

# Leadership Theory and Application for Nurse Leaders

*Linda Roussel, Patricia L. Thomas, and Carol Ratcliffe*

## LEARNING OBJECTIVES

1. Describe how leadership theory underpins healthcare management.
2. Discuss the guiding principles and competencies for nursing leadership practice.
3. Relate selected theories of leadership and management to organizational outcomes.
4. Discuss the role of nursing leadership in managing a clinical discipline.

## AONE KEY COMPETENCIES

- I. Communication and relationship building
- II. Knowledge of the healthcare environment
- III. Leadership
- IV. Professionalism
- V. Business skills

## AONE KEY COMPETENCIES DISCUSSED IN THIS CHAPTER

- III. Leadership
- IV. Professionalism

### III. Leadership

- Foundational thinking skills
- Personal journey disciplines
- Ability to use systems thinking
- Succession planning
- Change management

### IV. Professionalism

- Personal and professional accountability
- Career planning
- Ethics
- Evidence-based clinical and management practices

- Advocacy for the clinical enterprise and for nursing practice
- Active membership in professional organizations

### FUTURE OF NURSING: FOUR KEY MESSAGES

1. Nurses should practice to the full extent of their education and training.
2. Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.
3. Nurses should be full partners with physicians and other health professionals in redesigning health care in the United States.
4. Effective workforce planning and policy making require better data collection and information infrastructure.

## Introduction

Leadership counts, and leading like it matters is essential for inspiring and engaging our constituents, colleagues, and stakeholders. Without a spirited and deeply satisfied workforce, sustained safety and quality care are improbable. Gallup's *State of the American Workplace* report (2013) said a staggering 70% of Americans have negative feelings about their work. Some of the following findings were noted:

- Only 30% of employees are engaged and inspired at work.
- About 52% of employees are present but not engaged.
- A full 18% are actively disengaged or worse.
- As much as \$550 billion in productivity is lost because of the 18% of actively disengaged employees.

This chapter focuses on leadership theories and models and their application to administrative practices. How leaders impact workforce and patient outcomes serves as the impetus for ongoing improvements and innovations.

### WHAT DO LEADERS DO?

Kotter (2014) notes that management and leadership are different. Specifically, he notes the following:

- Management involves planning and budgeting. Leadership involves setting a direction.
- Management involves organizing and staffing. Leadership involves aligning people.
- Management provides control and solves problems. Leadership provides motivation and inspiration.

Gardner (1993) asserts that first-class managers are usually first-class leaders. Leaders and leader-managers distinguish themselves beyond run-of-the-mill managers in six respects:

- They think longer term—beyond the day's crises, beyond the quarterly report, beyond the horizon.

- They look beyond the unit they head and grasp its relationship to larger realities, such as the larger organization of which they are a part, conditions external to the organization, and global trends.
- They reach and influence constituents beyond their jurisdiction and beyond boundaries. Thomas Jefferson influenced people all over Europe. Gandhi influenced people all over the world. In an organization, leaders overflow bureaucratic boundaries, which is often a distinct advantage in a world that is too complex and tumultuous to be handled through channels. Their capacity to rise above jurisdictions may enable them to bind together the fragmented constituencies that must work together to solve a problem.
- They put heavy emphasis on the intangibles of vision, values, and motivation and intuitively understand the nonrational and unconscious elements in the leader–constituent interaction.
- They have the political skill to cope with the conflicting requirements of multiple constituencies.
- They think in terms of renewal. A routine manager tends to accept structures and processes as they exist. The leader or leader–manager seeks revisions of processes and structures that are required by a changing reality.

Good leaders, like good managers, provide visionary inspiration, motivation, and direction. Good managers, like good leaders, attract and inspire. People want to be led rather than managed. They want to pursue goals and values they consider worthwhile. Therefore they want leaders who respect the dignity, autonomy, and self-esteem of constituents (Morriss, Ely, & Frei, 2014).

The dynamic of complex relationship building in leading change necessitates various approaches to innovating health care. Dooley and Lichtenstein (2008) discuss methods for studying complex leadership interactions, centering on (1) micro, daily interactions using real-time experience, participant-observation actions; (2) meso interactions (days and weeks) involving social network analysis, where there is discovery of a set of agents and how they are connected and aligned over time; and (3) macro interactions (weeks, months, and longer) through event history analysis. The researchers describe agent-based modeling simulations, which are computer simulations using a set of explicit assumptions about how agents (leaders) are thought to operate and used as a means to study complexity leadership. Using a micro, meso, and macro interaction approach adds different lenses to social networks and interprofessional collaboration.

Effective nurse executives combine leadership and management and work to achieve these requisite goals. Leadership is a subsystem of a management system. It is included as an element of management science in management textbooks and other publications. In some sources, the term *leading* has replaced the term *directing* as a major function of management. In such a context, communication and motivation are elements of leadership (a concept that could be debated according to management theorists' philosophical bent) (Van Buren & Safferstone, 2014).

Management includes written plans, clear organizational charts, well-documented annual objectives, frequent reports, detailed and precise job descriptions, regular evaluations of performance against objectives, and the administrative ordering of theory. Nurse managers who are leaders can use these tools of management without making them a bureaucratic roadblock to autonomy, participatory management, maximum performance, and employee productivity.

## LEADERSHIP VERSUS HEADSHIP

A job title does not make a person a leader, nor does it cause a person to exercise leadership behavior. This is as true of nurses as it is of personnel in industry or the military. It is a mistake to refer to the dean of a college, a professor of nursing, a nurse administrator, a supervisor, a nurse manager, or any nurse as a leader by virtue of position. That person is in a headship position rather than a leadership position; leadership is more a function of the group or situation than a quality that adheres to a person who is appointed to a formal position of headship. A person's behavior indicates whether that person occupies a functional leadership position. Leadership is an attempt to influence groups or individuals without the coercive form of power.

Avolio, Walumbwa, and Weber (2009) describe the concept of leadership as moving toward a more holistic approach and that more positive forms of leadership are being researched and integrated into the literature. How an individual develops leadership competencies and skills has always been essential to leadership development and has earned greater attention in healthcare innovation. Working in virtual teams across national and international boundaries is underscored as technology is embedded in our daily work, signifying how e-leadership will need to be included in leadership development. Impacting short- and long-term outcomes is critical, particularly as the return on investment becomes increasingly important to financial viability. Leadership and followership provide an important dynamic system as interprofessional collaboration and team building are identified as competencies in the education of healthcare professionals (Institute of Medicine [IOM], 2003). Distributed and shared leadership continue to be part of the leadership development conversation, as leadership is viewed as a complex and emergent dynamic in organizations.

