**The Heart of Leadership: An Aggregation of Learning**

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**The Heart of Leadership: An Aggregation of Learning**

Leadership is about caring. When leadership is pursued, it should be due to a genuine concern for others; for nurses, for patients, and for the community being served. Leadership is not about telling people what to do or demanding that people adopt a prescribed perception of a person or a situation, it is about causing others to genuinely want to do what you’ve asked because your influence has made them share in the desire to satisfy the request. Caring enough to serve means that a commitment must be made to understanding the ways a leader can develop their own skills and abilities. A great leader is an active, empathic listener who motivates, teaches, and looks for opportunities to innovate and transform. Within these pages, a collection of wisdom offers to guide and shape the development and service of its curator.

**Organizational Climate and Culture**

The impact organizational climate and culture (OCC) has on nurses has been the subject of much interest throughout the last three decades. Nurse leaders contribute to this, and it is therefore important for leaders to appreciate and develop the skills and behaviors associated with improving OCC. The correlation between nursing job satisfaction and the OCC is seen throughout the research. Each topic in this compendium illustrates ways one can significantly enhance OCC.

**Literature Synthesis**

The climate is the unique feeling an organization transmits to nurses, and in turn, their patients. The culture of an organization defines how the workplace is perceived and contributes to productivity and teamwork. Mrayyan (2008) explained that the climate of an organization is composed of layers of dimensionality, meaning that there can be no one universal definition, or a singular game plan in which to follow. What is certain is that leadership, good, bad, or indifferent, affects the climate and culture of an organization. Moneke and Umeh (2013) supported this, stating that there is a profound congruence between how a leader behaves and the satisfaction experienced by those they lead. Job satisfaction, like organizational climate, can be affected in many ways.

Interventions that demonstrate a leader’s interest and commitment to their staff’s professional development contribute to a supportive culture, thereby creating a positive climate. Adopting shared governance models, providing opportunities to enhance education or professional growth, and encouraging autonomy, are ways leaders can demonstrate support (Green et al., 2014; Wilson et al., 2008). Cooperative or team-oriented workplaces have been prolifically reported as impactful on the positivity of OCC, as have actions that illustrate a leader’s support. A leader that invests in their team builds a culture that is strong, and a climate that is positive.

Being a supportive leader also necessitates attention to the resources nurses need to care for patients. The organizational culture can be degraded if nurses do not believe their needs are being met. Encouraging excellent care without being open to and aware of nurses’ perceptions can reduce trust and negatively impact OCC. While nurse leaders may not be able to quickly manage staffing shortages and other hindrances, it must be clear that a leader is doing all that they can to provide for their unit (Albert et al., 2022; Nurmeksela et al., 2021).

**Application**

Walking into an emergency department (ED) at Parkview Community Hospital was a surprising experience. Seeing the cramped and unruly parking lot, the unassuming exterior of the main hospital, the inside’s narrow hallways leading to dark corridors, and the single cafeteria which could be dwarfed by most Los Angeles food truck spots, I found myself bracing for a small, dog-eared department. And while the size was certainly consistent with the main building, the initial feeling upon entering the unit was intriguing. It was newly renovated as of 2019 and did not suffer the fusion of drab meets disorder commonly associated with small ED’s. The patients were seated in an internal waiting room which looked surprisingly comfortable. Staff flanked the area and when I rounded the corner, I saw a spacious nursing station.

In business professional dress, the director of patient care services (PCS) as my escort, I was aware that I looked like a surveyor. That did not deter the staff from making eye contact and offering smiles as I walked by. A physician assistant glanced up from his computer screen and asked me if he needed to put his coffee away, then chuckled and told me his name. The OCC was positive; even upbeat. The PCS director noted the ED director approaching and took the opportunity to introduce me to him. His smile was kind and bright as he offered to show me around. A tour of the department ended in the break room where he advertised his ED engagement board, the word “amazing” stenciled in colored pencil across the top, a border of rainbow dots framing the display. Pages of patient comments, clearly from an HCAHPS survey, boasted of the department’s successful patient encounters. After a small exchange I thanked him and congratulated him on his scores before heading to the liaison’s office.

Entering this tiny area, I was met by three more smiling faces. This is not normal to me, a point which I cannot stress enough. As I looked around the space, the size of a large bathroom outfitted with three chairs, I saw evidence of comradery. A wooden birthday sign hung in the corner, rectangular plaques engraved with names and corresponding birth dates of the three employees dangling from its hooks. I jotted down a note, curious if committing the names and dates to wood was a clever turnover reduction tactic or just optimism.

Stepping into the DOU, I again felt a cheeriness that I did not expect. It was something I hadn’t noted upon entering other peoples’ departments at my last hospital even though I was a manager there. As the PCS director and I rounded the small area, she greeted one of the nurses, and asked about her daughter. The nurse thanked her and said she was doing better, then told her about an event in the ED she wanted her to know about. It involved a staff member incorrectly placing telemetry leads on the daughter, and the nurse wanted to make sure the director wrote it down so she could facilitate education. The nurse wasn’t being theatrical or accusatory, she just wanted to help, and she felt empowered to say something.

