Leadership and Influencing Change in Nursing

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JOAN WAGNER

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This textbook can be referenced. For example, in APA citation style, it would appear as follows:

Wagner, J. (Ed.). (2018). *Leadership and Influencing Change in Nursing.* Regina, SK: URPress. Retrieved from: https://ourspace.uregina.ca/handle/10294/8296.

Contents

About the Book

JOAN WAGNER

Leadership and Influencing Change in Nursing is designed for a single-semester introduction to the professional nurse's leadership role as both a care provider and a formal leader. Nursing students will take this course in their third year as they prepare to assume a professional nursing role within the clinical health care environment. An assortment of authors with diverse nursing leadership roles across Saskatchewan and Canada have contributed to this textbook. These diverse voices are focused on providing student nurses with the foundational tools, techniques, and knowledge required to empower them to meet the leadership challenges found within the ever-changing Canadian health care environment. Assembling this information using an online format allows for the material to be updated regularly so as to keep pace with the rapid expansion of knowledge.

The specific goals of this textbook are:

- to ensure the information is relevant to Saskatchewan nursing students,
- to tailor the content to nursing students' needs for both practical knowledge and theoretical knowledge,
- to provide up-to-date, evidence-informed content on nursing leadership,
- to thread Indigenous content throughout the textbook, and
- to tailor the textbook to the curriculum.

APPROACH AND PEDAGOGY

This open access textbook introduces you to concepts related to leadership and the ability to influence change in the nursing profession. Essential theory and readings will be provided. The authors offer real-life management wisdom that is derived from a combination of clinical practice and evidence-based knowledge obtained through research. This wisdom will assist you in developing essential critical thinking skills that will enable you to make critical leadership decisions based on evidence-informed best practice. The authors will continue to work to ensure that the readings provided in this textbook contain the most up-to-date and relevant information. Since this is an open textbook, content will be reviewed and updated annually to ensure that the predetermined critical learning elements and outcomes are met for the course in which it is used. Instructors may assign additional readings in their classes in order to enrich your learning.

Each chapter begins with a significant leadership quotation relevant to the chapter content. **Key terms** throughout the chapters are highlighted in bold.

Coloured boxes are used in each chapter to differentiate and highlight important learning features (see diagram below).

Key Learning Features

The **Learning Objectives** set out at the beginning of each chapter provide a guide to chapter contents and structure to your learning.

Three types of textboxes in each chapter offer important information:

From the Field textboxes provide wise words from nurse leaders.

Research Notes demonstrate how each chapter is evidence-based and provide you with links to important academic research that further explores the critical topics addressed in each chapter.

Essential Learning Activities in each chapter include links to important resources. These Essential Learning Activities may also include podcasts from chapter authors that have been developed for this textbook. The authors have chosen to provide you with links to source documents and videos, rather than summarizing or restating the contents of these important resources. These Essential Learning Activities are an integral part of the chapter content and will provide you with an in-depth understanding of contemporary issues within the nursing profes-

sion. It is important to review the sources offered in Essential Learning Activities and complete the accompanying questions. These questions require you to apply critical thinking and synthesize new knowledge. The information within these links is an essential component of your course work. This important information will *not* be provided elsewhere within the textbook.

Each chapter ends with a **Summary**, which gives a general overview of chapter content and a review of the chapter objectives, a number of **Exercises** to give you an opportunity to review and use your new leadership knowledge, and a complete list of **References** for all material cited in the chapter to assist you in locating it as needed.

HYPOTHESIS

Hypothesis (or Hypothes.is) is an open source web annotation tool that students and instructors can use to highlight and annotate online text, which they can share publicly or privately (for group discussion) or use for individual study. Hypothesis encourages deeper engagement with academic text and other Internet resources.

Hypothesis has been enabled for the online format of this textbook. In order to use this tool, you will first need to create a free account with Hypothesis and then follow the step-by-step instructions.

For more information, Hypothesis offers the following Quick Start Guides:

1. Quick Start Guide for Students
2. Quick Start Guide for Teachers

CHAPTER STRUCTURE

Chapter 1 introduces the emerging nurse leader to leadership theory. Descriptions of the skills that form the core of leadership excellence are provided. In addition, a quick overview of different nursing leadership styles that have been practised over the past century is presented. Emerging nurse leaders are also given the opportunity to compare and contrast different leadership styles while building a foundation for their own leadership style.

Chapter 2 provides a comprehensive discussion of workplace diversity in health care organizations. The nurse leader is introduced to cultural diversity and theoretical models that provide guidance to nurses in their provision of culturally competent care. Nurse leaders are assisted in developing an understanding of diversity, which will help them, as nurse leaders, to manage the workplace.

Chapter 3 offers an introduction to Indigenous health care and supports nurse leaders "to become leaders in the 'Indian way' " (Nichols, 2004, p.177). The nurse leader is provided with a snapshot of the Indigenous worldview and the authors illustrate how worldviews affect leadership decisions. A review of the evolution of the health care system in Indigenous communities and the development of Indigenous health care structures provides the student with further essential knowledge required for nursing leadership. This chapter concludes with recommendations that will support the nurse leader in future collaborative work with Indigenous communities.

Chapter 4 illustrates the historical connections between the nursing profession and the Canadian health care system. Historically, the role played by nurses ranged from providing care to early settlers and Indigenous peoples, to lobbying for extensive changes to the Canada Health Act, to establishing PhD nursing programs, and finally, developing a unique body of Canadian nursing research. Nurse leaders have been a strong and vigilant group dedicated to building the future for nursing and health care in Canada.

Chapter 5 highlights some of the significant changes occurring within the Canadian health care system that have had an impact on nursing leadership and nursing practices. It contains a brief overview of the principles of a complex adaptive system and the importance of an organization's vision, mission, and values in providing guidance to nurse leaders for decision making. The chapter concludes with a discussion of the recent adaptations to our health care organizational culture, which have led to an evolving scope of practice for registered nurses and the creation of a protocol for delegation of care.

Chapter 6 stresses the need for collaboration between health professionals to provide quality health care to clients in the community. The shift to care in the community sector is challenged by the specialized care of a growing population of geriatric clients, with a distinct focus on Indigenous seniors, and the special attention required by people with mental health and palliative care needs. Strong nurse leaders are required to engage in interprofessional collaborative relationships that lead to effective teamwork focused on determining client needs and ensuring successful outcomes.

Chapter 7 focuses on the development of quality management initiatives throughout the world in response to emerging patient safety issues. The impact of Magnet hospitals in the United States and the Francis report in England on international patient safety culture will be described in this chapter. Finally, the ways in which quality care is affected by Lean management principles and quality improvement tools, such as the plan-do-study-act cycle, will be discussed.

Chapter 8 illustrates the importance of evidence-informed leadership and practice for the delivery of safe, quality patient care. The three clusters of innovation addressed by leaders to promote a transparent learning organization are reviewed in this chapter. Leaders must constantly question, listen, and explore better ways for delivering quality and safe care that it is based on evidence. The chapter concludes by describing the opioid crisis in Canada and the US and demonstrating how evidence-informed harm reduction approaches bring nurse leaders back to basic nursing principles.

Chapter 9 stresses the importance of nurse leaders as change agents. Different theories and models of change theories are presented and several theories are applied to the nurse leader's role in managing change. The chapter concludes with a discussion of resistance to change, with practical suggestions that will assist the leader in walking beside individuals throughout change.

Chapter 10 introduces the Canadian Nurses Association's (CNA) Code of Ethics, which guides Canadian nursing practice. With its focus on "how broad societal issues affect health and well-being," the Code of Ethics calls for advocacy to address health inequities. A discussion of advocacy, social justice, power, empowerment, critical social theory, whistle-blowing, and social activism provide the student with a foundation to better understand the requirements for nurse leaders to advocate for the health and well-being of all, as described in the Code of Ethics.

Chapter 11 shares the wisdom of mediators from the Ministry of Justice's Dispute Resolution Office, and other experts, on how to resolve conflict. This chapter starts with a description of conflict and provides different approaches to dealing with it. These approaches are then applied to real-life nursing scenarios. A description of how conflict escalates and advice on how to de-escalate conflict and coach people toward resolution concludes the chapter. This knowledge will assist nurse leaders in learning to understand others and adapt their leadership approaches accordingly.

Chapter 12 focuses on the tools and resources required to support the nurse leader and builds on ethical and professional nursing practices. The recent transformation of the Canadian health care system requires the nurse leader to be visionary and contemporary while demonstrating strong organizational and management skills. The authors discuss changes in the system that require the nurse leader to align personal and professional values, such as those found in the CNA Code of Ethics, with responsibilities for excellence in patient care.

Chapter 13 familiarizes nurse leaders with their role in emergency preparedness and disaster planning. Nurses frequently have extensive leadership responsibilities during times of natural or anthropogenic (caused by humans) disasters. This chapter provides a description of the four areas of focus in emergency planning: mitigation, preparedness, response, and recovery. Stu-

dents are given suggestions for how to prepare for unexpected events by planning responses that will minimize damage and facilitate the recovery. A coordinated effort among professionals throughout the health care, public, and private sectors is required to address the challenges presented by disasters, whether they are natural, anthropogenic, or technological.

Chapter 14 provides nursing students with an understanding of nursing informatics and technology. Different types of information technology are defined and discussed within this chapter. Technological advances bring many benefits to clients; however, the nurse leader must consider the safety, legality, and challenges associated with the use of information technology.

Chapter 15 discusses the role of professional nursing organizations to support and engage Canadian registered nurses in the development of a strong profession. The mandates of professional regulatory bodies, unions, and four national organizations (CNA, CFNU, CNPS, and CINA) will be discussed. In addition, the chapter will assist the nurse leader in understanding how these organizations are evolving and changing to more effectively support professional nurses in Canada by providing leadership in the delivery of safe, quality nursing care.

Chapter 16 describes the rapid evolution of nursing leadership and management linked to health care change. Changes include rapidly evolving international, national, and provincial health care landscapes, and system transformations that not only have impact on the workforce, but also entail changes in management systems and leadership styles. Many of these changes require that nurse managers and leaders have business acumen and tangible business skills. Finally, the consumer (or client) and family are requesting that their voices become a fundamental component of the care process. The rapidly evolving health care/nursing environment requires the nurse leader to manage personal stress by taking time for self-care. Self-care is especially important for new nurses as they transition from student to new graduate nurse.

Foreword

Improving Health Outcomes of Indigenous People

WENDY WHITEBEAR

The majority of my career and volunteer activities have been dedicated to the betterment of Indigenous people and communities. I strive to find positive outcomes for the pressing realities our people experience by working with like-minded people in every aspect of my life. In order to speak for those who cannot, I volunteer as a co-host of a local Indigenous women's talk show "The Four" that brings a voice to these contemporary issues. Our goal is to tackle Indigenous stereotypes and encourage discussion on the political and social issues that have shaped our existence.

During my employment with the Indigenous Peoples' Health Research Centre (IPHRC) I had the opportunity to meet allies such as Dr. Joan Wagner. As part of her ongoing research to identify solutions for inadequate health outcomes, especially for the Indigenous population, she became actively involved in a Saskatchewan Centre for Patient-Oriented Research project. Dr. Wagner expressed concern that the needs of First Nations people were not being met within the health care system. As she teaches students located in Treaty 4 and 6 territories, she is adamantly aware that she needs to educate future leaders who are sensitive to the diverse nature of Indigenous people within these territories.

I am acutely conscious of the fact that Indigenous people are over-represented in the health care system. This is a direct result of systemic policies developed to eradicate the Indigenous population from this country. These acts of cultural genocide have created extreme health disparities between Indigenous people and the general Canadian population. Without adequate knowledge of the true history of Indigenous people, racism and stereotyping will continue to be rampant among health care practitioners. Unless educators willfully guide our next generation of learners to develop into culturally sensitive leaders, this practice will continue and the health outcomes for the Indigenous population will remain the same or continue to deteriorate.

The modern social issues and poverty that plague Indigenous communities in our country adversely affect health outcomes. Indigenous people experience high rates of mental illness, alcoholism, fetal alcohol spectrum disorder, domestic violence, diabetes, and tuberculosis. Without holistic interventions and culturally sensitive care, these health issues will continue to spiral.

For future leaders in the health care system, it is imperative to take historical factors into consideration, as well as to take the time necessary to work with each patient, while always being respectful of cultural needs.

Since the inception of the reserve system, residential schools, and the Indian Act, First Nations people have experienced inherently unequal power relations with the rest of the Canadian population. "Cultural Competence and Cultural Safety in Nursing Education: A Framework for First Nations, Inuit and Métis Nursing" outlines six core competencies that are essential in working with Indigenous patients and colleagues. This framework recognizes that mitigating factors have contributed to the poor health outcomes of Indigenous people. The post-colonial understanding of cultural competence encourages the learning required to explore these issues so that health care providers become more proficient leaders within the health care system.