When heads are elected by a group, they keep their positions only as long as they satisfy the members' needs for affiliating with the organization. They are responsible only to the group, whereas appointed heads are usually responsible to both the appointive authority and the group. Nurses who are elected to chair committees or who preside over professional organizations will not be reelected unless they satisfy the members' needs.

Appointed heads may lack the freedom to choose relationships with associates because their supervisors do not allow it. They have authority and power without being accepted by the group. If appointed nurse managers are allowed to and can exercise their leadership abilities, they can be accorded leadership status by the group. Nurse managers understand and motivate employees in order to be trusted by them.

### Preparation of Nursing Leaders

Parks (2013) believes that leadership can be taught. Education begins in basic nursing education programs. To develop risk-taking behaviors and self-confidence, students should be encouraged to create new solutions and to disagree and debate, and they should be coached to make mistakes without fear of reprisal. Critical thinking and reflection are important to this process. Faculty should encourage and support students who exercise their leadership abilities in projects and organizations on campus and in the community.

Most nurses who graduate and enter the workforce are not ready to assume a leadership role. They require opportunities for self-discovery, self-reflection, and critical thinking to understand their strengths and build their skills. Skill building occurs through on-the-job training and coaching, along with support from peers and mentors who are effective leaders. Mentors must be dynamic, enthusiastic, and passionate about their work to positively influence those they mentor.

## LEADERSHIP MATTERS

Hewertson (2015) shares eight insights that shape our understanding of leadership as being foundational to igniting those we work with. The insights include the following: leadership knowledge, though important, must be followed by action; leading people is messy; leadership is a discipline, not an accident; leadership and individual contributions require opposite skills sets and motivations. The other insights pertain to relationship-based leadership: in leadership it is all about relationships, soft skills are hard skills; although most change initiatives fail, they need not; and leaders create and destroy culture.

Hewertson (2015) also describes four core masteries that every leader needs to attain at a reasonable level of competency: personal mastery, interpersonal mastery, team mastery, and culture and systems mastery. A self-assessment of leadership style; knowing yourself and your emotional intelligence, preferences, life purpose, values, and vision; and how you influence others are the focus of personal mastery. Knowing how you communicate; deeply listening; providing critical and constructive feedback; and managing conflict are the skills of interpersonal mastery. How your team works; how members come together; how information is handed off; and group dynamics are skills of team mastery, along with decision making that works; delegation for development; and meetings that garner great results. Culture and systems mastery includes understanding the interaction of the organization's culture and systems dynamics. Doing a cultural assessment is important to understanding how culture facilitates or deters change initiatives (Hewertson, 2015).

Learning skills to lead and motivate interprofessional teams fosters collaboration and cooperation. An engaged workforce facilitates engaged patients through the patient experience and patient-centered care. Manary, Boulding, Staelin, and Glickman (2013) report on the patient experience and health outcomes. Their research notes that when studies are designed and administered appropriately, patient-experience surveys can provide robust measures of quality, as accessing patient experiences can be critical to continued quality improvement in healthcare redesign. The researchers report that while there are challenging methodologic issues related to measuring and interpreting patient experience, such as mode and timing of survey administration, and patients' prior experience, it is essential to find ways to capture this vital information. Capturing indicators of healthcare quality can serve to improve healthcare structures and processes (admission, discharge, and educating patient). The authors underscore the importance of focusing on how to improve the patient's care experience by emphasizing care coordination and patient engagement activities noted to be associated with both satisfaction and outcomes. Other important activities include evaluating the effects of new care-delivery models on patients' experiences and subsequent outcomes and developing appropriate measurement approaches that can provide timely and action-oriented

information to enhance organizational change. These strategies can improve data collection methods and procedures and provide appropriate and accurate assessments of individual providers.

Stempniak (2014) describes patient engagement as a strategic imperative for hospital executives. Fully engaged patients can reduce costly readmissions and improve health literacy and patient satisfaction scores. Patients often come to a healthcare experience with past experience, expertise, and insights. This has been noted and addressed by the Centers for Medicare and Medicaid Services Stage 2 reimbursement, which is based on at least 5% of patients viewing, downloading, and transmitting their health information within 36 hours of discharge (Stempniak, 2014). Patients are consumers of health care, and engagement is an expectation for healthcare providers to meet regulatory mandates and standards of care. Leadership skills that provide innovative strategies for patient engagement are in demand. By creating a culture of engagement that inspires team members, the odds for patient engagement are increased.

## ARCHETYPES OF LEADERSHIP

Kets de Vries (2013) describes his approach to leadership assessment that is based on observational studies of real leaders, primarily at the strategic apex of their organizations. His focus is helping leaders see and understand that their attitudes and interactions with people are the result of a complex confluence of their inner circles and may include their relationships with authority figures early in life, memorable life experiences, examples set by other executives, and formal leadership training. Kets de Vries posits that the complex confluences may play out over time, and often there are recurring patterns of behavior that influence an individual's effectiveness within an organization. The author considers these patterns to be leadership archetypes that reflect the various roles managers and executives assume in organizations. It is a lack of fit between a leader's archetype and the operational context that may result in team and organizational dysfunction and leadership failure. The eight archetypes are as follows:

- The strategist: Leadership is a game of chess. These managers often excel when dealing with developments in the organization's environment. They provide vision, strategic direction, and outside-the-box thinking to create new organizational forms and generate future growth.
- The change catalyst: Leadership is a turnaround activity. These leaders relish messy situations. They are exceptional at reengineering and creating new organizational blueprints.
- The transactor: Leadership is deal making. Leaders as transactors are great deal makers. Because they are skilled at identifying and tackling new opportunities, they thrive on negotiations.
- The builder: Leadership is an entrepreneurial activity. The leader as builder often dreams of creating something and has the talent and determination to make the dream come true.
- The innovator: Leadership is creative idea generation. Innovators focus on new, exciting, and creative ideas. They possess a great capacity to solve extremely difficult problems.



