CHAPTER 5

Leading in an Era of Change and Uncertainty: Driving Excellence in Practice While Developing Leaders of the Future

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LEARNING OBJECTIVES

1. Describe attributes of leadership styles which promote contemporary care models.
2. Envision how nurse leaders position the discipline for success.
3. Acknowledge contributions of all team members in achieving organizational imperatives.

AONE KEY COMPETENCIES

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

AONE KEY COMPETENCIES DISCUSSED IN THIS CHAPTER

I. Communication and relationship building
II. Knowledge of healthcare environment
III. Leadership
IV. Professionalism

I. **Communication and relationship building**
   - Effective communication
   - Relationship management
   - Influencing behaviors
   - Diversity
   - Community involvement
   - Medical/staff relationships
   - Academic relationships

II. **Knowledge of healthcare environment**
   - Clinical practice knowledge
   - Delivery models/work design
   - Healthcare economics and policy
   - Governance
   - Evidence-based practice/outcome measurement and research

- Patient safety
- Performance improvement/metrics
- Risk management

III. Leadership

- Foundational thinking skills
- Personal journey disciplines
- Systems thinking
- Succession planning
- Change management

IV. Professionalism

- Personal and professional accountability
- Career planning
- Ethics
- Advocacy

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

Nurse administrators use many leadership styles, such as situational, motivational, transformational, and servant leadership, to drive change and sustain success. While all the aforementioned leadership styles provide value, situational leadership is perhaps currently the style that is most applicable for nurse leaders to stabilize, build, and inspire necessary culture shifts within healthcare systems moving forward. In 2010, the Affordable Care Act (ACA) was passed by Congress with the intent of creating a more affordable, accessible healthcare system while improving patient safety and quality (American Nurses Association [ANA], 2014; Centers for Medicare and Medicaid Services [CMS], 2010). Escalating costs to provide care, the aging of the baby boomer generation, and an economic downturn culminated in a crisis in 2008.

Healthcare costs in the United States represented 18% of the gross domestic product (GDP) in 2009. The situation was deemed unsustainable, and observers noted that if the trend was not curtailed, it would debilitate an already struggling American economy (Executive Office of the President Council of Economic Advisers, 2009). In spite of the United States spending the most dollars on health care worldwide, Murray, Phil, and Frenk (2010) note that the United States is ranked as 37th in quality and cost. The U.S. healthcare system was the most expensive and performed poorly compared to other industrialized nations in measures of quality, efficiency, and effectiveness (Commonwealth Fund, 2014).

The technological revolution has resulted in a society that is highly informed and expects superior results, exceptional customer service, and instant gratification. Patients no longer allow healthcare providers to make healthcare decisions independently; they expect to partner with the healthcare team. Quality scores are posted publicly, and performance and outcomes are tied

to reimbursement. Savvy customers are willing to travel outside their hometowns and around the globe for world-class care (Plonien & Baldwin, 2014).

Other forces affecting the current state of health care in the United States are an aging population and epidemic levels of obesity compounded with poor-quality food sources, limited accessibility, and compartmentalized care delivery models that lead to abysmal outcomes and failed attempts at improvement. Since January 2011, 10,000 baby boomers become eligible for Social Security each day (Kessler, 2014). Medicaid and Medicare face increasing financial struggles as costs and demands continue to grow. According to Nix (2012), Medicaid is consuming larger portions of state budgets, and Medicare's long-term unfunded obligations are estimated to be as high as $36.9 trillion. Since 2008, Medicare has been running deficits in the Hospital Insurance Trust Fund. It is anticipated that with the flood of new baby boomer enrollees, Medicare costs will continue to soar. While seemingly positive, technological advances increased costs to the healthcare system, raising the national expenses per patient. In 1958, the average American worker spent about $1,080 per year on health care compared to about $10,348 today (Centers for Medicare and Medicaid Services [CMS], 2018).

In spite of the ACA being signed into law, current legislators have sought to repeal the act, alleging the ACA to be unsuccessful and costly. Proposed legislative changes could leave millions uninsured, resulting in decreased access to care, limited preventive care, increased morbidity and mortality, and increased costs for individual states. This also limits safety net healthcare systems, often the only access to care that vulnerable populations have to healthcare providers. Uninsured individuals who do not qualify for Medicaid and who cannot pay for insurance are often turned away by providers, resulting in undiagnosed and untreated pathologies and increased hospitalizations (Johnson & Johnson, 2010). The ACA has not been without problems; the enactment resulted in increased Medicaid enrollment. Those who accessed the exchanges often found high-deductible plans that reduced monthly premiums still to be unaffordable, with the cost of imposed penalties being less than the cost of insurance. Some uninsured people have elected to pay for health care out of pocket because the expense is less than paying either a premium or the penalty (Gorman & Appleby, 2014). Far fewer young, healthy Americans enrolled than was predicted, resulting in a higher percentage of older Americans with preexisting and costlier conditions being covered.

The nation has recovered from the deep economic recession of 2008, resulting in the lowest unemployment rates in almost two decades. Many seasoned nurses are now retiring, leaving a void of experienced educators and clinicians with an aging population requiring chronic disease care management by a variety of providers. A radical and innovative approach to the design of new care delivery models is essential to meet the varied and complex health needs of the country. Unraveling the current disease-focused approach to care and the payment systems for these services requires an unwavering commitment to health promotion, establishing competencies and role functions of those engaged in care delivery, and an inspiring vision to bring care providers together to achieve desired outcomes. This shift will demand the best of interdisciplinary teams led by those who recognize the need to learn new ways to interact with patients as consumers. Embedding evidence-based practices is important to sustainable health and healthcare system outcomes. An evidence-based model called Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS) is one strategy to improve team communication and effectiveness.

TeamSTEPPS

A recent emphasis is placed on the impact of teams in providing care, recognizing that each team member provides a unique perspective that collectively maximizes interprofessional collaboration. The Agency for Healthcare Research and Quality (AHRQ, 2008) created the TeamSTEPPS curriculum in collaboration with the U.S. Department of Defense Patient Safety Program. The curriculum defines teamwork as a "set of interrelated knowledge, skills, and abilities (KSAs)

that facilities co-coordinated, adaptive performance, supporting one's teammates, objectives and missions" (AHRQ, 2008, p. 1).

