SEVENTH EDITION

LEADERSHIP
AND NURSING CARE MANAGEMENT

DIANE L. HUBER
M. LINDELL JOSEPH

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PREFACE

With the publication of the seventh edition of *Leadership and Nursing Care Management*, we start a new and exciting phase of incorporating Dr. M. Lindell Joseph as coeditor of the book. The history of this book began with the publication of the first edition in 1996, when Dr. Diane Huber wrote the whole first edition. She rewrote the whole second edition but invited chapter authors for the third edition in 2006, making it an edited book. The new phase means that a broader range of chapter authors were solicited, and there is double the editorial expertise. Welcome Lindell!

The development of the seventh edition occurred at a time of change and uncertainty in health care. This has reverberated within health care organizations and systems, in nursing professional organizations, and in the work life of nurses in leadership and administration. Hospitals and health care organizations are struggling with financial and workforce pressures. Nursing professional organizations, such as the American Organization of Nurse Executives (AONE) [now: American Organization for Nursing Leadership (AONL)] and the Council on Graduate Education for Administration in Nursing (CGEAN) [now: Association for Leadership Science in Nursing (ALSN)], have changed their names, as did the Institute of Medicine [now: the National Academies of Sciences, Engineering, Medicine, Health and Medicine Division] in 2016.

It is clear that nurses matter to health care delivery systems. Yet the United States is in the midst of a continuing and projected nurse shortage. Strong nurse leaders and managers are important for clients (and their safety), delivery systems (and their viability), and payers (and their solvency). Pressures remain to balance cost and quality considerations in a complex, chaotic, and turbulent health care environment.

Although society's need for excellent nursing care remains the nurse's constant underlying reason for existence, nursing is much more than that. Because nurses offer cost-effective expertise in solving problems related to the coordination and delivery of health care to individuals and populations in society, they have become a crucial linchpin in health care delivery and are highly valued for their clinical judgment. Nurses are well prepared to lead clinical change strategies and effectively manage the coordination and integration of interdisciplinary teams, population needs, and systems of care across the continuum. This has been increasingly important following implementation of the 2010 Patient Protection and Affordable Care Act (ACA), and nurses are needed to address care coordination and integration across the health care delivery system.

It can be argued that nursing is a unique profession in which the primary focus is caring—giving and managing the care that clients need. Thus, nurses are both health care providers and health care coordinators; that is, they have both clinical and managerial role components. Beginning with the first edition of *Leadership and Nursing Care Management*, it has been this text's philosophy that these two components can be discussed separately but in fact overlap. Because all nurses are involved in coordinating client care, leadership and management principles are a part of the core competencies they need to function in a complex health care environment.

Nurses need a strong background in nursing leadership and care management to be prepared for contemporary and future nursing practice. As nurses mature in advanced practice roles and as the health care delivery system restructures, nurses will become increasingly pivotal to cost-effective health care delivery, and research is bearing this out. This also is seen in the national trend to determine the most optimal organizational structure to effectively use and deploy large numbers of advanced practice providers such as nurse practitioners. Leadership and management are crucial skills and abilities for complex and integrated community and regional networks that employ and deploy nurses to provide health care services to clients and communities.

Today's nurses are expected to be able to lead and manage care across the health care continuum—a radically different approach to nursing from what has been the norm for hospital staff nurses. The COVID-19 pandemic in 2020 showed how critical it is to have nurses' expertise in care management. In all settings, including both nurse-run and interdisciplinary clinics, nursing leadership and management are complementary skills that add value to solid clinical care and patient- and

client-oriented practice. Thus there is an urgent need to advance nurses' knowledge and skills in leadership and management. In addition, nurses who are expected to make and implement day-to-day management decisions need to know how these precepts can be practically applied to the organization and delivery of nursing care in a way that conserves scarce resources, reduces costs, and maintains or improves quality of care. This is the emphasis on adding value, innovation, and prevention interventions.

The primary modality for health care in the United States has moved away from acute care hospitalization. As prevention, wellness, and alternative sites for care delivery become more important, nursing's already rich experiential tradition of practice in these settings is emerging. This text reflects this contemporary trend by blending the hospital and non-hospital perspectives with an eye toward systems leadership and management.

PURPOSE AND AUDIENCE

The intent of this text is to provide both a broad introduction to the field and a synthesis of the knowledge base and skills related to both nursing leadership and nursing care management. It is an evidence-based blend of practice and theory that breaks new ground by explaining the intersection of nursing care with leading people and managing organizations and systems. It highlights the evidence base for care management. It combines traditional management perspectives and theory with contemporary health care trends and issues and consistently integrates leadership and management concepts. These concepts are illustrated and made relevant by practice-based examples.

The impetus for writing this text comes from teaching both undergraduate and graduate students in nursing leadership and management and from perceiving the need for a comprehensive, evidence- and practice-based textbook that blends and integrates leadership and management into an understandable and applicable whole.

Therefore the main goal of *Leadership and Nursing Care Management* is twofold: (1) to clearly differentiate traditional leadership and management perspectives and (2) to relate them in an integrated way with the evidence base, contemporary nursing trends, and practice applications. This textbook is designed to serve the needs of nurses and nursing students who seek a foundation in the principles of leading and coordinating nursing services in relation to patient care, peers, superiors, and subordinates.

ORGANIZATION AND COVERAGE

This seventh edition continues the format first used with the third edition. The first two editions were Dr. Huber's single-authored texts. The edited book approach draws together the best thinking of experts in the field—both nurses and non-nurses—to enrich and deepen the presentation of core essential knowledge and skills. Beginning with the first edition, a hallmark of *Leadership and Nursing Care Management* has been its depth of coverage, its comprehensiveness, and its strong evidence-based foundation. This seventh edition continues the emphasis on explaining theory in an easily understandable way to enhance comprehension and is an easy-to-understand bridge to the evidence-based management practices from AONL.

The content of this seventh edition integrates leadership and care management topics with the nurse executive leadership competencies of the 2015 American Organization of Nurse Executives (AONE)/American Organization for Nursing Leadership (AONL). AONL has identified the evidence-based core competencies in the field, and this book has been aligned accordingly to reflect the knowledge underlying quality management of nursing services, thereby synthesizing theory, evidence-based management principles, and application exercises. This will help the reader develop the crucial skills and knowledge needed for core competencies.

The organizational framework of this book groups the 26 chapters into the following five parts:

Part I: Leadership aligns with the AONL competency category of the same name and provides an orientation to the basic principles of both leadership and management. Part I contains chapters on Leadership and Management Principles, Change and Innovation, and Organizational Climate and Culture, and Managerial Decision-Making.

Part II: Professionalism aligns with the AONL competency category of the same name and addresses the nurse's role and management of professional nursing practice. The reader is prompted to examine the role of the nurse leader and manager. Part II discusses

the content areas of Managing Time and Stress, Role Management, and Legal and Ethical Issues.

Part III: Communication and Relationship Building aligns with the AONL competency category of the same name. Part III focuses on Communication Leadership, Team Building and Working with Effective Groups, Power and Conflict, and Workplace Diversity. These are essential knowledge and skill areas for nurse leaders and managers as they work with and through others in care delivery.

Part IV: Knowledge of the Health Care Environment covers the AONL competency category of the same name and features a broad array of chapters. Part IV encompasses Organizational Structure, Decentralization and Shared Governance, Strategic Management, Professional Practice Models, Case and Population Management, Evidence-Based Practice: Strategies for Nursing Leaders, Quality and Safety, and Measuring and Managing Outcomes. This discussion highlights the importance of understanding the health care organizational structures within which nursing care delivery must operate. This section includes information on traditional organizational theory, professional practice models, and the dynamics of decentralized and shared governance.

Part V: Business Skills aligns with the AONL competency category on business skills and principles and contains an extensive grouping of chapters related to Prevention of Workplace Violence; Nursing Workforce Staffing and Management; Budgeting, Productivity, and Costing Out Nursing; Performance Appraisal; Emergency Management and Preparedness; Data Management and Clinical Informatics; and Marketing. These chapters discuss the opportunities and challenges for the nurse leader-manager when dealing with the health care workforce. The wide range of human resource responsibilities of nurse managers is reviewed, and resources for further study are provided. The significant share of scarce organization budgets consumed by the human resources of an institution makes this area of management a key challenge that requires intricate skills in leadership and management. This section examines some of the important factors that nurse leader-managers must consider in the nursing and health care environment. Also in this section are chapters that build on organizational theory and demonstrate the importance of integrating organizations and systems with the current technology and theory applications, including data management and informatics, strategic management, and marketing.

The 26 chapters in this text are organized in a consistent format that highlights the following features:

- Concept definitions
- Theoretical and research background
- Leadership and management implications
- Current issues and trends
- Case Studies and Critical Thinking Exercises
- Research Notes

This format is designed to bridge the gap between theory and practice and to increase the relevance of nursing leadership and management by demonstrating the way in which theory translates into behaviors appropriate to contemporary leadership and nursing care management. Case Studies and Critical Thinking Exercises offer opportunities for synthesis, application, and active learning.

TEXT FEATURES

This book contains several interesting and effective aids to readers' comprehension, critical thinking, and application.

CRITICAL THINKING EXERCISES

Found at the end of each chapter, this feature challenges readers to inquire and reflect, analyze critically the knowledge presented, and apply it to the situation.

RESEARCH NOTES

These summaries of current research studies are highlighted in every chapter and introduce the reader to the liveliness and applicability of the available literature in nursing leadership and management.

CASE STUDIES

Found at the end of each chapter, these vignettes introduce the reader to the "real world" of nursing leadership and management and demonstrate the ways in which the chapter concepts operate in specific situations. These vignettes show the creativity and energy that characterize expert nurse administrators as they tackle issues in practice.

NEXT-GENERATION NCLEX® (NGN) EXAMINATION CONTENT

The National Council of State Boards of Nursing (NCSBN) administers the national licensure exam for registered nurses (RNs), called NCLEX®. In 2013–2014 the NCSBN conducted a Strategic Practice Analysis that highlighted the complexity of decisions new nurses make while doing patient care. That prompted the question: Is the NCLEX® measuring the right things? To answer this question, the NCSBN launched the Next Generation NCLEX® (NGN), a research project to determine whether clinical judgment and decision making in nursing practice can reliably be assessed (https://www.ncsbn.org/next-generation-nclex.htm). They have developed a Clinical Judgment Measurement Model and analyzed the current NCLEX® item bank for clinical judgment domain distribution. The conclusion was a need for more research and the use of new item types on the NCLEX®. The research and development continue. As this text goes to press, it is projected that a revised NCLEX® exam will be rolled out in 2023.

The imperative for nursing students preparing to take the licensure exam and for nurse educators is to move into high gear with preparations for NCLEX®'s assessment of clinical decision-making testing even as the new test is in the development phase. New item types include enhanced multiple response, extended drag and drop, cloze items, enhanced hot spots, and matrix/grid. Layer 3 of the NCSBN's Clinical Judgment Measurement Model is focused on patient care and how the nurse recognizes cues, analyzes cues, prioritizes hypotheses, generates solutions, takes actions, and evaluates outcomes.

Leadership and Nursing Care Management, seventh edition, is not primarily focused on individual patient care (one nurse with one patient), but rather on the leadership and management of patient care delivery and the work of nurses. The content is most directly aligned with Layer 4 of the NCSBN's Clinical Judgment Measurement Model (https://www.ncsbn.org/14798.htm): Environmental Factor Examples. There are eight Environmental Factor Examples: (1) environment, (2) client observation, (3) resources, (4) medical records, (5) consequences and risks, (6) time pressure, (7) task complexity, and (8) cultural considerations. Layer 4 is concerned with the context within which a nurse is making clinical judgments and taking action. This is the realm of leadership and management of patient care. For example, the environment, situation, time pressures, resources, and cultural factors all have an influence on the nurse's clinical judgment and subsequent choice of action. The NGN focus is on what the nurse should do. This also applies to leadership and management in clinical practice.

Although NGN is still in development, and we are not informed as to how contextual/environmental content will be tested, we have addressed the NGN initiative in three ways: (1) ever since the first edition of *Leadership and Nursing Care Management*, each chapter has had a case study and a critical thinking exercise feature that promotes the analysis and integration of the application of the content and provides practice in managerial decision-making; (2) there is a dedicated chapter (Chapter 4) on managerial decision-making; and (3) as a new feature in this seventh edition, we have composed an NGN-type single episode case study for five selected chapters. Following the American Organization for Nursing Leadership's (AONL, 2015) Nurse Executive Competencies, which forms the broad structure of five parts of the content, the chapters chosen highlight the core of the five competencies: (1) leadership (Chapter 1), (2) professionalism/managing time and stress (Chapter 5), (3) communication (Chapter 8), (4) knowledge of the health care environment/decentralization and governance (Chapter 13), and (5) business skills/nursing workforce staffing and management (Chapter 21).

Students using this book may begin to prepare for NCLEX® (NGN) by using the NGN case studies. In addition, practice leaders or colleagues of future nurses can use these new case studies to foster their clinical imagination and model high-level thinking to help new graduate nurses prepare for NCLEX® (NGN).

LEARNING AND TEACHING AIDS

For Students

The Evolve Student Resources for this book include the following:

NCLEX® Review Questions, including rationales and page references

For Instructors

The Evolve Instructor Resources for this book include the following:

- *TEACH for Nurses* lesson plans, based on textbook chapter Learning Objectives, serve as ready-made,

modifiable lesson plans and a complete road map to link all parts of the educational package. These concise and straightforward lesson plans can be modified or combined to meet your particular scheduling and teaching needs.

