (Porter-O'Grady & Malloch, 2011).

Positive Deviance Method—a method to bring about improvements in an organization where those having different (deviant) practices/strategies that produce better (positive) outcomes share them with others.

Shared Governance—a structural team framework that affords nursing, and other disciplines, professional autonomy at the point of care.

Strange Attractor—"The activity of a collective chaotic system composed of interactive feedback between and among its various 'parts' and evidencing 'attraction' to its pattern of behavior" (Porter-O'Grady & Malloch, 2011, p. 14).

Throughputs—the processes or work that people do to achieve the output, the final product or service. In the healthcare system, throughputs are the patient care services provided to the patient and family. Throughput processes use the available inputs to create work processes (Malloch, 2011).

Value-Based Environment (second curve)—presently, reimbursement is changing to include organizational performance mandates. When protocols are not met, and when never events occur, insurers do not pay providers for the event or for the hospital stay. Reimbursement is value based.

Volume-Based Environment (first curve)—in the past, when reimbursement was determined by the volume of insured patients. Industrial Age organizational design was used.

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