In order to assist the learner in understanding that First Nations people have health views that are beyond the physical nature of institutional concepts, "Guidelines for Cultural Safety, the Treaty of Waitangi, and Maori Health in Nursing Education and Practice," which explores the multidimensional beliefs of Indigenous people, is a vital resource. As with the Maori people, First Nations people are diverse in their cultural beliefs and practices. Saskatchewan is made up of five different linguistic groups: Cree, Saulteaux, Dakota, Nakota, and the Dene. Each group has its own unique customs and beliefs; however, they do share some similarities. For example, during a health crisis, families will gather to show support and to assist in providing healing energy to the patient. It is common for the family to be present until the crisis is over. It is important for the well-being of the family and the patient that this custom is respected.

Learning the true history of First Nations and Métis and being sensitive to their cultural needs will have a positive effect on the learner and also assist in improving the poor health outcomes of Indigenous people. Health care workers who acquire the necessary tools to become competent health practitioners and who utilize best practices when working with Indigenous patients will make a significant difference to our people. The teachings in *Leadership and Influencing Change in Nursing* also offer the learner the opportunity to build confidence, integrity, inspiration, and passion that will serve them well as leaders in the health care industry. The textbook guides the student to a deeper understanding of what it means to be culturally sensitive, and utilization of the additional references will enrich and enhance these nursing leadership skills in a meaningful way.

1. Identifying Your Leadership Strengths and Opportunities for Growth

JOAN WAGNER

> *Gifted leadership occurs where heart and head—feelings and thought—meet. These are the two wings that allow a leader to soar.*
>
> —Goleman, Boyatzis, & McKee (2002, p. 33)

INTRODUCTION

Leadership does not occur in isolation. Leaders influence change by helping group members to accomplish their objectives. This chapter will provide you with a deeper understanding of the behaviours associated with the following terms: leadership, management, mentorship, and followership. The development of emotional and social intelligence will also be discussed as an integral aspect of effective leadership.

Learning Objectives

1. Discover your strengths and opportunities for growth as well as group members' strengths and opportunities for growth.
2. Define the characteristics of leadership, management, mentorship, and followership.
3. Identify the differences and similarities between nurse leadership and nurse management.
4. Propose conclusions regarding the role of mentorship within health care settings.
5. Propose conclusions regarding the role and value of self-development.
6. Propose conclusions regarding the importance of social and emotional intelligence in leadership development.
7. Gain an understanding of the Canadian Nurses Association's Position Statement on Nursing Leadership.
8. Examine and describe common leadership styles (i.e., servant leadership, resonant leadership, dissonant leadership, management by exception, and laissez-faire leadership), then identify your preferred leadership style.

1.1 MANAGEMENT, LEADERSHIP, FOLLOWERSHIP, AND MENTORSHIP

From the Field

Understanding principles related to management, leadership, followership, and mentorship is important for student nurses, who will both observe and experience countless examples of these four concepts throughout their careers. For example:

- Nurses working on a code team may need to learn how to be good followers and take direction.
- A charge nurse needs to be able to follow hospital-wide protocols.
- An experienced nurse orienting a new nurse to the unit may display good mentorship by setting good examples and working at a pace that helps the new team member learn.

Managers

Management has traditionally consisted of five essential functions: planning, organizing, commanding, coordinating, and controlling. In the late 1930s, these five functions were modified and expanded to include seven elements known by the acronym **POSDCORB** (MacLeod, 2012). **P**lanning refers to the action of determining goals for the future. **O**rganizing requires the manager to design an efficient and effective workplace. **S**taffing refers to the manager's responsibility for recruiting, hiring, training, and maintaining staff, while also **d**irecting or guiding the organization to meet specific objectives, and **co**ordinating or synchronizing the activities and use of resources. Finally, the manager demonstrates success in achieving goals by **r**eporting (communicating progress and results) and **b**udgeting (using scarce resources wisely). Although critics consider POSDCORB to be an overly simplistic view of management, each of the seven elements continues to be evident within management practices.

Leaders

The responsibilities of managers and leaders within a group or organization are closely linked. Leadership is regarded by many as the ability to guide others into actions that meet the needs of the organization. MacPhee describes leadership as "the process of engaging and influencing others" (2015, p. 6). Health care leaders identify the needs of clients, establish what is required for health (for both individuals and organizations), and then encourage others to engage in actions that meet these needs. Porter-O'Grady and Malloch (2011) state that the health care leader does not have to be an expert in operations or problem solving, but rather must be a "good signpost

reader." In addition, the leader transmutes this "signpost" knowledge of the future into action for followers. Leaders are recognized as providing visions and strategies, while managers are responsible for operationalizing those visions and strategies (Pangman & Pangman, 2010).

Leadership by individuals is evident throughout health care. Not all leaders are appointed to formal positions of leadership. Nurse leaders have the knowledge and skill sets required to assist individuals in leading healthy lives and to support health care organizations in building a quality health care system. Leaders communicate their vision for the future to others through a combination of words and actions. These health care leaders create and follow a vision for the future. Action is much louder than words alone. Leaders make a difference.

The Canadian Nurses Association's (CNA) Position Statement on Nursing Leadership (2009) states:

> Nursing leadership is about the competent and engaged practice of nurses, who provide exemplary care, think critically and independently, inform their practice with evidence, delegate and take charge appropriately, advocate for patients and communities, insist on practising to their full and legal scope and push the boundaries of practice to innovative new levels.

Followers

Followership is frequently described as the "upward influence" of individuals on their leaders and their teams. The actions of followers have an important influence on staff performance and patient outcomes (Whitlock, 2013). Being an effective follower requires individuals to contribute to the team not only by doing as they are told, but also by being aware and raising relevant concerns. Effective followers realize that they can initiate change and disagree or challenge their leaders if they feel their organization or unit is failing to "promote wellness and deliver safe, value driven and compassionate care" (Spriggs, 2016, p. 637). Leaders who gain the trust and dedication of followers are more effective in their leadership role (Hibberd & Smith, 2006). Everybody has a voice and a responsibility to take ownership of the workplace culture, and good followership contributes to the establishment of high-functioning and safety-conscious teams (Whitlock, 2013).

Mentors

Experienced and thoughtful mentors play an important role in the development of nurse leaders. Mentorship is defined as "a formal supportive relationship between two or more health profes-

sionals that has the potential to result in professional growth and development for both mentors and mentees" (Ontario Ministry of Health and Long-Term Care, 2017, p. 1). It is a reciprocal relationship between an expert and a novice; the expert provides advice, feedback, and guidance, and the novice assists the mentor with projects while maintaining a relationship of respect, loyalty, and confidentiality (Evans, 2015).

Mentors can provide emotional support and career guidance that advance new nurses and nurse managers to professional success. However, Porter-O'Grady and Malloch (2011) suggest that some mentorships are toxic. Toxic mentoring occurs when mentors perpetuate past practices that prevent necessary changes from happening, rather than encouraging growth and development. Toxic mentoring can also occur when the mentor fails to assist the mentee to develop his or her own identity and leadership style, so that when the mentor is no longer present, the mentee is unable to progress on his or her career path. Finally, the mentor may give unrealistic assignments to the mentee, which may remain unfulfilled, culminating in mentee failure. These examples of toxic mentoring illustrate the importance of mentees choosing their mentors carefully since this relationship requires trust and mutual positive regard.

Essential Learning Activity 1.1.1

For more information on the CNA's position on nursing leadership, read their "Nursing Leadership Position Statement."

1.2 LEADERSHIP STYLES

Overview

A review of the literature on leadership reveals a multitude of leadership styles. Marquis and Huston (2015) organize their scientific study of leadership using connections between leadership themes and specific time periods. Research on leadership started in the early 1900s with a focus on the great man theory (or trait theory); this was the dominant theory of leadership until about 1940. Since the 1970s, leadership theory has evolved into a study of the relationship between leaders and followers within organizations. The advancement of leadership theories illustrates that what is "known" about leadership continually changes as leaders' environments evolve and additional research is completed.

Adapting the individual nurse leader's style to meet the needs of the organizational environment is critical for leadership success. A systematic review of the nursing literature by Cummings et al. (2010) helps us to understand these different leadership styles by dividing nurse leadership theories into the two separate categories of task-focused leadership and relationally focused leadership. Observing leadership theories from the perspective of relationships has become crucial as we move into the age of technology associated with chaos and complexity science.

Task-focused leaders tend to focus on the tasks to be completed or on the transactions between leaders, colleagues, and followers that are required to complete the tasks, rather than on the relationships between individuals within the organization. **Relationally focused leaders**, on the other hand, consider relationships rather than tasks to be the foundation for achieving positive change or outcomes (Hibberd & Smith, 2006). There are multiple examples of both task-focused and relational leadership in the research literature (Villeneuve & Wagner, 2015).

Research by Wagner et al. (2013) explores the relationship between a resonant leadership style (relational style of leadership with a focus on building relationships and managing emotion), empowerment of registered nurses (RNs) in the workplace, and workplace outcomes such as job satisfaction, organizational commitment, and spirit at work (SAW). The study of SAW, a holistic measure of workplace experiences, looks at the perceptions of engaging work, sense of community, spiritual connection (connection to something greater than self while at work), and mystical experience (sense of transcendence while at work) of the individual nurse. Ongoing research indicates a strong relationship between resonant leadership and SAW. Research also indicates that these holistic measures of SAW account for more variance in employee workplace outcomes than job satisfaction (Wagner et al., 2013; Wagner & Gregory, 2015).

Research Note

Wagner, J. I. J., & Gregory, d. (2015). Spirit at work (SAW): Fostering a healthy RN workplace. *Western Journal of Nursing Research*, 37(2), 197-216.

Purpose

The purpose of this study was to explore and measure the relationships between SAW, job satisfaction, and organizational commitment for RNs located within two distinctly different practice contexts, with surgical RNs practising in the active acute care hospital environment and home care RNs usually providing direct nursing care in the client's home. We were interested in exploring the impact of practice context on SAW and job satisfaction of RNs. The first research hypothesis explored in this study was as follows: the experience, edu-

cation, practice context (surgical or home care), and SAW concepts predict the outcome variables of job satisfaction and organizational commitment of surgical and home care RNs. The second research hypothesis was as follows: there are differences in experience, education, SAW concepts, and the outcome variables of job satisfaction and organizational commitment between surgical and home care RNs (Wagner & Gregory, 2015, p. 200).

Discussion

SAW concepts of engaging work and mystical experience accounted for moderate to large amounts of model variance for both home care and surgical nurses, while significant positive relationships between SAW concepts, job satisfaction, and organizational commitment were also reported. Researchers concluded that SAW contributes to improved job satisfaction and organizational commitment and that the measurement of SAW concepts is sensitive to RN experiences across clinical contexts. As a holistic measure of RN workplace perceptions, SAW contributes essential information directed at creating optimal environments for both health care providers and recipients (Wagner & Gregory, 2015, p. 197).

Application to practice

We suggest that routinely monitoring RN perceptions of SAW and making the necessary modifications in response to RN concerns is prudent practice. For example, survey data revealed that RNs have numerous concerns about their workplace related to the four SAW concepts of engaging work, sense of community, mystical experience, and spiritual connection. These concerns collectively contribute to reduced job satisfaction and organizational commitment and ultimately to RN turnover (Aiken et al., 2008; Leiter & Maslach, 2009; Purdy, Spence Laschinger, Finegan, Kerr, & Olivera, 2010). "Critical assessment of these concerns may lead to the development of targeted responses aimed at alleviating stresses in the RN practice environment" (Wagner & Gregory, 2015, p. 211).

The RN work environment is undergoing multiple positive changes that are being led by both the government and the nursing union. SAW, with its holistic view of the workplace, appears to provide a more representative measurement of RN workplace perceptions than existing measurement tools (Wagner & Gregory, 2015, p. 213).

For more information on spirit at work, listen to the podcast Spirit at Work (SAW) from the *Western Journal of Nursing Research*.

1.3 EMOTIONAL AND SOCIAL INTELLIGENCE IN LEADERSHIP

Overview

The position of either leader or follower does not hold power. Rather, it is how we respond when we are in these roles, based on our emotional intelligence, that gives power to each role. **Emotional intelligence** has been described as the "ability to monitor and discriminate among emotions and to the use the data to guide thought and action" (Pangman & Pangman, 2010, p. 146). Goleman (1998), a researcher who has completed excellent work in the area of work performance, studied the importance of emotional intelligence in achieving personal excellence. He

defines emotional intelligence in greater depth, stating that it is composed of "abilities such as being able to motivate oneself and persist in the face of frustrations; to control impulse and delay gratification; to regulate one's moods and keep distress from swamping the ability to think; to empathise and to hope" (Goleman, 1995, p. 21). Goleman's model of emotional intelligence contains five skills that comprise personal and social competencies (see Table 1.3.1 below). The three skills of self-awareness, self-regulation, and motivation relate to the individual's personal competence. The remaining skills of empathy and social skills are classified as social competencies (Sadri, 2012, p. 537). Goleman stressed that all of the skills can be learned.