- *Test Bank* in ExamView format, featuring over 650 test items, complete with correct answer, rationale, cognitive level, nursing process step, appropriate NCLEX label, and corresponding textbook page references. The ExamView program allows instructors to create new tests; edit, add, and delete test questions; sort questions by NCLEX® category, cognitive level, and nursing process step; and administer and grade tests online.
- *Next-Generation NCLEX® (NGN)-Style Case Studies for Leadership and Nursing Care Management:* Four NGN-style case studies focused on Leadership and Management.
- *PowerPoint Presentations* with more than 650 customizable lecture slides.
- *Audience Response Questions* for i-clicker and other systems with two to three multiple-answer questions per chapter to stimulate class discussion and assess student understanding of key concepts.

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This book is dedicated to my children, Brad Gardner and Lisa Witte, and their spouses, Nonalee Gardner and John Witte, for their enthusiasm, caring support, and love. I am forever privileged that they are in my life. I thank them for the gifts of Kathryn Anne Gardner, Anthony James Gardner (A.J.), Logan Thomas Witte, and Olivia Morgan Witte. I love being Grandma to these wonderful people.

To my professional colleagues who inspired me and served as examples of excellence in nursing, I am grateful that you came alongside me and engaged in my life. I also am most grateful for my interdisciplinary health care colleagues who have taught me, role-modeled caring behaviors, and offered invaluable opportunities to learn and grow. To my nursing students, my thanks for being a source of continual intellectual stimulation and challenge. To all of you who have read and used this book, thank you. It is so very humbling and heartwarming when you mention this to me as we intersect on professional pathways. I am glad it is of use to you.

This book's first two editions evolved under the tender care of Thomas Eoyang, former editorial manager at W.B. Saunders Company, whose guidance, support, and caring were invaluable. To the editors in the Elsevier Nursing Division who worked so hard to facilitate everything related to the seventh edition, and to the excellent staff at Elsevier, a sincere thank you.

No acknowledgement is complete without an expression of sincere appreciation to Lindell Joseph for taking on the coeditor role. This textbook is truly enriched by your special talents. Together, all is better.

Diane L. Huber

My contributions in this book are dedicated to Dr. Diane L. Huber, an unbelievable mentor, colleague, and friend. I will always be thankful for her belief and support in my abilities. I am grateful to God, my mother Mary Madelina Joseph, husband Hector Guadalupe, daughter Geneva Guadalupe, cousin Caroline Norbal, aunts Albertha Corneille, Christine Corneille, Tenose Corneille, and Nicholina Felix, extended family members, friends, and Drs. Rose Sherman (Chief Editor of *Nurse Leader*) and Robyn Begley (CEO of AONL) for their ongoing support.

Recently, I had the privilege of observing the care management of my deceased nephew Kimani Joseph. During his battle with lupus, I observed many opportunities where the content in this book would have been useful. I hope that aspiring and current leaders could use this book as a resource to develop or improve care management practices.

I am truly honored and grateful to be the coeditor of the seventh edition of *Leadership and Nursing Care Management*. I am thankful to my colleagues who were invited to provide their expertise on specific content areas. Diane and I are hopeful that readers will find new insights for future leadership and care management practices. Once again, I am thankful to the selfless acts that Dr. Huber has demonstrated toward my personal and professional development.

M. Lindell Joseph

CONTENTS

1

Leadership and Management Principles

Diane L. Huber

http://evolve.elsevier.com/Huber/leadership

Health care is a challenging sector to lead and manage. Both the practice of health care professionals and the effectiveness of health care organizations are affected by change, complexity, and environmental turbulence. The twin skills of leadership and management are crucial to nurses' effectiveness and organizational survival. Fortunately there is an evidence base of knowledge about leadership and management, and both can be learned.

Issues of cost, access, methods, and structures of care delivery, human capital management, and quality surround the broader context of health care. The effect on nursing is an urgent need for leadership and management at all levels and places where nurses work. With approximately 3 million licensed registered nurses (RNs) in the United States (US Bureau of Labor Statistics, 2019), RNs are the largest segment of the health care workforce. Strong and prepared leaders are needed to guide their practice. Leading and managing are essential skills, made more acutely urgent given health care system characteristics of rapid change, complexity, and chaos.

Ongoing health care reform, integration of new technologies, and patient-centered care influence the health care delivery system by redefining both how care is delivered and the role of the nursing workforce (The National Academies of Sciences, Engineering, Medicine; Health and Medicine Division, 2020). Emerging care delivery models, with a focus on managing health status and preventing acute health issues, will likely contribute to new growth in demand for nurses as they assume new and/or expanded roles in preventive care and care coordination. An example is the explosion in the growth of roles for Advanced Practice Providers, including nurse practitioners. Supply and demand for nurses will continue to be affected by numerous factors, including population growth, increases in chronic conditions, the aging of the nation's population, overall economic conditions, aging of the nursing workforce, and changes in health care reimbursement.

Leaders guide and motivate nurses to achieve their care provision goals as they practice nursing. Managers organize and guide nurses' work in organizations where they practice. Together the result is structures and processes that deliver desired outcomes. For the health care system, there are two predominant sets of desired outcomes. The first is the six aims for the health care system (Agency for Healthcare Research and Quality, 2018): health care needs to be safe, effective, patient centered, timely, efficient, and equitable. The second is the Institute for Healthcare Improvement's (IHI) (2020) Triple Aim: health care needs to simultaneously improve the health of the population, enhance the experience and the outcomes of the patient, and reduce per capita cost of care to benefit communities. The Triple Aim has been extended to a fourth element ("Quadruple Aim") that focuses on the workforce and is aimed at improving the experience of providing care (Sikka et al., 2015).

The major national leadership initiatives in nursing are the Institute of Medicine's (IOM, now called The National Academies of Sciences, Engineering, Medicine; Health and Medicine Division) (IOM, 2011) report *The Future of nursing: Leading change, advancing health* and the Magnet Recognition Program® (American Nurses

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Credentialing Center [ANCC], n.d.). As nurses seek to embed themselves and grow in jobs and careers within health care services, leadership and management knowledge, skills, and abilities are important to overall effectiveness.

In nursing, leadership is studied to increase the knowledge, skills, and abilities that nurses need to facilitate clinical and administrative outcomes while working with people across a variety of situations, settings, and sites. Effective leadership can also increase understanding and control of nurses' professional work settings. *Effective* leadership is important in nursing, specifically because of its impact on the quality of nurses' work lives, because it functions as a stabilizing influence during constant change, and because it underpins nurses' productivity and quality of care delivery.

Nurse leaders and managers are responsible for designing, developing, implementing, and sustaining the organizational infrastructure and environment that enable both large- and small-scale interventions for quality and safety. Research has shown that there are organizational and cultural factors that mediate hospital or system-wide interventions. These include the prevailing culture, such as being patient-centered and having available effort and resources; human relationships, including leadership styles and teamwork; and an approach used for routine monitoring of systems and services (Clay-Williams et al., 2014; Stetler et al., 2014).

This chapter presents definitions and a detailed overview of both leadership and management. Theories are reviewed and important elements are discussed. There is a long history, rich literature, and evidence base regarding leadership theories, much of it from outside of nursing. Nursing has drawn from both classic and contemporary thinkers, especially from business management.

DEFINITIONS

There are a variety of definitions of **leadership**, one of which is the process of influencing people to accomplish goals. It has been described as "the art of motivating a group of people to act toward achieving a common goal" (Ward, 2020). Key concepts related to leadership are influence, vision, communication, group process, goal attainment, and motivation. Hersey et al. (2013) defined leadership as a process of influencing the behavior of either an individual or a group, regardless of the reason, to achieve goals in a given situation. Leaders mobilize others so that they want to make extraordinary things happen (Kouzes & Posner, 2017).

Most leadership definitions incorporate the two components of an interaction among people and the process of influencing. Thus leadership is a social exchange phenomenon. At its core, leadership is about influencing people. In contrast, management involves influencing employees to meet an organization's goals and is focused primarily on organizational goals and objectives. Thus the leader focuses on people, whereas the manager focuses on systems, processes, and structures. A leader innovates; a manager administers.

Management is defined as the coordination and integration of resources through planning, organizing, coordinating, directing, and controlling to accomplish specific institutional goals and objectives. Hersey et al. (2013) defined management as a process of working with and through individuals and groups, using resources (such as equipment, capital, and technology) to accomplish organizational goals. They identified management as a special kind of leadership that concentrates on the achievement of organizational goals.

Followership is defined as "a process whereby an individual or individuals accept the influence of others to accomplish a common goal" (Northouse, 2019, p. 295).

LEADERSHIP AND CARE MANAGEMENT DIFFERENTIATED

Leadership theory is often discussed separately from management theory. Some say leadership and management are two very different things. Yet clearly there is overlap in that an individual can be *both* leading and managing simultaneously in some cases. The area of overlap may not be clear or explained. The premise of this book is that leadership and management are not identical ideas. This can be seen in their distinct definitions, yet sometimes they occur together or via multitasking. Northouse (2019) differentiated leadership and management on elements of activities and outcomes: management produces order and consistency; leadership produces change and movement.

If the delivery of nursing services involves the organization and coordination of complex activities in the human services realm, then both leadership and management are important elements. Both are

used to accomplish goals; each has a different focus. Management is focused on task accomplishment, and leadership is focused on human relationship aspects. They may be sequential, and they are interrelated. Clearly, a balance of the two is necessary. Leadership and management have some shared characteristics. There is a "gray area" in which the focus of their outcomes overlaps. In this area of overlap, the processes and strategies look similar and may be employed for a similar outcome or blended together to accomplish goals. This overlap occurs where the two processes are integrated or synthesized to accomplish goals and where the same strategies are employed even though the goals may differ. For example, a nurse may use leadership strategies or management strategies to motivate others, but the desired outcome of the motivation is likely to be different. For example, leadership may be used to empower nurses and management to reduce costs.

Leadership and management are equally important processes. Because they each have a different focus, their importance varies according to what is needed in a specific situation. Hersey et al. (2013) thought that leadership was a broader concept than management. They described management as a special kind of leadership. This view would position management as a part of leadership, not as a distinct concept. However, according to the definitions, characteristics, and processes, the concepts of leadership and management are different; but at the area of overlap they look similar. For example, directing occurs in both leadership and management activities (the area of overlap), whereas inspiring a vision is clearly a leadership function. Both leadership and management are necessary. Leadership occurs in an interactive mode rather than through a stepwise linear process. The interactive nature makes relationships and relationship building fundamental elements. "Transformational change happens one relationship at a time" (Koloroutis, 2004).

Jennings et al. (2007) took an evidence-based approach to differentiating nursing leadership from management to identify discrete competencies through an integrative content analysis of the literature base. In 140 articles reviewed, they found 894 competencies, of which 862 (96%) were common to both leadership and management. Thus the overlap area appeared to be larger than previously thought. However, leadership and management do serve distinct purposes. Perhaps it is time to apply leadership and management concepts and competencies by setting, level of role responsibility, career stage, and social context to more fully apply the evidence base to practice. For example, the American Organization for Nursing Leadership (AONL, formerly AONE) (2015) promulgated two levels of administrative competencies: nurse manager and nurse executive.

LEADERSHIP OVERVIEW

Leadership is an activity of human engagement and a relationship experience founded in trust, communication, inspiration, action, and "servanthood". The four essential dimensions of leadership are process, influence, group setting (context), and vision (Miles & Scott, 2019). Leadership has elements of process, personalities, power relationships, actions, transformation, and skills, all of which are designed to influence. Ideally, for effectiveness, styles are matched. Northouse (2019, p. 5) found five core leadership components: (1) leadership is a process, (2) leadership involves influence, (3) leadership occurs in groups, and (4) leadership involves common goals. The leadership role is so important because it embodies commitment and forward-reaching action. Arising from a drive to make things better, leaders use their power to bring teams together, spark innovation, create positive communication, and drive forward toward group goals.

Leadership is important to study, learn, and practice in today's complex, rapidly changing, turbulent, and chaotic health care work environment. Such an environment generates challenges to the nurse's identity, coping skills, and ability to work with others in harmony. It also presents the opportunity to lead, challenge assumptions, consolidate a purpose, and move a vision forward. Leadership is important for nurses because they need to possess knowledge and skills in the art and science of solving problems in work groups, systems of care, and the environment of care delivery. The effectiveness of an individual nurse depends partly on that individual's competence and partly on the creation of a facilitating environment that contains sufficient resources to accomplish goals. This is an underappreciated reality when it is assumed that results occur from only individual competence and effort. However, health care delivery is a team effort.

The nurse leader combines clinical, administrative, financial, and operational skills to solve problems in

the care environment so that nurses can provide cost-effective care in a way that is satisfying and health promoting for patients and clients. Such an environment does not simply happen; it requires special skills and the courage and motivation to move a vision into action. For example, it may be easier to continue on the way things have always been done, but this strategy would not capture the advantages of new innovations. Thus the study of nursing leadership and care management directs critical thinking toward what it takes to be a nursing "environment architect," transition leader, and administrator of care delivery services.

Strong evidence for the nurse leader's critical role both in the business of a health care organization and in the quality and safety of service delivery can be found in influential documents by the IOM (2004), the ANCC's Magnet Recognition Program® (ANCC, n.d.a), and the AONL (2015). The IOM emphasized evidence-based management practice and focused on the following five areas of management practice:

- Implementing evidence-based management
- Balancing tensions between efficiency and reliability
- Creating and sustaining trust
- Actively managing the change process through communication, feedback, training, sustained effort and attention, and worker involvement
- Creating a learning environment

The ANCC's Magnet program acknowledges excellence in nursing services and leadership based on five components: transformational leadership, structural empowerment, new knowledge, exemplary professional practice, and empirical outcomes (ANCC, n.d.a). The Magnet Recognition Program® focuses specifically on nursing, is considered the "gold standard" in nursing, and is addressed in several chapters in this book because of its centrality to the evidence-based management practice called for by the IOM (2004). AONL's (2015) nurse executive competencies are described as falling within the following five domains of skill: communication and relationship management, leadership, business skills and principles, knowledge of the health care environment, and professionalism. Taken together, these source documents overlap and converge on the primary attributes, knowledge domains, abilities, and skills that nurse leaders need to lead people and manage organizations in health care.