Rounding with the chief nursing officer (CNO) was eye-opening. The nurse leader came across as naturally calm and approachable. She started by explaining how much progress had been made since her team joined the hospital in 2018. As we made our way through the halls, warm faces welcomed us. With a low and steady voice, she greeted each person by name. Between islands when there were no employees to regard, she explained her methods. She told me about her commitment to use of the 10 and 5 rule, which dictated that if anyone was 10 feet from her, she would smile and make eye contact, and if they were 5 feet away, she would address them verbally. As we walked and she spoke, she reached into her pocket and pulled out a glove, donning it before snatching a piece of fallen gauze from the doorway of a patient room. I must have looked a little surprised as she then shared her practice of carrying gloves, in the event something needs to be picked up from the ground. She asked if I would pick up a piece of trash from my living room floor, then smile an “Of course you would; it’s your home”.

The next week I spent time with the PCS director. While we were speaking, she got a phone call and had to give some instructions. After disconnecting the call, she told me that it was from her house supervisor informing her of a patient complaint. I asked if she needed to go and she declined, saying she wanted her house supervisor to try to handle the complaint. As it turns out, she is to be the new CNO as their current nurse leader has been offered the chief executive officer (CEO) position. The PCS director explained that some of her leaders are reluctant to manage conflicts themselves, and she has been encouraging them to be more independent in that regard. This encouragement of autonomy, though not necessarily relished by the house supervisor, was consistent with interventions that support organizational culture, thereby improving the climate.

The next week the CNO and I were scheduled to discuss Just Culture. We spent a few minutes catching up before I reached for my notebook. She stopped me, indicating that she wanted our risk manager to take the lead and explain the model to me. Naturally I agreed and walked with her to the risk manager’s office. On the way, she confided that the risk manager was very intelligent and a wonderful nurse, but that she could benefit from taking on some leadership roles. She felt this would be a good opportunity for me to get the information I needed while the risk manager could practice her presentation skills. I saw this as a great way to encourage personal growth for her employee, and immediately understood the CNO’s decision upon meeting the risk manager. A soft-spoken person, she seemed tense as she explained the model. It didn’t take long for her to relax and allow herself to answer my questions with a little more personal reflection as opposed to her initial perfunctory descriptions. The decision to let the risk manager share about Just Culture was aligned with the literature discussing the need for a leader to encourage professional development in staff.

Just Culture is all about identifying underlying causes of error, rather than rushing to judgement or discipline. Embracing Just Culture means that an organization appreciates that system failures are more commonly to blame for errors than individual employees. The risk manager explained that when a person doesn’t feel like a disciplinary outcome will be just and that they may be blamed or unfairly punished, they may avoid sharing information which could have been used to enhance future safety recommendations. Transparency on the employee’s behalf is encouraged by way of creating a sanctuary wherein they can speak honestly about the details of an error. These factors are then analyzed using a performance management decision guide. The term for this kind of organization is a high reliability organization (HRO), though the risk manager didn’t specifically call out that fact.

In reflecting on Just Culture, an organization that utilizes and values the model makes a commitment consistent with collaborative conflict resolution. Like a leader with high emotional intelligence, Just Culture facilities are self-reflective and self-aware, in that they are interested in determining what part they, as a facility, played in the error. I can also compare the self-control trait of a leader with a high EI, with that of a Just Culture Organization. So often I have seen hasty discipline administered in a reflexive jolt. Taking the time to think, analyze, and communicate demonstrates organizational self-control. When I think about the kind of organization I would want to serve, I know it would have to be an HRO. If have spent years searching for great questions to ask new hire candidates, but in writing this compendium, I have found myself writing a list of interview questions for a future employer. Are you an HRO? What drove you to consider the Just Culture model?

**Communication and Emotional Intelligence**

An environment that promotes effective communication affects OCC in a positive manner. Leaders that have high emotional intelligence are often the same leaders that exhibit excellent communication skills. Being aware of oneself, having control over one’s emotions, and having enough empathy to understand the feelings of others paves the way for clear and effective communication.

**Literature Synthesis**

Having excellent communication skills and an elevated level of emotional intelligence are two strengths essential for great leadership. While the two are commonly linked as if they are both skills, it is more accurate to think of emotional intelligence as internal awareness, and excellent communication as the external skill that can be developed and demonstrated because of that internal awareness. It is the leader’s self-awareness and control of their emotions that allows for transformative communication, which in turn contributes to a positive organizational culture (Center for Creative Leadership, 2016). According to Lambert (2021) “Emotional intelligence is the ability to perceive, evaluate and manage emotions in oneself, other people and groups” (p. 2).

Sadri (2012) asserted that having an elevated level of emotional intelligence does more to predict excellence in leadership than having a high intellectual quotient does. Leaders can and should learn how to be good communicators and to communicate with transparency. Further, they are encouraged to model communicative excellence and offer education on communication skills and strategies to their employees. Being emotionally intelligent and utilizing excellent communication skills can help build relationships and reduce conflicts (Albert et al., 2022; Lambert 2021; Sadri 2012).

Hunter (1998) identified becoming an active listener as one of the most crucial goals a leader can make for themselves. Active or effective listening is integral to effective communication and strong leadership. To better relationships and improve OCC, active listening should be used to demonstrate that a leader is open and available to their team. Striving for and practicing self-awareness helps the leader to improve their own self-control. But just as leaders must work on understanding their emotions and feelings, they must also practice developing empathy. Having an appreciation for another’s point of view, and listening with an empathic frame of mind, are key components of communication excellence. Lambert (2021) emphasized that empathic traits are ubiquitous in leaders that possess high emotional intelligence and effective communication skills, and that conflict resolution can be accomplished through active listening and the use of empathy.

