6.3: Leadership

What does it mean to be a leader? Is a leader authoritarian, outspoken, or self-assured? The leadership journey of many beginning nurses is often fraught with mistakes and much learning. Nurse leadership potential is recognized by other health care providers when someone shows an inherent aptitude to be a client advocate while working to meet client needs. When leadership is equated with working with clients and teams rather than “being the boss,” the journey becomes a little less rocky for everyone. The story of one leader’s journey is shared in the following “From the Field.”

From the Field

When one moves into an administrative role, one does not automatically acquire leadership qualities. Furthermore, leadership is developed rather than inherited. Students frequently equate leadership with management. My entrance to nursing administration, and what I thought was my first experience in leadership, came about much like many other nurse managers—the service area needed a manager and I was recruited. There was little or no orientation, let alone any educational component to management and/or leadership and indeed, at the time, I considered management and leadership one and the same.

According to the eras of leadership evolution described by Daft (2011), I entered formal leadership during Era 3, in the early 1990s, a time of instability and unrest, somewhat similar to our current situation in 2017. Indeed, in Saskatchewan, it was a time of staffing layoffs, hospital closures, and the first round of health board amalgamations. Experienced managers turned to team-based approaches to meet the needs of staff and organizations. Leadership was often shared among team leaders and members, with the most knowledgeable or experienced individual in a particular situation taking the lead; this horizontal collaboration led to more motivation and commitment from employees in this era of unrest (Daft, 2011).

As a new and inexperienced manager, working with an autocratic supervisor, I adopted a directive, task-focused
approach in dealing with all employees and situations. My attempts to facilitate change, to gain the trust of my subordinates and peers, and to direct and ensure optimal client care essentially failed. I had much to learn. I needed to understand that in order to be effective in my administrative work, cultivation of leadership would be critical. Daft (2011) argues that leadership is an intentional act, that most people are not born with natural leadership skills, and qualities, that these are learned and developed.

What has evolved over the years is a personal philosophy of leadership that embodies the administrative roles I have been in. “Both management and leadership are essential in organizations and must be integrated effectively to lead to high performance” (Daft, 2011, p. 15). I have grown to understand that leadership is the positive relational influence (Daft, 2011), which is essential in health care in order to have an optimal health system with the highest quality of care for our clients. “By investing energy into relationships with nurses, relational leaders positively affect the health and well-being of their nurses and, ultimately, the outcomes for patients” (Cummings et al., 2009, p. 19).

The style of leadership that is most meaningful to me involves the formation of partnerships in participative leadership that hopefully leads to empowerment for those I am working with, whether they are individuals or groups, staff or clients. Is this starting to sound like collaborative care?

Clark et al. (2008) suggest the participative leader’s ability to optimize commitment, involvement, and dedication among employees should be appealing to a manager wishing to uphold commitment to service quality—something we all desire in health care. I believe empowering leadership is the ultimate step forward and involves a true sharing of vision and values between leaders and employees to optimize quality client care and outcomes. Again, collaborative care resonates.

Inherent in the philosophy I have adopted is an understanding of the needs and attributes of the follower(s) and the specific situation at hand. This is necessary in order to determine which approach would be more useful. “Contingencies most important to leaders are the situation and the followers” (Daft, 2011, p. 65). I have learned through experience that getting to know the individuals or groups helps me to understand how to best approach a given situation or environment. This approach for me is very much akin to collaborative interprofessional leadership and care.

Success in an administrative role means being an effective leader, which, in turn, leads to collaborative interprofessional relationships and approaches to care. But effective leadership is not to be taken for granted. My personal philosophy of leadership has evolved over time; the literature supports its value and, as I edge toward retirement, I continue to learn and grow. Always remember that success and failure are great teachers—be open to learn from their lessons.

—Colleen Toye, RN, BSN, MN

Interprofessional Leadership

According to Health Canada (2010), interprofessional collaboration in health care delivery settings is
Working together with one or more members of the health care team who each make a unique contribution to achieving a common goal, enhancing the benefit for patients. Each individual contributes from within the limits of their scope of practice. It is a process for communication and decision making that enables the separate and shared knowledge and skills of different care providers to synergistically influence the care provided through changed attitudes and behaviours, all the while emphasizing patient-centred goals and values.