The TeamSTEPPS core program is based on 20 years of research and experience from the application of team science and principles in team building. The aim of TeamSTEPPS is to improve patient safety through the coordination and collaboration of interdisciplinary members. It is an evidence-based system facilitating communication and teamwork skills among healthcare professionals. TeamSTEPPS provides useful tools and a training curriculum that is readily available through online resources. The program emphasizes role clarity, responsibilities of team members, language to be used for handoffs, dealing with conflict to improve information sharing, and reducing barriers to quality and safety.

TeamSTEPPS has a three-phase process aimed at creating and sustaining a culture of safety with pretraining assessment for site readiness, training for onsite trainers and healthcare staff, and implementation and sustainment. The AHRQ describes the three phases as follows:

> The three phases of TeamSTEPPS are based on lessons learned, existing master trainer or change agent experience, the literature of quality and patient safety, and culture change. A successful TeamSTEPPS initiative necessitates a thorough assessment of the organization and its processes and a carefully developed implementation and sustainment plan.
>
> **Phase 1: Assess the Need**
>
> The goal of Phase 1 is to determine an organization's readiness for undertaking a TeamSTEPPS-based initiative. Such practice is typically referred to as training needs analysis, a necessary first step to implementing a teamwork initiative.
>
> **Phase 2: Planning, Training, and Implementation**
>
> Phase 2 is the planning and execution segment of the TeamSTEPPS initiative. Because TeamSTEPPS was designed to be tailored to the organization, options in this phase include implementation of all tools and strategies in the entire organization, a phased-in approach that targets specific units or departments or a selection of individual tools that are introduced at specific intervals (called a *dosing strategy*). As long as the primary learning objectives are maintained, the TeamSTEPPS materials are adaptable.
>
> **Phase 3: Sustainment**
>
> The goal of Phase 3 is to sustain and spread improvements in teamwork performance, clinical processes, and outcomes resulting from the TeamSTEPPS initiative. The key objective is to ensure that opportunities exist to implement the tools and strategies that are being taught, practice and receive feedback on skills, and provide continual reinforcement of the TeamSTEPPS principles on the unit or within the department. As an effective, evidence-based practice, TeamSTEPPS provides a multifaceted approach to improving team communication, patient handoffs, and safety, which can reduce the chaos and disorder of the complexity in health care. (AHRQ, 2008, About TeamSTEPPS section)

TeamSTEPPS 2.0 Core Curriculum is an iteration of the original work done on improving interprofessional communication. It is meant to help teams tailor a plan to train staff on teambuilding skills, thus facilitating improvement work in the organization. The Core Curriculum starts with the initial concept development, implementation, spread of the evidence-based strategies, and sustainment of positive outcomes (AHRQ, 2008).

The TeamSTEPPS curriculum is a user-friendly, comprehensive multimedia kit that contains basic modules in text and presentation format, a pocket guide that corresponds to the essentials version of the course, video vignettes to reinforce key concepts, and workshop materials, including a supporting CD and DVD on change management, coaching, and implementation (AHRQ, 2008, p. 1). While it is recommended that organizations use the comprehensive curriculum, selected

tools can be adopted by an organization who may want to "warm up" to the total TeamSTEPPS program.

For example, there are specific tools within the TeamSTEPPS model. One communication tool identifies the situation, background, assessment, and recommendations (SBAR). It is a situational briefing model that was developed to bridge differences in individual communication styles and perceived authority or power gradients of the people involved. The tool can reduce dependency on memory and uses prompts on an SBAR reporting document to help develop what information needs to be communicated. TeamSTEPPS integrates situational monitoring as the process of actively scanning and assessing elements of the situation in which the patient care team is functioning (AHRQ, 2008). Situational monitoring involves actively and systematically scanning the whole patient care environment. It includes problem recognition and promotes flexibility and adaptability, serving to keep the environment safer. A more focused form of situational monitoring is situation awareness, which is knowing what conditions affect the work. Using rigorously developed and tested tools provides consistency and constancy in chaotic, complex organizational healthcare systems. In addition, population health continues as part of the conversation of improving care and health status of those we serve in the continuum of healthcare delivery.

Complex Care Delivery System

Greater attention is being paid to the complexity of healthcare systems in the United States and how care is being provided across the continuum. Historically, high-acuity care was provided only within the confines of acute care hospitals. This has shifted so that higher-acuity care is now being offered in long-term care facilities, in long-term acute care hospitals, and in patients' homes (Mor, Caswell, Littlehale, Niemi, & Fogel, 2009). Nurse leaders are now expected to provide supervision and oversight to clinical care and quality outcomes across settings in healthcare systems.

As healthcare reform evolves and more care is provided in a variety of sites within a community, the need for authentic, transformational leadership requires the recognition that all members of a team—nurses, physicians, advanced practice providers, physical and occupational therapists, pharmacists, social workers, health coaches, assistants, and payer care coordinators and navigators—will require highly developed clinical, communication, and team-based skills. Likewise, expectations surrounding patient safety, which are highlighted in The Joint Commission National Patient Safety Goals, emphasize care across the continuum and the contributions of interdisciplinary team members to affect outcomes (The Joint Commission [TJC], 2015).

In terms of safety, the link between how teams function and how each of us perceives the quality and safety of care calls for leaders to engage staff members in conversation about a disciplined approach to improvement work. Systems theory acknowledges that a change in one element of care influences other elements, and in turn affects the entire system (AHRQ, 2008).

With the need to manage and coordinate care across the system, emerging themes in population health management and care transitions generate a paradigm shift. A recognition of care fragmentation; managing disease rather than wellness (Schultz, Pineda, Lonhart, Davies, & McDonald, 2013); and cost, efficiency, and effectiveness on the national stage have changed the conversations among providers, patients as consumers, employers, regulators, and healthcare policy makers (Dahl, Reisetter, & Zismann, 2014). Further, emerging leadership roles, such as the masters prepared clinical nurse leaders (CNLs), are demonstrating improvements in quality outcomes through enhancing team performance, patient engagement, and patient care transitions (American Association of Colleges of Nursing, 2007).