**Application**

When I think of excellent communication, I think of its personification in my Southern California CNO at Providence. She is consummate in her clarity, and is the most consistent, steady speaker I have ever known. As she has become a close friend, I have a unique vantage point, and am often the one assuring her that she most definitely did not seem aggravated when a practitioner failed to mute their line and ate cereal loudly during her meeting. My Providence CNO is self-aware to the point of being too hard on herself. It seems her comprehension of how she is feeling makes her worry that others can see it, which is not the case. I have witnessed her self-control and think about it often. Last year I misunderstood something she was saying, inadvertently making it appear that I had failed to follow through on something I had marked completed. She didn’t flinch as she asked if I had mistakenly credited myself with a task that required follow up. It was only then that I realized the misunderstanding and reassured her that I was referring to something else. Had I made the mistake she thought I had, it would have been very bad and could have been damaging for her. Still, she maintained perfect composure, though I know she would have corrected me next. When you trust that a leader will be fair and even with you, it becomes natural to imagine facing disciplinary action, and you don’t associate it with the same fear and resentment commonly associated with that prosect.

 Controlling my emotions has been never a strong suit. However, there was a day many years ago that I demonstrated the kind of self-awareness and control I want to be able to demonstrate consistently. My director and I were preparing for another meeting with the hospital’s RN union rep. We were fatigued after having at least 5 similar meetings in the last two weeks, and were not looking forward to another long, painful argument as they had all come to be. Just before we headed out of the department, we got a call that the state had arrived. My director branched off to deal with surveyors while I looked around for one of my supervisors. There was a rule that we never entered these meetings alone. He was new to meetings with the union, and I had little time to prepare him for the hostilities he would likely encounter.

We walked fast as I explained the protocols; when to let the director of labor relations speak, when to respond, and most importantly, the need to remain calm. When we entered, we were met with the initial niceties that only meant we hadn’t started. As soon as I took my seat the first question was asked. I read the room and answered, maintaining an unhurried pace. The dialogue quickly became contentious as I refused to back down from a firm stance in an area of progressive discipline the rep was trying to get me to step down. My supervisor looked terrified, and I gave him the tiniest nod that it was ok, then returned my attention to the rep. I apologized for being steadfast in my decision but reminded him that stepping down the disciplinary action could set a new precedence, and that I was unwilling to allow that. He jumped from his seat and began swearing, causing my supervisor to quickly stand and take a subtly defensive stance. I tugged at his jacket to get him to sit back down, which he did.

Once we were adjourned, I was able to explain that our collective bargaining agreement allowed for “passionate dialogue”, which basically meant the rep was allowed to curse at me. We debriefed for some time, and though it may have been startling for my supervisor, I felt that the experience had been handled as well as it could have been. I was relieved by my ability to communicate well and maintain my self-awareness and control. Because it was unusually well-managed, it’s one of the moments for which I am proud, and one that reminds me that the potential is there and can be developed through practice.

Active listening is such a challenge. Speaking with the director of PCS about communication, I learned the value of three steps she personally takes to ensure she gives great attention to whomever she is meeting with. First, when someone approaches and asks for a quick impromptu meeting, she assesses the situation. If she is in the middle of something that she knows will jeopardize her ability to listen intently, and their issue is not urgent, she tells the person that she’d like to see then in twenty minutes as she wants to be able to give them her full attention. Second, she has made it a habit to turn off her computer monitor and turn her phones over. She admits to being easily distracted, so this behavior helps to reduce distractions and serves as a reminder that active listening is the goal. Her third habit is to grab a small, standing desk mirror from her cabinet, and peer at it as she focuses on her eyes. She takes thirty seconds to make eye contact with her reflection and center herself before the meeting. I found these habits very helpful and plan to adopt them.

**Conflict Resolution**

It is easy to imagine how conflict can negatively impact OCC. A leader that has a high emotional intellect and persuasive communication skills can address conflict quickly and efficiently. A leader’s ability to react to conflict in a wise and constructive manner can do more than just defuse an issue. Such a reaction to conflict can be used to strengthen their team and the OCC. Teaching direct reports to work together to understand each other’s’ perspective created confidence in the team’s conflict resolution skills. Understanding and adopting the best conflict resolution style is an excellent way for a leader to transcend conflict.

**Literature Synthesis**

Conflict, or the state brought on by disagreement or dissimilarity, is often regarded as something that is negative and should be avoided. According to the literature, as much as a leader may try to prevent conflict from occurring, there is no way it can be entirely avoided. Conflict is an intrinsic element to existing in relationships with others. Due to diverse, ever-changing work environments, conflict is bound to occur (Albert et al., 2022; Labrague et al., 2018; Victor 2013; Wong et al., 2018). It is important to keep in mind the fact that with conflict comes opportunity. “A well-managed conflict can contribute to innovation and creativity, stronger organisational (sic) relations, and higher commitment in staff…” (Labrague et al., 2018, p. 903). The literature indicates that positive innovations can occur because of the changes conflict can necessitate.