What is important for interprofessional leadership is the framework within which this collaboration is achieved. Unlike some traditional models of leadership (i.e., those that are hierarchical in nature), interprofessional leadership is realized and practised through a collaborative relationship that is horizontal, relational, and situational. This leadership model is fostered via professional competency and healthy team dynamics (Anonson et al., 2009).

Interprofessional leadership fits with a participatory style of leadership. In turn, interprofessional leadership is supported by understanding and developing emotional intelligence and self-reflection and by understanding the concepts of shared leadership and appreciative inquiry. These three concepts are described in detail in the following sections. The Government of Canada (2015) described its hope for the future of health care as "inter-professional teams of providers [who] collaborate to 'provide a coordinated continuum of services' to individual patients supported by information technologies that link providers and settings" (p. 71).

**Emotional Intelligence and Reflective Practice**

**Emotional intelligence (EI) and reflective practice** are keys to self-understanding in successful interprofessional leadership, and both are integral to working with clients and teams. While EI has been discussed in Chapter 1, this chapter will emphasize its value in terms of working with clients and teams.

New nurse managers seldom have any formal administrative and leadership orientation, yet they are expected to lead individuals, teams, and service areas that are often vulnerable to emotion and high stress. In terms of influence, leaders who exhibit high EI have an effect on how individuals follow direction, interact with one another, and cope in stressful situations. EI leads to trust in leadership and relationship building, promoting teamwork and conflict resolution (Eason, 2009; Mackay, Pearson, Hogg, Fawcett, & Mercer, 2010; Samad, 2009). Managers with high EI influence by listening, focusing on employee strengths, and spending more time focusing on achievements, all of which results in energized staff and improved mood, especially in vulnerable times of change and uncertainty (Bisaria, 2011).

Daft (2011) tells us that having high EI—being sensitive to oneself and other’s emotions—helps leaders to identify the effect they are having on followers and optimizing their ability to adjust styles in order to create positive outcomes. These leaders become experts at “reading” a situation and adjusting their styles accordingly. Health care environments can change from minute to minute. Leaders who have the ability to read and react according to the environment of the moment will optimize their followers’ abilities to perform to their best.

EI often develops parallel to the growth of the nurse’s experience. However, EI skills cannot be taken for granted, and each one of us needs to be ever mindful to continue utilizing these skills. EI is a critical skill to learn and to harness, whether you are leading, collaborating, or following. Whatever role you are assuming, in a given situation, this skill will
potentiate success for the client, the team, and yourself.

From the Field

Not all collegial relationships are easy, and some are more difficult than others. A number of years ago, as I began to work with a new nurse coordinator and direct report, it became evident that this would be one of those more difficult relationships. We had dissimilar values and perspectives on issues, our managerial and leadership approaches were poles apart, and most importantly, our communication strategies with the team and other professionals were incongruous. At the time, I believed my strategies and approaches were superior and, rather than listening, focusing, and building on this employee’s strengths and achievements, I focused on this individual’s shortfalls and weaknesses. Our differences led to some form of struggle on a daily basis. While I presumed the conflict between us was not evident to the rest of the team, I could not have been more mistaken. It took a rather courageous employee to inform me that our differences were having a negative effect on the team and that morale would soon be at an all-time low.

In hindsight, would it have helped if that courageous employee had come to me sooner? I can only surmise that the employee’s intervention may have turned a negative to a positive, and perhaps I would have reconsidered my approach and been far more helpful to this new coordinator. The different approach would have prevented a substantive decline in team morale. However, it did not happen—the coordinator left the unit within the year. Another surprise to me, and one of my more powerful lessons as a leader, was that the negative impact on the team took several months to resolve.

—Colleen Toye, RN, BSN, MN

Reflective practice has many parallels to emotional intelligence. Reflective practice is the ability to examine actions and experiences with the outcome of developing practice and enhancing clinical knowledge (Caldwell & Grobbel, 2013). According to the College of Nurses of Ontario (2015), reflective practice benefits not only the nurse, but the clients as well. For the nurse, reflective practice improves critical thinking; optimizes nurse empowerment; provides for greater self-awareness; and potentiates personal and professional growth. For the client, reflective practice improves client quality of care and client outcomes (College of Nurses of Ontario, 2015).