- The processor: Leadership is an exercise in efficiency. Leaders who are processors create organizations that run smoothly, like well-oiled machines. They are very effective at setting up structures and systems that are needed to support an organization's objectives.
- The coach: Leadership is a form of people development. Coaches know how to get the best out of people and create high-performance cultures.
- The communicator: Leadership is stage management. Leaders who are great influencers have a considerable impact on their surroundings.

Kets de Vries (2013) notes that determining which types of leaders are on the team can advance the group's effectiveness. It helps to recognize how you and your colleagues can individually make the best contributions, which will in turn create a culture of mutual support and trust, reduce team stress and conflict, and foster creative problem solving. This can also enhance searching for new talent for the team. What kinds of personalities and skills are missing? For example, if the team needs an executive with a strategic outlook and who had turnaround skills and experience, then a communicator and coach would be more effectively leveraged to resolve an operational crisis. Working with human resources to identify particular skill sets that are required on the executive management team could be expedited using an archetypes of leadership model, which provides a framework for enhancing team effectiveness.

## TRANSFORMATIONAL LEADERSHIP

The healthcare system is immersed in tremendous change and chaos, and organizational situations and problems are increasingly complex. Healthcare organizations are restructuring and redesigning delivery models to meet the challenges of these changes. Health care is prohibitively expensive for many Americans. Hospitals and emergency rooms are financially burdened by uninsured people who may suffer from recurring and multiple chronic health issues, violence, drug overdose, and HIV infection. Many people, especially in rural areas and inner cities, do not have access to health care due to the downsizing of hospitals and a shortage of healthcare personnel. Leaders are tasked with keeping staff inspired and motivated in this chaotic, unstable environment. Effective leaders in this atmosphere of rapid change must acknowledge uncertainty, be flexible, and consider the values and needs of constituents.

Now more than ever, the need for transformational leadership is critical. Transformational leaders commit people to action, convert followers into leaders, and convert leaders into agents of change (Tuuk, 2011). The nucleus of leadership is power, as the basic energy to initiate and sustain action translating intention into reality. Transformational leaders do not use power to control and repress constituents. These leaders instead empower constituents to have a vision about the organization and trust the leaders so they work for goals that benefit the organization and themselves (Tuuk, 2012; Watkins, 2014).

Leadership is thus not so much the exercise of power itself as it is the empowerment of others. This does not mean that leaders must relinquish power, but rather that reciprocity, an exchange between leaders and constituents, exists. The goal is change in which the purpose of the leader and that of the constituent become

enmeshed, creating a collective purpose. Empowered staff members become critical thinkers and are active in their roles within the organization. A creative and committed staff is the most important asset that administrators can develop.

Transformational leaders mobilize their staff by focusing on the welfare of the individual and humanizing the high-tech work environment. Experts favor a leadership style that empowers others and values collaboration instead of competition. People are empowered when they share in decision making and when they are rewarded for quality and excellence rather than punished and manipulated. When the environment is humanized, people are empowered, feel that they are part of the team, and believe they are contributing to the success of the organization. Leaders who share power motivate people to excel by inspiring them to be part of a vision rather than punishing them for mistakes. In nursing, empowerment can result in improved patient care, fewer staff sick days, and decreased attrition. Nurses who are transformational leaders have staff members with higher job satisfaction and who stay in the organization for longer periods. This can be accomplished through the establishment of a shared governance model that includes staff-led councils that are composed of, but are not limited to, nursing practice, staff development, research, quality, recruitment and retention, and unit-based councils.

Nurse executives who like to feel they are in charge may feel threatened by the concept of sharing power with staff members, so they need to be personally empowered to assist in the empowerment of others. They will have a sense of self-worth and self-respect, and confidence in their own abilities.

### Transformational Leadership and Innovative Approaches

Transformational leadership and innovative approaches are needed for change in health care and are critical to successful organizational outcomes. Transformational leadership is central to safety in a variety of industries and to an organization's competitive cost position after a change initiative. Transformational leadership has been specifically identified by the Institute of Medicine (2001) in its work on medical error and patient safety. Changes in nursing leadership have been underscored in creating safe environments for patients and staff, particularly as the weakening of clinical leadership has been cited as a cause of organizational concerns and issues. The Institute of Medicine described outcomes of poor, problematic leadership (Buerhaus, Staiger, & Auerbach, 2000):

- Increased emphasis on production efficiency (bottom-line management)
- Weakened trust (reengineering initiatives, poor communication patterns)
- Poor change management (inadequate communication, insufficient worker training, lack of measurement and feedback, short-lived attention, limited worker involvement in developing change initiatives)
- Limited involvement in decision making pertaining to work design and work flow (hierarchical structures, limited voice on councils and committees)
- Limited knowledge management (process failures, limited second-order attention)

To address these challenges, the following recommendations were made for healthcare organizations by the Institute of Medicine, particularly related to acquiring nurse leaders for all levels of management (e.g., at the organization-wide



and patient care unit levels). Nurse leaders are challenged to do the following (American Nurses Association [ANA], 2009):

- Participate in executive decisions within healthcare organizations.
- Represent nursing staff to organization management and facilitate their mutual trust.
- Achieve effective communication between nursing and other clinical leadership.
- Facilitate the input of direct-care nursing staff into operational decision making and work process and work flow designs.
- With organizational resources, support the acquisition, management, and dissemination to nursing staff of knowledge needed for quality clinical decision making and actions.

Although no one particular organizational structure was identified for the placement of nurse leadership, the focus of the recommendations was on well-prepared clinical nurse leaders at the most senior level of management. Magnet and Pathway to Excellence hospitals have found some positive outcomes related to staff and patient satisfaction that correlated with participatory and transformational leadership. Clearly, transformational leadership is called for to address these challenges, to improve quality outcomes for patients and staff, and to heighten overall organizational effectiveness (ANA, 2009).

### *Buffering*

Nursing leaders can act as buffers or advocates for nurses. In doing so, they protect constituents from internal and external pressures of work. Nurse managers can reduce barriers to clinical nurses who are completing their clinical work. Buffering protects practicing clinical nurses from external health system factors, the health-care organization, other supervisors and employees, top administrators, the medical staff, and themselves when their behavior jeopardizes their careers. Buffering is another facet of the theory of leadership related to management, and it requires leadership training (Zheng, Singh, & Mitchell, 2014).

