Chapter 1
OVERVIEW OF NURSING LEADERSHIP

"Nursing management is as much a nursing specialty as any specialty and requires specialty leadership skills. Mentorship/leadership from senior leaders smoothes the transition from clinical roles to formal leadership roles. At the same time, nurse leaders must learn the business side of healthcare while maintaining the care side"

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WHAT IS LEADERSHIP?

Let's begin by defining leadership. There are many different competencies within the field of leadership but generally speaking, leadership is the ability to define a vision and guide individuals and groups toward that vision while maintaining group-promoting teamwork, commitment, and effectiveness. Teamwork embraces the productive aspects of group cohesion and it focuses on the leader's ability to ensure that team member relationships are collaborative and productive.

Guiding assists those being guided to "connect the dots." Leadership provides the foundation for motivation and sets the stage for obtaining commitment, rather than merely compliance, from those being guided. Guiding does not become the end point—it is part of the execution that leads to individual awareness, which sets the stage for behavioral change.

Leadership has been (and continues to be) one of the most studied and written-about topics. Going back more than 2000 years, even the great philosopher Confucius wrote about the elements of good leadership. He noted that domineering styles of management, based on top-down principles, were not as successful as creating a structure based on rules. In other words, people respond better when they know both why something is important and what the guidelines are to achieving the organization's outcome. Confucius also recognized that "leading by example" was important to strong leadership, as well as honing virtues such as respect and humility.

In my years of working alongside other nurse leaders and serving as faculty for the American Organization of Nurse Executives' Aspiring Nurse Leaders Institute, I have often observed that when people think about leadership, they tend to think about the characteristics of the person and not necessarily the tactical elements of the person's job. If I ask aspiring leaders to close their eyes and reflect on the leader they most admire, invariably they will describe that leader as honest, caring, supportive, guiding, teaching, and kind.

What they tend not to describe is how the leader does the job. They do not say that a good leader never misses a day of

work, or that good leaders are wizards at finance, able to develop programs that save their departments lots of money. Neither do they say that good leaders are doctorally prepared nor that they receive awards. They do not describe how many meetings the leader attends, or how the leader dresses. Instead, they describe who the leaders are as people. Their responses seem to mirror the new yardstick and measurement model developed by Daniel Goleman in his 1998 book, *Working with Emotional Intelligence*.[1] Goleman highlights four main points in his model:

1. Self-awareness, defined as the ability to read one's emotions and recognize their impact while using instinct to guide decisions.
2. Self-management, which involves mastering one's emotions and impulses and adapting to changing circumstances.
3. Social awareness, the ability to sense, understand, and react to others' emotions while comprehending the networks by which people interact.
4. Relationship management, which involves inspiring, influencing, and developing others while managing conflict.

The above domains describe how a leader handles himself or herself as well as how she or he works with others. Goleman notes that these acquired skills and competencies predict positive outcomes, whether at work, with family, or with friends.

It should be noted that very few students point to leadership in their academic field as being a career goal. They do not say they want to be the dean of a college, for example, although they may say that they aspire to be the president of a company, a chief executive officer, a chairman of the board of directors, a principal, a governor, and so on.

In fact, when we think about leadership in narrow terms, as referring only to being the ultimate person in charge of an organization or system, we overlook the many leadership positions that exist at various levels and times throughout life. Further, when we take on leadership positions, it is often a result of specific factors and timing, and our instinct to step up is based on a desire to help rather than a need to be in charge.

IMPRESSIONS OF LEADERSHIP

We should acknowledge that leadership opportunities are available throughout our work and professional lives—not simply the point at which we finish a degree or achieve a particular level of certification. For example, children have opportunities to become leaders when they are named the captain of a sports team or the president of a scout troop or dance club. Their leadership role as captain or club officer provides them with additional responsibilities and opportunities for learning. These early exposures to leadership are great testing points for young people. Over the course of their leadership experience, they can determine whether this type of role—with its added responsibility, visibility, and work—is something they want to pursue in the future.