Table 1.3.1 Emotional Intelligence Skills and Competencies (*Data Source: Table based on material from Sadri*, 2012.)

Competency	Skill Area	Description
Personal	Self-awareness	Knowing one's self
	Self-regulation	Managing one's self
	Motivation	Sentiments and passions that facilitate the attainment of goals
Social	Empathy	Understanding of others and compassion toward them
	Social skills	Expertise in inspiring others to be in agreement

Developing Emotional and Social Intelligence

Students are at an ideal stage of their lives and careers to check their emotional intelligence. Completion of the emotional intelligence quiz at the link below may help you identify areas for growth.

Essential Learning Activity 1.3.1

Visit Queendom.com to access an emotional intelligence assessment.

Now that you have identified an area for growth, you may ask, "How can I increase my emotional intelligence?" Your brain has been developing neural pathways in response to your environment since early childhood. Over time these pathways become hard-wired in your brain, allowing you to respond rapidly to circumstances in your environment. In fact, it is believed that emotional responses occur faster than cognitive responses, thus you seem to act before you think. Siegel's (2012) research in the area of interpersonal neurobiology shows that there is a way to change your brain's response to stressors. Increasing your "mindfulness" can provide you with an opportunity to "break the link between environmental stimuli and habitual responses" (Gerardi, 2015, p. 60) and to choose a different course of action. Daniel Siegel (2010) coined the term *mindsight* to refer to the phenomenon of becoming aware of emotional reactions and changing them in real time. Gerardi (2015) stressed that working on developing mindsight is hard but valuable work for those who wish to become successful leaders.

From the Field

It is important to step back, take a few deep breaths, and look at all aspects of the situation before reacting.

As a nurse, gaining emotional and social intelligence and using mindsight are all critical to becoming a successful leader in the field. You will encounter and be required to cope with many different types of people, both colleagues and patients. It is extremely important to be self-aware, reflect on your feelings, and think about how emotions can influence both actions and relationships (or social interactions). That is, you must learn to reflect on your clinical experiences and think of how you could have changed a situation by using self-awareness or mindsight. In the words of Pattakos, "Between stimulus and response, there is a space. In that space lies our freedom and our power to choose our response. In our response lies our growth and our happiness" (as cited in Gerardi, 2015, p. 60).

1.4 LEADERSHIP IN THE TWENTY-FIRST CENTURY

Advances in technology have brought the world from the industrial age into the information age. Porter-O'Grady and Malloch (2011) describe four factors, arising from technology, that are contributing to increased demands within health care and are associated with a depletion of resources: (1) endless change; (2) availability of information; (3) knowledge as a utility rather than a possession with knowledge users accessing the right knowledge at the right place and the right time; and 4) rapid advances that are changing the service relationship (i.e., technology-assisted procedures, which have reduced numbers and lengths of hospital stays). Dr. Keith A. Bezanson, the Canadian former director of the International Development Research Centre, concluded at a 1994 United Nations conference that society is experiencing a transformation so profound that it is impossible to forecast the future (Hibberd & Davies, 2006). Innovative areas of study, such as complexity science, are arising from this rapid convergence of empirical evidence around the world.

Complexity may be described as the "complex phenomena demonstrated in systems characterized by nonlinear interactive components, emergent phenomena, continuous and discontinuous change, and unpredictable outcomes" (Zimmerman, Lindberg, & Plsek, 1998, p. 263). At an international summit held at the University of Minnesota in 2003, one speaker described how Newton reductionism, which has guided scientific thinking for 300 years, has been replaced by complexity science in the twenty-first century (Hibberd & Davies, 2006). This same speaker stressed that

> complexity science can guide our understanding of the health care system, a multi-layered system largely driven by rapidly changing technology and information. In health care … practitioners … make up a continuously evolving system because of their innovative, diverse and progressive adaptations (Holland, as cited in Hibberd & Davies, 2006, p. 500).

Essential Learning Activity 1.4.1

For a more in-depth understanding of complexity science and complex adaptive systems in nursing, watch Pat Ebright's short video "Complex Adaptive System Theory" (4:30). Then answer the following questions:

1. Why is it important for the nurse manager to walk through the nursing unit? What does the "walk" tell her?
2. What is Pat Ebright referring to when she comments on a nurse's partner's "eyes glass[ing] over"?

MacPhee (2015) describes complexity-informed health intervention as a system. In this system, decision making is distributed among the members of the organization (i.e., at the practice level) and health care providers encourage patients and families to take more personal responsibility and ownership of their care.

Each individual has the capacity to lead, manage, or follow as needed. The flow among these roles fosters an empowering environment that diminishes fear and organizational silence on matters that are critical to patients, staff, and organizational outcomes (MacPhee, 2015, p. 13).

What kind of nursing leadership is called for in the age of complexity science? Experts stress that nurse leaders must understand the principles of a complex adaptive system, supporting change by ensuring that trust, risk taking, and flexibility flourish, thus permitting new ideas to emerge (Pangman & Pangman, 2010). Translated into action, this requires that leaders look at the organization through the **lens of complexity**, with unit leaders allowing issues on the unit to emerge. Leaders use **good enough vision** to solve difficulties by allowing individuals to develop and use innovative approaches within their work environment, rather than providing specific directions. Pangman and Pangman stress the need for the nurse leader to balance data (**clockware**) and intuition (**swarmware**) by circulating around the workplace, observing and providing support or suggesting a different way of doing things when a problem is identified. The real differences that occur between organizational goals and the day-to-day performance of the unit (**paradox and tension**) are identified through the leader's openness to challenging "sacred cows"—those ideas or systems that are generally considered beyond questioning or above criticism. The leader is aware of the different formal and informal networks (**shadow systems**) that influence the behaviour of staff. This awareness guides the leader in the exploration and endorsement of differing views. Overall, the leader values both cooperation and competition among staff, realizing that both behaviours, when encouraged and guided, can lead to increased productivity (Pangman & Pangman, 2010).

Relationally Focused Leadership Styles

Situational and contingency–based leadership theories, most popular from 1950 to 1980, suggest that no one leadership style is ideal for every situation. Leadership must be adapted according to the needs of the leader, the employees, and the environment (Marquis & Huston, 2015). Some examples of responses to the increasing complexity of our system include relationally focused leadership styles such as **strengths-based leadership**, in which leaders strive to empower workers' strengths rather than identify problems (Wong, 2012) and **authentic** or **congruent leadership**, wherein followers are inspired to act (Avolio, Walumbwa, & Weber, 2009). Robert Greenleaf espoused **servant leadership**, in which leaders' primary responsibilities are service to others and recognition that the role of organizations is to create people who can build a better tomorrow (Parris & Peachey, 2013). By contrast, **principal agent theory** emphasizes that the leader must provide incentives for followers to act in the organization's best interest, since not all followers are inspired to act in the leader or employer's best interest.

Another relationally focused nursing leadership style espoused widely across North America is the **transformational leadership style**. These leaders demonstrate four prevailing characteristics that include idealized influence, inspirational motivation, intellectual stimulation, and idealized consideration. They are sensitive to the requirements of others and endeavour to realign the existing organizational culture with a new vision (Bass & Avolio, 1993). **Feminist leadership**, founded on the principles of transformational leadership, further emphasizes an ethic of care expressed through the use of collaborative, relational skills and the development of gender equitable and empowering organizational goals (Christensen, 2011).

Quantum leadership, a direct response to the constant change present in the complex environment, "builds upon transformational leadership and suggests that leaders must work together with subordinates to identify common goals, exploit opportunities and empower staff to make decisions" (Marquis & Huston, 2015, p. 63). Another leadership style, developed in response to the increasing complexity of strategic issues that are cross-functional in nature, is **dyad leadership**, which involves the development of mini teams consisting of two or more individuals. Sanford and Moore (2015) described dyad leadership as "a model of formal leadership in which two individuals with different skill sets, education, and background are paired to better fulfill the mission of the organization" (p. 7).

Task-Focused Leadership Styles

The literature abounds with examples of task-focused leadership styles that place an emphasis on the accomplishment of assigned tasks, rather than on the development of productive rela-

tionships within the workplace. Task-oriented styles, such as **transactional leadership**—wherein the leaders tend to explain expectations and reward good performance, correct departures from expectations, and finally attempt to prevent future problems (Xirasagar, 2008)—can prove useful in fast-paced and high-stress environments, such as the emergency department. However other task-oriented leadership styles such as **laissez-faire**, which describes leaders who refuse to take responsibility and who are not concerned about organizational outcomes or follower behaviours (Avolio, Bass, & Jung, 1999), may have detrimental effects upon an organization.

The effectiveness of different task-oriented leadership styles depends on the needs of the organization. Additional commonly found types of task-oriented leaders include those who **manage by exception**, who focus on providing correction when tasks are not completed appropriately; **instrumental leaders**, who focus on strategy and expedition of work outcomes rather than on making values-based decisions (Antonakis & Atwater, 2002); **passive avoidant leaders**, who avoid taking action until problems become serious and corrective action is required (Avolio, Bass & Jung, 1999); and finally, **dissonant leaders**, who lack emotional intelligence and tend to be negative, without empathy for followers (Goleman, 1998).

Essential Learning Activity 1.4.2

Watch Joseph Trimble's TEDx Talk on "Culture and Leadership" (17:57), then answer the following questions:

1. Why does Joseph Trimble say that we are bidding farewell to the alpha male leadership style?
2. Trimble tells a story about Diane, an Indigenous woman from a small Alaskan village who was invited to take on a leadership role in her organization. She said no. When she was asked a second time, she went home to her village and spoke with her family, Elders, and spiritual leaders, before eventually accepting the offer. Her leadership brought about changes to the organization. How did she change the organization?
3. What do you think Diane's leadership style was?
4. What happened to the organization as a result of her culturally unique leadership style?

SUMMARY

The rapid societal changes and increasing complexity of society are demonstrated by the appearance of many different leadership styles. Excellent nurse leaders are aware of the circumstances within their own workplace environments and demonstrate a willingness to adapt their

leadership styles accordingly. Outstanding leaders ensure the provision of quality patient care while also promoting the achievement of organizational goals and objectives.

After completing this chapter, you should now:

1. Have discovered your strengths and opportunities for growth as well as group members' strengths and opportunities for growth.
2. Be able to define the characteristics of leadership, management, mentorship, and followership.
3. Be able to identify the differences and similarities between nurse leadership and nurse management.
4. Be able to propose conclusions regarding the role of mentorship within health care settings.
5. Be able to propose conclusions regarding the role and value of self-development.
6. Be able to propose conclusions regarding the importance of social and emotional intelligence in leadership development.
7. Have gained an understanding of the Canadian Nurses Association's Position Statement on Nursing Leadership.
8. Have examined and be able to describe common leadership styles (i.e., servant leadership, resonant leadership, dissonant leadership, management by exception, and laissez-faire leadership), and identify your preferred leadership style.

Exercises

1. What are the key personal attributes required to lead, manage, and follow? What are the differences between leadership, management, and mentorship?
2. Why is complexity science important to our understanding of nursing leadership, management, and followership?
3. Read "The Value of Active Followership" by J. Whitlock (2013) and identify the common human factors that can affect risk, then write a poor followership scenario for a typical RN clinical day. (Keep it short—300 words or less). Now rewrite the poor followership scenario as a good followership scenario. Identify the common human factors that can affect risk.
4. Reflect on a situation you've experienced related to nursing where you encountered frustration and reacted poorly. Considering your new learning on emotional and social intelligence, how will you react to similar situations in the future?
5. What is your preferred style of leadership? Why did you choose this style? How will you display this style of leadership as a student nurse?
6. When do you think it is most appropriate to employ (a) a relational leadership style, and (b) a task-oriented leadership style? Why? Give an example.

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2. Diversity in Health Care Organizations

SONIA UDOD AND LOUISE RACINE

> *In a multi-race society, no group can make it alone.*
>
> –Martin Luther King, Jr., March 31, 1968 (Phillips, 1999, p.136)

INTRODUCTION

Workplace diversity is becoming increasingly important in Canadian health care settings. As the nursing workforce and demographic patterns change, it is important for nurse leaders to understand and influence staff with various values, beliefs, and expectations. In this chapter, we first review cultural diversity, ethnicity, race, cultural competency, and cultural safety. Second, we explore the differences between cultural competency and cultural safety. Third, we present theories that can be used to guide the implementation and delivery of culturally competent nursing care. We review the role of nurse managers in supporting the implementation of culturally competent care with clients and within health care organizations. Finally, we will discuss how diversity applies to new generations and see how intergenerational conflicts arise from different cultural beliefs. We conclude with strategies for managing workplace diversity.