The Two Roles of a Nurse

Nursing is a service profession, the core mission of which is the care, restoration of health, and nurturing of human beings in their experiences of health and illness. This is the role of the nurse as a direct care provider. The nurse's care provider or "doing" role is sometimes seen as the most important and valued aspect of nursing. The nurse's second role, the coordinator/integrator role, is a complementary function that arises from nursing's central positioning in the day-to-day coordination of service delivery and central location at the hub of information flow regarding care and service delivery. This linkage relationship is shown visually in Fig. 1.1.

With the shift to primary care and care coordination, the nurse's care management role has become more prominent, needed, and valued. The delivery of nursing services involves the organization and coordination of complex activities. Nurses use managerial and leadership skills to facilitate delivery of quality nursing care. A current example is the shift to population health management (PHM), which is in concert with the Quadruple Aim. Nurses have emerged as well-prepared practitioners, especially at the clinical nurse leader (CNL) and nurse practitioner levels of preparation (Joseph & Huber, 2015).

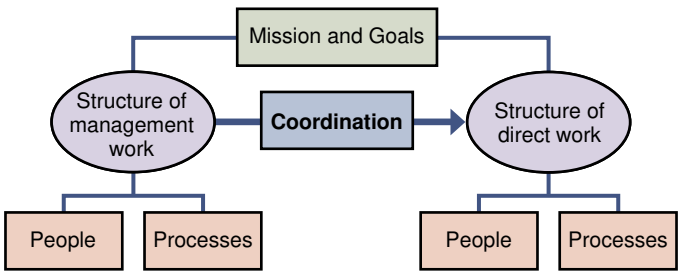

Fig. 1.1 Linkage of clinical and management domains.

The Leadership Role

Leadership is a unique role and function. It can be part of a formal organizational managerial position, or it can arise spontaneously in any group. Certain characteristics, such as being motivated by challenge, commitment, and autonomy, are thought to be associated with leadership. Effectiveness is a key outcome of leadership efforts in health care. It has been suggested that there is a scarcity of leaders and a crisis in leadership in nursing. In times of chaos, complexity, and change, leadership is essential to provide the guidance, direction, and sense of stability needed to ensure followers' effectiveness and satisfaction. Nurses are challenged to respond with leadership and can best respond by demonstrating vision, using innovativeness (Joseph, 2015; Joseph et al., 2016), adapting to changes, seeking new tools for dealing with the new health care environment, and leading the way with client-centered strategies. Effective leaders are change agents and promote innovation. Innovation is seen as a viable mechanism to address care delivery complexity and is further discussed in Chapter 2.

Leadership Skills

Leadership is a natural element of nursing practice because the majority of nurses practice in work groups or units. Possessing the license of an RN implies certain leadership skills and requires the ability to delegate and supervise the work of others. Leadership can be understood as the ability to inspire confidence and support among followers, especially in organizations in which competence and commitment produce performance.

Leadership is an important issue related to how nurses integrate the various elements of nursing practice to ensure the highest quality of care for clients. Every nurse needs two critical skills to enhance professional practice. One is a skill with interpersonal relationships. This is fundamental to leadership and the work of nursing. The second is skill in applying the problem-solving process. This involves the ability to think critically, identify problems, and develop objectivity and a degree of maturity or judgment. Leadership skills build on professional and clinical skills. Hersey et al. (2013) identified the following three skills needed for leading or influencing:

1. *Diagnosing:* Diagnosing involves being able to understand the situation and the problem to be solved or resolved. This is a cognitive competency.
2. *Adapting:* Adapting involves being able to adapt behaviors and other resources to match the situation. This is a behavioral competency.
3. *Communicating:* Communicating is used to advance the process in a way that individuals can understand and accept. This is a process competency.

Emotional Intelligence

Relational and emotional integrity are hallmarks of good leaders. Among the important personal leadership skills for nurses is **emotional** intelligence (EI). EI traits are emotional factors consisting of five defining attributes: self-awareness, self-regulation or discipline, motivation, social awareness, and relationship management. EI can be understood as a constellation of self-perceptions of the person's empathy, impulsivity, and assertiveness, also including elements of social and personal intelligence. EI is seen as an intellectual skill helping to understand and assess the meaning of emotions, to reason, and to problem solve. EI has a strong and positive impact on organizational climate. A positive organizational climate is less likely to contain counterproductive work behaviors or unethical dysfunctional organizational behavior (Al Ghazo et al., 2019). EI has been studied in nursing and shown to be related to transformational leadership (Spano-Szekely et al., 2016), nursing team performance and cohesiveness (Quoidbach & Hansenne, 2009), quality of care (Adams & Iseler, 2014), and as a moderator of **stress** and **burnout** (Görgens-Ekermans & Brand, 2010). Spano-Szekely and colleagues recommended that EI characteristics be considered during the hiring of nurse managers.

Adaptive thinking abilities are needed for leadership in the complex, volatile, and unpredictable environment of health care (Spano-Szekely et al., 2016). This is because the leader operates in a crucial cultural and contextual influencing mode within the organizational environment. The leader's behavior, patterns of actions, attitude, and performance have a special impact on the team's attitude and behaviors and on the context and character of work life. Followers observe and respond to all aspects of what leaders say and do (or do not do). Followers need to be able to depend on role consistency, balance, and behavioral integrity from the leader. The four EI skill sets needed by good leaders are as follows:

1. *Self-awareness:* Ability to read one's own emotional state and be aware of one's own mood and how this affects staff relationships

2. *Self-management:* Ability to take corrective action so as not to transfer negative affect to staff relationships
3. *Social awareness:* An intuitive skill of empathy and expressiveness in being sensitive and aware of the emotions and moods of others
4. *Relationship management:* Use of effective communication with others to disarm conflict and the ability to develop the emotional maturity of team members

Relationship Management and Relational Coordination

High performance, organizational health, and effectiveness are organizational goals. Relationship-based care has been proposed as a model for nursing care that promotes organizational health, thus resulting in positive outcomes (Koloroutis, 2004). Relationship-based care focuses on the care provider's three crucial relationships: relationship with patients and families, with self (nurtured by self-knowing and self-care), and with colleagues (commitment to healthy interpersonal relationships) (Creative Health Care Management, 2020).

Gittell (2016) emphasized the centrality of relationship management because patient care is a coordination challenge. She noted that relational coordination drives quality and efficiency outcomes and health care performance. Relational coordination is defined as "… coordinating work through relationships of shared goals, shared knowledge, and mutual respect" (p. 13). Relational coordination focuses on *relationships among roles* rather than between individuals.

Interpersonal relationship skills are crucial to the work of leadership. Leaders are pivotal for connecting the efforts of followers to organizational goals in order to produce outcomes. However, good leaders manage relationships and are anchors to the vision and the larger mission, guides to coping and being productive, and champions of energy and enthusiasm for the work.

BACKGROUND RELATED TO LEADERSHIP

Terms related to leadership are *leadership styles, followership*, and *empowerment*. **Leadership** styles are defined as different combinations of task and relationship behaviors used to influence others to accomplish goals. **Followership** is defined as an interpersonal process of participation: "a process whereby an individual or individuals accept the influence of others to accomplish a common goal" (Northouse, 2019, p. 295). **Empowerment** means giving people the authority, responsibility, and freedom to act on their expert knowledge and skills.

Self-awareness is an important aspect of both leadership and followership. This means that nurses can assess themselves to better understand their own style and leadership characteristics. Self assessment tools are available to assist nurses in awareness of both leadership and followership behaviors. Examples are the LEAD instruments developed by Hersey et al. (2013), the Multifactor Leadership Questionnaire (MLQ) (Bass & Avolio, 2019), and multiple training instruments. Leadership related research instruments were identified, compared, and evaluated by Huber and colleagues (2000). Some instruments are useful for research and others for leadership training or self-diagnosis. A wide variety of tools are available to help individuals increase their effectiveness through greater awareness and subsequent honing of both their leadership and followership skills.

Leadership can be best understood as a process. Much attention has been focused on leadership as a group and organizational process because organizational change is heavily influenced by the context or environment. Nurses need to have a solid foundation of knowledge in leadership and care management at all levels, although the depth and focus of care management roles and skills may vary by level. For example, the clinical nurse care provider or direct care ("bedside") nurse concentrates on the coordination of nursing care to individuals or groups and is a leader and manager within his or her scope of practice. This may include such activities as arranging access to services, providing direct care, doing referrals, and supporting a patient's family.

Nurses without formal positional authority are **informal leaders**. They influence peers and administrators and function in an influence sphere within interdisciplinary teams. They have varying forms of power, but they are a part of the shadow organization that operates behind the scenes of the formal chain of command in informal networks of people and influence. They serve as advocates for the work being done and heighten the contributions of themselves and others through influence, relationship building, knowledge, and expertise. These nurses can be developed and empowered to affect unit performance and culture.

At the next level, the nurse manager concentrates on the day-to-day administration and coordination of services provided by a group of nurses. The nurse executive's role and functions concentrate on long-term

administration of an institution or program that delivers nursing services, focusing on integrating the system and building a culture. CNLs and advanced practice registered nurses (APRNs) provide leadership in the care and care transitions of individuals and populations while providing expertise to the organization in specialty areas.

LEADERSHIP: FIVE INTERWOVEN ASPECTS

Hersey et al. (2013) noted that the leadership process is a function of the leader, the followers, and other situational variables. The leadership process includes five interwoven, connected but distinct, aspects: (1) the leader, (2) the follower, (3) the situation, (4) the communication process, and (5) the goals. Fig. 1.2 shows how these components relate to one another. All five elements interact within any given leadership circumstance.

Process Part 1: The Leader

The values, skills, and style of the leader are important. His or her internalized pattern of basic behaviors influences actions and the ability to lead. Leaders' perceptions of themselves, their roles, and their expectations also have an impact on their followers. Self-awareness is crucial to leadership effectiveness and is an EI skill. Among the internal forces in leaders that impinge on leadership style are values, energy level, confidence in employees, leadership inclinations, motivation for leadership, and sense of security in uncertainty. Interpersonal, emotional, and social intelligence skills also contribute to effective leadership.

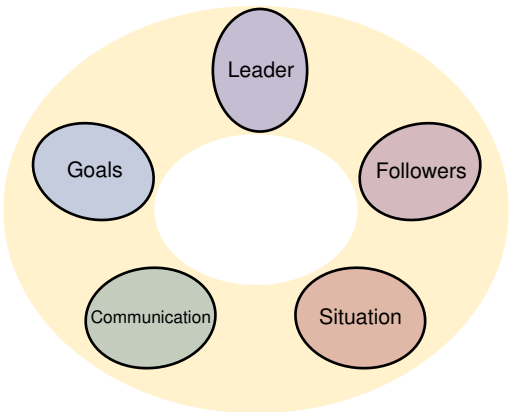

Fig. 1.2 Components of a leadership moment.

Self-awareness is an important aspect of both leadership and followership. This means that nurses can assess themselves to better understand their own style and leadership characteristics. Self-assessment tools are available to assist nurses in awareness of both leadership and followership behaviors. Examples are the LEAD instruments developed by Hersey et al. (2013), the Multifactor Leadership Questionnaire (MLQ) (Bass & Avolio, 2019), and multiple training instruments. A wide variety of tools are available to help individuals increase their effectiveness through greater awareness and subsequent honing of both their leadership and followership skills.

Process Part 2: The Follower and Followership

Followership is the flip side of leadership. It is likely that without followers there is no leadership. Followers are vital because they accept or reject the leader and determine the leader's personal power (Hersey et al., 2013). Followership skill is underappreciated. Grossman and Valiga (2017) suggested that leaders are only leaders if they have followers. Followership can be learned and consciously developed. Northouse (2019) differentiated followership based on roles or positions within an organizational structure versus based on relationships in an interpersonal context.

Types of Followers

There are several typologies that distinguish types of followers. Styles can be plotted along the two axes of passive to active and dependent to independent. Grossman and Valiga (2017) identified types of followers on dimensions of activity and independence: effective or exemplary, alienated, yes people, and sheep.

Understanding types of followers is as important as understanding types of leaders: it creates the ability to match leadership style to effectiveness in care delivery. Effective followers are an asset to be nurtured, developed, and valued. Effective followers contribute to success in organizations because they contribute motivation, enthusiasm, expertise, energy, innovation, and goal-orientation. Nurses can and should examine their own behavior and ask themselves the question, "In this situation, what kind of follower am I?"

There are types of followers, ranging from being vital to the success of the group to being passive and unthinking. Using the variables of performance initiative (high to

low) and relationship initiative (high to low), Grossman and Valiga (2017) developed a grid of four followership styles: subordinate, contributor, partner, and politician. Effective followers show characteristics of assertiveness, determination, willingness to challenge ideas, an ability to act, and openness to new ideas. Followers also need self-awareness to know themselves and their expectations. Situations in which members of a group are not accustomed to working together or do not hold shared expectations frequently lead to conflict. Followership is based on trust. Groups have personalities that include a discernible level of trust. The wise leader assesses the trust and readiness to change levels of the group. Northouse (2019) discussed four typologies of followership. For example, Kelley's Typology plots active/passive and independent/dependent critical thinking into five types: passive, conformist, alienated, pragmatic, and exemplary. Other typologies plot dominance versus passivity, support versus challenge, and followers' levels of engagement.