POPULATION HEALTH

Managing care across the continuum in an era of healthcare reform is focused on population health, recognizing the current disease-focused, episodic, fee-for-service delivery model is costly

and ineffective in managing the overall health and well-being of those served, particularly the most vulnerable. The goal of population health is to keep people healthy, minimize high-cost interventions in emergency rooms or hospitals, and judiciously use imaging tests and procedures. In this model, individuals interface with providers throughout a disease trajectory and are offered tools and information that promote health (Felt-Lisk & Higgins, 2011; Institute for Health Technology Transformation, 2012). This offers care in a lower-cost setting and redefines health care as a service based on concern about individuals when they are sick and when they are taking steps to maintain their health for an overall sense of well-being.

Although population health does not ignore high-risk ill individuals, it distributes resources toward prevention and health promotion, particularly for those with chronic illness, recognizing that some risk factors are modifiable. Provider-based care delivery is one of many factors that influence outcomes, albeit a relatively small percentage. Public health intervention, sociodemographic status, genetics, and individual behaviors are also important determinants of health (Institute for Health Technology Transformation, 2012; Kindig & Stoddart, 2003). Social determinants of health are recognized as essential to long-lasting health outcomes. Specifically, our health is also attributed in part to access to social and economic opportunities. That is, consideration of resources and supports available in our homes, neighborhoods, and communities; the quality of our educational experiences; safe workplaces; clean water, food, and air; and the nature of our social interactions and relationships are critical elements to a healthy lifestyle and quality of life. Our living conditions explain in part why some Americans are healthier than others and why more generally are not as healthy as they could be. Healthy People 2020 illuminates the criticality of embracing the social determinants of health by including "Create social and physical environments that promote good health for all" as one of the four overarching goals for the decade (Secretary's Advisory Committee on Health Promotion and Disease Prevention Objectives for 2020, 2010). The World Health Organization (Commission of Social Determinants of Health [CSDH], 2008) underscore these goals in the Commission on Social Determinants of Health in the published report, *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health* (CSDH, 2008). This focus is also supported by other U.S. health initiatives such as the National Partnership for Action to End Health Disparities and the National Prevention and Health Promotion Strategy (National Partnership for Action & The National Stakeholder Strategy for Achieving Health Equity, 2011).

Population health improvement has been defined by the Care Continuum Alliance as having three components: (1) primary care providers taking leadership roles that are central to care delivery, (2) patients becoming active participants who are involved in and responsible for their own health care, and (3) increasing care coordination and patient engagement as a result of a focus on wellness and chronic care and disease management (Care Continuum Alliance, 2012). To accomplish this, proactive care needs to be given between encounters, relying heavily on technology and care managers or navigators that support individuals in their efforts to manage their own health. High-risk patients would be supported by care managers who hope to prevent the individual from becoming unhealthier and experiencing complications.

Primary care is the core of public health, but the shortage of primary care physicians offers a space where a team of providers—including advanced practice nurses, nurses, medical assistants, dieticians, health coaches, care managers, physical and occupational therapists, and pharmacists—will be charged to coordinate services to meet patient needs (Grumbach & Grundy, 2010). No single provider or setting of care will be sufficient to accomplish this work (Margolius & Bodenheimer, 2010).

We can anticipate that work flow in the future will be dramatically different from what we are currently experiencing. Out-of-office contacts will become the norm, supported by interactions via email, group visits, centering practices, and technology-enhanced intervention (Margolius & Bodenheimer, 2010). Aside from the oversight of hospital operations, nurse leaders are expected to demonstrate expertise in managing programs and projects across the continuum. Big data and

analytics coupled with predictive modeling to prioritize and guide patient-centered, timely interventions are expectations and require deep knowledge about complexity and systems thinking. In light of this, nursing will be positioned to reclaim its focus on health promotion, educating and coaching patients and families. It is essential that nurses practice to the full scope of their license, educational preparation, and certification standards. Care manager, health coach, and care coordinator are only a few of the roles that nurses assume in assisting patients in shared decision making and self-care management. Advanced practice nurses will continue to serve as preferred healthcare providers, particularly in rural and primary care settings. Telehealth will play a larger role in patient access as well as in timeliness in care provided (AHRQ, 2008).

POSITIONING NURSE LEADERS FOR SUCCESS

Nurse leaders at all levels of organizations, in communities, and in policy settings at state and national levels will be called upon to shape new work cultures. In addition to shaping, managing, and leading change in the care delivery processes, they will be called upon to ensure the clinical competency of those providing care. New, revised, and refined skills in leading and managing teams will become central to success. Clarity in language, a commitment to continuous learning, and practicing resilience are essential during change and paramount in care delivery and services across care settings. Nurse leaders will set and articulate the vision to inspire nurses in fulfilling expectations inherent in the healthcare reform paradigm. Mindful practice and intentionality in care deliberation are now part of a mainstream conversation as interdisciplinary team members examine their values, motives, and responsibilities in their unique role in the healthcare system. Kitzpatrick (2017), lead author of the new Institute for Healthcare Improvement (IHI) Open School course, PFC 103: Incorporating Mindfulness into Clinical Practice, describes this course as one step in bringing this important training to the healthcare workforce. Kitzpatrick reports that there is increasing evidence that the practice of mindfulness results in an improved sense of calm and well-being. That is, mindfulness is a useful way of cultivating self-kindness and compassion by bringing increased awareness to and acceptance of situations that are beyond our control.

The recommendations from the Institute of Medicine (IOM, 2010) in *The Future of Nursing: Leading Change, Advancing Health* provide the foundation and a springboard for nurses to practice to the full scope of their education and licensure, achieve higher levels of education and training, become full partners with physicians and other healthcare professionals in redesigning the U.S. healthcare system, and contribute to workforce planning and policy making. Population health, technology-enhanced practices, and a willingness to enact elements of the profession that are held in high regard by both nurses and patients harken back to historical events in public health and community activism. Nurses will have the opportunity to lead teams, enact flexible evidence-based practices in the community, expand health literacy, and execute plans that engage others in health promotion.