Young people are often exposed to leadership through their families. By observing their parents, siblings, and other relatives in their work and community life, they may see opportunities to influence their community and create a positive place to live. However, along with the benefits of having a leader in their midst, family members sometimes experience the difficulties that accompany leadership. Children may find that their leader-parent is not available as much as they might like because of other commitments. When a parent is not available for homework help, or misses a school event, it may create confusion or a bad impression that stays with the child for years afterward.

Similar impressions of a leadership role can develop in the work setting. Within a work group, staff members may observe the long hours that their leader puts in without understanding the various tasks and responsibilities that she or he faces each day. Staff persons may observe that unlike their own shifts, which are completed in 8 hours, their leader's "shift" goes on and on, as he or she takes work home on weekends and during the week. This, too, creates an impression of the role of leadership. The observing employee may view the leader as being overwhelmed with work or infer that the person is not able to prioritize. However, often the need for extended hours and additional work is based on other factors entirely.

For example, to facilitate communication with trauma surgeons and the trauma team, the best time to meet may be at 6 AM. Community and board meetings may need to take place in the evenings to facilitate the work schedules of attendees. Leaders understand that their role is not defined by an 8-hour workday and that adapting to the schedule is simply part of their position. Variability and flexibility are important elements for leaders to embrace. Likewise, good leaders will communicate and provide a context for their peers to help them understand why schedules and workloads appear as they do.

Continuing with the preceding example, most organizations have a board of directors. Their role is to represent the interests of the community while also providing advice and counsel to the organization. The members of the board are leaders themselves, and their input into the organization is vital. The diversity of their thinking is crucial to the organization's success because they take management thinking outside the organization's internal vacuum and provide a different perspective. Their outside input assists in making the business more effective and successful. The cross-pollination of learning among leaders, as well as their different styles and perspectives, gives even greater support and intelligence to organizational decision making. It also promotes greater leadership growth for all of the participants.

In most cases, these board members are volunteers. Staff leaders working with the board understand that, as part of their own leadership role, they must meet with and receive information from the board through meetings that are not interrupted by the day-to-day work of the organization. For both the volunteer leader and the staff leader, these meetings occur outside of working hours; thus, involvement becomes a personal decision and commitment. How leaders present the value of this added responsibility is vitally important. Choosing to participate in an organization's leadership group (whether as a volunteer or as a staff person) will have both a short-term and a long-term impact on the community in which the organization operates. Family members, staff members, and colleagues can be encouraged to view the leader's involvement as a valuable commitment

to improving lives rather than as time away from home or work life.

Leadership is a feature not only of our own organizations, but of our industries as well. In health care, serving at the local, regional, or national level provides a great vantage point from the field and a network second to none. One can read the literature again and again; however, exposure to the field provides an even greater opportunity for personal and organizational growth.

For the purpose of this discussion, the focus in the rest of this chapter will be on choice—specifically, choosing leadership as a career path. This choice, as noted above, can and will have implications. What these implications will be depends in large part on the frame that is placed around these choices, and on the individual's attitude and ability to articulate the impact leadership has on his or her personal and professional life.

WHO BECOMES A NURSE LEADER, AND HOW?

People who become nurse leaders tend to have two qualities. First and foremost, they are excellent clinicians. Often, they also have innate leadership acumen, meaning they are natural mentors and informal opinion guides for their peers. These are the nurses that younger nurses seek out for clinical, professional, and even personal advice. They are also the nurses most likely to identify opportunities for improvement and volunteer to lead the improvement initiative.

Simply because a nurse has clinical expertise and acumen does not mean he or she will be immediately successful as a leader. Once tapped by management to assume an entry-level leadership position, new leaders often struggle with how to transfer their informal leadership capability into the formal role. Both the individual leader and his or her peers experience a change as the new leader is separated out by title and responsibility. Without some formalized means to learn their new role, many new leaders become frustrated. They want to succeed in

the position, but the adjustment can be difficult when those who were "stars" before assuming the formalized leadership role are not immediately stars in the new role. In such cases, frustration and misaligned expectations often lead to a new leader's failure.