Nurse managers can buffer, and therefore protect, nurse practitioners, extended-role nurses, staff nurses, and ancillary personnel. Professional nurses do not want to have additional responsibilities delegated to them if they are already under severe pressure and stress. The delegation of decision making is power; the delegation of work is drudgery. Professional nurses are there to motivate, inspire, and engage, not to dissatisfy.

Management writers say there is a difference between leaders and managers, but their textbooks and writings on the subject include leadership content. Professional nurses want to be led, mentored, and coached, not directed or controlled. Also, nurse managers can learn the concepts, principles, and laws that will assist them in becoming effective leader-managers.

Different situations require different leadership styles. The leader-manager assesses each situation and exercises the appropriate leadership style. Some employees want to be involved; others do not. There must be a fit between the leader and the constituents. The leader demonstrates this by changing the leadership style and training others until a transition is made. A flexible leadership style

is necessary and vital. Participatory, transformational, innovative, and quantum leadership principles have received much attention. This is primarily due to the frenetic pace of health care and a focus on safe, quality care. Using leadership frameworks to guide practice may include authentic leadership, servant leadership, and lateral leadership (Avolio, Walumbwa, & Weber, 2009; Dinh et al., 2014; Johnson, 2014).

### Competencies for Transformational Leaders

Bennis and Nanus (1985) believe the most important trait of successful leaders is having positive self-regard. Positive self-regard is not, however, self-centeredness or self-importance; rather, leaders with positive self-esteem recognize their strengths and do not emphasize their weaknesses. A leader who has positive self-regard seems to create in others a sense of confidence and high expectations. Techniques used to increase self-worth include visualization, affirmations, and letting go of the need to be perfect.

Through research and observations, Bennis (1991) defined four competencies for dynamic and effective transformational leadership: (1) management of attention, (2) management of meaning, (3) management of trust, and (4) management of self. The first competency, management of attention, is achieved by having a vision or a sense of outcomes or goals. Vision is the image of a realistic, attainable, credible, and attractive future state for an organization. Vision statements are written to define where the healthcare organization is headed and how it will serve society. They differ from mission and philosophy statements in that they are more futuristic and describe where energies are to be focused. The vision of nursing is supported by a nursing strategic plan that is integrated in and supports the overall organizational plan.

The second leadership competency is management of meaning. To inspire commitment, leaders must communicate their vision and create a culture that sustains the vision. A culture or social architecture, as described by Bennis and Nanus (1985), is “intangible, but it governs the way people act, the values and norms that are subtly transmitted to groups and individuals, and the construct of binding and bonding within a company” (p. 176). Barker (1991) believes that “social architecture provides meaning and shared experience of organizational events so that people know the expectations of how they are to act” (p. 207).

Nursing leaders transform the social architecture or culture of healthcare organizations by using group discussion, agreement, and consensus building, and they support individual creativity and innovation. To do this, Barker (1991) believes the nurse transformational leader will pay attention to the internal consistency of the vision, goals, and objectives; selection and placement of personnel; feedback; appraisal; rewards; support; and development. For example, rewards and appraisals must relate to goals, and the vision must be consistent with the goals and objectives. Most important, all elements must enhance the self-worth of individuals, allow creativity, and appeal to the values of nurses. For many nurse leaders, these are new skills that will take time and support from mentors to develop.

Because vision statements are a new concept to many, nursing leaders should provide opportunities for staff to openly explore feelings, criticize, and articulate negative reactions. Face-to-face meetings between nursing leaders and staff are desirable because in reactions involving trust and clarity, memoranda and suggestion boxes are not adequate substitutes for direct communication (Barker, 1991).

This can be achieved through nursing forums, rounding, huddles, or small group meetings.

The third competency is management of trust, which is associated with reliability. Nurses respect leaders whose judgment is sound and consistent and whose decisions are based on fairness, equity, and honesty. Staff can be heard to comment about leaders they trust with statements such as “I don’t always agree with her decision, but I know she wants the best for the patients.” Bennis (1991) believes that “people would much rather follow individuals they can count on, even when they disagree with their viewpoint, than people they agree with but who shift positions frequently” (p. 24).

The fourth competency is management of self, which is knowing one’s skills and using them effectively. It is critical that nurses in leadership positions recognize when they lack management skills and take responsibility for their own continuing education. Incompetent leaders can demoralize a nursing unit and contribute to poor patient care. When leadership skills are mastered by nurse leaders, stress and burnout are reduced. Nurse leaders thus need to master the skills of leadership (Bennis, 1991).

Although effective leaders support shared power and decision making, they continue to accept responsibility for making decisions even when their decisions are not popular. Constituents like to have their wishes considered, but there are times when they want prompt and clear decisions from a leader. This is especially true in times of crisis.

Transformational leaders are flexible and able to adapt leadership styles to the chaos and rapid change that is occurring in the current healthcare environment.

### Transformational Leader as Coach

Coaching and mentoring are important skill sets for transformational leaders. Coaching denotes a way of being with others that provides opportunities to facilitate growth and development. Coaching requires exquisite communication skills that model ways of interacting and networking with others, whereby those coached will find ready examples of best practices in working with others. Hill (2007) describes the predictable process of coaching, which includes the following:

- Observing
- Examining coach motives
- Creating a discussion plan for the coaching session
- Initiating
- Providing and eliciting feedback
- Having a follow-up meeting

As a coach, observing behaviors and responding with insights and strategies will go further than instructing others on what to do. This approach will afford greater opportunities for learning and advancing skills and opportunities. Porter-O’Grady and Malloch (2007) describe innovation coaching, stating the importance of creating the structure and content of the experience. Specifically, the following guidelines are given to facilitate this effort:

- Setting the bar high
- Being clear about who you are
- Treating transformation as a mission, not a job

**BOX 2-1 Impediments to Effective Coaching****Use of power**

- Inadequate power
- Autocratic application of power
- Lack of empowerment
- Nonstrategic use of power

**Self-image**

- Poor self-esteem
- Unclear role
- Psychological flaws

**Knowledge**

- Undeveloped knowledge
- Learning needs
- Inexperience
- Lack of personal technique