The organizational climate and culture can be damaged if conflict resolution is handled poorly, or not responded to in a timely manner. Conversely, the OCC of an organization can be elevated by leaders that manage conflict well, and even more importantly, those that make it a habit to teach elements of conflict resolution to those they lead (Albert et al., 2022). Transformational leadership is dependent on learning to become skilled at conflict resolution and developing a benevolent style. Positive timely management of conflicts was found to be associated with improved teamwork and confidence (Wong et al., 2018). The researchers further submit that teaching conflict resolution is important as teams with repetitive exposure to mediation strategies grow stronger and more confident in their ability to manage conflict.

Many styles of conflict management have been identified by researchers. Styles that are collaborative, sometimes referred to as cooperative or integrative, have been found to the most frequently adopted by good leaders (Labrague et al., 2018; Victor 2013; Wong et al., 2018). Cooperation being synonymic to collaboration, managing conflict through collaboration strengthens relationships and draws a team closer. When the team uses cooperation to produce mutually beneficial outcomes, parties on each end of the conflict achieve unity and learn to trust the collaborative process.

**Application**

Rounding in the emergency department usually results in an opportunity to witness conflict resolution. During one of my Parkview visits, I watched the ED director’s swift action in addressing an issue early. One patient was struggling with emotional problems and was demanding medication that had not been prescribed. The director calmly and casually apologized, telling him that he couldn’t get him any more medication, but that they he would grab him a sandwich and a cola. The patient continued to insist, and the director responded by listing the varieties of sandwiches from which he could choose. The technique was impressive and successfully distracted the patient’s irritation into a reduced state. Demonstrating this kind of conflict resolution modeled the way for employees and likely built trust as the director was managing obstacles rather than leaving his staff to deal with resource-draining challenges. It was also consistent with the idea that even if you cannot keep a problem from occurring, knowing that a leader is doing all they can to address an issue enhances staff perceptions and prevents negative impacts to OCC.

I was excited to have an opportunity to see a collaborative conflict resolution style in practice. During my March 1st visit I learned that the medical surgical floors, each having their own directors, had been fighting over staffing the day prior. The director of PCS explained that they dislike each other, and that one wing was hoarding staff even though the other wing was in desperate need. To address this, the director had to go to their units and perform an emergency huddle. I was disappointed to have missed this but was surprised when just before lunch on the day of my visit, she got another call from them complaining about the same issue. I was able to join her as she went to the unit and called another emergency huddle. She gathered the directors and charge nurses around and explained that she “needed their help”. Her face was ripe with emotion as she spoke. She explained that everyone that works in the hospital is part of a family, and “we don’t let family down”. She spoke about the value of cooperation and the expectation that they would work together before inviting the charge nurses to speak.

After giving the two charge nurses some time to explain their issues and frustrations, she said that it was clear they all needed to communicate more frequently. She said that going forward, they were to conduct morning huddles and develop a break plan for staff wherein they would cross-cover each other. She also stated that they would need to be transparent about how many nurses and patients they each had at the start of a shift, and that there would be no hiding of resources. I noticed that she remained very calm and optimistic during this intervention, but also noticed a few nonverbal reactions from the directors and charge nurses that made me wish she had asked more questions of them. Still, it was a good opportunity to witness quick action to deal with conflicts. I expect that there will be many opportunities to witness conflict resolution during the April go-live of the hospital’s new EHR.

Using the book Crucial Conversations, Parkview senior leaders hold monthly meetings with the leadership team. I was delighted to hear this as I am familiar with the book and the associated vignettes. The meetings include role-playing opportunities, and plenty of open forum time to discuss recent challenges and successful encounters. The director of PCS used one of the meetings to talk about a technique she has found beneficial. In dealing with a leader at another hospital that was too abrasive, the director used empathy, saying that she can find herself being too blunt at times, and must catch herself as such rigidity harms relationships. She explained that being vulnerable enough to share that a challenge is mutual, makes it easier for the person being coached to encourage reflection and accept advice.

Developing goals for my own teams at Providence, I can feel the difference in my objectives as compared to when I wrote them last year. I feel that my tendency to avoid conflict was excessively practiced prior to this coursework, and I have completely adjusted my focus. There is a tremendous relief that washed over a person when one looks at conflict with eager eyes rather than those filled with dread or self-doubt. I now anticipate conflict as an opportunity to discuss new ways of thinking, working, and building systems. This new way of looking at conflict has made me wonder why I feared it so. It explains how a person can still be confident without having to know everything, which I felt was my responsibility prior to this course. I am working on a SharePoint site for my staff and will be adding an innovation page as well as a “ConTEST-CONtest” page, wherein teams will be able to compete to come up with opposing viewpoints to our workflows. I want to encourage innovation, and I definitely want my staff to feel like they can show me better ways of performing tasks, as what matters most is making the work efficient and rewarding.

**Fiscal Responsibility & Sources of Funding**

Personnel and resource mismanagement in healthcare and in many other industries has contributed to unnecessary fiscal waste. Similarly, inadequate healthcare funding models have made it challenging to provide great care while preserving capital. Leaders must use collaboration and creativity to maximize fiscal resources and should encourage the conservative efforts of their staff.

**Literature Synthesis**

When looking at the operating budgets of medical institutions, staff salaries take up a significant amount of available funds. Though this may seem obvious and unavoidable, the way staffing schedules are assigned can significantly impact productivity. While Goetz et al. (2011) focused on reductions in superfluous new hire orientation hours and the mindful management of incremental overtime, it is important to remember that if leaders fail to examine the census closely and frequently, they miss an opportunity to adjust staffing levels. Mincsovics and Dellaert (2010) identified the need for close monitoring of the census and its fluctuations. Some leaders imagine that because nursing shifts traditionally begin or end at seven and last for twelve hours, all they can do to combat fluctuations in census is to call in extra staff when patient numbers increase or send staff home when numbers decrease. But innovation can be exercised in the development of staffing models. McCaffrey and Pearson (2015) suggested that innovation means appreciating previously overlooked resources.