Reflective practice teaches the importance of active listening, which does not come easily to many people. As you reflect on the meetings you have participated in, you may begin to understand that even though you very eagerly provided your perspective and suggestions, you were not as attentive to other’s viewpoints and potential ideas, which may have been diverse, valuable, and creative approaches to problem solving. Conscientiously practicing active listening opens the doors for comprehensive planning, whether that is client care or programming.

In an interview with the Canadian Nurse, David Byres, a registered nurse leader with experience in direct care roles as well as high-profile formal leadership roles, was asked, “What is the best piece of career advice you have received”? His answer: “Listen to learn and learn to listen” (Huron, 2017, p. 38).

Reflective practice and active listening helps the individual engage more deeply with staff, other disciplines, clients, and families. The skill of listening is often undervalued, when in fact it is one of the more critical components of communication within interprofessional leadership and collaboration. As students develop emotional intelligence and reflective practice, a deep awareness of self and others ensues. These key elements for interprofessional leadership support relationships with other professionals and clients.
Shared Leadership

Within a framework of team- and collaborative-based practice, interprofessional leadership is a shared leadership. All practitioners must recognize the necessity of situational leadership, adjusted according to client and family needs, and the professional competencies to meet those needs (Anonson et al., 2009).

Shared leadership can be complicated when the interprofessional team requires a change in leader based on a change in client needs and care (Sanford & Moore, 2015). This happens regularly with complex clients in all settings, and particularly in the community setting. For example, a client’s medical needs may be stable and straightforward, but their emotional or social needs remain. Ideally in this situation, leadership of the interprofessional team moves from medicine to social work or mental health services (Sanford & Moore, 2015).

Anonson et al. (2009) studied participants who were unanimous in their opinions that effective interprofessional team-based practice is the most beneficial framework for successful client outcomes, specifically for clients with complex needs and circumstances. Moreover, these authors found that team leadership was viewed as a shared responsibility of the team as a whole. Given the nature of this collaborative team-based approach that is ideal for our ever-increasing number of clients with complex needs, all practitioners require leadership knowledge, skills, and ability, as well as knowledge of shared leadership practice.

Ultimately, commitment to client outcome rather than one’s own professional discipline is the goal of collaborative health care teams (Anonson et al., 2009). This is where active listening, trust and relationship building, emotional intelligence, and reflective practice become critical, in order to strengthen oneself within that leadership role, while truly understanding distinct client needs and what each discipline has to offer individual clients.

Appreciative Inquiry

The participative leader embraces group involvement in decision making. This involvement fosters an understanding of the issues by those who must carry out the decisions since team members are more committed to actions when they have been involved with the decision making (Darvish & Faezeh, 2011; Daft, 2011). Participative leadership suits the strategy of appreciative inquiry as it engages individuals, teams, and the organization (Daft, 2011). Meaningful change is more likely to occur when those most affected are given the opportunity to decide on the changes themselves (Pan & Howard, 2010).

Appreciative inquiry (AI) reinforces positive actions, focusing on learning from successes and on what is working well in order to bring the desired future into being (Browne, 2008; Daft, 2011). Faure (2006) frames AI as a method for positive change in which the focus is on what works rather than illuminating what does not work, and suggests that the change effort should begin by asking, “What works best and what do we want more of?” According to Browne (2008):

AI is based on the simple idea that human beings move in the direction of what we ask about. When groups query human problems and conflicts, they often inadvertently magnify the very problems they had hoped to resolve. Conversely, when groups study exalted human values and achievements, like peak experiences, best practices, and worthy accomplishments, these phenomena tend to flourish. (p. 1)
AI optimizes continuous improvement and has many applications including team development, multi-agency teamwork, service user engagement, organizational projects, and positive culture change (McAllister & Luckcock, 2009). AI provides opportunities for individual voice through a four-phase process:

1. **Discovery** or appreciating, where individuals identify and share the best of what exists.
2. **Dream** or envisioning, where the group imagines what could be and creates a shared vision of the best possible future outside the traditional boundaries of what was done in the past.
3. **Design** or co-constructing, where plans are made about what the organization needs to do in order to get to where they want. This phase sets the stage for new and innovative practice.
4. **Destiny** or sustaining, where the group translates plans into action steps and commits to implementation and evaluation of the new design or changes (Daft, 2011; McAllister & Luckcock, 2009; Pan & Howard, 2010; Richer, Ritchie, & Marchionni, 2010). The group values the positive focus of AI and is keen to work together using an AI strategy. Once the process begins, it is carried out over several sessions.