Transformational leadership has been shown to be the most influential factor in leading and sustaining change in organizations and systems. In *Good to Great*, Collins and a team of graduate students studied successful organizations over a 15-year time span (Collins, 2001). Without fail, the organizations that sustained growth and success had transformational leaders at the helm. Collins (2001) also defined five levels of leadership. The highest-level leader (level five) is one who transforms the organization by developing transformational leaders.

In health care, transformational leadership is needed now more than ever. Transformational nurse administrators are positioned to play a key role in the future of health care. In this exciting yet challenging time, nurse leaders have the opportunity to positively influence the face of health care as we know it. Nurses, by nature, are creative, caring communicators and collaborators. These attributes will serve them well as they establish transformative leadership styles. The American Organization of Nurse Executives (AONE, 2015) offers a dynamic evidence-based model for leading and transforming health care in an era of reform.

AONE NURSE LEADER COMPETENCIES

AONE outlined key competencies for current and aspiring nurse leaders as a template to drive toward its vision of shaping the future of health care through innovative nursing leadership. The competencies are categorized into overarching domains, with specific competencies established within them. The domains are communication and relationship building, knowledge of healthcare environment, leadership, professionalism, and business skills and principles. Specific skills and attributes are further explicated for each domain (AONE, 2015).

Leadership

AONE's core competencies in nursing leadership are foundational thinking skills, personal journey disciplines, the ability to use systems thinking, succession planning, and change management. Foundational thinking skills address ideas, beliefs, or viewpoints that should be given serious consideration. These skills recognize methods of decision making and the role of beliefs, values, and inferences. Being able to critically analyze organizational issues after a review of the evidence is essential to problem solving. Maintaining curiosity and an eagerness to explore new knowledge and ideas further promotes nursing leadership as both a science and an art. The model of strengths-based leadership begins within and provides a framework for visionary thinking on issues that have an impact on healthcare organizations.

Personal Journey Disciplines

Personal journey disciplines are the essential skills and self-reflections that are critical to nurse leaders if they are to bring value to the healthcare team, the patient experience, and the healthcare delivery system at large. AONE (2015) describes these essential components as follows:

- Value and act on feedback that is provided about one's own strengths and weaknesses.
- Demonstrate the value of lifelong learning through one's own example.
- Learn from setbacks and failures as well as successes.
- Assess one's personal, professional, and career goals and undertake career planning.
- Seek mentorship from respected colleagues.

Knowing one's strengths is essential to professional development. This does not mean individuals should ignore their weaknesses; rather, they should leverage their strengths to build capacity for improvement. A visual tool, such as in the following example, can be useful in identifying personal strengths and opportunities for improvement. This tool can also be utilized when identifying team members who will bring diverse skills and contribute to a well-rounded team. The following steps, which are accompanied by examples that illustrate how to apply the model, provide a framework for identifying strengths, areas for improvement, and opportunities for growth and development:

- Identify the individual's strengths (gifts) and weaknesses (opportunities for growth). In the example, the nurse leader's strengths are identified and include emotional intelligence, communication, and creativity, which denote an excitement for taking on projects. The nurse leader is easily distracted, loses track of time, and may lose focus. This knowledge can help teams prepare to maximize capacity.
- Identify traits that are required for success of the individual or team. Note the attributes and the relative strengths or weaknesses of each member, as well as the overall team, to see a visual representation of what may be needed to balance the traits of individuals and teams. Using a scale (1–5) for each attribute could be helpful in determining how best to leverage skills. The higher the level, the greater the skill.
- Plot the strengths and weaknesses in emotional intelligence, communication, problem resolution, organizational skills, creativity, and time management. **Figure 5-1** illustrates

the attributes and strengths of Nurse A, which indicates the individual's strengths and areas for further growth, development, and coaching.

Each team member can be color-coded and compared to other team members to discover skills that may be missing from the team. The attributes and strengths of Nurse B are shown in **Figure 5-2**. Nurse B ranks high (level 5) for resolving problems through organizational skills and time management. Creativity, communication, and emotional intelligence are low level, thereby necessitating a balance of team members who demonstrate the capacity to solve problems creatively and communicate options for improvement. Emotional intelligence could be enhanced through modeling and coaching, particularly by team members who demonstrate high levels of emotional intelligence.

Although it is desirable for all nurse leaders to be well rounded, it is a rare occurrence. In Figure 5-2, gaps are readily visible and can serve as a strategy for leadership development. Nurse A will need to share his or her creativity, communication, and emotional intelligence skills with the organization while striving to develop organizational skills and time management. When working on projects or interviewing potential teammates, Nurse A should seek an individual who will complement the existing skill set.

FIGURE 5-1 Attributes and strengths of Nurse A

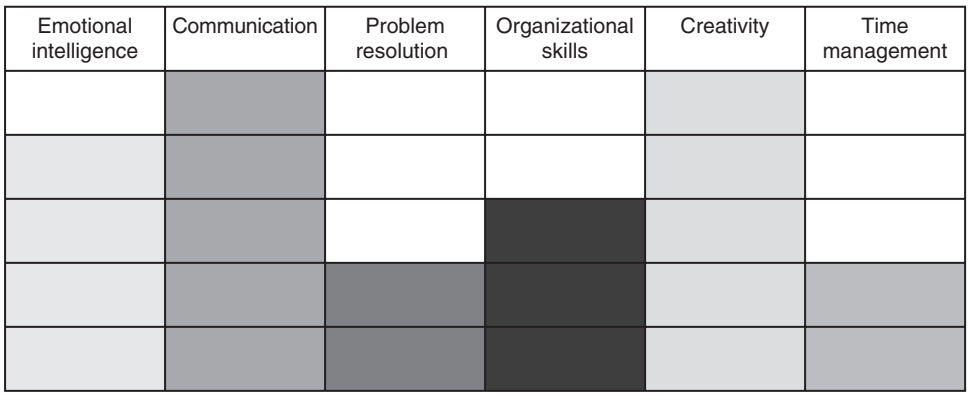
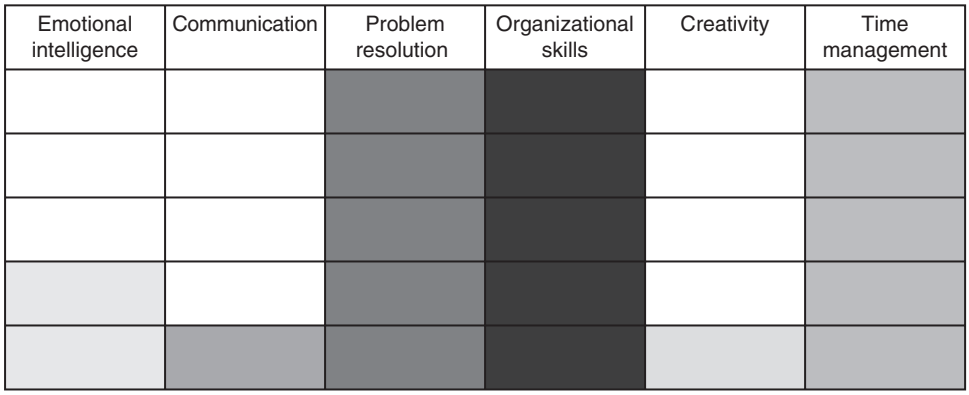