Wasted salary funds due to the failure of leaders to effectively manage problematic employee behaviors should also be avoided. As Middaugh (2015) pointed out, there are often factors outside of behavioral causes for an employee’s deficient performance, and those causes must be understood. As if echoing the need to manage controllable productivity issues, Goetz et al. (2011) discussed the importance of teaching nurses to be autonomous and suggested that rather than being told an organization must save money, it should be explained that nurses have an important part to play in reducing waste. Eliminating environmental causes for reduced productivity and motivating nurses to be accountable for their part in being as efficient as possible, are ways that leaders can promote fiscal responsibility.

Wasteful work practices can strain financial resources and reduce productivity. Reducing waste demonstrates a collaborative appreciation for financial goals and frees up time that can be redeployed to improving patient care. Lean is a philosophy that guides process optimization, whereas Six Sigma is a program focused on reducing defects. As quality improvement efforts are always a priority in healthcare, combing Lean with Six Sigma processes can accomplish quality improvement and can help eliminate wasteful practices. Utilizing a lean six sigma model allows workflow impediments to be discovered and addressed, leading to increased productivity, reduced costs, and increase nursing and patient satisfaction (Davies et al., 2019).

Another area of overspending can come from funding models that promote imbalances in quality and resources. Inadequate funding models can drain precious fiscal resources by removing incentives aimed at cost savings, cutting quality in favor of reduced spending, and disincentivizing innovative solutions. James and Poulsen (2016) proposed that a population-based payment model be adopted. “Population-based payment (PBP) gives provider groups strong incentives to perform interventions so that their services aren’t needed in the first place” (p. 110). Research around funding models do not unanimously agree on one, but most concede that basing payment on value is an improvement over models that reward unnecessary services or withhold beneficial care. Shrank et al. (2021) described some of the potential advantages to value-based care models, though they list many changes that would be necessary if a better system were possible.

**Application**

Sitting with the Parkview ED director I was delighted to learn that census monitoring guided scheduling. The department has a staffing target that changes with each season, and they staff up Friday through Sunday. Peak nursing resources are allocated from 3:00 pm through 3:30 am, which is not traditional. This practice is consistent with the literature, which calls for census-driven staffing. When I asked the ED director how he avoids financial waste by utilizing appropriate discipline, he made it clear that everyone gets a coaching prior to any discipline. He documents these encounters and holds staff accountable if repeated failures occur, but says he always hopes that will not be necessary. Even in coaching he infuses humor and a somewhat casual approach. He considers Just Culture to be a beneficial part of the disciplinary process as it allows staff to discover opportunities with the leader as situations are discussed.

Lean practices are in place at Parkview, though under a different name. They have mapped certain procedures and eliminated some superfluous steps, but the environment is fairly relaxed. They have not specifically ventured into the Sigma Six model, and I have not personally witnesses resolutely standardized workflows. In speaking with Parkview senior leadership, I have learned that there is a plan to do more with Lean Sigma Six, and the goal is to introduce the new hybrid operating rooms to the practice. Their Lean program is called Parkview Excellency by Design. Looking through the Excellence by Design binder, I saw that searching and motion-waste was a focus, as there was not a standard location for supplies prior to the adoption of the Lean model. The CNO taught me about the Lean team’s use of “Gemba walks” which she described as a sustainment plan involving rounding on staff to identify productivity gains. I have asked to join the Gemba walks “owner” the next time he performs these.

During one of my visits, sources of funding was discussed with the CNO, who explained that Parkview does take capitated patients. The payer-mix is not ideal, the organization facing challenges such as lower reimbursements, but that is not unusual for the area. When asked about value-based care versus fee-for-service models, she admitted that she finds fee-for-service frustrating in that it encourages procedures that may not be necessary. She expressed a preference for diagnosis-related group models, but also lamented that such a decision was beyond her control, and will remain that way even once she is the CEO. She shared Parkview’s three major endeavors to increase reimbursement: 1) HAC or hospital-acquired conditions rounds to assess the need for and appearance of catheters, 2) missing equipment rounds, especially would vacs and telemetry boxes as they are pricy and frequently lost, and 3) reimbursement meetings aimed at reducing denials attributed to the incorrect use of observation versus admission status.

Being a former ED manager means that I’ve acquired a lot of experience in emergency services, but I have not been as not privy to financial concerns outside my department. My March 1st meeting with the CNO was financially illuminating. I was invited to participate in an orthopedic meeting and took notes as I listened. There were several unfamiliar terms that I had to look up later, many of them turning out to be acronyms, and I started to hear plans to procure specialty surgical tables and the like. The CNO mentioned that they could persuade a doctor to come back to Parkview using this acquisition, which piqued my curiosity. After the meeting we went to her office, and I got to ask about the comment. She explained that certain purchases are strategic in that they can be used to entice surgeons to choose Parkview over hospitals that don’t offer the same specialty equipment.