**Problem solving**

- Inadequate worldview
- Intolerance of diversity
- No clear process
- Situational solutions

- Exposing staff to different messages and different messengers
- Creating an egalitarian organizational structure
- Putting money where the ideas are
- Letting the talented experiment
- Allowing people to share in the fruits of their creativity

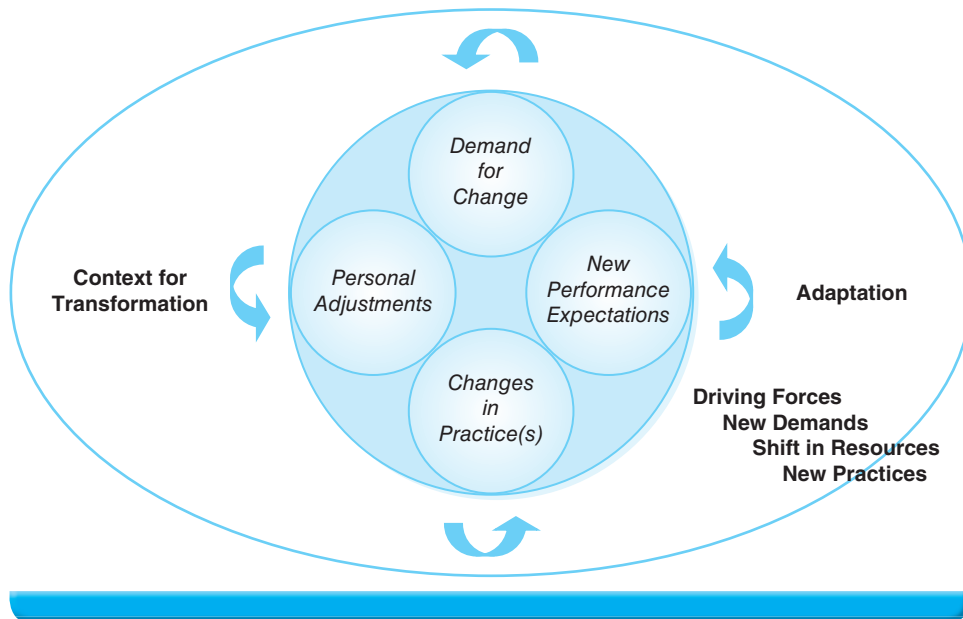
**Box 2-1** illustrates impediments to effective coaching, and **Figure 2-1** illustrates a transformational model of coaching.

**STRATEGIC LEADERSHIP**

Schoemaker, Krupp, and Howland (2013) identified strategic leadership skills that are essential to leading. Their self-assessment tool for determining strategic leadership is available in the cited publication. It includes the following skills: anticipate, challenge, interpret, decide, align, and learn. Each skill includes methods to improve strategic leading; some examples are as follows:

- **Anticipate:** The actions include talking to customers, suppliers, and other partners to understand their challenges, and conducting market research and business simulations to understand competitors' perspectives, gauge their likely reaction to new initiatives or products, and predict potential disruptive offerings. Additional activities might include scenario planning to anticipate possible futures and prepare for the unexpected, and viewing trends and fast-growing rivals by examining strategies they have used that are surprising.
- **Challenge:** Leaders can improve by focusing on root causes, applying the five whys of Sakichi Toyoda, encouraging debate by creating safe-zone meetings that facilitate open dialogue and conflict, including naysayers in decision-making processes to discover challenges early, and capturing input from persons who are not directly affected by a decision who may have a good perspective on the repercussions.

**FIGURE 2-1 A Model for Considering Coaching from a Transformational Perspective**



- **Interpret:** Strategies include listing three possible explanations for observations, inviting perspectives from diverse stakeholders, and supplementing observations with quantitative analysis. Additional strategies may include stepping away to get a fresh perspective, going for a walk, listening to unfamiliar music, looking at art, and other activities that promote open-mindedness.
- **Decide:** Leaders can reframe binary decisions by asking team members about other options for decision making, dividing decisions into chunks to understand component parts and reveal unintended consequences, and tailoring decision criteria to long-term versus short-term projects. Leaders can be transparent about decisions by letting others know if they are seeking divergent ideas and debate or if they are moving toward closure. It is also important to determine who needs to be directly involved and who can influence the success of the decision.
- **Align:** Leaders should communicate early and often to keep the two most common complaints in organizations from becoming a reality: no one ever asked me, and no one ever told me. Additional strategies include using structured and facilitated conversations to expose areas of misunderstanding or resistance and reaching out to resisters directly to understand their concerns and then address them.
- **Learn:** Useful strategies include creating a culture in which inquiry is valued and mistakes are considered learning opportunities, conducting learning audits to see where decisions and team interactions may have fallen short, and identifying initiatives that are not producing as anticipated and examining their root causes.

Organizational managers, including nurse executives, teach frontline managers the nature of leadership. They coach nurse managers in leadership skills and put managers in challenging scenarios to learn leadership. Critical reflection, debriefings, and innovative problem solving extend these lessons, which include starting up an operation, turning around a troubled division, moving from a staff position to a line position on an organizational chart, working under a wise mentor, serving on a high-level task force, and getting promoted to a more senior level of the organization.

Nurse executives and managers should be educated and socialized to coach their constituents on leadership skills and strategies. Constituents can be socialized to help managers with leadership. Leaders can listen and articulate, persuade and be persuaded, use collective wisdom to make decisions, and teach relationship building and upward communication skills (Galinsky & Kilduff, 2014).

### Lateral Leadership

Johnson (2014) describes lateral leadership as involving a constellation of capabilities that includes the following:

- Networking
- Constructive persuasion and negotiation
- Consultation
- Coalition building

In networking, leaders cultivate broad networks of relationships with people inside and outside their companies whose support is needed to carry out initiatives. Johnson (2014) says if networking does not come naturally to a leader, it is important to connect with those who are portals to other people; that is, people who can connect the leader to bigger networks.

Constructive persuasion and negotiation is way to view those involved in projects and initiatives as peers, not targets. Developing constructive persuasion and negotiation abilities may be facilitated by taking courses and reading articles and textbooks to improve. These capabilities can also be enhanced by finding seasoned colleagues who can serve as confidantes and brainstorming partners.