FIGURE 5-2 Attributes and strengths of Nurse B



Leaders often tend to hire themselves; that is, they seek individuals who are similar to themselves. However, hiring those who complement the traits of the leader or the team will enable more diversity and success.

Nurse leaders model and encourage lifelong learning. Nurse leaders stay abreast of current best practices and standards of care and gain much from experiences played out in the healthcare world. Interactions with patients, their families and loved ones, physicians, and administrators can provide an education that is invaluable. Knowledge becomes wisdom when it is applied, integrated, and embedded in daily operations. Classrooms cannot prepare nurses to master the political environments they may encounter. Some lessons are hard learned, but the greatest growth can be realized from mistakes, setbacks, disappointments, or choices one regrets. The challenge is to take these life lessons and transform them into not only a personal growth experience but one that others can learn from as well. During these trying times, strength and valuable advice can be sought from respected and trusted mentors. The development of these valuable relationships is a hallmark of successful nurse leaders.

Nurse administrators are responsible not only for leading the department or division of nursing but also for setting the pace for healthcare collaboration, moving systems forward, and enabling the success of all healthcare team members for the benefit of healthcare recipients. To achieve this level of collaboration, nurse administrators must be emotionally mature individuals who are self-aware, reflective, and devoted to continuous growth and development.

Communication and Relationship Building

In the IOM (2010) report *The Future of Nursing: Leading Change, Advancing Health*, complex issues that face U.S. health care and recommendations for nursing's role and contributions moving forward are detailed. One of the core recommendations is that "nursing should be full partners, with physicians and other health professionals, in redesigning health care in the United States" (p. 2). The development and mentoring of present and future leaders within nursing and other disciplines is essential to successful organizations and their members. Building trusting and collaborative relationships is an essential competency for nurse executives.

Communication and relationship building provide competencies that guide nurse leaders in their quest to develop teams, to better collaborate, and to work cohesively. For example, due to Emergency Department (ED) overcrowding and full hospital occupancy, a decision is made to expand in-patient beds. An opportunity to relocate the Trauma floor adjacent to the Surgical Trauma Intensive Care Unit (STICU) would provide improved continuity of care through team rounds on all trauma service line patients, rather than separate rounding in each area. In September 2017, TJC issued Sentinel Event Alert 58, which addressed inadequate handoff communications as a safety risk to patients, and promoted 8 Tips for High Quality Hand-Offs. Standardizing tools and processes is recommended as a best practice by TJC in having an impact on high-quality handoffs (TJC, 2017). **Exhibit 5-1** is an example of a risk assessment tool that can be used to create standard terms and scoring that provides decision-support for improved patient care outcomes. Processes that promote continuity of care bridge gaps in communication, which could lead to potential safety events and medical errors. Utilizing one nurse leader over both the STICU and the Trauma floor units could improve continuity of care as well as communication between the STICU and Trauma floor staff. The CNL, as a lateral integrator to coordinate care and communication, has also demonstrated improved patient safety and error reduction. Recognizing this, the nurse administrator collaborates with the nurse manager, CNL, and physician leader to develop strategic goals, determine areas of desired improvement, research best practices, and develop an action plan. **Table 5-1** provides an example of a plan to develop and implement evidence-based, standardized team rounding and handoffs on all trauma service line patients to improve continuity of care, improve outcomes, and reduce avoidable healthcare expenses (30-day readmissions and/or avoidable emergency room visits). **Exhibit 5-2** is an example of an adapted team-based service line criteria tool to standardize criteria for readiness to discharge from the Surgical Trauma ICU to the Trauma floor.

EXHIBIT 5-1 Sample Tool: Adult Risk Assessment: STICU to Trauma Floor

Lower Level of Care Transfer/Change of Status			
			Score
Respiratory rate	< 12	≥ 22	2
Heart rate	< 50	≥ 115	1
SBP	< 80	≥ 180	1
Temperature	< 97	≥ 101	1
Altered LOC	Yes		1
O_2 Sat <92%	Yes		2
Requires frequent suctioning > Q3 hrs	Yes		2
Circle the Indicators That Apply Above			
			Total Score: _____
Low Risk = 0–1	Medium Risk = 2		High Risk = ≥ 3
Medium Risk: Contact MD to assess transfer criteria.			