Followership is not as simple as it seems. Followership can be assessed similar to leadership style and becomes a part of self-awareness (e.g., Followership Questionnaire in Northouse, 2019).

Leaders do not operate in isolation. Instead, leadership involves cooperation and collaboration. The basic nature of leadership is interactive; it revolves around the interpersonal relationships among leaders and followers. Therefore cooperation and collaboration between the leader and followers enhance the group's effectiveness. Although it may seem obvious, followership quality is important. There is a dynamic relationship between leaders and followers, and both are important.

Followership is an interpersonal process of participation. It implies an engagement of the follower with the leader, and possibly a group, by which the follower takes guidance and direction from the leader to accomplish group goals. The importance of followership is emphasized because leadership requires the presence of followers. The relationship between the leader and the followers defines leadership. The corollary to leadership is followership, which is helping to get the job done. A good leader clearly needs good followers, and this relationship is based on giving direction, trust, and hope. Kouzes and Posner (2017) noted that for people to follow willingly, they need to believe the leader is honest, forward looking, competent, and inspiring. With these three elements in place, followers are empowered in their participation efforts. Any situation can be analyzed to determine whether the desired leader attributes are present and to what extent.

Process Part 3: The Situation

The specific circumstances surrounding any given leadership situation will vary. Elements such as work demands, control systems, amount of task structure, degree of interaction, amount of time available for decision-making, and external environment shape the differences among situations (Hersey et al., 2013). For example, in acute care hospitals, staffing levels and policies strongly influence many aspects of a nurse's work life. Organizational culture and ethos are also important factors in the situation. For example, in one setting the culture may resemble one big happy family, with an emphasis on teamwork and morale boosting. The cultural aspects of that leadership situation are different from those of an organization where there is a fast-paced tempo and people seem too busy and/or in a bullying environment. Environmental or cultural differences also cause the leadership situation to vary. The leadership situation in a group that is knowledgeable and experienced in solving problems is very different from the leadership situation in a group that is not experienced at the task or at working together. The personality styles of both superiors and subordinates have an influence on the situation, the work demands, and the amount of time and resources available.

Process Part 4: Communication

Communication processes vary among groups regarding the patterns and channels used and the degree to which the communication flow is open or closed. Communicating is basic to the process of influencing and thus to leadership (see Chapter 8). Almost every issue or problem contains a communication aspect. Through communication, the leader's vision and message are received by the followers. After choosing a channel, the sender transmits a message, but the message is filtered through the receiver's perception. Communication is transmitted through both verbal and nonverbal modes. Organizations include a variety of communication structures and flows. These may be downward, upward, horizontal, grapevines, or networks. Communication may be formal or informal (Hersey et al., 2013). Certain acts performed by leaders have positive effects and make people feel more respected; listening and informal chatting are prime examples because they foster interpersonal and relational trust and social cohesion.

Process Part 5: Goals

Organizations have goals, and individuals working in organizations also have goals. These goals may or may not be congruent. For example, the goal of the organization may be to decrease costs or increase revenue. In contrast, the goal of the individual nurse may be to spend time counseling and teaching clients because that is what is seen by the nurse as the most important activity. Goals may thus be in conflict, in which case there is tension and a need for leadership.

Clearly, leadership is a complex and multidimensional process. Nurses need to be aware of the interacting elements in any leadership situation. Critical thinking can be applied to diagnosing and analyzing the five elements, adapting to the situation, and communicating for effectiveness. For example, if a nurse works in a situation in which there is a high level of frustration, it may be time to step back and analyze the basic five elements. Doing so sets the stage for better decision-making about change strategies and strategic management.

LEADERSHIP THEORIES

Leadership is so critical that it has been studied for a very long time, especially in the business literature. There are numerous theories and extensive research. The condensation here will highlight core concepts and common theories.

Leadership is fundamentally about the two basic elements of tasks and relationships. **Tasks** are the job aspects that must be done to produce the product (e.g., nursing care). Human **relationships** are the "people element": the interpersonal workings of humans in a job environment.

Hersey et al. (2013) have done a thorough overview of leadership and organizational theory up through the situational leadership school of thought. From an early awareness of the leader's need to be concerned about both tasks and human relationships (output and people) sprang a long history of leadership theories that can be grouped as *trait, attitudinal*, and *situational* (Hersey et al., 2013). The trait approach focuses on identifying specific characteristics of leaders. The attitudinal approach measures attitudes toward leader behavior. The situational approach focuses on observed behaviors of leaders and how leadership styles can be matched to situations.

Trait Theories: Characteristics of Leadership

Leadership theories have evolved away from an early focus on the traits or characteristics of the leader as a person because it was found that it is not possible to predict leadership from clusters of traits, yet interest remains in the characteristics to look for in good leaders. In the trait approach, theorists have sought to understand leadership by examining the characteristics of leaders, leading to multiple lists of traits proposed to be essential to leadership. One result was the awareness that leadership skills can be both taught and learned. It is important for nurses to recognize that they can learn, practice, and improve their personal leadership competencies.

Leaders are active, not passive. Leaders engage their environment with behaviors of doing, influencing, and moving. These are action terms that need to be melded with expertise and empathy. Leaders are those who talk about adventures into new territory and take the risks inherent in innovation (Kouzes & Posner, 2017). Leadership means giving guidance and using a focused vision.

Characteristics such as knowledge, motivating people to work harder, trust, communication, enthusiasm, vision, courage, ability to see the big picture, and ability to take risks are associated with important leadership qualities in research findings. Kouzes and Posner (2017) found that for people to be willing followers, the leader needs to be honest, forward-looking, competent, and inspiring. They identified the Five Practices of Exemplary Leadership that correlate with leadership excellence:

1. *Model the way*: Leaders set an example and structure events so that incremental progress is celebrated as small wins.
2. *Inspire a shared vision*: Leaders envision the future and enlist others in sharing the dream.
3. *Challenge the process*: Leaders go beyond the status quo to search for opportunities, experiment, and take risks to achieve lofty goals.
4. *Enable others to act*: Leaders foster collaboration and develop and strengthen others so that the whole team performs well.
5. *Encourage the heart*: Leaders appreciate and recognize individual contributions and formally celebrate accomplishments.

This model of leadership has been used in nursing research looking at staff nurse clinical leadership (Patrick et al., 2011).

Vision and Trust

Although the lists of leadership characteristics and competencies vary somewhat, the functions of visioning, setting the direction, inspiration, motivation, and enabling systems and followers are at the core of leadership activity. The one specific defining quality of leaders is vision: the ability to create a vision and put it into operation.

Leadership is founded on trust: "Trust is the emotional glue that binds leaders and employees together and is a measure of the legitimacy of leadership" (Malloch, 2002, p. 14). Organizations that focus on sustaining a healing culture rebuild organizational trust by focusing on trust in relationships with employees. Behaviors that build trust include sharing relevant information, reducing controls, and meeting expectations. Trust-destroying behaviors include being insensitive to beliefs and values, avoiding discussion of sensitive issues, and encouraging competition via winners and losers. Trust goes both ways and needs to be nurtured. Nurses can start by examining their own behaviors and then taking deliberative actions to strengthen trust in the environment.

Leadership Styles Theories

As leadership theories evolved, leadership came to be viewed as a dynamic process and an interaction among the leader, the followers, and the situation. Leadership theory began to move beyond a focus on traits to explore the concept of leadership styles. Styles of leadership range from authoritarian to permissive to democratic and from transactional to transformational. The individual nurse's task is to determine in which environments he or she functions best and is most comfortable or where he or she most likely will succeed. This facilitates placement for success and a better match between leader and follower.

Leadership styles are defined as different combinations of task and relationship behaviors used to influence others to accomplish goals. They are sets or clusters of behaviors used in the process of effecting leadership. Hersey et al. (2013) defined these terms as follows:

- *Task behavior*: The extent to which leaders organize and define roles; explain activities; determine when, where, and how tasks are to be accomplished; and endeavor to get work accomplished
- *Relationship behavior*: The extent to which leaders maintain personal relationships by opening communication and providing psycho-emotional support and facilitating behaviors

Hersey et al. (2013) said that leadership styles are the consistent behavior patterns exhibited in influencing the activities of others by working with and through them, as perceived by those others. Different styles evoke variable responses in different situations. A leader's leadership style is some combination of task and relationship behavior. A style may range from democratic to authoritarian (or subordinate centered to leader centered) (Fig. 1.3). Schooley (2019) identified nine different leadership styles:

1. **Autocratic leadership:** The leader primarily uses directive behaviors. Decisions of policy are made solely by the leader, who tends to dictate tasks and techniques to followers. Leaders tell the followers what to do and how to do it. This style emphasizes a high concern for task. Authoritarian leaders are

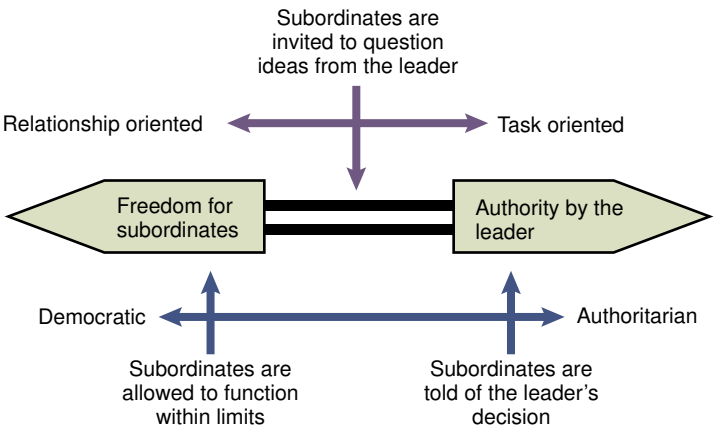

Fig. 1.3 Continuum of leader behavior.

characterized by giving orders. Their style can create hostility and dependency among followers; this may also stifle creativity and innovation. On the other hand, this style can be very efficient, especially in a crisis or during a code situation.

2. **Bureaucratic leadership:** Although not as strict as autocratic leaders, bureaucratic leaders tend to strictly enforce regulations and statuses in the hierarchy. They strive to maintain the status quo. They carry out policies and procedures. This leadership style can be effective in complex healthcare and safety environments or where there is high risk and stability is desired.
3. **Charismatic leadership:** Charismatic leaders have an infectious presence that attracts followers and motivates their team to follow their lead. Their likability helps achieve success. This leadership style can be effective in high-energy work environments that need a lot of positive motivation and team morale. The danger arises in following the "cult of personality" instead of using critical thinking.
4. **Democratic leadership:** A democratic leader often welcomes subordinate participation in decision-making. This approach implies a relationship and person orientation. Policies are a matter of group discussion and decision. The leader encourages and assists discussion and group decision-making. Human relations and teamwork are the focus. The leader shares responsibility with the followers by involving them in decision-making. In nursing, interdisciplinary teamwork is a major element in effectiveness. The democratic style may appear to move more slowly and is thought to take longer than using an authoritarian style. This is because group consensus needs time and facilitation to be fostered. Furthermore, the needs of disenfranchised minority groups must be balanced. Intergroup cohesion is a focus with this style. The challenge of the democratic style is to get people with different professional backgrounds, personal biases, and psychological needs together to focus on the problem and next action steps. Motivating participation is a constant challenge. This leadership style is often admired and can be effective in creative work environments that do not require quick decisions.
5. **Laissez-faire leadership:** Laissez-faire leaders have a hands-off approach and let their employees assume responsibility in the decision-making process, although they must still set expectations and monitor performance. This style promotes complete freedom for group or individual decisions. There is a minimum of leader participation. A leader using this style may seem to be apathetic. Because the style is based on noninterference, a clear decision may never be formulated. The laissez-faire style results in a decision, conscious or otherwise, to avoid interference and let events take their own course. The leader is either permissive and fosters freedom or is inept at guiding a group. Followers may need greater structure than the leader gives them. Despite its potential drawbacks, this style has advantages when used with some circumstances involving groups of fully independent care providers or professionals working together. This leadership style is seen as effective when working with highly experienced and confident employees.
6. **Servant leadership:** Servant leaders are those who share power and decision-making with their subordinates and direct the organization based on the interests of the team. Servant leaders put others first. They choose to make sure that other people's highest-priority needs are being served in a way that promotes personal growth and helps others become freer and more autonomous. This leadership style can be effective for humanitarian organizations, nonprofits, and teams that need to create diversity, inclusion, and morale.
7. **Situational leadership:** Situational leaders see the use of leadership style as situational or contingent based on what produces effectiveness. They first do a specific assessment of all aspects of the situation and then modify their style to match the situation based on the needs of their employees and the environment. Because of its versatility, this type of leadership can be effective in most organizations.
8. **Transactional leadership:** A transactional leader is focused on day-to-day operations and uses a reward/consequence system to motivate employees to achieve success or discourage them from failure. Transactional leadership is a social exchange (this for that). This leadership style can be effective for teams or individuals who are motivated by rewards or immediate needs.
9. **Transformational leadership:** Similar to charismatic leaders, transformational leaders use their inspiring energy and personality to create a magnetic workplace. They engage with others so that leaders and

followers raise each other to higher levels of motivation. The transformational type is often more effective than charismatic leadership, because it also is centered on the followers', not the leader's, needs and goals and motivates teams to build confidence, skills, achievement, and accountability. Transformational leadership can be effective in organizations with intellectual team members who thrive in interactive environments.