Consultation is a useful skill in lateral leadership. It involves taking time to visit people whose buy-in is needed. Leaders should ask for others' opinions about initiatives they are championing and get their ideas and reactions. Lateral leaders will get better results if they commit to and advocate for the desired outcome, such as inviting peers to participate in defining the process for achieving specific outcomes.

Coalition building involves gathering influential people to form a single body of authority. By building coalitions, leaders ask the following questions: Who is most likely to be affected by the change? Whose blessing is needed, either in the form of political support or access to important resources or individuals? Whose buy-in is crucial to the success of the initiative?

There can be challenges to developing a lateral leadership style. Leaders may be too focused on their own functional silos that limit awareness of information and resources beyond one's internal group. They can combat functional focus by



taking time to find out who makes things happen in the organization and asking the following questions:

- Who do people go to for advice and support?
- Who tends to set up roadblocks to changes and new ideas?

Informal contact and casual get-togethers can increase networking and reduce a functional focus. Additionally, by dedicating a specific amount of time each week to making contacts and getting support, lateral leadership skills can be sharpened.

## LEADERSHIP AND JUST CULTURE

Creating a fair and just culture is an essential responsibility of nursing leadership. A fair and just culture is important to high-reliability organizations in facilitating safe patient care. Frankel, Leonard, and Denham (2006) describe three initiatives that are critical to the ethics of creating and maintaining a safe environment for patients and staff: (1) develop a fair and just culture; (2) intelligently engage by using frontline insights to directly influence operational decisions; and (3) provide systematic and reinforced training in teamwork and effective communication. Ethical decision making and actions underscore safe, high-quality care.

## NURSING AND LEADERSHIP HEALTHCARE POLICY

Nursing is conspicuous in its absence from lists of national leaders. National consumers do not perceive nurse leaders as having power. The healthcare system has failed to recognize nurses as professionals who have knowledge that is useful in creating solutions to complex problems. The Institute of Medicine's (2011) report on the future of nursing further underscores the need for nurses to be at the table by being better educated and by being full partners with physicians and other healthcare professionals in redesigning health care in the United States.

Historically, nurses have avoided opportunities to obtain power and political muscle. The profession now understands that power and political savvy will help achieve the goals to improve health care and increase nurses' autonomy. Also, if the healthcare system is to be reformed, nurses must participate individually and collectively. Nurses need to find ways to influence healthcare policy making so their voices are heard. Milstead (2013) believes that nurses have the capacity for power to influence public policy and recommends the following steps to prepare:

- Organize.
- Do homework to understand the political process, interest groups, specific people, and events.
- Frame arguments to suit the target audience by appealing to cost containment, political support, fairness and justice, and other data that are relevant to particular concerns.
- Support and strengthen the position of converted policy makers.
- Concentrate energies.
- Stimulate public debate.
- Make the position of nurses visible in the mass media.
- Choose the most effective strategy as the main one.

- Act in a timely fashion.
- Maintain activity.
- Keep the organizational format decentralized.
- Obtain and develop the best research data to support each position.
- Learn from experience.
- Never give up without trying.

Nurses in leadership positions are most influential in organizational, systems, national, and international changes that impact global policy initiatives.

### FUTURE DIRECTION: QUANTUM LEADERSHIP

Porter-O'Grady and Malloch (2015) describe quantum leadership as new leadership for a new age. From a conceptual perspective, quantum theory considers the whole, integration, synthesis, relatedness, and team action. **Box 2-2** compares the Newtonian and the quantum perspectives. According to Porter-O'Grady and Malloch (2015), quantum theory has informed leaders that change is not an occurrence or an event; it is a dynamic that is essential to the universe. Quantum leadership incorporates transformation, a dynamic flow that integrates transitions from work, rules, scripts, chaos, and loss. Adaptation considers driving forces from sociopolitical, economic, and technical perspectives. The term *chaos*, as used in quantum leadership, refers to the transitional period focused on relational and whole systems thinking, as compared with separate components and linear thinking (**Figure 2-2** and **Figure 2-3**).

Porter-O'Grady and Malloch (2015) further describe seven imperatives for the new age (**Box 2-3**).

### INNOVATIVE LEADERSHIP

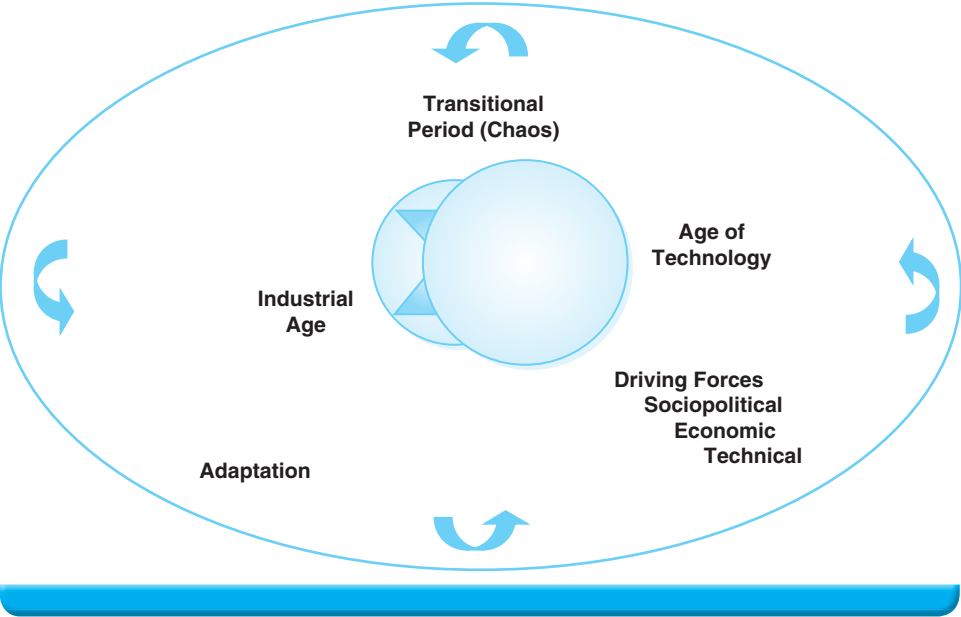
Porter-O'Grady and Malloch (2007) describe concepts of innovative leadership in preparing organizational systems for change. They outline stages of innovation adoption that include knowledge, persuasion, decision, implementation, and confirmation. Individuals are also identified and include innovators, adopters, early majority, late majority, and laggards. Concepts include design thinking, thinking inside the box, disruptive innovation, and scenario planning.