TABLE 5-1 Service Line Communication and Relationship-Building Project

(A) Form a Core Service Line Leadership Team (Team Mentor- Nurse Executive)	(B) Service Line Core Leadership Team Sets Clearly Defined, Measurable GOALS	(C) Provide TeamSTEPPS Training for Core Team Members	(D) Develop Team-Based Tools and Metrics for Measurement
▪ **CNL- Team Leader** ▪ Clinical nurse leader (CNL) ▪ STICU nurse leader/ director ▪ STICU nurse practitioner ▪ Trauma floor nurse practitioner ▪ Trauma physician champion ▪ RN champions STICU and floor ▪ Service line case manager ▪ Trauma clinic manager	**Sample Goal** By utilizing evidence-based, standardized processes for multidisciplinary rounding and handoff, harm events will decrease by 10%, average hospital length of stay (LOS) will be ↓ by 0.5 day, 30-day readmissions will be ↓ by 10%, and post Discharge (DC) ED visits within 30 days will be less than the national average.	Conduct training sessions with a TeamSTEPPS master trainer. Core team members will learn TeamSTEPPS communication methods and apply these concepts when developing rounding and handoff tools.	▪ Perform a literature search ▪ Adapt tools to the service line ▪ Clearly define roles and processes ▪ Develop education plan and a timeline for the project ▪ Validate measurement tools ▪ Measure process ▪ Measure outcomes

(*continues*)

TABLE 5-1 Service Line Communication and Relationship-Building Project (Continued)

(E) Educate the Pilot Trauma Service Line Team Members	(F) Pilot Tool and Process Measure Processes and Outcomes	(G) Measure and Share Data with Team Members	(H) Hardwire Processes to Ensure Sustainability
Utilize core team members to conduct TeamSTEPPS training for pilot service line team members. Select one tool to pilot using TeamSTEPPS model with the pilot team members. ▪ Core team members are crucial participants in the pilot team process.	**Pilot one selected tool** Example = discharge rounding tool ▪ Utilize debriefing tools or direct observations to measure compliance to the new discharge rounding tool process. ▪ Monitor harm events, LOS, ED visits, readmissions	Engage pilot team members to improve processes in daily/ weekly huddles. ▪ Review outcome data as it becomes available;, compare to baseline data, share with remaining staff and leadership.	When compliance to the new process reaches near 100% and is sustained for several weeks, outcomes can be associated with the process changes. ▪ Educate, spread the new process, monitor results

Data collected during the pilot is shared by the core leadership team with the pilot team members, key leadership, and administrators. This data was used to further improve processes, and to educate team members as the new processes are spread to all team members, and all areas. Nurse leaders must continue to survey team members for adoption and sustainability (see **Table 5-2**).

Relationship building and the development of collaborative skills among all healthcare disciplines is essential to the success of the organization. Frontline nursing staff, all healthcare disciplines, students, physicians, and community leaders can build relationships to enrich the health of community members. Nurse executives are often charged with mobilizing diverse resources to benefit improved systems. While organizations often cite benefits from these relationships, community members also describe how the interactions brought them greater focus and awareness about where synergies exist.

Another example of communication and relationship building includes work with heart failure patients readmitted within 30 days of discharge. Readmission rates affect reimbursement and may result in financial penalties. It is the responsibility of healthcare providers to consider the continuum of care and correctly prepare patients for discharge to prevent costly, avoidable readmissions. In the following example, the nurse executive brings a team together to address heart failure readmissions. The team consists of the members shown in **Table 5-3**.

The team utilized the plan-do-study-act (PDSA) model for process improvement. Goals were set for 30, 60, 90, and 120 days. **Table 5-4** identifies goals, including identifying the gap, educating, implementing and evaluating, and ensuring sustainability.

For example, an investigation of best practices revealed that, in successful models, patients who were unable to afford prescriptions were provided with a 2-week supply of critical medications at discharge to prevent readmissions for heart failure. The cardiologist and nurse practitioner provided data demonstrating that when their patients were readmitted, it was often because they could not fill their prescriptions and take medications as prescribed. The team agreed to find a way to adopt the best practice, and formulated a plan. **Table 5-5** shows the actions, core justifications, and anticipated results.

Lessons learned from this experience include that engaging and leading a team toward improved outcomes means that the entire team gains valuable leadership skills. The cardiologist learned the importance of financially justifying giving medications to patients to maintain wellness and prevent

EXHIBIT 5-2 Sample Team-Based Discharge Rounding Tool

STICU Service Line Transition of Care (TOC) Rounding Tool

Primary Contact _____ Phone number _____

Patient Contact 1 _____ 2_____

Patient Identifiers Adult Risk Assessment Score _____ (0–2 = Transition from STICU to floor)

Admission Date/Time _____ Anticipated Discharge Date/Time _____

Actual Discharge Date/Time _____ Days Discrepancy _____ LOS_____

Discharge Plan Addressed _____

Home Rehab Nursing Home Home Health Method of Transportation _____

Transportation Verified Date/Time/Signature _____

Barriers to Discharge CNL to Coordinate Care

Education Needed Before DC _____

TOC/DC Education Completed before DC Date/Time/Signature _____

Medications Consult Pharmacy Indigent Medication Program

Physical Therapy

Equipment Needed 1 _____ 2 _____ 3 _____

Equipment Ordered Date/Time _____ Date/Time _____ Date/Time _____

Follow-up appointments scheduled

Appointment 1 _____

Appointment 2 _____

Appointment 3 _____

* Place discharge rounding tool in collection box in nurses station. Nurse manager and clinical nurse leader will compile data to share with team and improve processes.

recurrent hospitalizations. The team learned to collaborate with other disciplines and respect the expertise of each team member. The team also learned to research evidence and implement a best practice. The collecting of baseline data and comparing them to postimplementation data clearly demonstrated the success of the project and the potential value of replicating the process with other chronic diseases (AONE, 2015).