There is no one "right" style. Each has its strengths. Effectiveness comes from pairing leadership styles with organizational fit, timing, and needs. There are situational and contextual factors to consider when choosing a style. Styles should vary according to the appropriateness of the situation with reference to an evaluation of effectiveness. Flexibility is important. For example, if a nurse prefers to operate in a democratic style yet suddenly a code situation occurs, then the nurse must rapidly switch from a democratic to an authoritarian style. Some democratic leaders cannot vary their style sufficiently to handle crises. On the other hand, in a staff meeting, an authoritarian leader may be ineffective with a group of professionals and would need to be flexible enough to switch to a democratic or laissez-faire style, depending on the circumstances. The basic needs are for leader self-awareness and knowledge of the group's ability and willingness levels before examining the situational elements and choosing a leadership style. Self-awareness is key to strategically using leadership styles.

Feminist Leadership Perspective

Leadership styles appear to have a gender component. The feminist perspective on leadership was presented originally by Helgeson (1995a, 1995b). She identified female leadership as a web-like structure that is dynamic and continuously expanding and contracting. It is characterized by a concern for family, community, and culture. The inclination is for a democratic power style, and the emphasis is on the importance of establishing relationships, maintaining connections with others, and deriving strength from empowering others. By contrast, leadership approaches described by men, as a generalization, tend to be influenced by the military and participating in team sports. Men tend to spend their time on meetings and tasks requiring immediate attention, focusing on completion of tasks and achievement of goals. Women tend to focus on process; men tend to focus on achievement and closure. Women tend to be more flexible and value cooperation, connectedness, and relationships. Exploring the feminist perspective on leadership is valuable in that it provides food for thought as health care organizations and the predominantly female nurses working in them struggle with not wanting to let go of the familiar hierarchical management style yet needing to reconfigure to the circular or web structure to be effective. It is not known whether gender differences are permanent characteristics or are culturally mediated artifacts that blur with time.

Reynolds (2011) explored the thesis that servant leadership is a gender-integrative, partnership-oriented approach to leadership, using the feminist ethic of care. Leadership is a system for organizing activity, and gender is a system for organizing meaning. Yet mainstream leadership theory has ignored gender-related aspects of power. Scholars of communication and leadership have identified the management of meaning as one of the significant acts of leadership.

Situational Leadership Theories

A group of leadership contingency theories posit that organizational behavior is contingent on the situation or environment. This means that which theory or style is the best all depends on the situation at hand. What is needed by the leader is diagnostic ability. The leader observes and analyzes which abilities and motives are present in the followers. With sensitivity, cues in the environment can be identified and used to make choices regarding leadership style. One choice a leader has is to alter his or her own behavior and the leadership style used. Personal flexibility and leadership skills are needed to vary one's style when the followers' needs and motives change or vary. The ability to diagnose, choose, and alter behavior to implement a leadership style best matched to the situation is a critical skill needed for effective leadership (Hersey et al., 2013).

In situational leadership theories, leadership in groups is never a static circumstance. The situation is dynamic and subject to change. In a very difficult situation, relationships may be the leader's preferred emphasis. However, if interpersonal relationships are not an immediate problem or if the group is on the verge of collapse, then strong authoritative direction is needed to get the group moving and accomplishing. For this situation, the task-oriented leader is a more effective match between leader and job. However, groups do not remain static; they move back and forth through stages. When

the problem is no longer just the need to get the group moving but also includes solving numerous interpersonal conflicts, a relationship-oriented leader is better matched to the situation. Eventually, as the situation progresses, a relationship-oriented leader can become less effective. This occurs because once the group has less conflict, individuals may begin to coast along, and positive motivation may be lost as individuals become apathetic. Once again, a task-oriented style is called for to challenge individuals by using the motivation they need to continue to produce. Because of the factor of constant change, maintaining good leadership is complicated for any group.

The Situational Leadership® Model

The Situational Leadership® Model of Hersey et al. (2013; The Center for Leadership Studies, 2020) focuses on the interplay among three elements: the amount of guidance and direction (task behavior) a leader gives; the amount of socioemotional support (relationship behavior) a leader provides; and the Performance Readiness® Level that individuals or teams (followers) exhibit in performing specific activity, task, or job. Using a grid that results from task and relationship axes ranging from high to low, task behavior is plotted on the horizontal axis, and relationship behavior is plotted on the vertical axis. See the grid on The Center for Leadership Studies' (2020) website: https://situational.com/situational-leadership/. This makes it possible to describe leader behavior in four quadrants: (1) high task, low relationship (S1, telling); (2) high task, high relationship (S2, selling); (3) high relationship, low task (S3, participating); and (4) low task, low relationship (S4, delegating). As applied to the continuum of authoritarian versus democratic styles, telling would be authoritarian and participating would be democratic.

To choose an appropriate style, the leader needs to be knowledgeable about the Performance Readiness® level of the followers. This leads to the third dimension of effectiveness: the situation, or environment, which determines the effectiveness of a leader's behavior style (Hersey et al., 2013). Thus the difference between effective and ineffective styles often will not be the actual behavior of the leader but rather the appropriateness of the leader's behavior as matched to the environment in which it is used.

Found below the basic grid is a continuum of Performance Readiness® ranging from low to high. The Performance Readiness® level of an individual or group is determined by both ability and willingness. The first consideration regarding readiness is the followers' ability. *Ability* is the demonstrated knowledge, experience, and skill that a follower brings to a task or activity. *Knowledge* is demonstrated understanding of the task. *Skill* is the demonstrated proficiency in the task. *Experience* is the demonstrated ability gained from performing a task (Hersey et al., 2013).

The other part of readiness is *willingness*. Willingness is the extent to which a follower has demonstrated confidence, commitment, and motivation to accomplish a specific task. *Confidence* is demonstrated self-assurance in the ability to perform a task. *Commitment* is demonstrated dedication to perform a task. *Motivation* is demonstrated desire to perform a task (Hersey et al., 2013). Both ability and willingness need to be assessed; then they can be plotted on the grid to determine readiness.

Hersey et al. (2013) combined the aspects of ability and willingness and showed them displayed on the grid in four levels of readiness: (1) R1: both unable and unwilling or insecure; (2) R2: unable but willing or confident; (3) R3: able but unwilling or insecure; and (4) R4: both able and willing or confident. The Situational Leadership® Model correlates the four different levels of Performance Readiness® to the four basic leadership styles. The result is a visual display and model that provides the opportunity for the leader to assess a follower's behavior and identifies a way to understand and select the leadership style that has the highest probability of effectively influencing a specific person for a specific task.

Thus at the Situational Leadership® Model's core, Hersey et al. (2013) emphasized the importance of the readiness of followers. Any leader behavior is predicted to be more or less effective depending on the Performance Readiness® of the followers that the leader is attempting to influence. The leader's chosen leadership style would have to consider where the followers are in terms of their Performance Readiness® level. The principles of the Situational Leadership® Model can be applied to a work group. The leader begins with assessment and analysis. Have the members worked together for a long time in the job, or are they new employees? The culture is more solidified in a work group that has worked together for many years on a unit. Using the Situational Leadership® Model, leaders (1) identify the specific

job, task or activity, (2) assess current Performance Readiness®, and (3) match and communicate by selecting and exhibiting the appropriate leadership style: S1, S2, S3, or S4 (Hersey et al., 2013). For example, telling is an appropriate leadership style to use with followers who are at the novice level and with followers who are unable, unwilling, or insecure. An example is when a nurse is appointed as chair of a committee. The nurse needs to assess and then adapt his or her leadership style to match the Performance Readiness® level of the followers in order to be most effective.

Thus in this view of leadership, it is situational or contingent and concerned with what produces effectiveness. Hersey et al. (2013) noted that the common themes include the following: the leader needs to be flexible in behavior, able to diagnose the leadership style appropriate to the situation, and able to apply the appropriate style given the Performance Readiness® of followers.

Transactional and Transformational Leadership

Another way of looking at leadership is how leaders produce quantum results. The concept of leadership styles broadened over time to include two types of leaders: the transactional leader and the transformational leader.

A *transactional leader* is defined as a leader or manager who functions in a caretaker role and is focused on day-to-day operations. Such leaders survey their followers' needs and set goals for them based on what can be expected from the followers. A transactional leader is focused on the maintenance and management of ongoing and routine work. Transactional leadership is a social exchange: one thing is exchanged for another, generally to accomplish daily work (Steaban, 2016).

A *transformational leader* is defined as a leader who motivates followers to perform to their full potential over time by influencing a change in perceptions and by providing a sense of direction. Transformational leaders use charisma, individualized consideration, and intellectual stimulation to produce greater effort, effectiveness, and satisfaction in followers. Transformational leaders grow and develop others by empowering them (Steaban, 2016). Fig. 1.4 distinguishes between transactional and transformational leadership.

The transactional leader is more common. This type of leader approaches followers in an exchange posture, with the purpose of exchanging one thing for another,

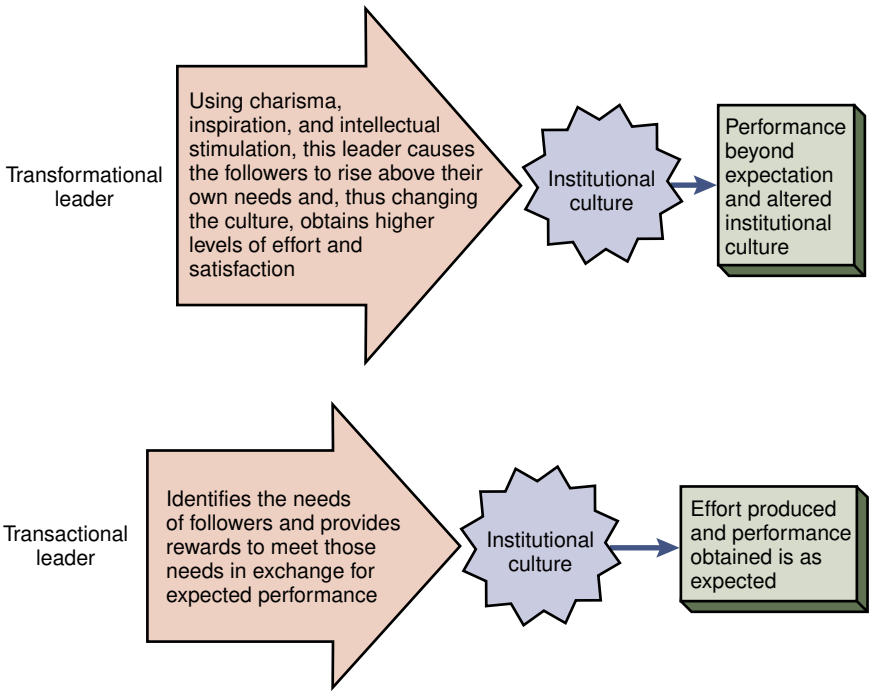

Fig. 1.4 Transactional and transformational leadership.

such as a politician who promises jobs for votes. Transactional leadership is about the exchange of valued things. Therefore transactional leadership is comparable to a bargain or contract for mutual benefits that aids both the leader and the follower. The transactional leader works within the existing organizational culture and is an essential component of effective leadership at the level of task accomplishment. Examples would be the exchange of a salary for the services of a nurse to provide care or when a leader offers release time or paid time to entice staff members to do project or committee work. Continuous or incremental change, the first order of change, can be handled well at the transactional level.

Transformational leadership occurs when persons engage with others so that leaders and followers raise each other to higher levels of motivation. Instead of emphasizing differences between the leader and the followers, transformational leadership focuses on collective purpose and mutual growth and development. Transformational leadership augments transactional leadership by being committed, having a vision, and empowering others to heighten motivation in a way that attains extra effort beyond performance expectations. Transformational leadership is used for higher-order change and to change the organization's culture. Circumstances of growth, change, and crisis call forth transformational leaders, and transformational leadership has been studied regarding successful change management (Deschamps et al., 2016).

There is nursing research to demonstrate the positive outcomes of transformational leadership. The American Nurses Credentialing Center's (ANCC, n.d.a) Magnet Recognition Program® has emphasized transformational leadership approaches. For example, the chief nursing officer of Magnet-designated organizations' transformational leadership style has been shown to have a positive impact on the work environment (Buck & Doucette, 2015). Transformational leadership was the type of leadership most often reported in early Magnet research studies (Upenieks, 2003a; 2003b). A transformational leadership style has been shown to generate greater follower commitment, follower satisfaction, and overall effectiveness (Kleinman, 2004). In nursing homes, the most transformative style of top managers (consensus managers) was found to be associated with better quality outcomes (Castle & Decker, 2011). Deschamps et al. (2016) found that leadership is an important factor in implementing changes, but justice is also a crucial factor. The positive impact of transformational leadership is mediated by organizational justice.

Transformational leaders have been shown to have an impact on both organizations and individuals. Organizational impacts include increased organizational citizenship, stronger organizational culture, and clearer organizational vision (Thomson et al., 2016). Improvements in outcomes for individuals, including empowerment, job satisfaction, commitment, trust, self-efficiency, beliefs, and motivation, have also been linked to transformational leadership (Givens, 2008). Transformational leadership is also associated with a decrease in staff turnover (Weberg, 2010). Overall, transformational leadership qualities appear to be better suited to the work of professionals and important for leadership in nursing.

CONTEMPORARY LEADERSHIP: INTERACTIONAL AND RELATIONSHIP-BASED

In this information age there has been a metamorphosis in health care organizations as they transform into knowledge or learning organizations. Nurses are knowledge workers who use expertise and specialized knowledge in the care of patients. They need matching organizational structures that will value, nurture, and foster the acquisition of the data, information, and knowledge needed for effectiveness. Today's health care environments demand that frontline workers such as nurses have and maintain the expertise and have the information necessary (e.g., evidence-based practice) to take action to solve problems. They need leadership that is interactional, relational, and transformational at all levels.