Many organizations try to help young leaders by providing a mentor. Mentorship can help in the short run by providing a trusted guide to the operational aspects of the new role. However, mentorship runs the risk of creating many different types of leaders as each mentee adopts the style and the approach of the respective mentor. Such emulation is to be expected: Every learner mirrors and repeats the beliefs, processes, and opinions of the teacher. Over time, however, the organization risks creating multiple "right approaches" based on differing styles of the individual mentors. As we will discuss at length in chapter 3, variation is one of the greatest dangers in health care. The same is true in training new leaders. Without a standardized process for identifying, training, and supporting leaders (at every level), an organization risks significant variation in how leaders lead. We will discuss these issues further in chapters 6 and 7.

In the meantime, nurse leaders continue to emerge from the pool of strong clinicians who have stable and abiding relationships with their organizations. For individuals who aspire to leadership roles, there is always value in shadowing leaders; participating in councils, committees, and task forces; and studying the formal and informal roles that leaders hold.

WHO ARE THE LEADERS IN HEALTH CARE ORGANIZATIONS, AND WHAT ARE THE TOOLS THEY USE IN LEADING?

For the purpose of this discussion, we will limit our focus to hospitals, because the majority of nurses work in hospital settings. Hospitals have numerous types and levels of leaders, all working together.

The highest authority within a hospital is the board of directors (also known as the governing body). The board is a group of individuals who, by virtue of their community role, health care expertise, business acumen, and interest, are appointed for terms typically ranging between 2 and 4 years. Most often, board members are volunteers, although certain members of the board, such as the hospital chief executive officer, chief financial officer, chief medical officer (and in some cases chief nursing officer), may sit on the board *ex officio*, which means "by virtue of their office." *Ex officio* members may or may not have voting privileges on the board. The board is responsible for all activities of the hospital, including finances, quality, service configuration, medical staff appointments, and employee performance. The hospital board is ultimately responsible for ensuring that safe and appropriate care is provided to the community. It is accountable to patients, the general public, payers, and the government. About 18% of community hospitals are investor-owned for-profit businesses.[2] In those cases, the board is also responsible to the organization's investors.

All boards use a set of rules (or bylaws) to guide their actions. The bylaws specify everything from how often the board meets, to how many seats it has, to the role and process of board-level committees, including, for example, the finance committee, audit committee, credentialing committee, quality committee, strategic planning committee, and others. No two boards operate exactly alike; therefore, the bylaws are an important tool used in the board's work.

The board or governing body sets the direction for the organization. Management, in turn, is responsible for implementing the direction established by the governing body. Examples of such direction may include

1. The mission to be achieved or sustained by the organization will be defined.
2. Employee satisfaction will meet or exceed benchmark.
3. The net bottom line will achieve a certain percentage.
4. Average age of plant will not exceed a certain age.
5. Quality ratings will be within a certain percentile of all hospitals reporting.

6. Capital expenditure will not exceed a certain dollar amount without express board approval.
7. Patient safety indicators will meet or exceed benchmark.

Boards often use benchmarks to track the organization's performance. Benchmarking can be applied in various ways. One way is to measure the organization's performance over time, comparing current activities to previous periods of time. Benchmarking may also include comparing the hospital's performance to nationally, regionally, or state-recognized performance goals or established industry targets. Many organizations use a combination of both types of benchmarking to understand how they are performing relative to best-in-class levels, as well as how the organization's performance has changed over time. The governing body fulfills its fiduciary responsibility by regularly meeting to review and analyze reports of the organization's progress toward its goals and benchmarks.