This led to a long conversation about the job of the business development professional. I was not aware that the role entailed meeting with prospective physicians and asking about what it would take to get their business. She shared that they would soon be acquiring a DaVinci Surgical System robot in the hopes of gaining a few coveted surgeons that are new to the area. She was very honest about the importance of building up operating theaters and “rolling out the red carpet” so that surgeons would bring Parkview their patients. She explained priorities like managing turnaround time and investing in efforts to improve operating room (OR) staff efficiency so that their surgeons’ time is maximized. Parkview is soon hiring a surgical first assistant to try to attract vascular surgeons to the hybrid operating rooms being built this year. She also shared that she is looking to increase the education of OR staff as a big physician dissatisfier is feeling that nurses are not robustly trained in surgery.

**Influence Versus Power & Leadership and Management**

Influence and power, like leadership and management, are often used interchangeably. However, there are important distinctions between these words, and understanding those distinctions can lead to great personal growth. A manager can be a good leader, and a leader a good manager, though different skills, tactics, and points of view make how they manage or lead distinct and noteworthy. Managers are people hired to oversee other people. Leaders, on the other hand, can acquire the cooperation of others, regardless of title.

**Literature Synthesis**

Putting it simply, leaders motivate using influence, while managers control using power. The power associated with management is autocratic while leadership is democratic. The reason the disparity should be appreciated is that relying on force over finesse can negatively impact relationships (Albert et al., 2022; Anonson et al, 2014; Formosa, 2015; Hunter, 1998). In his classic book about servant leadership, Hunter (1998) explained the difference between power and authority, suggesting that power is yours if you can make someone do what you say, but leadership involves having influence. Power can be given to a person, but leaders do not need power to motive. Leadership is about the relationship that is built, and the interactions strengthened through those interactions.

Good leaders are often described as being humble or acting with humility. They understand the importance of letting others to see them as they truly are. Allowing oneself to be vulnerable is important as it demonstrates honesty and self-awareness, which are traits necessary when forming relationships. Trying to pretend that you are impervious is not being open or honest, and certainly fails to demonstrate humility. Good leaders are optimistic and inspirational, in part due to their willingness to be honest about their abilities. This openness invites others to develop trust in the leader (Albert et al., 2022; Anonson et al., 2014; Ellis & Abbott, 2013; Hunter, 1998; Pintar at al., 2007).

Transformational leaders manage conflicts quickly and efficiently and teach those they lead to use communication to reduce conflict rather than taking a managerial approach, which relies on setting expectations or placing demands (Anonson et al., 2014; Ellis & Abbott, 2013). Gobble (2013) said that transformational leaders understand the importance of creating sustainable changes and innovation, and made a distinction between managers and leaders, saying that while managers shy away from strife, leaders use it to promote change that may not have otherwise occurred.

**Application**

During my second week of leadership rounds I attended a new nurse orientation presentation. The CNO welcomed the group and discussed the hospital’s recent growth and accomplishments and highlighted its vision for the next decade. She discussed the two hybrid operating rooms being added, as well as the new cardiac catheterization lab being built, then thanked the new employees for joining the hospital. The director of PCS was next to take the stage. She began the presentation by saying that back when she began her career as a nurse, her own customer service skills wouldn’t have warranted her completing orientation. When she said, “I would have fired myself”, the room seemed a little stunned by her honesty. She went on to explain that excellent customer service was not a part of her nursing curriculum, but that it would be a large part of the new hires’ orientation. This was in line with 1) the understanding that a lack of ego contributes to a leader’s influential presence and 2) leaders can and should offer staff development as it betters the employee and increases OCC 3) the appreciation the PCS director has for vulnerability and honesty.

Parkview’s ED director has a staff that would follow him anywhere. His high energy, ever-present style is partly responsible, as is his lack of ego. His staff trusts that if he asks them to do something, it is for a very good reason. The connection he has with techs, nurses, registration clerks, and environmental services staff is worth seeing. He is on a first name basis with everyone, and I was surprised to learn that he has only been a director for a year. During rounds with him in February he excused himself two times to personally deal with patient issues.

During my February 8th leadership experience the CNO and I discussed power versus influence, and I asked her if she ever resorted to demanding certain outcomes. She shared that when she first took her role, staffing at the hospital was abysmal. No one was happy about it, but the nurses made matters worse by resisting the need to serve as preceptors for new staff. Frustrated by their reluctance yet confident that the problem needed to and could be solved, she made a declaration that there would be a hiring fair, and that all qualifying staff would serve as preceptors despite their lack of desire. Looking back, she considers the plan successful, as they were able to hire and train twenty-five new nurses.

**Innovation, Systems Thinking, Change Management**

Innovation in partnership with system thinking can be used to take a hard, broad look at something old that could benefit from a new approach. Nursing leaders committed to innovation can serve as change agents, encouraging an organizational climate and culture that moves to the beat of unity, openness, and improvement.  Considering the needs of an entire hospital rather than looking at each department as if separate islands, leaders can strive toward cohesive improvements.