Design thinking involves integrating work from art, craft, science, and business. Understanding consumers and the market is essential to designing programs

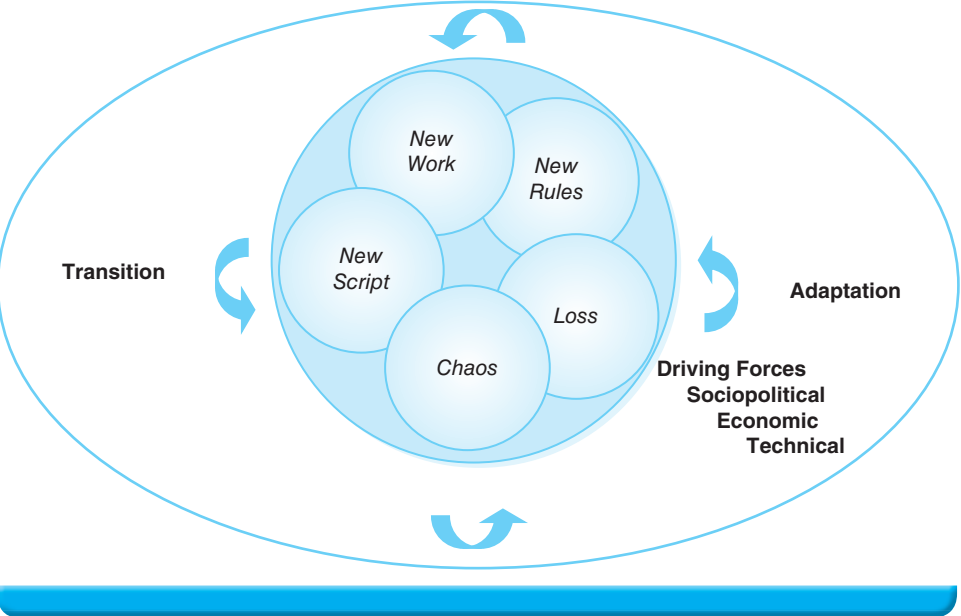
#### BOX 2-2 Newtonian Characteristics

- Vertical orientation
- Hierarchical structures
- Focus on control
- Process-driven action
- Reductionistic scientific processes
- Top-down decision making
- Mechanistic models of design

**FIGURE 2-2 A Pictorial View of the Conceptualization of Transformation for Quantum Leadership. New Rules Will Apply in the New Age.**



**FIGURE 2-3 A Pictorial View of the Conceptualization of Transformation for Quantum Leadership. New Rules Will Apply in the New Age.**



**BOX 2-3 Seven New Age Imperatives**

1. Open access to health information
2. Medicine and nursing based on genomics
3. Mass-customized diagnosis and treatment
4. User-specific insurance programs
5. Integration of allopathic and alternative therapies
6. Payment incentives tied to outcomes (quality)
7. Focused service settings for specific populations

that are sensitive to the needs of patients. Thinking inside the box considers that those closest to the work and those who are familiar with the existing challenge have the greatest insights into the processes. As innovation leaders become knowledgeable about processes by thinking inside and outside the box, positive deviants become evident. Positive deviants increase the knowledge pool by offering different perspectives that may, on the surface, be divergent to the status quo. Disruptive innovation defines a performance trajectory by introducing new dimensions of performance compared with existing innovations. New markets are created by bringing new features to nonconsumers or offering more convenient or lower prices to consumers. Scenario planning allows for a dry run and creating what-if scenarios for new ideas. Scenario planning provides an opportunity to capture essential elements for evaluating healthcare situations. The information garnered from this type of strategy provides invaluable information that teams can use to confront uncertainty and deal with serious problems that may seem outrageous from a traditional thinking perspective. “The purpose is to move out of traditional thinking patterns and develop creative solutions not previously considered” (Porter-O’Grady & Malloch, 2015, p. 113).

**SUMMARY**

The theory of nursing leadership is part of the theory of nursing management. Leadership is a process of influencing a group to set and achieve goals. Bennis and Nanus (1985) define a theory of leadership they call transformational. This leadership style involves change in which the purposes of the leader and follower become intertwined. Effective leaders create a vision for the organization and then develop a commitment to the vision. Bennis and Nanus (1985) believe the wise use of power is the energy needed to develop commitment and to sustain action.

Nurse managers should learn to practice leadership behaviors that stimulate motivation within their constituents, practicing professional nurses, and other nursing personnel. These behaviors include promotion of autonomy, decision making, and participatory management by professional nurses. They are facilitated

by effective nurse manager-leaders. Strategic and lateral leadership also provide frameworks for contextual thinking about leading.

Quantum leadership offers a new-age perspective as one transforms and redesigns the workplace into a culture of greater safety and quality.

### REFLECTIVE QUESTIONS

1. Reflect on how you lead and follow and describe how leadership theory underpins how you manage.
2. Describe the guiding principles and competencies that frame your leadership style and the perceptions of those you lead.
3. Consider leadership theory as a lens through which you view your leadership practice. Does this relate to selected theories of leadership and management, as well as organizational outcomes, within your healthcare system?
4. How do you view the role of nursing leadership in managing a clinical discipline?

### CASE STUDY 2-1 Is a Leader Only a Leader When Paid?

#### Arlene H. Morris and Debbie R. Faulk

S. M., a midlevel administrator in a medical home, has been quite active in the state nurses' association since moving to the state 10 years ago. S. M. was recently elected to the office of president-elect (a 2-year term followed by 2 years in the president role). Although S. M. perceives election as an honor and an expression of other members' confidence in her leadership abilities, she wondered what preparation would be needed and how much time would be involved in this professional volunteer service. Additionally, it was a surprise when the higher-level administrators did not look favorably on her election. In fact, a few asked S. M. to describe how the state nurses' association was or was not functioning as a labor union and how the officer role would influence her role as midlevel administrator.