The board also oversees the hiring, supervision, and evaluation of the chief executive officer (CEO), who holds the highest employed role within the organization. Chief medical officers (CMOs) are often a close second in authority to the CEO. CEOs may have had many types of experiences in their professional preparation; some were physicians, some were chief operating officers (COOs). Originally some were chief financial officers (CFOs), others were chief nursing officers (CNOs), and some progressed from other positions in the health care industry. Many organizations also have a COO who is a part of the "C-Suite." The COO may oversee an entire organization or key components of the organization such as all clinical resources or nonclinical resources used within the organization. It is not uncommon for a CNO to report to a COO.

All CEOs have one thing in common: they are the visionary head of the organization, and they are responsible to the board for the overall performance of the organization. CEOs work with the board to set the organizational agenda and then track performance at the highest level through key performance indicators. These indicators usually fall into at least five categories including: clinical outcomes, finance, patient satisfaction, employee retention and performance, and growth.

Working with the CEO is a team of leaders who often have the descriptor "chief" or "vice president" as part of their title. Most organizations have a COO, who is responsible for all of the nonclinical resources used within the hospital, as well as the overall operations of the organization. The CFO is responsible for the budget, which includes the pricing of services, the collection of revenue, and the monitoring of budget to ensure capital purchases and fiscal stability. Organizations may also have attorneys as chief counsel, as well as vice presidents of marketing or planning or both; vice presidents of service or product lines, such as ambulatory services and cardiac care; vice presidents of facilities, human resources, fundraising (foundation), and so on.

Two other key roles are the CMOs and the CNO. The CMO is a physician who is ultimately responsible for all physician-related matters within the organization. CMOs often have business, health administration, or public health degrees in addition to a medical degree. The CMO is responsible for assisting the organized medical staff with physician appointments and credentialing, graduate medical education and continuing education, quality, and physician satisfaction. The CMO often works with a team of chiefs, who bear administrative responsibility for each of the clinical specialties, and medical directors, who are responsible for the clinical and administrative processes and quality within each specialty.

Hospital medical staffs are often comprised of a mix of physicians, physician assistants, nurse practitioners, and other individuals with high-level credentials. The medical staff may encompass private physicians, dentists, allied health professionals, full-time attending physicians, physicians with courtesy privileges, and faculty members. Over the past 10 years or more, services that are staffed 24/7 by physicians in positions such as intensivist, emergency medicine specialist, and hospitalist have emerged. As a result, hospitals have had to develop new rules and regulations pertaining to these roles. Although the primary function of medical staff bylaws is to describe the rules, regulations, responsibilities, and credentialing policies that apply to physicians and mid-level providers, this document is useful for nurse leaders as well, providing insight for nurses as they carry out the directions

of the medical staff. The bylaws describe important elements of the chain of command, which may help nursing staff to communicate better and to feel secure in decisions they make as patient advocates. All medical staff leaders, including the CMO, play vital roles in the ongoing development and direction of the medical staff. Their interaction with nurse leaders helps to ensure the quality and safety of patient care.

Paralleling the medical staff's relationship with the CMO, the staff nurses have a leader who is ultimately responsible for the direction of the nursing organization. The CNO is a registered nurse who often has a master of science in nursing (MSN) degree as well as advanced training in business or health administration. Many CNOs and other nurse leaders also receive certification in nursing leadership through the American Nurses' Credentialing Center. CNOs have responsibility for all nursing-related patient care, and they often have additional areas of responsibility such as social work, pharmacy, laboratory, respiratory therapy, chaplaincy, and other services that work in tandem with nursing.

A hospital's nursing division accounts for the largest single discipline within the organization. In contrast to private physicians, who make rounds to check on their patients, and members of other services, who see patients at regular times during the course of their hospitalization, nursing is accountable for patient care 24/7. This incredibly valuable resource requires the utmost management due to its size and the complexity of its competencies. The biggest mistake nonclinicians make is to suppose "a nurse is a nurse is a nurse." We would never say the same thing about physicians. We know there is a vast difference between a cardiovascular surgeon and a psychiatrist. Recognizing and advocating for the various types of nursing roles, and the expertise and skills needed for each, is a crucial aspect of nursing leadership.