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**Appreciative Inquiry Applied**

The following section provides as an example of how the four phases of appreciative inquiry can be successfully applied.

**Discovery.** A multidisciplinary group was assembled and included a client representative and a facilitator. The group began to discover by thinking about the organization’s strengths and best practices or about positive client experiences. The following discussion ideas and questions, adapted from Lewis et al. (2006) and Jones (2010) were presented to the group.

- When are you most engaged at work and what do you value most about yourself and the organization?
- Describe a positive hospital stay from the client perspective. Describe a positive experience with a discharge plan and execution (from a staff perspective and a client perspective). Share a process you have heard or read about that you think may enhance discharge planning.

Each discussion idea or question was presented on a large poster, and the participants were invited to share their answers on sticky notes, which were then applied to the posters. The following themes emerged:

1. Staff are most engaged at work when the team and all care providers involved in a client’s care communicate and work well together, when timelines for diagnostics and treatments are met, and when there is time to discuss concerns with the client and family.
2. Staff values the ability to provide quality client care. Staff values autonomy, good communication, and service areas that trust and respect one another. It is such a good feeling when staff from another service area calls to say “thanks” for the excellent transfer information.
3. From the client perspective, it was revealed that it is important to be informed, to feel listened to by care providers including their physician, and to be very involved in their care planning decisions, including plans for home or for long-term care.
4. Staff and clients described an effective discharge experience as one that is contributed to by the client and all care providers involved, one that is written and understood by the client, and one that is started shortly after the client is admitted to the hospital. The group described two situations in which this has occurred.
5. Two individuals shared that they have read about a new process called “D minus three,” which is related to identifying anticipated client readiness for discharge within three days.

During the discovery stage, the group was getting to know one another and positive relationships were developing.

**Dream.** The group took the next step and started thinking about “what could be” if those themes in discovery became the norm (Daft, 2011). The group was quick to identify with and agree that the desired future state is safe, high-quality client care that includes timely diagnostics and treatment throughout the client’s hospital stay and beyond the client’s discharge or transfer to another facility. This desired vision included a well-informed team, a well-informed client who understands his or her medical progress and anticipated length of hospital stay, and a discharge plan that is created with the client. Underlying this vision is dignity and respect for all. Relationships and trust within the group continued to grow.

**Design.** Planning began here in terms of transforming the vision into reality. The group reached consensus that staff in all departments within the hospital and home care must work closely and be highly communicative on a regular basis, and that the client must have a high level of engagement regarding his or her care activities and discharge care planning. The group agreed the physician is an integral component of the team with the same communication and relationship responsibilities as the rest of the team. Ideas for improved processes materialized.

**Destiny.** Process leads were determined and the group committed to initiate and evaluate the following action steps:

- Implement daily multidisciplinary rounds on the medical unit with a focus on client progress and discharge planning. Discharge lead for each client will be established and close communication with client and team will ensue. Discharge care plans will be in writing and available to all team members in the hospital, in home care, and to the client.
- Create an information pamphlet specific to the client containing relevant information and questions for the client to consider in preparation for discharge.
- The need for long-term care assessment will be established by the client and the multidisciplinary team once the client is stable and care needs are evident. If the client’s needs can be met at home, that assessment will be completed in the home, as will the wait for a placement. If the client needs to remain in 24-hour care, a transfer to an outlying facility will be discussed with the client and family well in advance of the transfer.
- The medical unit will re-establish the use of expected length of stay guidelines. The physician representative in the group will provide educational support to all admitting physicians.
- “D minus three” will be investigated by representatives from the hospital and home care.

The discovery phase should take place again, following implementation of actions to ensure continued reflection and sustainability (Richer et al., 2010).

This was a start for the hospital and so began the positive change for discharge planning as it related to the client, the family, and the work of the multidisciplinary team. The key for success was framing the issues in positive ways, in the building of relationships and trust, and in the human potential to co-create a better future (Daft, 2011; Richer et al., 2010).