Arising in conjunction with the application of complexity theory and chaos theory (as discussed under Contemporary Management Theories), leadership was described by Wheatley (2006) as having important elements of connectedness and relationships within self-organizing systems. Nursing has a natural niche within interactional and relationship leadership theories. Optimal health care delivery is truly interdisciplinary, holistic, and highly team based. When connections and relationships are strong, patients benefit. Contemporary definitions of leadership describe leadership as being the result of a relationship between leaders and followers where a distinct set of competencies is used to allow the

relationship to achieve shared goals. This is complex and requires nurses to be creative and flexible. It is proposed that "quantum" leadership is needed to produce results in today's health care environment. Quantum leadership is about discovering using an ongoing process of exploration, curiosity, and asking questions. Driven by organizational stress and the feeling that something more and different in work life is needed, quantum leadership is one type of leadership strategy that helps nurses focus on the future, stretch and break boundaries, and encourage breakthrough thinking to solve problems in a complex and fluid care environment. Quantum approaches build on feminist and transformational leadership perspectives and dive more deeply into the behavioral, relational, and interactional elements that form the activities and functions of a leader. Innovation is desired and encouraged.

Complexity Leadership

Traditional leadership theories were developed during the industrial era and describe traits, situations, and a role with power concentrated in a position in the organization. The focus is on maximizing production and reducing variance. Linear models assume input will yield a proportional output (linear processes). Weberg (2012) argued that a focus on linear systems requires management, not leadership, because it removes the capacity for the system to change and innovate. Using complexity science principles and systems thinking, Weberg advocated for complexity leadership because it gives a context for organizational operations whereby the behaviors of leadership foster interaction, increase network strength, and generate stability in order to create the energy for constant change, growth, and adaptation. Interconnectedness and change become normal operating conditions. Complexity leadership is a type of leadership "based on adaptive capacity, understanding the external environment and connecting with the internal organizational culture and thriving in situations where groups need to learn their way out of unpredictable problems" (Weberg, 2012, p. 271). In health care, this will require a shift toward complexity behaviors that embrace complex systems and continually search for value-added innovations. Leaders need to develop innovation competence.

Servant Leadership

Another popular contemporary leadership concept is called *servant leadership*. Greenleaf (2002) originally used the term to describe leaders who choose first to serve others and then to be a leader, as opposed to those who are leaders first (often because of a power drive or need to acquire material possessions) and later choose to serve. When applied to health care, servant leadership is an attractive alternative to the traditional bureaucratic environment experienced by nurses. The servant leadership model draws attention to the necessity for leaders to be attentive to the needs of others and is a model that enhances the personal growth of nurses, improves the quality of care, values teamwork, and promotes personal involvement and caring behavior. Reynolds (2011) melded the feminist and servant leadership perspectives, calling servant leadership gender-integrative leadership that values equally the masculine and feminine dualities, qualities, activities, and behaviors. Hanse et al. (2016) studied the impact of servant leadership dimensions on leader–member exchange among health care professionals and found that servant leadership dimensions are likely to help develop stronger exchange relationships between nurse managers and individual subordinates. A servant leader culture involves interpersonal interaction and promotes strong relationships and trust between leaders and followers.

Authentic Leadership

Following from the IHI's Triple Aim and moving to the Quadruple Aim, focus has now turned to the importance of employees thriving in organizations for organizational performance. Thriving at work is defined as a state where individuals at work experience both a sense of vitality and a sense of learning (Mortier et al., 2016) and is an aspect of work life and nurse vitality. Mortier and colleagues found that nurse managers' authentic leadership enhances nurse thriving.

Authentic leadership was described by Avolio and Gardner (2005) as a leadership style rooted in the concept of authenticity ("to thine own self be true"), where the leader is a fully functioning person in tune with themselves and their basic nature, self-actualizing, and having strong ethical convictions. Authentic leaders are "those who are deeply aware of how they think and behave and are perceived by others as being aware of their own and others' values/moral perspectives, knowledge, and strengths; aware of the context in which they operate; and who are confident, hopeful, optimistic, resilient, and of high moral character" (Avolio & Gardner, 2005, p. 321).

There are four aspects of authentic leadership:

- Self-awareness: how the leaders perceive themselves in comparison with the world and with their understanding of their own strengths and weaknesses
- An internal moral perspective: leaders align their beliefs with their actions and are not often persuaded by external pressures
- Balanced processing: their decision-making is based on analyses of all relevant data, being positive or confirming information or negative clues
- Relational transparency: how openly the leader presents him- or herself to others

The authentic leadership style is seen as fair and supportive and one that provides a healthier and more ethical work environment (Avolio & Gardner 2005; Mortier et al., 2016). This style has been studied in nursing and shown to have a positive effect on nurse job satisfaction and performance (Wong & Laschinger, 2013).

Clinical Leadership

All nurses in all positions exhibit leadership. For example, the "bedside" nurse uses informal leadership to influence high quality care delivery. Mannix et al. (2013) used an integrative review of literature on clinical leadership to elicit defining attributes of contemporary clinical leadership in nursing. The technical and practical skills necessary for competent clinical practice and leading a team emerged. The data were grouped into three categories of clinical leadership with either a clinical, follower/team, or personal qualities focus. "Clinical leaders who demonstrate clinical competence, possess effective communication and are supportive of colleagues have been linked to building healthy workplaces" (Mannix et al., 2013, p. 19). For example, one staff nurse who worked on a surgical and neuroscience intensive care unit recognized that there was incomplete and incorrect spinal cord injury/surgical patient assessment and documentation, which is critical when a patient's condition declines so that the degree of change is known. She took the initiative and contacted the nurse manager, invited other staff nurses to join her, set up a small committee, updated and simplified the assessment tool, and led the education of the staff on the revised tool with positive outcomes. This is clinical leadership.

There is a renewed focus on clinical leadership models at the point of care. Typically aimed at a hospital unit where care is delivered, the crucial role played by nurses in quality, safety, care coordination, and related aims of the IOM and IHI are the centerpiece. Nursing roles of care coordinator, CNL, and APRN have emerged and show continued growth. Joseph and Huber (2015, p. 56) defined clinical leadership as "the process of influencing point-of-care innovation and improvement in both organizational processes and individual care practices to achieve quality and safety of care outcomes." Patrick et al. (2011) viewed every registered staff nurse as a clinical leader and used Kouzes and Posner (2017) model of transformational leadership as a framework to describe and measure clinical leadership practices. Their review of literature identified five key aspects of clinical leadership: clinical expertise, effective communication, collaboration, coordination, and interpersonal understanding. Empowering work environments create a supportive structure for staff nurses as clinical leaders to achieve the best outcomes of care. "Clinical leadership uses the skills of the RN and adds components of general leadership skills, skills in management of care delivery at the point of care, and focused skills in using evidence-based practice for problem solving and outcomes management. There is clearly a need for clinical leadership in nursing because of the many and varied point-of-care implementation problems that arise" (Joseph & Huber, 2015, p. 56).

EFFECTIVE LEADERSHIP

Effective leadership is an integrated blend of leadership principles and characteristics with management principles and techniques. Nurses can grow such skills by knowledge and awareness (e.g., through assessment tools) and then may put knowledge and skills to work through guided exercises and mentored experiences. This is especially true for succession planning and the development of nurse managers (Mackoff et al., 2013).

Leadership effectiveness is based on the ability to adapt in a complex and chaotic environment. Adaptive problems arise from change and chaos and are often systems problems that affect people, planning, institutional operations, or work processes. Effective leaders first have strong self-awareness of their leadership strengths and weaknesses as well as preferred or most comfortable leadership styles and flexibility. Then they expand this to a grasp of themselves, their team, their goals, nursing and health care, and important evaluative data for "dashboards." They use their personal style, vision, and energy to focus on goal attainment and

group satisfaction. Starting with whatever natural talent a nurse possesses, essential leadership skills can be practiced over time for greater effectiveness. Effective leadership uses empowerment. For nurses, empowering means that the power over clinical practice decisions is invested in staff nurses, enabling them to do what they do best and make decisions related to their practice. This process is similar to nurses empowering clients. Leadership involves elements of vigor and vision and can be understood as a dynamic combination of competence, willingness to take responsibility, and strength of character to do what is right because it is the right thing to do. See Chapter 10 for further discussion of sources of power.

MANAGEMENT OVERVIEW

Along with an array of opportunities such as instantaneous communication across vast distances, health care organizations and the people in them struggle with an ever-accelerating rate of change, knowledge explosion, technology, and information flow. The recruitment, development, deployment, motivation, and leveraging of human capital (nurses) as scarce resources and prime assets are critical management issues for service industries in general and specifically for nursing and health care. At the core, managers manage people and organizations. People's time and effort—as well as organizations' money, facilities, and supplies—need to be directed in a coordinated effort to achieve best results and meet objectives. Managers focus on the needs of the organization and on getting the work done.

Because nurses are the central hub of care delivery and information flow, it is helpful to think of the work of nurses as having both care delivery and care coordination aspects. Although the coordination of care has always been a key nursing function, it is becoming more visible and valued in health care and as nurses assume care coordination roles that focus on integrating clinical care. However, the relative proportion of the nurse's role that is devoted to management and coordination functions varies within nursing according to the job category. Nurse managers balance two competing needs: the needs of the staff related to growth, efficiency, motivation, morale, and accomplishment with the outcome of staff satisfaction and the needs of the employer for productivity, quality, and cost effectiveness with the outcome of productivity.

DEFINITIONS

Management is defined as the process of coordination and integration of resources through activities of planning, organizing, coordinating, directing, and controlling to accomplish specific institutional goals and objectives. Management has been viewed as an art and a science related to planning and directing both human effort and scarce resources to attain established organizational goals and objectives.

Management, then, applies to organizations. The definition of leadership emphasizes actions that influence toward group goals; the definition of management focuses on organizational goals. The achievement of organizational goals through leadership and manipulation of the environment is management. In a systems approach to management, the inputs would be represented by human resources and physical and technical resources. The outputs would be the realization of goals through task accomplishment, culture development, removal of barriers, and efficiency optimization.

Thus management is a separate function with a specific purpose and related roles but one that is focused on organizations and operations. It is associated with important day-to-day functions geared toward maintenance and stability and associated with transactional leadership or "doing things right" via task accomplishment. To achieve organizational goals, managers are involved in activities such as analyzing issues, establishing goals and objectives, mapping out work plans, organizing assets and supplies, developing and motivating people, communicating, managing technology, handling change and conflict, measurement, analysis, and evaluation. Without talent and attention to these functions, effectiveness and morale drop. This affects quality. In addition, it is important to do the background work needed to keep the organization functioning ("making the trains run on time") so that services are delivered seamlessly. Effective managers are thought to be those who can weave strategy, execution, discipline, inspiration, and leadership together as they unite an organization toward achieving its goals.

BACKGROUND: THE MANAGEMENT PROCESS

Drucker (2004) suggested that effective executives do not need to be leaders. "Great managers may be charismatic or dull, generous or tightfisted, visionary or numbers oriented. But every effective executive follows eight simple practices" (Drucker, 2004, p. 59). These eight practices are divided into the following three categories:

A. Practices That Give Executives the Knowledge They Need
   1. They asked: "What needs to be done?"
   2. They asked: "What is right for the enterprise?"

B. Practices That Help Executives Convert Knowledge to Action
   3. They developed action plans.
   4. They took responsibility for decisions.
   5. They took responsibility for communicating.
   6. They were focused on opportunities, not problems.

C. Practices That Ensure That the Whole Organization Feels Responsible and Accountable
   7. They ran productive meetings.
   8. They thought and said "we" not "I."

Effective management also appears to be a result of artful balancing, because managers need to function at the point at which reflective thinking combines with practical doing. This is described as managerial mind-sets within the bounds of management practice. Managers interpret and deal with their world from the following five perspectives (Gosling & Mintzberg, 2003):

1. *Reflective mind-set*: Managing self
2. *Analytic mind-set*: Managing organizations
3. *Worldly mind-set*: Managing context
4. *Collaborative mind-set*: Managing relationships
5. *Action mind-set*: Managing change

These five mind-sets were described as being like threads for the manager to weave. The process is as follows: analyze, act, reflect, act, collaborate, reanalyze, articulate new insights, and act again.

Management is central to the work of nursing. **Nursing management** is defined as the coordination and integration of nursing resources by applying the management process to accomplish nursing care and service goals and objectives.

It is important to recognize that managers perform unique and discrete functions: they plan, organize, coordinate, and control. Nurses work to deliver care (produce the product); managers manage organizations toward goal achievement. Someone needs to monitor financial indicators; hire, train, and evaluate personnel; improve quality; coordinate work and effort; fix systems problems; and ensure that goals are met. In nursing, this means that nurses do the work of providing nursing care while nurse managers coordinate and integrate the work of individual nurses with the larger system and solve problems for them so they can deliver high quality care. These are distinctly different activities.

The four steps of the management process are planning, organizing, directing/leading, and controlling. These functions make up the scope of a manager's major effort. Planning involves determining the long-term and short-term objectives and the corresponding actions that must be taken. Organizing means mobilizing human and material resources to accomplish what is needed. Directing/leading relates to methods of motivating, guiding, and leading people through work processes. Controlling has a specific meaning closer to the monitoring and evaluating actions that are familiar to nurses. The management process can be compared with an orchestra performing a concert or a team playing a football game. There is a plan and an organized group of players. A director manages the performance and controls the outcome by making corrections and adjustments along the way but does not play an instrument or a position. The management process is a rational, logical process based on problem-solving principles.