WHAT ARE THE OTHER TYPES OF NURSE LEADERS?

Working with the CNO are other vital staff members including directors of nursing, who oversee clinical and administrative areas such as emergency care, surgery, nursing education, nursing

informatics, quality, and nursing research. Each director of nursing works with nurse managers, who are responsible for the daily operation of individual units. Within each unit, there may be charge nurses, shift leaders, team leaders, council leaders, and so on. Depending on the governance of the nursing organization (a topic we will discuss at length in chapter 4), there may also be leaders for clinical quality, professional ethics, research, resource allocation, and other types of councils. Beyond the leadership roles in group settings, there are also one-on-one leaders, such as peer mentors, nurse preceptors, and clinical resource specialists.

HOW ARE NURSE LEADERS PREPARING FOR THE FUTURE?

Opportunities for leadership in nursing abound. As a nurse leader, it is imperative to participate in establishing direction for the organization. It is also imperative that a nurse leader know the organization's strategic plan, the governing body's targets for performance, and the role that nursing is to play in achieving such goals.

At a higher level, nurse leaders also need to understand the future direction of the nursing industry in the United States. The role of nurses and the demographics of the nursing workforce are changing. In 2008, the federal government instituted new Medicare payment rules that would penalize organizations demonstrating poor performance on eight nursing-sensitive indicators. For the first time, hospital payment is tied to the quality of nursing care. This represents a sea of change for nurses, both in terms of the care they provide and the ways in which that care is documented. As a recent article in the *American Journal of Nursing* noted, managing nursing quality to achieve benchmark-level performance is not always easy.

> Among the challenges nurse leaders face is the relative lack of data on the quality of nursing care and inconsistencies among the evaluation tools used to measure care quality. These inconsistencies exist even among data collection initiatives focused on nursing performance, such as the National Database of Nursing Quality

> Indicators (NDNQI) and the California Nursing Outcomes Coalition Database (CalNOC) Project. And they persist despite endorsement by the [National Quality Forum] NQF of Voluntary Consensus Standard for Nursing Sensitive Care.[3]

At the same time that the focus on quality is heating up, the face of nursing is changing significantly. A review of nurse staffing trends for the period 2000–2007 indicates that, while the current nursing shortage seems to have peaked in 2001, the short- and long-term implications of this shortage are still very much with us. In the short term, we are seeing a greater preponderance of older nurses—in part because of the large cohort of baby boomers who entered the nursing workforce in the 1970s and 1980s, and in part because the faltering economy has kept those persons in the workforce longer than anticipated. In 2007, registered nurses over the age of 50 were the fastest growing age group among the RN workforce, increasing 11% between 2003 and 2007.[4] The same study also found a growing trend toward foreign-born nurses, who represented over 30% of the total growth in RN employment during the same period.[4]

Over the long term, there are significant concerns about nursing education programs. In brief, program capacity is too small and the faculty too few to accommodate the growing need for nurses that the baby boom has created. Both the American Association of Colleges of Nursing and the National League for Nursing have noted that thousands of qualified applicants have been turned away from nursing programs because of space and faculty constraints.

The American Organization of Nursing Executives (AONE) recognizes that these issues create significant management challenges for nurse leaders. In the July 2004 issue of *Hospital and Health Networks* magazine, AONE's CEO, Pamela Thompson, noted:

> Even though we don't know what future patient care models will require, we have to act now. There is an old but familiar adage, "May you live in interesting times." Certainly, that applies to health care. Each day we are sculpting the shape of our future patient care delivery system, but its shape is ill-defined and we really don't know what it will look like in the end.[5]

We can make some assumptions. By 2010, there will be inadequate numbers of health care workers to deliver care using the same models that we use today. Advances in information management, therapeutics, and technology are dramatically altering the care required. Linear thinking is giving way as we embrace the science of chaos theory and complex adaptive systems.

These changes mean we have many questions about what the future will require, but we cannot wait until we have all the answers. We must begin to experiment and act now. One of the most important tasks is to define the work of the future; then we can identify the roles and competencies that we will need to do that work.