Professionalism

AONE outlines core competencies of professionalism, including personal and professional accountability, career planning, and ethics. To be personally and professionally accountable, nurse leaders create an environment that allows the team to initiate actions that produce results, hold self and others accountable for actions and outcomes, create an environment where others are setting expectations and holding each other accountable, and answer for the results of one's

TABLE 5-2 Sample Data Measurement Chart Team-Based Discharge Rounding Tool

Metric	Baseline	Pilot	Results	Goal	Volume	Savings	Goal Status
STICU length of stay	4.4	4.1	↓ 0.3	↓ **LOS 0.5**	550	$231k	Met
Trauma floor LOS	3.8	3.6	↓ 0.2			$55K	
Catheter-associated urinary tract infection (UTI)	1.25	1.15	↓ 0.08	**Reduce Harm Events by 10%**	1473 Cath Days	$2,008	Progressing
Central line blood stream infection (CLABSI)	0.85	0.80	↓ 0.04		586 Cath Days	$36,441	Progressing
Ventilator-associated events	1.5	1.15	↓ 0.37		1260 Vent Days	$59,814	Met
Readmission rates	13%	9%	↓ 0.31		550	$164703	Exceeded

TABLE 5-3 Heart Failure Process Improvement Team

Nurse executive	Cardiologist	Heart failure NP	Nurse manager, Cardiology unit	Coding/documentation specialist	Clinical pharmacist
Nurse informaticist	Dietician	Clinical nurse leader (CNL)	Case manager social worker	STICU and Trauma floor nurses	Cardiology clinic operations director

TABLE 5-4 Team Goals

30-Day Goals	60-Day Goals	90-Day Goals	120-Day Goals
▪ Research best practices ▪ Outline current practices; collect baseline data ▪ Perform gap analysis	▪ Formulate plan ▪ Education plan ▪ Implementation plan	▪ Roll out plan ▪ Concurrent evaluation; review data ▪ Revise and retrain as appropriate	▪ Ensure sustainability ▪ Report to administration ▪ Share with other disciplines

TABLE 5-5 Reducing Heart Failure Readmissions: Actions and Results

Actions	Results
▪ Cardiologist and nurse practitioner to determine crucial generic medications required to prevent readmissions. ▪ Nurse executive and assistant CFO to determine cost avoidance of prevented readmissions and justification for providing free medications. ▪ Nurse educator trains nurses on new practice. ▪ Nursing alerts nurse practitioner of all heart failure admissions. ▪ Nurse practitioners assesses heart failure patients' ability to purchase heart failure medications at discharge. ▪ Nurse practitioner sends a request to pharmacy for heart failure home medications 48 hours before discharge when possible. ▪ A pharmacist delivers the medications to the bedside and educates the patient on each medication, using a teach-back technique. ▪ Nurse practitioner calls each heart failure patient within 72 hours of discharge and sees each patient in clinic within 2 weeks of discharge. ▪ Nurse practitioner coordinates care with community resources to provide medication assistance. ▪ Nurse practitioner and cardiologist will continue to collect readmission data to review with the team, administration, and finance. ▪ Nurse executive and assistant CFO review the financial benefits of the pilot program and provide results to the team and administration.	▪ Nine months' postimplementation revealed only two heart failure readmissions, which were unrelated to heart failure. ▪ All heart failure patients who were provided with medications at discharge were taking medications appropriately at the first postdischarge clinic visit. ▪ All 9-month heart failure readmissions compared to previous year were reduced. ▪ Project was determined to be successful and will be disseminated to other services. This model may also be useful in other patient populations, such as diabetic patients. ▪ Data will continue to be collected to ensure sustainability.
Cost Justification:	
▪ Cost to care for heart failure patient per day (non-ICU) ($500). Average length of stay of 6 days ($3,000) and average costs of Emergency Department visit preadmission ($500).	Total = $3,500
▪ Previous 12-month heart failure readmission costs (42 patients at $3,500).	Total = $147,000
▪ Heart failure readmission related to lack of medicine funds; potential avoidable readmission costs avoidance; total estimated annual costs to provide medications ($1,022 × 42 patients).	Total = $42,924
▪ By implementing an evidence-based best practice, patients with heart failure would be able to take critical medications required to prevent readmissions while potentially saving the healthcare system avoidable expenses.	
	Total estimated potential annual savings = $104,076

own behaviors and actions (AONE, 2015). The nurse leader's responsibility in career planning is to develop his or her own career plan and measure progress according to that plan, coach others in developing their own career plans, and create an environment in which professional and personal growth is expected (AONE, 2015).

The ethical component of professionalism includes articulating the application of ethical principles to operations and integrating high ethical standards and core values into everyday work activities (AONE, 2015). For nurse leaders, articulating the connection to the ANA (2010)

Code of Ethics to emphasize the commitment and responsibility we have to the public is aligned with our decisions and actions.

Professionalism can be reflected in the example of a newly appointed chief nursing officer (CNO) at a university hospital who is asked to collaborate with the College of Nursing (CON) faculty as part of a national improvement science research study. The goal of the study was to identify interruptions in nursing care on medical–surgical units. The CNO gained consensus with the medical–surgical nurse managers and agreed to serve as a principal coinvestigator with a senior faculty member. The CNO created an environment that allowed the team to initiate actions that produce results, held herself and others accountable for actions and outcomes, created an environment in which others are setting expectations, and answered for the results of his or her own behaviors and actions.

In an environment sensitive to team strengths and cultural diversity, the study provided an excellent opportunity for team building. The study incorporated tally cards that were carried by the staff nurses, who would record each interruption as it occurred for 2 weeks. The data from the cards were entered into a database, and the results were to be shared at some point in the future. After the cards were collected, the CNO approached the CON faculty about meeting with the frontline staff to begin resolving some of the issues they had identified during the study. A core faculty group partnered with the CNO, and the Frontline Innovations (FI) research group was formed. Delegates were asked to join the FI group, and the disgruntled or disillusioned squeaky wheels were invited too. Both shifts of nurses were represented. To build team cohesiveness, the group met at lunch once a month. Nurse managers and nurse educators agreed to relieve the staff so they could attend the meeting, and lunch was provided by the administration. Many frontline improvements were made with the support of the CNO and the faculty.

One project the staff adopted was missed medications. According to the FI nurses, medications were often missing at the time they were due to be administered. Much time was spent contacting and communicating with the pharmacy, making calls, and sending repeated fax notifications. In addition, medications were not given on time. Coming together to better understand the processes and outcomes provided a venue in which interprofessional teams could be developed and empowered to lead and coach other staff members along the way.

Working through the study with newly created teams, baseline data were collected for 1 week by utilizing a tool created by the nurses. After the results were reviewed, the nurses invited representatives from the pharmacy to their next meeting. Nursing voiced mistrust of the pharmacy, but after one meeting with the pharmacist and technician, a partnership of collaboration was born. Over the course of the year, processes for daptomycin, heparin infusions, patient-controlled analgesia (PCA), and an interdisciplinary vancomycin protocol were developed by this team. Nurses learned to investigate best practices, collect data, collaborate with other disciplines, and improve processes. They began to believe in an empowered nurse workforce and saw the ability to determine their destiny.