Learning Objectives

1. Understand the concepts of culture, cultural competence, and cultural safety in leading and managing nursing.
2. Discuss cultural diversity and the ways in which people differ.
3. Identify theoretical models that can facilitate culturally competent patient care.
4. Articulate the generational differences among Veterans, Baby Boomers, Generation X, and Generation Y.
5. Explore the issues of workplace diversity in health care organizations for nursing staff, nurse leaders, and patients and families.
6. Describe how the nurse leader can manage workplace diversity.

In Canada, the general population is becoming increasingly diverse in colour, culture, religion, ethnicity, and origin (Statistics Canada, 2017). Data suggest that in 2011, 20 per cent of the Canadian population were immigrants, and projections are that the percentage of immigrants in Canada will continue to increase (Statistics Canada, 2017). The influx of immigrants to Canada has been characterized by sustained immigration and an increased diversification of immigrants, which has been designed to meet Canada's economic needs and to provide a welcome refuge for vulnerable refugees.

The number of new immigrants and their geographical locations could affect the ethnocultural diversity of various regions in Canada. For example, the top ten countries from which immigrants come to Saskatchewan have been Philippines, India, China, Pakistan, Ukraine, United Kingdom, United States, Bangladesh, Iraq, and South Africa (The Canadian Magazine of Immigration, 2016). Such changes to the cultural reconfiguration of the prairie landscape will affect workplace diversity.

These changes have led to a growing challenge in nursing leadership related to the management of a culturally diverse work environment. Cultural and generational differences related to attitudes, beliefs, work habits, and expectations have proven to be challenging for nurse leaders (Kramer, 2010) and will continue to be a critical managerial and leadership priority. Demographics, language, education, cultural, gender, race, and generational differences are factors that have increased conflict within health care teams, which is associated with burnout and decreased job satisfaction (Almost, 2006; Mortell, 2013). When conflict and disharmony occur within a team, the nurse leader plays a significant role. Results of misunderstandings and misinterpretations related to cultural and generational differences can be costly to organizations as they can result in increased absenteeism, decreased staff satisfaction, and decreased quality patient care (Weingarten, 2009).

2.1 CULTURAL DIVERSITY

Canada, the United States, and European nations are presently facing a migration crisis of a magnitude that has not been seen since the massive population displacements of the post–World War II era (Fleras, 2015). Due to the effects of globalization, economic policies, financial constraints, and forced migrations due to environmental or armed conflicts, nurses are providing health care to very diverse and sometimes vulnerable populations such as refugees and asylum seekers (Racine & Lu, 2015). On the other hand, globalization also brings increased ethnic and cultural diversity within health care organizations, which affects the way nurses deliver care and how they interact with nurses coming from other countries. More than ever, nurses must be culturally competent and culturally safe in their everyday practice regardless of the health settings

in which they work. Similarly, nurse managers need to understand their roles in supporting cultural competency and safety at both the individual and the organizational level. Cultural competency and cultural safety are key skills for nurses to acquire and sustain. The Canadian Nurses Association, the Canadian Association of Schools of Nursing, the American Nurses Association, the American Organization of Nurse Executives, and the US Office of Minority Health are among the major regulatory nursing bodies and organizations that recognize the moral and ethical duty of nurses to advocate for and provide culturally competent care.

2.2 TERMINOLOGY

Cultural diversity refers to cultural differences and how individuals and groups vary based on certain ethnic, racial, and cultural attributes. However, the concept of cultural diversity is complex, as the recognition of this diversity does not mean that the differences of the "Other" are respected and accepted (Bhabha, 1994). Andrews and Boyle (2012) define **diversity** as "differences in race, ethnicity, national origins, religion, gender, sexual orientation, ability or disability, social and economic status or class, education, and related attributes of groups of people in society" (p. 5). Cultural diversity in our country requires that nurses become culturally knowledgeable and conscious of their attitudes toward people from other ethnocultural groups. Issues of race and ethnicity are often conflated and emerge as problematic issues arising from cultural conflicts or misunderstandings between individuals and groups. It is, therefore, important to understand the differences between ethnicity and race.

Ethnicity and Ethnocentrism

The context of race and ethnic relations represent a challenge of contemporary nursing practice as our world becomes more global and diversified. Cornell and Hartmann (2007) define an **ethnic group** as "a collectivity within a larger society having real or putative common ancestry, memories of a shared historical past, and a cultural focus on one or more symbolic elements defined as the epitome of their peoplehood" (p. 19). Ethnicity and race represent different concepts, yet they sometimes overlap. For example, Ericksen (2010) underlines that Croatians, Serbs, and Bosnians can be seen as caucasian, but they form various ethnic groups. The same reasoning applies to Asian peoples with ethnic differences that include Vietnamese, Chinese, Korean, and Cambodian peoples. Cornell and Hartmann (2007) reinforce the notion that ethnic groups are self-conscious of their distinct characteristics. Eriksen (2010) defines **ethnicity** as "the relationships between groups whose members consider themselves distinctive" (p. 10). Ethnicity and the values underlying the belonging to an ethnic group may be used to categorize individuals and

groups based on some norms or values that can cause prejudice. This process is called ethnocentrism.

Ethnocentrism refers to the "universal tendency of human beings to think that their ways of thinking, acting, and believing are the only right, proper, and natural ways" (Purnell, 2013, p. 7). Ethnocentrism can lead to cultural impositions, which may create conflicts with clients and nurse colleagues because of different worldviews on health, illness, or nursing. Ethnocentrism not only affects interactions between nurses and clients or groups, but also creates or reinforces inequities in accessing health care. Ethnocentrism may affect health and clinical outcomes because underserved and underprivileged groups may refrain from consulting nurses or other health professionals if they feel these professionals do not respect their ethnocultural beliefs (Sampselle, 2007). Ethnocentrism violates nursing's mandate of advocacy and social justice by bringing prejudices into the professional delivery of care (Boutain, 2016).

Race, Othering, and Racialization

Race remains controversial because it is rooted in colonialism, where differences constructed between European and non-European peoples led to marginalization (Driedger, 2003). From a colonialist perspective, race can be used to assign differences based on skin colour, yet the view of race as a strict biological construct is highly problematic because it paves the way to racism. Cornell and Hartmann (2007) argue that race is a social construct as race relates to meanings attributed to certain biological differences. They state that **race** refers to "a group of human beings socially defined by physical characteristics. Determining which characteristics constitute the race, the selection of markers and, therefore, the construction of the racial category itself, is a choice human beings make" (2007, p. 25).

In other words, race is socially constructed as people select the markers of racial differences based on biological or cultural attributes.

Purnell (2013) argues that "race has social meaning, assigns status, limits or increases opportunities, and influences interactions between patients and clinicians" (p. 8). Racism is a "negative concept, based on the belief that some races are inferior to others" (Driedger, 2003, p. 216). As a biological and social construct, race can be used as a means of social stratification also called **othering**. Canales (2010) argues that othering is both exclusionary and inclusionary. Othering represents a process of racialization (Ahmad & Atkin, 1996). Canales contends that othering "often uses the power within relationships for domination and subordination with the potential consequences being alienation, marginalization, decreased opportunities, internalized oppression, and exclusion. Othering correlates with the 'visibility' (e.g., skin color, presence of an accent, sexual orientation) of one's otherness" (2010, p. 5). It is hard to reflect on one's racial

biases, but it is a necessary step toward developing and implementing cultural competency and safety.

Our discussion of race and ethnicity underlines that "cultures and cultural differences are not discovered, they are constructed" (Allen, 1999, p. 230). If stereotypes are socially constructed, it is safe to argue that cultural competency and safety are processes by which nurses will *deconstruct* race and ethnicity to avoid applying racial and cultural stereotypes in their interactions with individuals and groups from different racial and ethnocultural groups. Nurses have an ethical duty to respect other persons' and groups' cultural beliefs related to health and illness. This respect intersects with culture and cultural competency to help us move beyond the boundaries of race and ethnicity and to treat individuals who are culturally different from us in a humanistic and caring way (Andrews & Boyle, 2012).

Andrews and Boyle (2012) mention that transcultural nursing enables the development of a "scientific and a humanistic body of knowledge to provide culture-specific and culture-universal nursing care" (p. 4). To provide culture-specific and culture-universal nursing care, nurses have to strive to know those who come from different ethnocultural backgrounds. Nurses must endeavour to become culturally competent and culturally safe in their interactions not only with clients, but also with other nurses and health care providers.

2.3 CULTURAL COMPETENCY

Description

Cultural competency is a concept that arises from the seminal work of Madeleine Leininger, who was trained as a nurse and an anthropologist. Leininger first saw the importance of culture in nursing care delivery. Leininger's theory of cultural care diversity and universality (1995) is based on the fundamental assumption that culture affects people's health and illness experiences as well as nursing care delivery. Leininger (1995) postulates that "culture is an integral and essential aspect of being human, and the culture care aspects cannot be overlooked or neglected" (p. 4). Culture represents "the learned, shared, and transmitted knowledge of values, beliefs, norms, and lifeways of a particular group that guides an individual or group in their thinking, decisions, and actions in patterned ways" (Leininger, 1995, p. 60). Religion, gender, and socialization influence cultural patterns and create a diversity of needs when applied to nursing and health care. Nurses need to possess cultural competency when navigating culturally diverse clienteles and multicultural workplaces.

Cultural competency is both an individual and an organizational process (Andrews & Boyle, 2012). Purnell (2013) defines cultural competence in health care as "having the knowledge, abilities, and skills to deliver care congruent with the patient's cultural beliefs and practices" (p. 7). Jeffreys (2010) refers to cultural competence as "a multidimensional learning process that integrates transcultural nursing skills in all three dimensions (cognitive, practical, and affective), involves transcultural self-efficacy (confidence), and aims to achieve culturally competent nursing care" (p. 36). Campinha-Bacote (2002) defines cultural competency as an "ongoing process in which the health care provider continuously strives to achieve the ability to effectively work within the cultural context of the client [individual, family, community]" (p. 181). Campinha-Bacote's *Process of Cultural Competency and Model of Care* (2002) builds on the assumption that cultural competency is an ongoing process of being and becoming. Campinha-Bacote (2002) points out that to be effective, this model "requires health care providers to see themselves as becoming culturally competent rather than already being culturally competent" (p. 181). This ongoing process means that nurses are immersed in a continual process of education where there is no end point to learning about cultural differences.

In her article, Bourque Bearskin (2011) points out that "culture is everything about people: the way they live, the way they view things, the way they communicate" (p. 4). It is through encounters with peoples from different ethnocultural backgrounds that nurses start their journey of becoming culturally competent. Cultural competency cannot happen if there is no exposure to cultural diversity. Similarly, Campinha-Bacote underlines that encountering cultural diversity is a prerequisite or an antecedent for the development of cultural competency. In her model, Campinha-Bacote describes five interrelated concepts: (1) cultural awareness, (2) cultural knowledge, (3) cultural skill, (4) cultural encounters, and (5) cultural desire.

Cultural Assessment

Cultural awareness involves assessing one's cultural and racial biases as a means to identify how one's cultural stereotypes may affect the delivery of nursing care to cultural or linguistic minority groups. **Cultural knowledge** refers to knowledge about cultural groups and how their cultural beliefs and norms may impact on perceptions and experiences of health and illness, and influence access to health care and relationships with nurses and other health care professionals. It is important to know how ethnicity and race may affect pharmacotherapeutics or how culture shapes lifestyle and other health-related behaviours.

Campinha-Bacote (2002) argues that the acknowledgement of culture implies that nurses must develop knowledge and **cultural skills** to conduct a cultural assessment of each client. A **cultural assessment** is defined as "a systematic appraisal or examination of individuals, groups, and com-

munities as to their cultural beliefs, values, and practices to determine explicit needs and intervention practices" within the context of the health encounters (Leininger, 1995, p. 122). Other theories can be used to conduct cultural assessments using Giger and Davidhizar's *Transcultural Assessment Model* (2002), Leininger's *Cultural Care Diversity and Universality Theory* (2002), Purnell's *Model for Cultural Competence* (2013), or Spector's *Model of Cultural Diversity in Health and Illness* (2009). For instance, Giger and Davidhizar's *Transcultural Assessment Model* (2002) explores six cultural phenomena, believed to be culturally unique among persons, that become the object of cultural assessment. These variables are: (1) communication, (2) space, (3) social organization, (4) time, (5) environmental control, and (6) biological variations (Giger & Davidhizar, 2002, p. 185). Similarly, Purnell's *Model for Cultural Competence* (2013) assesses 12 domains of culture. The domains of culture are:

> 1) overview, inhabited localities, and topography, 2) communication, 3) family roles and organization, 4) workforce issues, 5) biocultural ecology, 6) high-risk behaviours, 7) nutrition, 8) pregnancy and childbearing practices, 9) death rituals, 10) spirituality, 11) health care practiced, and 12) health care provider. (Purnell, 2013, p. 18)

Cultural encounters focus on cross-cultural interactions. Cross-cultural interactions enable nurses to engage with culturally diverse clients or groups to change or challenge ethnic and racial biases. Communication and language are important factors to facilitate access to clients' lived experiences of health and illness. In cases of a lack of linguistic fluency, nurses may use interpreters or cultural brokers to access clients' knowledge of their illness or conditions.