Planning

Planning is the managerial function of selecting priorities, results, and methods to achieve results; setting the direction for a system; and then guiding the system. It is decision-making and determining courses of action. **Planning** is defined as "[a] basic management function involving formulation of one or more detailed plans to achieve optimum balance of needs or demands with the available resources. The planning process (1) identifies the goals or objectives to be achieved, (2) formulates strategies to achieve them, (3) arranges or creates the means required, and (4) implements, directs, and monitors all steps in their proper sequence" (BusinessDictionary.com, 2020a). Planning can be detailed, specific, and rigid, or it can be broad, general, and flexible. Planning is deciding in

advance what is to be done and when, by whom, and how it is to be done. It is traditionally thought of as a linear process. Hersey et al. (2013) described planning as involving the setting of goals and objectives and developing "work maps" to show how they are to be accomplished. Planning activities include identifying goals, objectives, methods, resources, responsible parties, and due dates. There are two types of planning: strategic and tactical.

Strategic planning: More broad-ranged, this approach means determining the overall purposes and directions of the organization. This is often focused on mission, vision, and major goal identification (see Chapter 14).

Tactical planning: More short-ranged, this type means determining the specific details of implementing broader goals. Examples are project planning, staffing planning, and marketing plans.

Planning heavily depends on the decision-making process. Part of planning is choosing among a number of alternatives. Thus in nursing, the manager often must balance the needs of patients, staff, administrators, and physicians under conditions of limited resources.

Planning involves considering systems inputs, processes, outputs, and outcomes. The process of planning in its larger context means that planners work backward through the system. Starting with the results, outcomes, or outputs desired, they then identify the processes needed to produce the results and the inputs or resources needed to carry out the processes. Typical planning phases include the following:

- Identify the mission.
- Conduct an environmental scan.
- Analyze the situation (e.g., SWOT analysis of strengths, weaknesses, opportunities, and threats).
- Establish goals.
- Identify strategies to reach goals.
- Set objectives to achieve goals.
- Assign responsibilities and timelines.
- Write a planning document.
- Celebrate success and completion.

The nurse is engaged in a constant mental planning operation when deciding what specific things are to be accomplished for the patient. The same is true for the nurse manager who is deciding how to devise, implement, and maintain a positive and productive work environment for nurses. Planning is a function that assumes stability and the ability to predict and project into the future. A turbulent environment makes planning difficult. Learning and adapting are important abilities in a changeable environment.

Organizing

Organizing is a management function related to allocating and configuring resources to accomplish preferred goals and objectives. It is the activities done to collect and configure resources to implement plans effectively and efficiently and involves coordination. **Organizing** can be defined as "assembling required resources to attain organizational objectives" (BusinessDictionary.com, 2020b). It is the mobilizing of the human and material resources of the institution to achieve organizational objectives. The organizing function is focused on building up material and human structures into a working infrastructure. Authority, power, and structure are used for influence. The goal is to get the human, equipment, and material resources mobilized, organized, and working effectively. Organizing so that the goals and objectives can be accomplished includes forging and strengthening relationships between workers and the environment. The first step is to organize the work, then the people are organized, and finally the environment is organized. The essence of organizing is the integration and coordination of resources (Hersey et al., 2013).

There are a wide variety of topics related to organizing, which is considered to be one of the major functions of management. For example, organizing can be thought of as a process of identifying roles in relationship to one another. Thus organizing involves activities related to establishing a structure and hierarchy of jobs and positions within a unit or department. Responsibilities are assigned to each job. The complexity of this aspect of organizing is related to the size of the organization and the number of employees and jobs. Organizing in nursing also relates to the activities of budget management, staffing, and scheduling and to other human resources and personnel functions such as developing committees and bylaws, orientation, and staff in-service. Institutions organize by establishing a structure, such as a hierarchy with divisions or departments, and by developing some method for division of labor and subsequent coordination among subunits.

Directing/Leading

Directing/leading is the managerial function of establishing direction and then influencing people to follow

that direction. This involves managing, motivating, and directing people/teams to carry out desired actions. Directing is defined as "a basic management function that includes building an effective work climate and creating opportunity for motivation, supervising, scheduling, and disciplining" (BusinessDictionary.com, 2020c).

Along with communicating and leading, motivation is often included with the description of the activities of directing others. Motivating is a major strategy related to determining the followers' level of performance and thereby to influencing how effectively the goals of the organization will be met. The amount of employee effort that can be influenced by motivation is thought to be from 20% to 30% at the low end and as high as 80% to 90% for highly motivated people (Hersey et al., 2013). A wide range of effort can be affected through motivation.

On a day-to-day basis, coaching is used as a technique to direct and motivate followers. The manager delegates activities and responsibilities when making assignments. The function of directing involves actions of supervising and guiding others within their assigned duties. The use of interpersonal skills is required to delicately balance the need to direct and supervise for task accomplishment with the need to create and maintain a motivational climate with high participation and positive outcomes.

Within nursing there is a legal aspect to the managerial directing function. Under some state licensing laws, supervision is a defined and regulated legal element of nursing practice. Because delegation and supervision are viewed legally as a part of the practice of nursing, nurses have a specific need to know and understand this area of nursing responsibility within their scope of practice. Nurses carry responsibility and accountability for the quality and quantity of their supervision, as well as for the quality and quantity of their own actions regarding care provision. Nurse managers carry the added responsibility and accountability for the coordination of groups of nurse providers and assistive or ancillary personnel, sometimes across settings and sites of care. Nurse managers also have an overall responsibility to monitor and provide surveillance or vigilance regarding situations that can lead to failure to rescue, patient safety errors, or negligence. Too many hours worked, nurse fatigue from stress, too heavy a patient workload, and other systems problems are situations to monitor regarding legal accountability.

Controlling

Controlling is the management function of monitoring and adjusting the plan, processes, and resources to effectively and efficiently achieve goals. It is a way of coordinating activities within organizations by systematically figuring out whether what is occurring is what is wanted. It is the activities focused on monitoring and evaluating what is occurring. The controlling aspect of the managerial process may seem at first to carry a negative connotation. However, when used in reference to management, the word *control* does not mean being negatively manipulative or punitive toward others. Managerial controlling means ensuring that the proper processes are followed. In nursing, the term *evaluation* is used to refer to similar actions and activities. Control or evaluation means ensuring that the flow and processes of work, as well as goal accomplishment, proceed as planned. **Controlling** is defined as "the basic management function of (1) establishing benchmarks or standards, (2) comparing actual performance against them, and (3) taking corrective action, if required" (BusinessDictionary.com, 2020d). Thus it is concerned with comparing the results of work with predetermined standards of performance and taking corrective action when needed by taking some action to modify, remediate, or reverse variances.

The coordination of activities of a system is one aspect of managerial control, along with financial management, compliance, quality and risk management, feedback mechanisms, performance management, policies and procedures, and research and trend analysis. Ongoing, careful review using standardized documents, informatics systems, and standardized measures prevents drift and the waste of time and resources that occur when direction is vague. Well-exercised, managerial control is flexible enough to allow innovation yet present enough to effectively structure groups and organizations toward goal attainment. This is an artful balance.

The management function of controlling involves feeding back information about the results and outcomes of work activities, combined with activities to follow up and compare outcomes with plans. Appropriate adjustments need to be made wherever outcomes vary or deviate from expectations (Hersey et al., 2013). For example, when a standardized clinical practice protocol is used in nursing to track client care, the variances are analyzed and corrected as a function of managerial control. The controlling function of management is a constant process of internal reevaluation.

CONTEMPORARY MANAGEMENT THEORIES

Human organizations are complex in nature. It is tricky to provide overall direction for an organization in times of rapid environmental change. The recent focus of leadership theory has been on interactional, relational, and transformational leadership to guide organizations through successful change and chaos. However, less attention has been focused on how to advise managers who are working toward the organization's goals and trying to use resources effectively and efficiently under conditions of change, scarcity, and complexity. Forces such as technology, the Internet, social media, increasing diversity, and a global marketplace create pressure to be more sensitive, flexible, and adaptable to stakeholders' expectations and demands. This is like a fine dance on a balance beam.

The result has been a push toward reconfiguration or restructuring of many organizations from the classic hierarchical, top-down, rigid form to a more fluid, organic, team-based, collaborative structure. Health care is evolving toward multidisciplinary team-based care. This has had an impact on how managers manage. Managers cannot control continued rapid change. Old familiar plans and behaviors no longer provide clear direction for the future. Managers now need to focus on two major aspects of management: managing change through constant assessment, guidance, and adaptation and managing employees through worker-centered teams and other self-organizing and self-designing group structures. Bureaucratic management is out; organic and virtual management is in.

A variety of contemporary theories of management have arisen to help organize management thought. Four major management theories now predominate: contingency theory, systems theory, complexity theory, and chaos theory. Each one contributes principles useful for nursing management and administration and for nurse managers working to coordinate and integrate health care delivery.

Contingency Theory

Contingency theory is considered a leadership theory, but it also applies to management. The basic principle is that managers need to consider the situation and all its elements when making a decision. Managers need to act on the key situational aspects with which they are confronted. Sometimes described as "it all depends" decision-making, contingency theory is most often used for choosing a leadership or management style. The "best" style depends on the situation. This relates to concepts of situational leadership theory.

Systems Theory

Systems theory has helped managers to recognize their work as being embedded within a system and better understand what a system is. Managers have learned that changing one part of a system inevitably affects the whole system. General systems theory is a way of thinking about studying organizational wholes. A system is a set of interrelated and interdependent parts that are designed to achieve common goals. Systems contain a collection of elements that interact with each other in some environment. The elements of an open system and related examples in health care are shown in Table 1.1.

A key principle of systems theory is that changes in one part of the system affect other parts, creating a ripple effect within the whole. Using systems theory implies a rational approach to common goals, a global view of the whole, and an emphasis on order rather than chaos. The input–throughput–output model exemplifies this linear thinking aspect of general systems theory.

Systems theory is easy to understand but difficult to apply in bureaucratic systems or organizations with strong departmental "silos." This is because coordinators and integrators with sufficient organizational power to cross the system are needed but often not deployed. Without integrators, systems parts tend to make changes

TABLE 1.1 Open System Elements and Health Care Examples

Open System Elements	Health Care Examples
Inputs to the system (resources)	Money, people, technology
Transforming processes and interactions (throughputs)	Nursing services, management
Outputs of the system	Clinical outcomes, better quality of life
Feedback	Customer and nurse satisfaction, government regulation, accreditation, lawsuits

without consideration of the whole system. Shifting to systems theory thinking helps managers view, analyze, and interpret patterns and events through the lens of interrelationships of the parts and coordination of the whole.

In health care, concepts such as interrelatedness and interdependence fit well with multidisciplinary teamwork and shared governance professional models (see Chapter 13). However, concepts of attaining a steady state and equilibrium are difficult to reconcile with the reality of uncertainty, risk, change, and ambiguity that characterize the turbulence of the change occurring in the health care delivery environment. An example of the use of systems theory is basing an analysis of a planned change, such as implementing a new program, on systems concepts by identifying inputs, throughputs, outputs, and feedback loops to more effectively plan how the new program fits into the existing system. Sometimes this process is used for short time frame or rapid response team projects.

Complexity Theory

Complexity theory is a more general umbrella theory that encompasses chaos theory. Arising in scientific fields such as astronomy, chemistry, biology, geology, and meteorology and involving disciplines such as engineering, mathematics, physics, psychology, and economics, the body of literature on the behavior of complex adaptive systems has been growing since the late 1980s. Complexity theory explains the behavior of the whole system. Complex systems are networks of people exchanging information and are self-organizing. Complexity theory core concepts are self-organization, interaction, emergence, system history, and temporality (Chandler et al., 2015). The focus of complexity theory is the behavior over time of certain complex and dynamically changing systems. The concern is about the predictability of the behavior of systems that perform in regular and predictable ways under certain conditions but in other conditions change in irregular and unpredictable ways, are unstable, and move further away from starting conditions unless stopped by an overriding constraint. What is most intriguing is that almost undetectable differences in initial conditions will lead to diverging reactions in these systems until the evolution of their behavior is highly dissimilar?

Stable and unstable behavior can be thought of as two zones. In the stable zone, a disturbed system returns to its initial state. In the unstable zone, any small disturbance leads to movement away from the starting point and further divergence. Which subsequent type of behavior will occur depends on environmental conditions? The area between starting and divergence is called *chaotic behavior*. This refers to systems that have behavior with certain regularity yet defy prediction based on that regularity. This unpredictability was puzzling.

Complexity theory has informed classical management theories. Previous management theories heavily emphasized rationality, predictability, stability, setting a mission, determining strategy, and eliminating deviation. Discoveries from complexity and chaos theories include the fact that the natural world does not operate like clockwork machinery.

Managers need to alter their reflexive behaviors, put an emphasis on "double-loop learning" that also examines the appropriateness of operating assumptions, foster diversity, be open to strategy based on serendipity, welcome disorder as a partner, use instability positively, provoke a controlled ferment of ideas, release creativity, and seek the edge of chaos in the complex interactions that occur among people. Change management takes on a noticeably different form when complexity theory is used. Complexity theory is being used in health care to explain the complexity of the social context in order to better explain the organization of health care and patterns of professional behavior (Chandler et al., 2015). "A new style of leadership is required in complex adapting organizations. This style is one in which the leader serves their people with vision and guidance to see the interconnectedness of the whole system. The leaders must first gain and communicate a shared identity and then be able to allow the organization ownership of that identity" (Berry, 2006, p. 2).

Chaos Theory

Most would agree that one characteristic of nursing is its unpredictability and its chaos and complexity. To use a theory about chaos and complexity is intuitively attractive. Sometimes no matter how hard nursing leaders try to maintain consistency and control, things do become chaotic. Projects seem to take off on their own and defy direction. Chaos is commonly known as disorganization and disorderliness, but the meaning for this concept in chaos theory is quite different. It refers to behavior that is unpredictable despite certain regularities.