Building on the success of the team's initial work and interprofessional team involvement, a core CON faculty member suggested the team apply for a small grant and consider moving toward a shared governance model. In collaboration with the CON, including the biomedical librarian, articles about shared governance were distributed to staff nurses, and all agreed to a site visit at an institution with a well-developed shared governance structure. Upon returning from the site visit, the FI staff requested they lead the frontline meetings from that point forward. A governing council was formed, bylaws were written, and the first Nurse Congress was born. Recruitment during the Nurses' Week breakfast was a joint effort between the governing council and the CON faculty. All units were included rather than only the medical–surgical units.

To get a stronger picture of the ongoing success of this collaborative work, a survey for readiness was conducted by the governing council, and it was determined that nurses throughout the organization were ready and interested in shared governance. Within 1 year, the Nurse Congress held a pinning ceremony to celebrate the membership and success of the Nurse Congress. Many

evidence-based improvement projects have resulted from the work of the Nurse Congress. Members are presenting their work at conferences and evidence-based practice summits, and nursing is seen throughout the organization as an innovator and driver of healthcare improvement and excellence. Professionalism was demonstrated through the various processes, actions, and follow-up planning.

Professional accountability underscores the importance of creating an environment that enables the team to initiate actions that produce results, hold itself and others accountable for actions and outcomes, create an environment in which others are setting expectations and hold one another accountable, and answer for the results of individual behaviors and actions. Working with staff nurses provided career planning opportunities for the CNO and frontline staff, including coaching the development of others by creating an environment in which professional and personal growth is an expectation. Facilitating an ethical milieu underscored the ethics of the organization. By articulating the application of ethical principles to operations and integrating high ethical standards and core values into everyday work activities, the CNO was able to live the story.

COMPLEXITY SCIENCE AND HEALTH CARE: IMPLICATIONS FOR NURSE LEADERS

The science of complex adaptive systems provides important concepts and tools for responding to the challenges of health care in the 21st century. Clinical practice, organization information management, research, education, and professional development are interdependent and are built around multiple self-adjusting and interacting systems. In complex systems, unpredictability and paradox are ever present, and some things will remain unknowable. New conceptual frameworks that incorporate a dynamic, emergent, creative, and intuitive view of the world must replace traditional reduce-and-resolve approaches to clinical care and service organization (Plsek & Greenhalgh, 2001).

SUMMARY

Nurse leaders are being offered an opportunity of a lifetime during this time of healthcare reform. What remains to be seen is whether we will capitalize on this moment to elevate and showcase what many nurses believe is their claim to health promotion, care delivery, and service. Transformational leaders will embrace the complexity, uncertainty, and clean slate offered by healthcare reform to enact competencies outlined by AONE for nurse executives based on the IOM *Future of Nursing: Leading Change, Advancing Health* report to practice to the full scope of our education and use data to mobilize an interdisciplinary workforce to establish outcomes that are demonstrative of the health and well-being of patients and their families. With technology to help us become instruments of change, the possibilities are endless!

REFLECTIVE QUESTIONS

1. Identify a nurse leader you believe embodies transformational leadership abilities and has been courageous in implementing innovative care delivery change. What attributes does this nurse leader have that has allowed him or her to accomplish this work? Use the AONE competencies as a guide to your evaluation.
2. Describe a situation in which you have demonstrated elements of the personal journey disciplines to achieve a goal. What were your strengths, and what would you like to develop more fully?
3. Examine TJC National Patient Safety Goals in light of TeamSTEPPS. What steps could you take to move toward the structures and processes to engage a team?

CASE STUDY 5-1 Aligning Strengths and Opportunity to Lead Effective Teams

Stephanie Burnett

Jackie is a new nurse manager. She had no prior experience in a management position, but she was eager to accept the challenge of managing her own unit. She had been frustrated in her past positions as a staff nurse, staff educator, and nurse coordinator, feeling powerless to make significant change. She had enjoyed great success in these roles leading hospital projects, and she had received rave reviews from her peers and supervisor. When this new nurse manager position became available and the opportunity was offered to her, she jumped at the chance to move to the next level into a real leadership role, though she had no expertise in the specialty of her new unit. She had heard that the staff was a very cohesive team, and she was eager to finally have authority to bring about change and influence.

She entered into the nurse manager position very enthusiastic to make immediate changes and with the hope of improving staff accessibility and greater utilization of technology when possible. In the first few months, after a brief orientation to the department, Jackie made many changes, such as changing the staff work patterns and scheduling process, quickly filling all vacant positions, eliminating the staff break room/lounge, and eliminating routine monthly staff meetings.

With each change, Jackie felt great pride in the changes she'd made, believing the staff would accept and appreciate the value in the changes, and she awaited the subsequent improved outcome. However, in less than 6 months, half of the new staff she'd hired had resigned, along with four existing staff members, creating an even greater vacancy rate. Staff call-ins increased by 50%, and the staff felt disconnected, unappreciated, and distrustful of Jackie. Many reported feeling that she was frequently unavailable and did not support them or appreciate their opinions or input.

Jackie found that she was very uneasy having direct communication with the staff. She perceived all voiced concerns or complaints as a challenge to her nurse manager skills and authority, and she resisted all suggestions from them. When members of the interdisciplinary team approached her with areas that needed improvement, she felt personally attacked. She realized she had not anticipated how much personal contact the staff seemed to require. She was even more unprepared for how much supervision was necessary to monitor care delivery, patient and family satisfaction, and adherence to policy. Yet Jackie was eager for the staff to like her and feel friendly toward her.

Case Study Questions

1. What leadership principles did Jackie fail to apply when managing an effective team?
2. How would individual and team evaluations be useful in determining strengths and opportunities for each member?
3. How might Jackie's director best coach and mentor her in addressing her own strengths and opportunities to better manage and lead her nursing staff?

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