Cultural skill represents the ability to perform the cultural assessment when meeting with clients or families. **Cultural desire** refers to the motivation and the genuine desire for cultural understanding, as opposed to the obligation of encountering cultural diversity. Campinha-Bacote suggests that caring is an antecedent of cultural desire in the fact that the nurse cares about those from different cultures. Cultural desire can be manifested through openness to cultural diversity and a willingness to learn from others. Campinha-Bacote explains that becoming culturally competent is an interactive and transformational endeavour.

Professional Nursing Guidelines for Culturally Competent Care

The delivery of culturally competent care is embodied in standards and codes of ethics set by international, national, and provincial nursing regulatory bodies, including the Canadian Nurses Association. The International Council of Nurses (2012) mentions that "in providing care, the nurse promotes an environment in which the human rights, values, customs and spiritual beliefs

of the individual, family, and community are respected" (p. 2). The Canadian Nurses Association supports the view of social justice that is inherent to the delivery of culturally competent nursing care. The Canadian Nurses Association (2010) defines cultural competency as "a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals and enable them to work effectively in cross-cultural situations" (p. 1). In a document entitled "Cultural Competence and Cultural Safety in Nursing Education: A Framework for First Nations, Inuit and Métis Nursing," the Aboriginal Nurses Association of Canada (now the Canadian Indigenous Nurses Association), the Canadian Association of Schools of Nursing, and the Canadian Nurses Association stipulate that Canadian nurses must know the impact of colonialism on Indigenous health issues to avoid the pitfalls of ethnocentrism and cultural imposition. Nurses need to learn how to communicate and respect Indigenous ways of knowing. While cultural competency encompasses attributes like cultural awareness, sensitivity, and humility, the ultimate goal of developing and applying core cultural competencies is to advocate and protect the dignity of individuals and groups (Douglas et al., 2014).

Similarly, in the United States, the Office of Minority Health (OMH), part of the US Department of Health and Human Services, requires that US citizens have access to "culturally and linguistically appropriate services, are respectful of and responsive to the health beliefs, practices and needs of multicultural and diverse patients" (OMH, 2017). Cultural competency is therefore not only a nurse's individual and ethical duty, but also an organization's responsibility—a responsibility to enable and facilitate the establishment of rules and policies that will promote cultural competency within work relations in nursing workplaces.

Finally, the Saskatchewan Registered Nurses' Association (SRNA) stipulates that the development of cultural safety is a core competency that must be addressed in nursing curricula. Cultural competency is reflected in Standard II.2 (44): "Negotiates priorities of care and desired outcomes with clients while demonstrating an awareness of cultural safety and the influence of existing positional power relationships" (SRNA, 2013, p. 13). We now examine the characteristics of culturally competent organizations.

2.4 CULTURAL COMPETENCY WITHIN ORGANIZATIONS

Canada's increased cultural diversity requires organizations to adapt their services to the demographic mosaic of our country. The delivery of culturally competent care cannot be effective without the implementation of culturally competent nursing values within health care organizations. Although social determinants of health affect people differently, health organizations must strive to adapt nursing and health care delivery to meet the needs of a culturally diverse pop-

ulation. Knowing that inequities affect health outcomes, both nurses and health organizations should strive to provide quality care that will take into account cultural diversity.

In the United States, issues of cultural competency among organizations represent a priority for the Office of Minority Health. The Office of Minority Health has contributed to the development of national standards for culturally and linguistically appropriate services (CLAS) in health and health care. There are 15 national CLAS standards directed at improving the quality of health care and advancing health equity within health organizations. The three main principles undergirding the standards are: (1) governance, leadership, and workforce, (2) communication and language assistance, and (3) engagement in continuous improvement and accountability.

Andrews and Boyle (2012) believe that organizational cultural competence involves characteristics shared within an organization. They assert that organizations must have principles and policies that will sustain nurses and other health care professionals to work effectively in diversity contexts. According to Andrews and Boyle (2012), these organizations will "value diversity, conduct self-assessment, manage dynamics of differences, acquire and institutionalize cultural knowledge, and adapt to diversity within hiring and staffing processes" (p. 18). While Douglas et al. (2014) state that a one-size-fits-all approach to cultural competency within an organization does not apply to all health settings and cultural groups, some general principles or guidelines may demonstrate organizational openness to cultural diversity. Douglas et al. (2012) define ten guidelines that support cultural competency at the instructional level: (1) knowledge of cultures, (2) education and training in culturally competent care, (3) critical reflection, (4) cross-cultural communication, (5) culturally competent practice, (6) cultural competence in health care systems and organizations, (7) patient advocacy and empowerment, (8) multicultural workforce, (9) cross-cultural leadership, and (10) evidence-based practice and research.

Although we refer you to the article by Douglas et al. (2014) for further details, the guidelines delineate the critical role played by nurse managers and administrators in creating a positive and open environment for managing cultural diversity. Also, health care organizations must provide the tools and context for nurse leaders to support cultural competency. Andrews and Boyle (2012) underscore the need for training and education in cross-cultural communication, as well as access to linguistically adapted tools and to interpreters who can also act as cultural brokers, enabling the understanding of behaviours, attitudes, and norms about experiences of health and illness. Cultural competency also implies that organizations will be mindful of cultural diversity within their organizations. The ongoing issue of nurse migration illustrates the need for health agencies to develop strategies to address cultural conflicts and support internationally educated nurses in their adaption to a new working environment (Douglas et al., 2014).

In summary, cultural competency is a core competency required from all nurses. Providing culturally competent nursing care is an ethical and respectful way to acknowledge that one's clients, families, and communities see health and illness in ways that may differ from oneself. Cultural competency does not require nurses to know every detail about peoples' ethnocultural backgrounds. Cultural competency is about demonstrating attitudes of openness and flexibility to enter into a meaningful dialogue with clients or families (Bourque Bearskin, 2011; Woods, 2010). Respect and ethical practice are the hallmarks of cultural competency. Cultural competence is closely aligned with the concept of caring (Leininger, 1995). Caring always involves the respect of cultural differences and cultural diversity (Racine, 2014). To achieve cultural competency, nurses must also be mindful of power relations. As such, nurses must examine their own cultural values and the attitudes they bring to their nursing practice with diverse ethnocultural groups.

2.5 CULTURAL SAFETY

Despite the remarkable growth in the literature in nursing on cultural competency, the delivery of culturally safe nursing care remains to be achieved (Racine, 2014). Cultural safety is a concept that originated from the pioneering work of Irihapeti Ramsden, a Maori nurse who described the persistent inequities affecting the Indigenous peoples of New Zealand (Nursing Council of New Zealand, 2011). Although cultural safety is a relatively new concept, it is critical to the understanding of the persistence of health inequities among Indigenous and minority populations in Canada. The continued existence of health inequities explains why cultural competency alone cannot address systemic and institutional barriers that affect health and health outcomes (Racine, 2014). Cultural competency helps us to understand other cultural norms and behaviours, but tends to overlook systemic barriers or those created by unequal access to the social determinants of health. The reason is that at the centre of race relations lies the concept of power, and race relations cannot be dissociated from issues of power that affect racial, gender, ethnic, and language discrimination (Racine, 2014). Cultural safety requires nurses to be aware of power relations in their interactions with clients or colleagues at work.

Cultural safety is defined as "nursing or midwifery action to protect from danger and/or reduce risk to patient/client/community from hazards to health and well-being" (Papps & Ramsden, 1996, p. 493). Contrary to cultural safety, transcultural nursing does not require nurses to examine their own cultural attitudes and behaviours and the impact these ethnocentric attitudes may have on patients (Ramsden, 1993). In cultural safety, the nurse becomes the centre of reflection whereas cultural competence focuses on knowing the ethnocultural backgrounds of clients, families, or communities. Cultural safety shifts the critical lens to the nurse, and the client judges the quality of culturally safe nursing care. As such, any nursing intervention that does not account for power relations may jeopardize individuals' and groups' health and integrity,

and therefore can be seen as culturally unsafe. The presence of power relations within the nurse–client professional encounter requires nurses to reflect on their biases and racial or ethnic privileges when caring for culturally diverse individuals and groups. In other words, being culturally competent is not enough to provide nursing care that will be responsive to the health care beliefs and practices of diverse and vulnerable clienteles (Andrews & Boyle, 2012). Cultural safety theorists urge nurses to become cognizant of the location of health problems within historical and social processes. Cultural safety is about building trust to make clients, families, and communities feel accepted and welcomed in the health care system. Browne and Fiske (2001) underline that culturally unsafe practices jeopardize clients' access to health care because of nurses' and other health care providers' negative stereotypes about cultural differences. Cultural safety represents a powerful analytic lens to explore issues of power and how power affects nursing care and delivery (Smye & Browne, 2002).

Cultural safety is about power relations and more specifically about the impact of colonialism and post-colonialism in creating health inequities among marginalized groups (Racine, 2008). As well, Bourque Bearskin reminds nurses that their responsibilities "for cultural safety must include paying attention to the disparities in health care" (2011, p. 6). Within the twenty-first–century context of globalization, nurse migration and the massive displacements of refugees from developing to developed countries compels Western nurses to apply both cultural competency and cultural safety in professional encounters with non-Western clients and families. This ever-changing context of cultural diversity requires that nurse managers become aware of their central role in creating opportunities for training and advocating for the professional, cultural, and social integration of non-Western nurses in nursing workplaces. Although many efforts to achieve culturally competent and safe managing practices have been defined (see, for example, American Organization of Nurse Executives, 2015; Canadian Indigenous Nurses of Canada, 2009; Canadian Nurses Association, 2010; International Council of Nurses, 2012; Nursing Council of New Zealand, 2011), much action still needs to be taken as health inequities persist and internationally educated nurses still face challenges within Western health care systems (Mortell, 2013).

Research Note

Dauvrin, M., & Lorant, V. (2015). Leadership and cultural competence of healthcare professionals: A social network analysis. *Nursing Research*, 64(3), 200-210.

Purpose

The purpose of this study was to describe the cultural competence of leaders and the health care staff, and to determine the association between leader cultural competence and staff cultural competence using a social network analysis.The first research question hypothesized that health care staff would likely be more culturally competent if their leaders were culturally competent. The second research question hypothesized that the leadership effect would depend on the characteristics of the leader, including the leader's expertise in cultural competence.

Discussion

Three geographical zones reflecting non-resident populations were selected in Belgium. The final sample consisted of 24 health services: five outpatient primary care services and 19 inpatient services recruited from four hospitals. The 19 inpatient health services included four geriatric units, four intensive care units, four oncology units, three psychiatry units, two communicable disease units, one palliative care unit, and one endocrinology unit. Participants included leaders (n=71) and health care professionals (n=436). The Cultural Competence Scale was adapted to the Belgian context for all health care providers. The scale consisted of five different culturally competent domains: (1) paradigm (ability to adapt to a different type of care), (2) communication (ability to provide information to patients in clear language), (3) specificity (ability to provide specific care for specific groups), (4) organization (ability of the organization to adapt to the needs of the patients), and (5) mediation (ability to negotiate with patients).

The cultural competence of the health care staff was associated with the leader's cultural competence. This was especially significant in the cultural domains of mediation and paradigm, suggesting workplaces that encourage and role model different ways of providing care and that teach staff how to mediate cultural differences are better equipped to provide quality care to various migrant populations.

Application to practice

International migration is a global phenomenon challenging leaders and health care providers in the provision of culturally competent care. Leaders with formal positions have a greater positive impact on the diffusion of cultural competence among health care staff. Strategies such as role modelling may help to convey the value of empathy, respectful attitudes toward individuals of all cultures, and professionalism. Social relationships and leadership effects within health services should be considered when developing and implementing culturally competent strategies. Further research from a Canadian perspective is warranted.

2.6 THEORIES AND MODELS OF CULTURAL COMPETENCY

There are a number of conceptual models and theories that exist to guide the application of cultural competency in nursing education. One of the major critiques is that these theories or models of cultural competency remain patient or client-oriented rather than focused on organizations.