Randomness and complexity are two principal characteristics of chaos. There is a paradox in the fact that even in the simplest of systems, it is extraordinarily difficult to accurately predict the course of events, yet some order arises spontaneously even in these simple systems. Patterns form in nature. Some are orderly, and some are not. Concepts of nonlinearity and feedback help explain situations of complexity without randomness (with order). Chaos theory suggests that simple systems may give rise to complex behavior, and complex systems may exhibit simple behavior. At the essence of chaos is a fine balance between forces of stability and those of instability. Two examples are snowflake formation and the behavior of the weather.

Chaos has become one concept of complexity theory. Over the past three or four decades, complexity theory has been the focus of scientific disciplines such as astronomy, chemistry, physics, evolutionary biology, geology, and meteorology. Systems studied in these disciplines have phenomena in common, which seem to pass from an organized state through a chaotic phase and then emerge or evolve into a higher level of organization. There are examples from sciences such as pharmacology, where chaos theory and complexity theory seemed relevant to some patients' unpredictable responses to drugs. The field of research called pharmacogenomics has emerged as a part of precision medicine to address this chaos by studying how a patients' genes affect how they respond to medications.

In management, the traditional focus for leaders is to identify organizational goals and to make decisions facilitating goal achievement. Control is central to logical management processes, but in complexity theory, the idea of control is considered a delusion because uncertainty and deviations would be denied and disregarded. The natural world, according to this theory, does not operate this way and is continually evolving to a higher level of complexity. In complexity theory, the future is so unpredictable that long-term planning is not helpful. Rather, it is suggested that managers need to look for instability and complex interactions among people so that learning occurs and the best result "emerges." The idea of the interconnectedness of the parts (people) of the whole suggests that communication among the parts (people) is a key feature of complexity theory.

Chaos, as used in complexity theory, is not utter confusion and disorder but rather a system that defies prediction despite certain regularities. Chaos is the boundary zone between stability and instability, and systems in chaos exhibit bounded instability and unpredictability of specific behavior within a predictable general structure of behavior. At first, this seems to make no sense. However, chaos theory principles can be applied in health care. For example, managerial planning for an evidence-based practice change such as bedside reporting can produce chaos and unpredictable results. An example of chaos theory in action is when a seemingly small change, such as using assistive personnel instead of professionals, in effect creates ripples and larger impacts on the system than preplanning would seem to indicate. This is why organizations use small tests of change.

As many health care organizations move away from bureaucratic models and recognize organizations as whole systems, more organic and fluid structures are replacing the older ones. Sometimes referred to as "learning organizations," these structures are tapping into the inherent capacity for individuals to exhibit self-organization. In the transition, experiences of change, information overload, entrenched behaviors, and chaos reflect human reactions to organizations as living systems that are adapting and growing (Wheatley, 2006). Complexity and a sense of things being beyond one's control create a search for a simpler way of understanding and leading organizations.

The manager's job is to reveal and handle the mostly hidden dynamics of the system and forge a direction for the organization as a complex adaptive system. The goal is for a self-managed system with people capable of engaging in cooperative behavior, using feedback to learn and adapt, self-organizing, and operating with flexibility.

LEADERSHIP AND MANAGEMENT IMPLICATIONS

It can be argued that all nurses are managers. Staff nurses are the employees at the most critical point in fulfilling the purpose of health care organizations: They are in close and frequent contact with the patient at the point of care, and they coordinate the delivery of health care services.

As nurses work in a rapidly changing practice environment, leadership is important because it affects the climate and work environment of the organization. It affects how nurses feel about themselves at work and about their jobs. By extension, leadership affects

organizational and individual productivity. For example, if nurses feel goal-directed and think that their contributions are important, they are more motivated to do the work. Important for the professional practice of nurses is how they feel about themselves and how satisfied they are with their jobs. Both aspects have implications for how well nurses are retained and recruited. Leadership cannot be overlooked because leaders' function as problem finders and problem solvers. They are people who help everyone else overcome obstacles. The leadership role is one of bridging, integrating, motivating, and creating organizational "glue."

Leadership in nursing is crucial. *First*, it is important to nurses because of the size of the profession. Nurses make up the largest single health care occupation and one that is experiencing critical shortages. Pressures in the health care environment, including costs, thrust nurses into leadership roles in highly complex and stressful work situations.

Given the challenges of cost containment, increased chronic conditions, an aging population needing more health care services, and issues of access and quality of care, nurse leaders are experiencing greater pressure to perform and produce more effective alignment of key processes, functions, and resources. Organizations have underinvested in nursing leadership skill development. Thus there is a call for structured transition management and leadership development programs for nurses assuming leadership and management responsibilities in organizations (Campbell, 2016).

Second, nursing's work is complex, often conducted in complex and chaotic settings. Tremendous changes in nursing have occurred. Leadership is needed to guide and motivate nurses and health care delivery systems toward positive achievements for better patient care. Leadership in nursing is needed to influence the organizational context of care for greater effectiveness and productivity because leaders establish norms and values, define expectations, reward behaviors, and reinforce culture. Authenticity and caring are valued in nurse leaders as are people who are genuine, trustworthy, reliable, and believable and who create a positive environment.

Third, nurses are knowledge workers in an information and high-tech age. Knowledge workers respond to inspiration, not supervision. Nurses as functioning professionals in complex systems need protection and support from leaders and managers in order to be creative and innovative followers and deliver care in complex environments. Leaders need to model what they want. Nurses can read, learn, and practice effective leadership and followership.

CURRENT ISSUES AND TRENDS

Current issues and trends that have significance for leadership in nursing include the dramatic US demographic data related to both the aging of the baby boom generation and the demographic profile of nursing in the United States. A major societal and public policy issue related to the aging of a large demographic bulge of baby boomers is beginning to reach a critical point. Called the "2030 problem" (Bahrampour, 2013), this socioeconomic and demographic phenomenon is real, looming, urgent, and fraught with health care challenges. Statistics show that there are approximately 49.2 million Americans ages 65 years and older, representing 15.2% of the population, or one in seven Americans (Administration on Aging, 2018). The percentage of Americans 65 years of age and older has tripled since 1900. Issues related to health burdens and chronic illness are characteristic of older adults. In fact, persons 85 years of age and older may spend up to half of their remaining lives inactive or dependent.

US population and health trends are assessed and monitored by governmental agencies such as the US Census Bureau, Administration on Aging, Centers for Disease Control and Prevention, Bureau of Labor Statistics, and Health Resources and Services Administration. The statistics related to the baby boom generation are impressive. Born between 1946 and 1964, baby boomers in 2030 will be between the ages of 66 and 84 years, are projected to include 60 million people, thus one in five (20%) Americans will be 65 or older. In addition to baby boomers, the US population in 2030 is projected to also include 9 million people born before 1946. By 2029, all of the baby boomers will be 65 years or older, making more than 20% of the population over the age of 65 years. The projected population of people 65 years and older in 2050 is 88.5 million (US Census Bureau, 2014). This predictable tidal wave will make chronic illness and long-term care a huge economic burden. Medical costs and the costs of long-term care loom large. An overwhelming economic burden could occur if tax rates need to be raised dramatically, economic growth is retarded because of high service costs, or future generations of workers have worse general

well-being because of service costs or income transfers. Nurses and the health care system will be challenged to find evidence-based care delivery and service systems models and strategies that address the projected growth industry in chronic illness care. One response has been the emphasis on prevention and wellness, targeting behavior change upstream from the development of chronic illness.

Leadership is considered key to the success of health care organizations. Nurses are pressed to demonstrate the outcomes of their care and provide evidence of the effectiveness of their service delivery. The link between leadership style and staff satisfaction highlights the importance of leadership in times of chaos. A nurse leader needs to be dynamic, show interpersonal skills, and be a visionary for the organization and the profession. The ability to inspire and motivate followers to carry out the vision is crucial. Effective leadership has a profound impact on nurse recruitment and retention.

The classic notions of management and managerial work were developed in a sociopolitical era of industrialization and bureaucratization. Competitive pressures and economic forces now are compelling organizations to adopt new flexible strategies and structures. Organizations are being urged to become leaner, more entrepreneurial, and less bureaucratic. This trend has created levels of complexity and interdependency that challenge nurse leaders and managers.

Current and emerging issues in health care are complex and ethically challenging for managers. The "big three" issues of access, cost, and quality continue to be persistent themes that affect any organization's internal operations. Medical insurance coverage is an issue of access, as is the geographical location of facilities, providers, and services. Increased complexity and technology prompt provider specialization and affect cost. Consumer preferences and increased health care awareness affect both cost and quality. Critical medical errors and patient safety issues create pressure related to the need for quality. Complexity, randomness, and chaos created by change call for new management and leadership strategies.

As health care reconfigures, health care delivery settings will likely be knowledge-based organizations composed primarily of specialists whose performance is directed by organized feedback from colleagues, patients, and data analytics. Nurses are positioned at the care coordination intersection and have needed skills for facilitating flow and integrating care delivery. Nurses' roles may change, but their need for leadership inspiration and managerial competence will remain. Nurses are well prepared to serve as leaders, care providers, integrators, and facilitators of patient care. This is the age of the nurse as leader and manager.

RESEARCH NOTE

Source

Shaughnessy, M.K., Quinn Griffin, M.T., Bhattacharya, A., & Fitzpatrick, J.J. (2018). Transformational leadership practices and work engagement among nurse leaders. *Journal of Nursing Administration*, 48(11), 574–579.

Purpose

Transforming the work environment is important to support the work of nurses and meet the challenges of a complex health care system. The purpose of this study was to identify and describe transformational leadership (TL) characteristics and work engagement (WE) by clinical nurse leaders in the United States. The research question asked about the relationship between TL and WE among nurse leaders.

Discussion

Transformational leadership has been shown to inspire followers and create an environment that enhances nurse satisfaction, recruitment, and retention. Work engagement has been shown to be connected to organizational outcomes such as lower levels of burnout and sustaining a culture of professional nursing practice. To explore the relationship between TL and WE, a descriptive correlational study was done with a convenience sample of clinical nursing leaders such as Chief Nurse Officers (CNOs), nurse managers, and educators, who attended the American Nurses Credentialing Center's National Magnet Conference in October 2016. The Leadership Practices Inventory (LPI) by Posner and Kouzes, the Utrecht WE Scale (UWES), and a demographic questionnaire were administered to 218 RNs. Of note, half of the sample was master's prepared, and about 75% were certified. Descriptive statistics were computed, including correlation analyses. A statistically significant positive relationship of moderate strength was shown between LPI and UWES total scores.

RESEARCH NOTE—cont'd

Application to Practice

This study sample was different regarding the level of education and job titles (higher than comparison studies). Nurse leaders' lowest scores were on future vision, taking risks, and supporting innovation, with "inspiring a shared vision" being the weakest leadership behavior. In the literature, an adapted clinical leadership program on leadership competencies was found to create significant improvement. TL can be learned. Leaders play a crucial role in infusing followers with a shared vision and by taking risks and supporting innovation. Nursing practice benefits from greater WE that fosters autonomy and professional growth.

NEXT-GENERATION NCLEX® EXAMINATION-STYLE CASE STUDY

The medical/surgical units at St. Helens Community Hospital are busy with a complex mix of patient diagnoses and conditions and have a staff of 88 employees, with a few nurses of long tenure, but mostly new graduates and nurses with less than 2 years of experience. They have 4 very different leaders:

1. Nurse Manager Dan has 3 years of experience as a nurse manager. He prefers to tell the followers what to do and how to do it in order to get tasks done.
2. Nurse Manager Maria has 3 years of experience as a nurse manager. She prefers to use her outgoing personality and likability to achieve success, using positive motivation and team morale.
3. Nurse Manager Jorge has 3 years of experience as a nurse manager. He prefers to have a hands-off approach and let his employees assume responsibility in the decision-making process.
4. Nurse Manager Olivia has 3 years of experience as a nurse manager. Her unit is busy with a complex mix of patient diagnoses and conditions. She prefers to use her inspiring energy and personality to create a magnetic workplace by engaging with others, centering on followers' needs and goals, and thus raising each other to higher levels of motivation.

Use the numbered scenarios above, to indicate the best approach and priority area to lead the unit.

Nursing Situation	Best Approach
The entire facility has a power outage in a storm. Backup generators do not come on in the ICU.	
Nurses complain about being understaffed for Christmas vacation.	
Nurses have organized a shared governance committee.	
The bariatric unit does not have an adequate number of Hoyer lifts, and the NM is concerned about future back injuries.	

CRITICAL THINKING EXERCISE

Nurse manager Mike Catney has a problem. He has detected angry venting and counterproductive work behavior affecting the morale of the clinic. He goes to observe and assess. It was the end of another long, hectic, and frustrating day in Ambulatory Clinic A for Nurse John Folkrod. There were daily issues with sluggish patient flow and long wait times for patients in the waiting room. John's usual reaction was to bottle up the frustration, causing personal health issues, or to vent it by complaining to colleagues. Neither method influenced a positive change in the situation. Fortunately, the nurse manager is a visionary, authentic leader. However, John has not

approached him, assuming that the situation was obvious to the manager and not desiring to "make waves" or be seen as a troublemaker. In the meantime, Nurse Catney evaluates the organizational climate (how the surroundings are perceived by the staff) and reviews principles of EI. He consults the literature (Al Ghazo et al., 2019).

1. What is the problem?
2. Whose problem is it?
3. What are John's followership role and options for followership strategies to resolve the situation?
4. What leadership behaviors and styles might be effective? What should nurse manager Catney do?
5. How might the situation be analyzed using relationship-based care and EI principles?

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