AONE continues to address these challenges. It created a task force to address the question: "What are the principles that can guide us as we define future patient care delivery models and who is the nurse who will be providing care to our patients in the future?" Out of this effort came seven principles that are now being disseminated in the hope they will stimulate conversations that will help define our future.

1. The actual work of nurses will change in the future, but the core values of caring and knowledge will remain.
2. The care provided will be decided in partnership with the patient.
3. The knowledge base of the nurse will shift from "knowing" a specific body of knowledge to "knowing how to access" the ever-changing information needed to manage care.
4. Processing the information accessed will expand the nurse's use of "critical thinking" to "critical synthesis," coordinating and negotiating care across multiple levels, disciplines, and settings.
5. The knowledge that is leveraged and the care provided are grounded in the relationships between the patient and the multidisciplinary team.
6. Relationships with patients will be dramatically altered by the increased application of technology, requiring that we further define the relationship context as being "virtual" or "physical" and know when each is required.

7. The ultimate future work of the nurse will be to partner with the patient or client to help him or her manage the individual journey of care.[5]

Although these seven principles may seem simple, they will become the platform for the conversations that will guide us as we sculpt the future.

"The ability to deal with ambiguity while developing physician relationships and partnerships [is] integral to the work of the nurse leaders. It is also important that leaders demonstrate work-life balance so that our young talented nurses will desire to move into leadership positions."

—Patricia Crome, RN, MN, CNA, FACMPE
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CASE STUDY

Mercy Hospital is a community hospital with 250 inpatient beds. The facility provides care to a geographic distribution of 275 square miles. Mercy Hospital is a member of a system of 25 hospitals called Mercy Healthcare System (MHS). The MHS home office is centrally located in the upper Midwest; however, the 25 hospitals are located in four surrounding states.

After an intense strategic planning session, which included management from the system facilities as well as membership from the nearby community and local colleges, the governing body of MHS delivered the following strategic direction to its 25 hospitals and key leadership:

1. Bottom line: 3%+ net.
2. Installation of a centralized clinical documentation system within 36 months.
3. Ranking in the top 10% nationally for patient satisfaction using a nationally recognized tool.
4. Completion of a community benefits *pro forma* for community dissemination at the end of the fiscal year.
5. Employee satisfaction rating of 88% or higher.
6. Quality rating in the top 10% for the clinical indicators identified by the Center for Medicaid and Medicare Services (CMS).
7. Implementation of at least one strategy that results in new revenue.

Assessment Questions

1. Who are the key leaders in your organization, and how do they interact with each other and with the nursing staff?
2. What is your organization's mission and vision statement, and how do those statements influence leader decision making?
3. What are your organization's goals, and how do nurses help to achieve those goals?
4. What goals affect you directly?
5. What role will you play in assuring achievement of these goals?
6. What department-specific goals have you developed, and how have staff members assisted in development as well as achievement of these goals?
7. Describe the role you play in relationship to the medical staff and goal achievement.
8. Who are the nurse leaders in your organization, and how did they become leaders?
9. What are the opportunities to become a leader within your own organization?
10. How is leadership development encouraged and supported?

Best Practice

- Know who your leaders are, what they do as leaders, and how their leadership influences the organization.
- Know your organization's mission and vision, and how they influence leadership processes.
- Be knowledgeable about the organization's strategic directives and goals.
- Nursing leadership success requires regular interaction with the medical staff for communication, relationship building, goal achievement, goal development, and policy and practice changes.
- Always allow for ongoing feedback on ways to improve processes in your area as well as the organization as a whole. Use this feedback as a way to close the loop with staff and let them know you follow through.
- Recognize that leadership takes on many different forms and roles, both informal and formal.
- Remember that success as a leader takes time, support, and teamwork.
- Recognize the opportunities for leadership growth for yourself and others.
- Remember that leadership styles and functions may take many forms, but that all leadership should be aligned around common goals.

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