The lack of utilization of nursing cultural theories to guide research about organizational cultural competency may be associated with the fact that competency has been studied from an individual point of view rather than from an organizational perspective. It also means that nursing remains culturally homogenous. A substantial body of knowledge on internationally educated nurses has been developed over the years, but less research has been done on issues of managing cultural diversity in nursing management. In the context of mass migration and globalization, nurse leaders may need to review Leininger's cultural care diversity and universality theory in applying best managerial practices to integrate migrant nurses and other forms of diversity (generational, demographic) (McFarland & Wehbe-Alamah, 2017).

The purpose of Leininger's theory on cultural care diversity and universality is to "discover, document, know, and explain the interdependence of care and culture phenomena with differences and similarities between and among cultures" (McFarland & Wehbe-Alamah, 2017, p. 5). While care, caring, and culture represent central concepts of the theory, Leininger found the concepts of emic and etic knowledges, ethno-history, environment, worldview, and professional nursing care as profoundly influenced by culture (McFarland & Wehbe-Alamah, 2017). In using these latter concepts, it becomes possible to apply Leininger's theory to explore organizational cultures. The emic knowledge represents the people's, participants', clients', families', or communities' knowledge, whereas the etic knowledge describes professional (elitist) knowledge. Ethno-history refers to the "facts, events, instances, and experiences of human beings, groups, and institutions that occur over time in particular contexts that help explain past and current lifeways [practices]" (McFarland & Wehbe-Alamah, 2017, p. 15). The environmental context refers to the social, cultural, economic, and technological factors that influence corporations and organizations.

The use of cutting-edge technology influences nurse managers' decisions, as well as their perceptions of complex health care problems. A worldview refers to an individual's perception of issues of everyday life like health, illness, and the delivery of health services; this worldview reveals societal and organizational values. Also, worldviews can be seen as ideologies that influence health care organizations and define missions and strategic planning activities. Leininger's theory can be applied to explore, discover, and understand an organizational culture and how it affects the vision, mission, and delivery of health care services. Leininger's theory is a grand nursing theory, and due to its broad scope, one can more easily shift its focus from individual nurses to a health care organization.

Essential Learning Activity 2.6.1

Review four of the references provided below and select a key takeaway from each to discuss with your classmates.

For more information on diversity, see "Sustaining the Workforce by Embracing Diversity" on the Canadian Nurses Association's website.

For more information on cultural competency, see Dr. Josepha Campinha-Bacote's "Process of Cultural Competence in the Delivery of Healthcare Services."

For more information on cultural competency and cultural safety, see "Cultural Competence and Cultural Safety in Nursing Education. A Framework for First Nations, Inuit and Métis Nursing" (2009) published by the Aboriginal Nurses Association of Canada (now the Canadian Indigenous Nurses Association).

For more information on cultural competency, see the Canadian Nurses Association's "Position Statement on Promoting Cultural Competency in Nursing." (2010)

For more information on cultural competencies, see the Saskatchewan Registered Nurses' Association's "Standards and Foundation Competencies for the Practice of Registered Nurses." (2013)

For more information on cultural safety, see the Nursing Council of New Zealand's "Guidelines for Cultural Safety, the Treaty of Waitangi and Maori Health in Nursing Education and Practice." (2011)

For more information on Dr. Madeleine Leininger's theory of cultural care diversity and universality, visit the website of the Transcultural Nursing Society.

For information on cultural competence, see the website of the US Office of Minority Health.

For more information on competencies, see the American Organization of Nurse Executives' "Nurse Manager Competencies." (2015)

Essential Learning Activity 2.6.2

Divide yourselves into groups of four or five. Choose an ethnocultural group to study and discuss. (Your instructor will circulate a sign-up sheet with a list of groups that are present in your geographic area.) As a group, prepare a 10- to 15-minute presentation for the class (10 minutes for the presentation and 5 minutes for discussion and/or questions). In your presentation, you should:

- provide information about your chosen ethnocultural group;
- identify cultural factors that may influence health care services for individuals that belong to that group; and

- identify culturally sensitive strategies that may have a positive impact on the provision of care.

In your discussions, consider the following: How would an employee from each identified cultural group affect the workplace? When does nursing care become culturally unsafe? Why does cultural safety remain unachieved in nursing?

2.7 GENERATIONAL DIVERSITY

Generational diversity can be found in every health care organization. Each generation has its own set of values, views on authority, attitudes toward work, communication styles, and expectations of their leader and of their workplace (Stanley, 2010). **Generational cohorts** refer to groups of people who share birth years, history, and a collective personality as a result of their defining experiences (Kramer, 2010). Nurse leaders are challenged to embrace and respect a multigenerational staff while simultaneously developing and supporting a highly functioning and cohesive nursing team (Hahn, 2011). Familiarity with the characteristics and core values of each cohort can lead to better understandings of each other's generational personality and enable individuals to work better as a team, increase productivity, and influence retention. **Generational markers** are events that affect members of a generation (Huber, 2014). There is a tendency among generational cohorts to view each other as having character flaws rather than to appreciate their cultural and generational differences (see Table 2.7.1 Generational Cohorts).

Generational Diversity Workforce

Four distinct generational cohorts make up the present nursing workforce: Veterans, Baby Boomers, Generation X, and Generation Y. Generation Z is the most recent generational cohort, yet less is known about them in the context of the workplace. The profiles of each generational cohort, set out below, allow us to understand their values, work ethics, attitudes toward authority, and professional aspirations (Kramer, 2010). Recognizing and respecting differences can promote a work environment that effectively meets the different needs, expectations, and behaviours of each generation, and leads to a cohesive work group.

Veterans (before 1946)

This cohort of nurses is quickly diminishing in the workforce, yet a few individuals remain. Veterans are experienced, loyal, dedicated, and reliable nurses who value consistency; for them change does not occur easily (Hahn, 2011). This generational cohort grew up in political and economic uncertainty with life experiences that include the Great Depression and World War II. Authority figures are to be obeyed and achievement comes from hard work and following the rules. Due to their loyalty, duty, respect for authority, and hard work, this group values command and control leadership styles. Face-to-face or written communication is typically more effective than electronic communication technologies. Evidence of the Veteran generation's work ethic is still apparent in the bureaucracies, policies, and practices of health care organizations today.

Baby Boomers (1946–1963)

The Baby Boomer generation is typically defined as including individuals born between 1946 and 1963 (Duchscher & Cowin, 2004). Baby Boomers were born after World War II and did not face the same harsh expectations to respect authority or to conform (Blythe et al., 2008). Consequently, Baby Boomers grew up in an era characterized by optimism, team orientation, opportunity, and growth (Hart, 2006; Solaja & Ogunola, 2016; Stanley, 2010). This generation's core values include a strong sense of duty, involvement, health and wellness, and a strong work ethic equated with self-worth and fulfillment (Duchscher & Cowin, 2004; Hart, 2006; Solaja & Ogunola, 2016; Stanley, 2010; Weingarten, 2009).

Baby Boomers are considered to be workaholics, driven by material rewards, and critical of those with differing opinions from their own (Blythe et al., 2008; Lavoie-Tremblay et al., 2010; Widger et al., 2007). Many Baby Boomers had secure jobs, material prosperity, and access to education (Stanley, 2010).

Currently, many Baby Boomers in the workforce have leadership roles in health care organizations (Solaja & Ogunola, 2016). However, these leaders are increasingly reaching or surpassing the age of retirement, and subsequently leaving the workforce.

Generation X (1964–1980)

Members of Generation X were born between 1964 and 1980 (Duchscher & Cowin, 2004). Central to Generation X is the focus on work to live. This group grew up in a time where double-income households were becoming more commonplace, divorce rates were on the rise, and family instability was experienced by many (Hart, 2006; Solaja & Ogunola, 2016). This group is dependent and

self-directed (Hahn, 2011). At the same time, technological innovations, such as the introduction of the computer, began to play a transformative role in communications. Members of Generation X value diversity, balance, informality, global thought, the ability to multitask, and independence (Gursoy, Maier, & Chi, 2008; Hart, 2006; Solaja & Ogunola, 2016; Weingarten, 2009).

One of the largest contrasts between Generation X and the Baby Boomer generation is their viewpoints on work: Generation X feel their work is only one part of their identity (Jovic, Wallace, & Lemaire, 2006; Wendover, 2002). A focus on questioning the status quo and questioning authority figures is commonplace, and they recognize job security as a thing of the past (Stanley, 2010). As a cohort they value feedback, and tend to be self-reliant and resourceful individuals who prefer to work alone rather than as part of a team (Hahn, 2011).

Generation Y (1981–2000)

Individuals born between 1981 and 2000 are classified as members of Generation Y or the Millennials (Duchscher & Cowin, 2004). Their lives have been significantly impacted by the availability and accessibility of information and instant communication through the internet and smartphones. Born to older parents who were involved in coaching their children in multiple after school activities, their experiences shaped the values of this generation, which include confidence, civic duty, morality, achievement, and sociability (Calhoun & Strasser, 2005; Duchscher & Cowin, 2004; Hart, 2006; Solaja & Ogunola, 2016). Overall, this group is considered to be quite distinctive compared to preceding generations: they are the youngest and largest group in the workforce; they have a higher level of affluence and education; and their members are more ethnically diverse.

As Generation Y enters the workforce, they bring with them a distinct work ethic. This ethic emphasizes completing work at one's own pace and in one's own style. Consequently, members of Generation Y require upper management to clearly define work expectations and deliverables, provide feedback, communicate resource allocation, and set timelines. This cohort values a flexible work schedule to achieve work–life balance. Like Generation X, Generation Y places higher importance on skill development while job security is less important (Bova & Kroth, 2001; Loughlin & Barling, 2001). Members of Generation Y have been found to be highly productive in their work, especially when they believe in its outcomes and the larger organization's values and goals (Erickson, 2009). They are optimistic and sociable, and they embrace teamwork and diversity (Hahn, 2011; Stanley, 2010).

Generation Z (2000–early 2010s)

There is still some debate as to the exact birth year range of Generation Z; however, it is agreed that this cohort constitutes one of the largest yet to be entering the workforce (Wiedmer, 2015). As the majority of individuals within this generation have not yet entered the workforce, little is known about how they will perform.

Comparison

Overall, among Baby Boomer nurses, job satisfaction is generally high, and pay and promotional opportunities are of low concern (Blythe et al., 2008). This may be because the age of retirement is near, their seniority affords some level of protection during periods of organizational restructuring, and they likely hold full-time positions. Baby Boomers perceive their younger counterparts as less committed to the profession and arrogant (Blythe et al., 2008). Comparatively, Generation X nurses value education and skill development, which is indicative of a divergence from previous generations (Blythe et al., 2008). Among Generation Y nurses, more emphasis is placed on monetary compensation, prestige and recognition, and diverse career opportunities (McNeese-Smith & Crook, 2003). These younger nurses are less critical of their older counterparts and view themselves as self-reliant rather than arrogant (Blythe et al., 2008).

Table 2.7.1 Generational Cohorts ***(Data Source: Table based on material from Clipper, 2012 and Hahn, 2011.)***

Generations	Events	Core Values	Work Values	Work Ethic
Veterans	• The Great Depression • Pearl Harbor • World War II • Age of the Silver Screen	• Hard work • Dedication • Respect for authority • Peace and harmony (i.e., they are uncomfortable with conflict) • Acceptance of delayed reward	• Financial security	• Defined by the clock (time) • Strong work ethic
Baby Boomers	• Civil Rights movement • President Kennedy, Robert Kennedy, & Dr. King assassinations • First lunar landing	• Strong sense of duty • Teamwork • Peace and harmony (i.e., they are uncomfortable with conflict) • Immediate gratification and reward	• Self-fulfillment and meaning	• Visibility • Enjoy face-to-face interaction • Willing to work to get ahead (i.e., overtime)
Generation X	• Resignation of President Nixon • Watergate scandal • AIDS epidemic • Three Mile Island disaster	• Self-direction • Self-reliance • Work and play balance • Diversity • Action rather than words • Individual positive feedback	• Achievement of financial goals without sacrificing personal time	• Get the job done and move on • Strive for work–life balance
Generation Y	• Columbine shootings • Oklahoma City bombing • Gulf War • Global War on Terrorism	• Optimism • Diversity • Ambition • Can-do attitude • Flexibility	• Fun and meaningful work	• Use technology to make work more efficient to free up time • Want meaningful jobs and work–life balance

Essential Learning Activity 2.7.1

You are a new nurse on the neurology unit in a large teaching hospital. You have noticed there are a lot of "older nurses" working on the unit and that the nurse manager is "older" as well. Many of the nurses your age have graduated within the last five years and want to work more effectively with all members of the health care team.