Although she was surprised at the administration's response, S. M. met with her supervisor to discuss the mission and vision of the state nurses' association, focusing on promoting excellence in nursing practice across all settings of care and advocating both for nurses within the healthcare delivery system and for quality and safe health care for the state population. The chief executive officer (CEO) later met with S. M. and asked her to specify what the role would entail and how it would impact her work role. S. M. thought of a past state association president who encouraged her to run for office and who was a role model and mentor for her. The past president often spoke of transformational leadership theory, and from what S. M. had encountered, it was the best example of this theory in action.

S. M. responded to the CEO by relaying her hopes of developing her own leadership skills and influencing the quality and safety of nursing in the healthcare delivery system within the state and across the nation. The CEO emphasized that the volunteer activities must not interfere with S. M.'s job responsibilities in any way. S. M. left the meeting puzzled and discouraged, wondering why the CEO did not see her election as a way for S. M. to increase her leadership competencies and a wonderful opportunity to advance professional nursing practice within the state.

*(continues)*

**CASE STUDY 2-1 Is a Leader Only a Leader When Paid? (Continued)****Case Study Questions**

1. What are the intended purposes and benefits of membership in a state nurses' association?
2. What are similarities and differences between state nurses' associations and state or national nursing specialty organizations?
3. What theory (or theories) of leadership would be helpful for S. M. as she assumes a leadership role in a voluntary professional membership association?
4. In the role of advocate for the thousands of licensed nurses within S. M.'s state, what issues should S. M. anticipate, and how will they most effectively be addressed?
5. How could S. M. pursue interaction with current state nurses' association leaders to ensure adequate succession planning for her benefit and for the benefit of the association?
6. Describe how S. M.'s leadership role in the state nurses' association would potentially benefit her performance in her midlevel management role.
7. What business skills, management abilities to work with state nursing association employees and volunteers, and knowledge of the healthcare delivery system are needed? How can S. M. develop the necessary knowledge, skills, and abilities?

**CASE STUDY 2-2 Managing Conflict****Sergül Duygulu**

Sevda has worked for 6 years at a private hospital with a capacity of 20 beds. She recently earned her bachelor's degree in nursing and is now working as a clinic nurse in orthopedics and traumatology at the hospital. As a student, Sevda wanted to change several unfavorable conditions in patient care after she graduated. Her belief that nothing could be done about system failures had solidified after spending so many years working at the hospital. On the other hand, Sevda is experiencing family burdens, including caring for her husband, who is unemployed, and her 3-year-old daughter, which led Sevda to continue working at the same hospital. She goes to work every day with the hope that she can at least make a difference in the lives of her patients.

There are eight nurses and a unit charge nurse in the orthopedics and traumatology department where Sevda works. Four of them have bachelor's degrees in nursing, and four of them are graduates of vocational schools. The hospital management is forced to hire vocational graduates because of a high turnover rate. Three nurses work the day shift, two nurses work the evening shift, and one nurse works the night shift. Although there is an effort to provide service in accordance with predefined standards, it is known that there are often patient care mistakes. However, the measures taken to reduce the mistakes have been limited. People have been held responsible, and the necessary warnings have been made.

Sevda is working with another nurse on the evening shift. She is more senior than the other nurse, who is a vocational school graduate and has recently completed her first year in the profession. After they take over from the day shift nurses, Sevda and her colleague divide the patients and start to provide care. Two of the patients under Sevda's care require careful attention because they have recently come out of surgery. Midway through the shift, one patient's fever has gone up, and the other has started to bleed. Sevda asks the other nurse to help her by checking the vital signs of her other patients, but the nurse says she is too busy with her own patients.



## CASE STUDY 2-2 Managing Conflict (Continued)

Sevda was barely able to finish her work as her shift drew to a close. She remembered that the daughter of one of the other nurse's patients asked Sevda to give pain medication to her mother. Because Sevda was busy with her postsurgical patients, she told the daughter that the other nurse was assigned to her mother, and that she should be available soon. At the end of the shift, Sevda and her colleague handed off their patients to the night nurse and went home.

The next morning, when the unit charge nurse visited patient rooms, the daughter who asked Sevda for her mother's pain medication complained, saying that neither of the evening nurses stopped by her mother's room, and her mother did not get her pain medication until the night nurse gave it to her. The unit charge nurse, who believes that patient satisfaction is essential, apologized and said she would take care of the situation. She reviewed the records from the evening shift and found a note saying the evening nurse visited the patient three times to take her vital signs and twice to give medication. The unit charge nurse called Sevda and the other evening nurse and asked them to come to a meeting that afternoon.

In the meeting, the unit charge nurse asked Sevda and her colleague to explain what happened. Sevda said the woman was not her patient; she cared for 10 patients, two of whom were in critical condition. She explained that the daughter who complained had asked her for pain medication, and she told the daughter that the other nurse should come by. Sevda said she did not know anything else about the situation. Sevda's colleague said the patient and her daughter were lying. She said she went to the patient's room at least five times, as noted in the hospital record.

The unit charge nurse did not know what to do, so she referred the issue to the nursing services director, who requested the videotape from the camera that records patient room entrances. The tape showed that no nurse had entered the patient's room except when the patient was handed off between shifts.

The nursing services director called Sevda to her office. She told Sevda that, as an experienced nurse, she should manage the evening shift better. She told Sevda that if another such mistake is made, her employment will be terminated. Sevda loses her motivation and begins to think that she should take the necessary steps to find a job in another hospital.

The nursing services director told the other nurse that her employment was terminated. The nurse responded by saying that many nurses make the same mistake, but the director said her conduct is unacceptable. She stands by her decision to terminate the nurse so the other nurses will see the outcome of such behavior.

Now that one evening nurse has been terminated, only one nurse will work that shift.

### Case Study Questions

1. Describe the issues that complicate the case. How are these issues interrelated?
2. What possible system problems occurred in this situation?
3. If you were Sevda, how would you have handled the situation?
4. How do you assess the leadership behaviors of Sevda, the unit charge nurse, and the nursing services director in handling this situation?
5. Who are the power holders in this case, what power sources did they use, and how did they use that power to manage the situation?
6. How did the players' actions impact the resolution of the problem?
7. Do you think the problem was solved?
8. How do you assess this case in terms of effective leadership?
9. If you were the unit charge nurse or the nursing services director, how would you have handled the situation?

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