**Literature Synthesis**

Having a strong mission or vision statement is often the goal of any organization, though it is not always lived. Being an innovative leader, one that transforms employees and brings meaningful change, must become instinctive through practice. Innovating leaders wishing to promote an integrated, cooperative culture must help their teams to learn how to work collaboratively. Greater innovation and productivity are possible when cooperation and collaboration are a part of the workflow. Ensuring that the mission is lived by each team member is crucial for strengthening the service core. (Albert et al., 2022; Center for Creative Leadership, 2016; Formosa, 2015; Wong et al., 2018)

Still, people by nature are resistant to change, and this requires knowledge of and prowess in change management. Gobble (2013) discussed the importance of removing cognitive dissonance when overcoming resistance to change. Changing organizational behavior can only be accomplished once the mindset of the organization changes. There are times when adding a new system is not the solution, but revising a broken system is desirable. Formosa (2015) argued that “the challenge for any system lies in identifying ways that will transform the system to one that is more viable” (p. 421). Herein exists an opportunity to demonstrate interest in professional growth and invite nurses to participate in innovative thinking. By encouraging nurses to look at systems and provide feedback on what could be done to improve a system, leaders can inspire engagement and solution partnership/

Systems thinking is a way of looking at the entirety of processes with an expanded analytical view (Albert et al., 2022; Formosa, 2015). Needed changes can only be appreciated if the totality of a system is understood.  In healthcare, there has been a historical tendency to think and operate in silos. Systems thinking allows leaders to consider cause and effect throughout the organization. As a great deal of complexity is involved in most systems, big-picture assessment and the search for improvement opportunities must be ongoing. Once opportunities are realized, it is critical that leaders do not turn to quick fixes, but long-term, holistic solutions that will lead to system improvement (Albert et al., 2022).

System improvement can be accomplished by including nurse leaders into the solution equation. To improve the future of healthcare, nurses need to be included in the development and distribution of policy. Partnerships between financial and nurse leaders have led to better outcomes, demonstrating that including nurse leaders in policy and process development is essential (Center for Creative Leadership, 2016; Goetz et al., 2011; Rafferty 2018). As role models, nurse leaders model the way for change in the work that they do (Gobble, 2013). Albert et al. (2022) encouraged leaders to get their staff excited about change by demonstrating a willingness to take risks. Nurse leaders who have built strong relationships with their staff, and are committed to change, enable and inspire their teams through their own actions.

Innovation is a process that allows for the creation of a new solution, or the improvement of a solution previously identified. The innovative nurse leader will be called on more and more, as the need for change in healthcare is routinely identified in healthcare literature (Center for Creative Leadership, 2016; Goetz et al., 2011; Mrayyan, 2008; Wilson et al., 2008). Courageous leadership will be necessary for both transformational leadership and in motivating innovation. Albert et al. (2022) explained that it takes bravery to pursue innovation, as the risk of failure is real and must be contemplated. Risk adversity marked former leadership expectations, but being overly cautious is not transformative. An innovative leadership style is collaborative, inclusive, and encourages creativity and prudent risk-taking.

Hunter (1998) made the point that being a good leader means providing people with what they need, as opposed to giving into disadvantageous and potentially deleterious wants. It can be challenging to imagine how one can convince those they lead to follow, despite being unable to acquiesce to desires or wield the power of a title to force action. Leaders must motivate change without resorting to tactics that are destructive or cause ephemeral obedience.

**Application**

The mission and values at Parkview do not appear to be constantly reiterated, but at Providence, they are discussed regularly. That does not mean they’re always perfectly lived, but I can attest that they are illustrated most of the time. As a leader I have been inspired to speak up when I see something inconsistent with our mission and values. Early 2021 was consumed with plans to deploy mega Covid-19 vaccine sites. I was one of the leaders that had to design workflows, perform training, and manage these sites.

As passionate as I was about creating large, efficient vaccine enterprises, I was still empathic enough to realize that not everyone felt comfortable getting such a new vaccine. I was disappointed when I saw examples of leaders shaming and name-calling during meetings when vaccine hesitancy was discussed. After one particularly spirited director made her usual dig about antivaxxers, I finally got enough nerve to tell her that labeling our beloved caregivers did not seem like something our founding sisters would be proud of. I told her that some people are genuinely afraid, and that it isn’t fair to shame people who already feel guilty for being noncompliant.

Many of the caregivers that were torn between feeling concerned about the vaccine’s safety and the perception of their reluctance came to me in confidence. Though I protected their identity, I shared some of their sentiments with the spirited leader and a few others. I asked how we are supposed to care for the poor and vulnerable if we can’t even be kind to our own caregivers during a time of conflict and internal struggle. The normally aggressive and usually boisterous leader appeared instantly saddened by my words, and to my surprise, apologized and thanked me for reminding everyone that we are here to show love and compassion always. Much like my successful dealings with the union, this is one of only a handful of times in my career when I surprised myself with personal strength. This serves as a reminder of what should be the norm I strive for, not a rare example of good leadership.

 During my March 1st leadership experience day at Parkview, I sat in on an orthopedic meeting wherein a group of leaders was discussing a new educational innovation. Recognizing the fact that patients have a lot of difficulty remembering discharge education, they decided to create pre-surgical patient education sessions using a collaborative team via Zoom. The meetings were to be monthly, with input from nursing, physical therapy, pre-admit testing, and case management. This was very exciting as I did not appreciate how much effort goes into planning for a patient’s care and success after a surgery. The CNO suggested that the classes be recorded, adding that the recordings could then be broadcasted on a channel the hospital controls via a service. While the meeting only lasted an hour, there were so many ideas and contributions from the leaders. A culture of innovation is certainly brewing.