Working in pairs, identify how a Baby Boomer nurse manager can successfully bridge generational divides between the "older nurses" and Generations X and Y. What leadership strategies can the manager use to create a more positive workplace environment?

2.8 MANAGING WORKFORCE DIVERSITY

Nurse leaders play a pivotal role in creating a supportive work environment where cultural and generational differences are valued and individual differences are supported and accommodated. The following are some key recommendations and strategies for nurse leaders in a diverse workforce:

- Set an example through your own behaviour by appreciating diversity in order to create and maintain a supportive work environment. Employees want to feel valued and involved regardless of their age or job title. Demonstrating respect for cultural and generational perspectives is a way to support and foster teamwork (Yukl, 2013). Withholding judgement, emphasizing the positive, and practising good communication techniques creates success.
- Hold all staff to the same employment expectations and organizational goals related to valuing workplace diversity. In doing so, you set ground rules for each individual's professional conduct and professional practice.
- Seek to learn more about diversity and educate your staff about cultural and generational differences with respect to attitudes, behaviours, and values while simultaneously fostering a cohesive work group (Yukl, 2013).
- Match the diverse needs of workers with diverse patient needs. Embracing commonalities and maximizing diversity through individual talents is critical to lead positive change in the work environment. In turn, success with culturally diverse patients and families can foster the recruitment of a diverse workforce. The synergy of diverse viewpoints can improve nursing's knowledge base and care strategies.
- Use a flexible, open, and approachable leadership style sensitive to creating equal opportunities and eliminating discrimination while acknowledging differences. Although this approach takes considerable effort and energy, it is vital for creating a supportive work

environment.

- Be flexible in accommodating a variety of communication styles that align with cultural and generational preferences.
- Explain benefits of workplace of diversity (Yukl, 2013). An open forum with staff that engages new and different ways of thinking and approaches to problem solving and conflict resolution can improve care practices.
- Recognize that differences can be a source of stress and conflict (Hahn, 2011). The differences among the generations can have a direct impact on how problems, assessments, and intervention strategies are determined (Huber, 2014). Consider issues of communication style, interpersonal space, time sense, and other variations in beliefs and behaviours in order to promote effective teamwork.
- Create workplace autonomy and promote professional growth by coaching and mentoring staff in various stages of career development. Doing so can influence workplace culture and practices to enhance job satisfaction and retention. Providing opportunities for leader development, advancement of clinical skills, and participation in committee work can improve communication skills, motivational efforts, and problem solving. For example, supporting a staff member's participation on a unit or hospital committee may increase group cohesion, innovation, and autonomy in the workplace (Kramer, 2010).

SUMMARY

Understanding the motivations, perspectives, and drivers of each generation can facilitate the nurse leader's ability to better understand generational differences. As global immigration continues to impact Canada, there is a greater need to understand cultural differences and minimize conflict that is detrimental to building effective teams.

Capitalizing on the best each individual has to offer can create a powerful network of nurses and maximize their contributions to working collaboratively in providing safe, quality patient care. Over the next ten years, we will see a large number of Baby Boomers retire and Generations X and Y will continue to actively engage in the workforce and assume leadership roles. Our collective understandings of workplace diversity can leverage staff cooperation and collaboration in a high-intensity health care workplace.

After completing this chapter, you should now be able to:

1. Describe the concepts of culture, cultural competence, and cultural safety in leading and managing

nursing.
2. Discuss cultural diversity and the ways in which people differ.
3. Apply theoretical models that facilitate culturally competent patient care.
4. Describe the generational differences among Veterans, Baby Boomers, Generation X, and Generation Y.
5. Identify and describe the issues of workplace diversity in health care organizations for nursing staff, nursing leaders, and patients and families.
6. Describe how the nurse leader can manage workplace diversity.

Exercises

1. Why is understanding cultural and generational differences important in clinical practice?
2. What can nurse leaders do to manage diversity in health care organizations?
3. How can a registered nurse be an effective follower in supporting diversity in the workplace?
4. Define cultural safety and cultural competency.
5. Differentiate cultural safety from cultural competence.

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3. Working with Indigenous Leadership and Indigenous Environments

ANTHONY DE PADUA AND NORMA RABBITSKIN

> *Leadership is about being grounded by our principles rooted in the values and practices of our culture.*
>
> —Norma Rabbitskin, 2017

INTRODUCTION

Being an effective leader involves developing skills, knowledge, and attitudes that foster good working relationships with Indigenous communities, leaders, and individuals. Nichols (2004) points out that nursing schools prepare people to become nurse leaders, but do not prepare people to become leaders "in the Indian way" (p. 177). Other researchers (Julien, Wright, & Zinni, 2010) recognize that current leadership theories often reflect cultural ideas of Western societies and do not take into account Indigenous worldviews. This chapter presents selected Indigenous worldviews and challenges students to compare their own understandings of Indigenous culture with those presented in the chapter. In addition, recommendations and examples are provided on how leaders can negotiate and make sense of the different cultural worlds they work with and dwell in. While this chapter discusses Indigenous perspectives, it is important to recognize that Indigenous cultures in Canada are extremely diverse, not only from one treaty territory to the next, but also among neighbouring communities. However, there are still common norms that apply to many Indigenous communities. In this chapter, the authors will share selected stories and their knowledge of nursing leadership with the intention of providing students with a better understanding of how to work in their roles as nurse leaders alongside Indigenous leadership.

Learning Objectives

1. Identify the differences between your own worldviews and Indigenous worldviews.

2. Critique how different worldviews affect leadership decisions.
3. Recognize Indigenous leadership structures within Indigenous communities.
4. Determine the advantages of working with Indigenous community members.

3.1 A GLANCE AT THE LITERATURE

There are a number of differences between Indigenous and other types of leadership styles. One such example is the use of traditional imagery and storytelling (Julien et al., 2010; Nichols, 2004). Lessons are taught through stories and also have a connection with the land and Indigenous identity (Nichols, 2004; Wolfgramm, Spiller, & Voyageur, 2016).

From the Field

Consider the importance of being open to different styles of learning and listening to other perspectives.

As a non-Indigenous person, I remember the first time I spoke with an Indigenous Elder about his perspectives on individuals and a particular issue I felt was important in the correctional setting. The Elder asked me to sit with him and drink some tea as we talked. Initially I thought I was going to interview this person, but instead it was a conversation with a humble and experienced man who had decades of experience under his belt. His unassuming nature made me feel at ease and the way he spoke and addressed me made me acknowledge how much more I needed to learn. As I asked him questions, he would share stories with me that made me realize that I needed to look at the questions I was asking in a different way.

—Anthony de Padua, RN, PhD

Nichols (2004) conducted focus groups with Native American nurse leaders and found that the point of reference for the Indigenous nurse leaders were the individuals they worked with: their families and tribal communities. The Indigenous nurse leaders were tied closely to their communities and their view of leadership was about leading the organization and community as a whole.

Felicity (1999) and Nichols (2004) also reinforced the holistic view of Indigenous leadership and leaders' concerns for the community. Julien and colleagues (2010) took this notion of holistic

leadership a step further by describing spirituality as a central element of Indigenous leaders' practices and beliefs:

> One respondent noted that, while his non-Aboriginal colleagues had a tendency to focus on processes and were greatly motivated by outcomes that were purely profit-driven, he felt his work was a spiritual endeavor. He expressed that "the work we do—it's not about education, it's not about research—it's about spirituality; the other things are just part of the whole process." (p. 119–120)

Julien and colleagues (2010) also described time elements that Indigenous leaders value. The knowledge that departed Elders had shared needed to be considered, built upon, and valued. It was also important to consider the impact that resolutions would make on future generations (i.e., seven generations into the future).

Nurse leaders need to consider the population being served, as explained by nursing theorist Madeleine Leininger. Her transcultural nursing theory encompasses "the concept of cultural competence, that is, the nurse's ability to incorporate considerations of an individual's cultural background into nursing practice [and leadership]" (Johnson & Webber, 2015, p. 207).

3.2 LIVING WITHIN THE COMMUNITY: GAINING AN UNDERSTANDING OF INDIGENOUS WORLDVIEW AND LEADERSHIP STRUCTURES

Section 3.2 "Living within the Community," as told by Norma Rabbitskin of Big River First Nation, is based on Traditional Knowledge. Norma is a Knowledge Keeper of the ways of the Big River First Nation. This Traditional Knowledge IS NOT licensed under Creative Commons Attribution 4.0 International License (CC BY). Please respect the Protocol of Indigenous Traditional Knowledge translation and contact Norma Rabbitskin at the Sturgeon Lake Health Centre if you wish to use this content further.

Entering into a healing profession came naturally for Norma Rabbitskin. She is a fluent Cree speaker from Big River First Nation. Norma's work experience includes over 29 years as an RN, with the majority of her career within First Nations communities. In the following section of this chapter, she passes on her various nursing knowledge and the teachings instilled by her family, ceremonialists, knowledge keepers, and various leaders. Norma shares her experience working within First Nations communities and the essential leadership skills required to oversee a nursing program.

First and foremost, as First Nations people we acknowledge the Creator and the principles of creation. We uphold natural law, our ways of being, and how to live in harmony on *askîy pimâtisiwin* (Earth Life). Knowledge is transferred to each generation through the oral tradition and is renewed in ceremony starting with the creation story. Culture is a way of life; this maintains and preserves the sacredness of life and teaches us how to live in harmony within the Circle of Life and with all relations on this Earth. *Keytayak* (old ones) role modelled a gentle integrative process where every individual envisions their full capacity and well-being to achieve their potential.

Holistic Model of Leadership Using the Circle of Life Teachings

As nurse leaders, we need to look at ways to be effective in empowering our clients and families and we need to understand what healthiness looks like for a First Nations community. We do this by taking part in experiential learning regarding Indigenous culture and worldview.

Circle of Life Teachings

Our Elders tell us that the human maturational and learning process is not linear, but rather that life is a circle, reminding us that wherever we go and whatever we experience, the self is still present, bringing us home to ourselves, families, and community with all that we have become during our learning process. Teachings of natural laws create a foundation for healing and understanding the interconnectedness of our Indigenous development (mentally, emotionally, physically, and spiritually) and our human relations (family, community). The Circle of Life teachings represent a way of life that promotes health and wellness. This approach reflects a holistic and earth-centred philosophy of life and healing that is not often found in Western approaches to health. Elders say that the Circle of Life teaches us about interconnectedness: when you do your own healing as an individual, you help your family heal. When families begin to change or heal, then communities also change. As our communities come into wellness, our people will heal. When planning or developing programs, we need to consider everyone, as in the holistic view: the individual, family, and community.

Individual

Our Elders teach that all aspects of a person—the physical, the mental, the emotional, and the spiritual—must be addressed, and in balance, in order to promote holistic health and healing. Good health implies an optimum state of well-being in all four areas. Well-being flows from maintaining balance and harmony between all of these areas and with nature. A holistic approach

to health also takes into account the importance of culture, language, and tradition. Elders are sought for emotional guidance.

Mental health refers to our thinking and thoughts including knowledge, education, reading, and learning about chronic disease. Individuals learn to practise self-discipline, make healthy decisions, problem solve, and create change. Optimal mental health results in healthy choices.

Emotional health refers to identification and acceptance of feelings—fear, anger, confusion, sadness, depression, loneliness, worry, and anxiety. Learning to express feelings appropriately with effective coping skills that help maintain balance leads to a sense of well-being during times of adversity. Optimal emotional health results in improved self-esteem, self-awareness, positivity, trust, honesty, and hope.

Physical health refers to caring for the body: eating a healthy, balanced diet, controlling one's weight, exercising and moving daily, and resting. Individuals learn to develop healthy routines and avoid destructive habits such as tobacco misuse, drug use, and alcohol abuse. Self-care is achieved as individuals learn to take responsibility for their health, to be good and kind, and to love and respect themselves.

Spiritual health refers to seeking harmony with a higher power and finding purpose in life. By adopting values, individuals can then choose activities and behaviours that are consistent with them. Individuals seek Elders for spiritual guidance and participate in sharing circles, healing circles, and talking circles. Optimal spiritual health is reflected in a life of prayer, faith, belief, hope, love, acceptance, forgiveness, and respect.

Health professionals today are actively engaged in identifying the attributes of health or wellness as defined by the people they serve. To be effective in empowering our clients, we as nurses need to understand what healthiness looks like for a First Nations community. One needs to be mindful of the population being served and the cultural healing practices being used. Historically, Indigenous communities have followed a holistic model that dictates a way of responding to ailments. For example, there are different health outcomes for clients:

- when using a wellness focus versus an illness focus;
- when working with a family versus an individual; or
- when taking a long-term versus an episodic perspective.