Systems thinking has become a part of daily life at Parkview using an app called “Group me”. This app is used by the hospital leaders to share status updates about their units in real time. They also use the app to report urgent needs, failures, and even successes. This prevents some of the silo tendencies that can occur and creates a climate of teamwork. Another initiative that reduces silos is the daily patient experience meeting where all the directors round on their units and report back to the entire leadership team, sharing patient complaints as well as staff recognitions.

Change management is currently being utilized by the CNO and the director of PCS to implement the hospital’s new electronic health record (EHR). My own professional experience allowed me to hear about implementation efforts with some heightened awareness, and when I saw a demo of the system on February 2nd, I was concerned about how the leaders were going to remove cognitive dissonance. The EHR is called CPSI and looks very outdated and clunky. If it was introduced as my new EHR there would be a fight to hold back strong resistance. Nearly a month after seeing the system I was able to join a meeting where the CNO from another hospital came to teach on the EHR and get the staff excited about it. She did a marvelous job of finding benefits that the staff would appreciate, thereby reducing cognitive dissonance. She highlighted good points such as the EHR’s modifiability and Parkview’s ability to control content, explaining that EHRs like Epic cannot be adjusted as needed. She also pointed out that CPSI will require less double charting. Explaining that the system, though not sleek, will give more time back to nurses seemed to be regarded favorably by the staff.

Demonstrating a willingness to take risks, the CNO recently pitched the idea of hiring three midwives to support obstetricians. Her plan is based on the hope that this change will attract new doctors and thereby patients to Parkview’s birthing center. The risk in this plan is mostly financial, as Parkview averages only five to six births a day, and three midwives will take up a lot of financial resources. She explained that if the move did not increase their delivery admissions, it could cost her some leverage with her chief executive. I asked her if she has shared the decision with the leadership team to inspire a culture of innovative risk-taking, and said that she had, but I perceived that there was room to be more open about the initiative.

Parkview does not have the means to pay nurses all that they want, and the leaders spent an enormous amount of time in negotiations with their union last year. They are, however, committed to providing nurses with what they need. During their patient experience meetings, after all the opportunities have been identified, the facilitator stands at a white board and asks each leader to report on positive patient feedback. Every leader offers at least one story of praise for a specific staff member, and their name is written on the board. As this is happening the director of PCS takes notes on the names, which she later uses to write individual thank you notes using the STAR method.

The STAR method is an acronym for situation, task, action, and result. The director specifically identifies how the staff members actions affected the patient experience, and the note reinforces and recognizes great service. I can appreciate why using a structured method like this is important. When I reflected on my own leadership style, I had to admit that I don’t always specify reasons for praise with as much detail as I should. I thought of moments when I have received praise that really made me feel engaged, compared to times when I barely noticed or worse, felt like the compliment was so vague it was almost patronizing.

A few months ago, a work friend asked me to help her with a resume, and I made her a beautiful bio. I used an elegant template, enhanced all her professional experiences, stylized her content, and even added her picture, an homage to our biosketch assignment. When I asked if she received it via email, she said “Yes, thank you. Great job.” I was deflated, as I had put a lot of time, energy, and attention to detail in the favor, and the vague response left me wondering if she had even seen it. Last year I won the most prestigious award in our organization’s ambulatory care division, and my picture went up at all the Providence St. Joseph clinics in Orange County. The award came with a heartfelt speech by my Providence CNO, which meant more than the associated flowers, cheers, and similar fanfare. I will never forget her words, or the lasting effects they had on me, as she took the time to bring up specific, thoughtful examples of why I won the award.

My weekly meetings with the CNO have become something that I really look forward to. We have developed the habit of sharing what has gone poorly and what has gone well since our prior meeting. Some of the questions I have asked have cause much more reflection on the part of the CNO than I anticipated provoking. One of the recent questions that made the CNO pause, was regarding how she reduces cognitive dissonance. This question hung like a cloud, and she asked to get back to me on it. A few times throughout the day she repeated the phrase and looked pensive. When she quizzically repeated the phrase later in the afternoon, I took the opportunity to expand on it, sharing how I was learning the importance of using the prospective of a project’s mutual benefit to motivate team engagement, rather than just expecting compliance.

I can tell that the Parkview leaders are interested in much of what I am currently learning. Happily, I have been invited to participate in creating a Parkview leadership development training retreat with the CNO and the director of PCS. We will be working on this in April, after the go-live of the new EHR. The CNO has purchased The Servant by Hunter (1998) and will be ordering copies for her team. We have decided to focus on understanding financial stewardship, conflict resolution, and innovative changes as the main topics. The timing of this is interesting as it will coincide with the promotion of both leaders, which I suggested could be used to create an event aimed at celebrating a new way of hacking leadership.

**Compendium Summary**

The experience of researching, writing, and reflecting on leadership examples during the creation of this compendium has made it very clear that I am not the leader I want to be. The experience has illustrated much of what it will take to get there. I have seen great examples of leadership at Parkview and have also seen missed opportunities. Noting moments that could have been used to improve a situation has become a strong goal, which I have learned to follow with reflection and journaling on what could have been done differently. For me, leadership means using humility when building trust, collaboration when unraveling conflict, passion when encouraging change, confidence when offering autonomy, dedication when eliminating waste, empathy when administering correction, emotional intelligence when communicating, and wisdom when innovating. I appreciate the tools this project has allowed me to amass and look forward to using them to transform myself into a great leader.

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