Family

Our greatest gift is our family. Elders teach us that the Creator gives us our kinship system, which is the place where all teachings are handed down from grandparents to parents and to children. Knowing this, each person in the family is responsible for maintaining the health and well-being of each other. In your role as a nurse, it is important to build a nurse–client and a nurse–family relationship, which become central to quality client and family holistic care. This relationship facilitates a positive experience built on communication and understanding of physical, emotional, mental, and spiritual needs, while also respecting client and family rights to make their own decisions. As nurses, we are facilitators for change who assist them in attaining their vision for health and well-being.

Working in Indigenous communities requires nurses to use critical thinking and nursing assessment skills. Integration of effective tools, such as the Family Assessment and Intervention Model, which builds "on the family's strengths by helping the family identify its problem solving strategies" (Kaakinen et al., 2014, p. 92.), is essential. Use of this tool requires the nurse to develop knowledge about both the client and their family through completion of a family genogram (family tree). This is individualized care and demonstrates respect for the client and family.

Strong communication and interpersonal skills are critical aspects of quality nursing care in an Indigenous community. If nurses do not have these skills, they will contribute negatively to the already stressed situation of Indigenous clients and families. Another effective tool for Indigenous clients and families is the Family Systems Stressor–Strength Inventory. This is an assessment tool that guides "nurses working with families who are undergoing stressful health events . . . to build on the strengths of the family" (Kaakinen et al., 2014, p. 93).

As nurses, we need to develop interventions that lead to holistic care for our clients and their families based on a good assessment. Care of the individual is built upon a respectful and therapeutic relationship between the nurse and the individual and family. It is only by using critical reflection to examine our values and beliefs and our knowledge of family nursing that we can facilitate a shift in attitudes and develop a trusting therapeutic relationship with our clients and their families. To build a strong rapport we need to take the time to listen and schedule home visits, make telephone calls, and keep the family engaged. An essential component of clinic and community assessments includes inquiring about health concerns and asking clients how we can help them meet their goals.

Community

> First Nations have accessed broader views of healthiness using cultural lenses and holistic paradigms that pay attention to the interconnecting modes of mind, body, and spirit. With such an inclusive perspective, the culture of beliefs, customs, and practices as foundations of Indigenous society in which the people are immersed, open up as sites for integrated and responsive services for people in community-based settings. Some ways of culture, as an example, such as valuing land as a site for health, relationship building, and developing strong focused minds through Indigenous ways of knowing are acknowledged as factors in building strong people, or as localized health determinants that are real. Assessing the state of health and well-being in communities would necessarily involve examining the community ethos that embodies the beliefs, values, and practices deemed essential for community vitality. (Willie Ermine, Indigenous Knowledge Keeper, personal communication, April 2017)

As a grandmother, and as one who has chosen a profession in nursing leadership, I appreciate how leadership decisions are made within an Indigenous community. A community foundation is shaped by the guidance provided by community knowledge keepers, healers, ceremonialists, leaders, and Elders. Through their examples I came to appreciate the full spectrum of service leadership. These pipe carriers, ceremonialists who dedicated their lives to maintaining medicine and cultural ways, assisted me in stepping seamlessly into a nurse leadership role. As well, my decision-making processes arose out of my Cree upbringing and this lived experience, and they are based on inclusivity, with full recognition that all life forms are sacred.

Within my worldview, decisions are made with the spirit of reciprocity, which is the backbone of my *nehiyaw* (Cree) worldview. In the spirit of reciprocity, we give before we take, and it is the true partnership of sharing of space and resources, of how we interact. I acknowledge the humanness of all people, that we are never perfect. I believe our ceremonies and traditional practices are the foundation supporting people to live out their responsibilities and to help others.

Fulfilling a nursing leadership role within Indigenous communities requires one to be aware of the co-existing leadership systems. The elected leadership, who adhere to terms of office set out by different levels of government, must answer to the people. I work in a First Nations community, located within Treaty 6 territory. This community has its own sovereign approach and the people control their own health care system. Decisions are voted on by chief and council and presented as Band Council Resolution (BCR), through a highly political process lead by elected members of the reserve. These men and women step into these elected roles because they want

to serve their community by leading its members through a formal organized process. The protocols and ceremonies are in place to inspire individuals to work toward the well-being of the community.

Understanding the Indigenous leadership structures that exist within our diverse Indigenous communities begins by first creating a process of dialogue that engages in reciprocity, maintaining a balance of mutual coexistence. Respect is central to our lives. Our oral tradition as *nehiyaw* people exemplifies the values of how to live in balance and in harmony within natural law. This is truly land-based leadership. There are two main types of *onikaniwak* (for those who lead) within our Indigenous communities. They are: (1) service leadership, and (2) elected leadership of chief and council. Bear in mind, both types of *onikaniwak* are practised by the Elders and people, but through different approaches.

3.3 HISTORY OF THE HEALTH CARE SYSTEM IN INDIGENOUS COMMUNITIES

In the spirit and intent of treaty negotiations, the Indigenous people negotiated access to both "medicines" and "medical expertise needed to deal with new diseases" included in the Treaty 6 medicine chest clause to supply all that was required to maintain proper health (Office of the Treaty Commissioner, 2000). The federal government is responsible for supplying and maintaining health services for First Nations. Since the time of the treaties, these "medicines" have included Indian hospitals, medicine, doctors, examinations and treatment of the sick, x-rays, and medical technology.

Historically, relationships between Indigenous people and settler society have been characterized by a number of negative experiences and the two societies developed separately from one another. For the majority of Canadians, health care services are guaranteed by the Canada Health Act and provincial legislation. Indigenous people can access the same services but to differing extents.

In 1989, the National Health and Welfare and Treasury Board of Canada started work toward the transfer of health services for Indigenous communities from the federal to the community level. The transfer of health services is an administrative mechanism that shifts delivery of financial resources from the First Nations and Inuit Health Branch (FNIHB) to Indigenous communities for a select number of health programs. This health transfer supports Indigenous communities in exercising a higher level of governance over their community health care system and lobbying for change as required in the health system.

The goals and objectives of the health transfer policy were:

- to provide Indigenous people opportunities to become actively engaged in planning, administration, and delivery of on-reserve health care services, policy planning, and research;
- to improve health for Indigenous people;
- to ensure Indigenous people have the same quality of seamless care as the rest of Canadians;
- to enable communities to design health programs, establish services, and allocate funds according to community health priorities;
- to strengthen and enhance accountability of leaders to their members; and
- to ensure public health and safety are maintained through adherence to mandatory programs. (National Health and Welfare & Treasury Board of Canada, 1989; Smith & Lavoie, 2008)

The following table describes models of service delivery provided through a contribution agreement with Health Canada under FNIHB.

Table 3.3.1 Models of Health Service Delivery (*Data source: Table based on material from Lavoie et al., 2005.*)

Transferred Community	Integrated Communities	FNIHB–Controlled Community
• Transferred public health programs are delivered at the community level or by Tribal Council. • Financial accountability is the responsibility of the community or Tribal Council. • Five-year funding is provided for programs. • The public health programs are guided by: (1) a transfer implementation framework; (2) a community health plan; and (3) an evaluation plan.	• FNIHB provides non-transferable programs. • FNIHB provides semi-transfer of public health programs. • Communities can hire their own nurses.	• FNIHB delivers non-transferable public health programs to communities. • FNIHB delivers second- and third-level health programs directly to communities. • FNIHB provides policy and specialty health services. • FNIHB allocates nursing staff.

The table above outlines the differences between the health care delivery systems that the communities may choose to adopt based on a community's readiness, needs, and evaluation recommendations. This permits them to meet the changing health trends at the community level.

The community I work under is a fully transferred community, therefore the community delivers the following programs at the community level and some services are delivered by second- or third-level support:

- community health programs (health promotion and prevention)
- Community Primary Care
- communicable disease control and surveillance programs (Northern Intertribal Health Authority, third-level support)
- community immunization programs
- Environmental Public Health Program (Tribal Council, second-level support)
- National Native Alcohol and Drug Abuse Program (NNADAP) and
- Home and Community Care Program (semi-transferred)

Community-based services are delivered in the community by nurses and community health representatives, which includes addiction workers and maternal child care workers. Environmental health services are supplemented by environmental health officers at the second level of organization (Tribal Council) and are supported by the third level of organization (the health region or province).

The transferred community service delivery model is guided by the transfer implementation framework, which outlines how the services are to be delivered and evaluated. Communities follow a strict reporting criterion before funding is released, as outlined in the FNIHB's contribution agreements documents. Provision of health services for the integrated delivery model differs significantly from the transferred community model and was approved in 1994 under separate Treasury Board authorities. An integrated model is understood as a step toward the full transfer model. Communities can select a range of community-based programs under a single contribution agreement that can be up to five years in length. Funding is based on community work plans and the community or Tribal Council must seek permission from FNIHB to make changes. The carry-over of funds is not allowed and any unspent funding must be send back.

FNIHB has a fiduciary responsibility (a legal duty to act for the benefit of the community) and is accountable for the overall health delivery system for people living on a reserve, a First Nations community. The National Treasury Board transfers money to the region to ensure the health needs of every Indigenous person is addressed. Today, FNIHB continues to monitor the quality of service delivery by First Nations communities to ensure adherence to contribution agreements. The type of health funding found in each community depends on the particular facility designation; these include: health office, health station, health centre, health centre with treatment, or nursing station. Each designation is differentiated by the type and scope of services it delivers.

This is an ongoing concern for some communities since it affects the level of funding an organization can access.

From the Field

For me, as an Indigenous nurse leader working in an Indigenous community, it is critical to teach new nurses about the complexity of the service delivery model and to build their awareness of the historical events that form the basis of the present negative stereotypes and racial attitudes about Indigenous people. Many advances have occurred to build positive relationships within the system.

—Norma Rabbitskin, RN, BN

For further information on the history of health and disease patterns of Indigenous peoples in Canada, see *Aboriginal Health in Canada: Historical, Cultural, and Epidemiological Perspectives* (2006) by Waldram, Herring, and Young or learn more on the *Evaluation of the First Nations and Inuit Health Transfer Policy* (2004) by Lavoie et al.

3.4 LEADERSHIP STRUCTURES

Over the years since the health transfer system was introduced, there have been key lessons learned and identified by First Nations and Inuit people who continue today to address the gaps by advocating for equitable, seamless health care that honours treaty rights. First Nations communities work with organizations that support communities in carrying out policy and protect treaty rights. The Federation of Sovereign Indigenous Nations (FSIN) represents 74 First Nations in Saskatchewan, and the Assembly of First Nations (AFN) is the national representative organization of 630 First Nations in Canada. These organizations work with First Nations through their leaders to promote, protect, and implement the treaty promises in areas such as Indigenous and treaty rights, economic development, education, languages and literacy, health, housing, social development, justice, taxation, land claims, and environment, as well as an array of issues that are of common concern. First Nations communities fall under 50 culturally and linguisticly distinct groups dispersed across Canada. There are a number of other political entities that also represent the different First Nations populations at different levels, including local Band Councils, Tribal Councils, and provincial organizations.

The following table sets out the levels of leadership within the First Nations leadership structure and the responsibilities that fall under each level. As a nurse leader, it is important to understand

First Nations leadership structures in order to know who has responsibility for areas that nurses may want to address.

Table 3.4.1 Levels of Leadership within the First Nations Leadership Structure

Responsible for the following to manage, maintain, and provide health care services:	
First and second levels (First level – First Nations community; Second level – Tribal Council or organization of multiple communities)	• Record management (including staff activity records) • Administration system to hire and supervise staff • Professional support • Program design and delivery • Program direction • Program support • Program evaluation • Purchasing of educational materials • Supervision of educators and professionals • Advocacy • Data collection and report preparation • Development of program linkages and coordination to facilitate single source access to social programs for children and families • Capacity building including training, education, community development, peer support, and networking • Community-based research
Third level (Regional or provincial)	• Maintenance of a working relationship with Health Canada, Service Canada, Indigenous and Northern Affairs Canada (INAC), and the Assembly of First Nations (AFN) • Representation on regional, provincial, and national working and advisory groups • Northern regional strategic planning for the North • Data stewardship for partners as mandated • Data collection and coordination with partners • Development of program linkages and coordination to facilitate single source access to programs and services • Capacity building including training, education, community development, peer support, and networking • Program support, such as the distribution of relevant documents and information • Program and clinical expertise • Coordination of training • Program evaluation and monitoring • Research and evaluation

Fourth level (National)	• Facilitation of research • Maintenance of a working relationship among Health Canada, MSB (Medical Services Branch), AFN, the Inuit Tapiriit Kanatami, and INAC • Coordination of National Steering Committee activities and follow-up to their direction • Ongoing communication of information to First Nations on national developments • Development of program standards for training and care • Data analysis and report preparation from a national perspective • National evaluation and accountability activities • Facilitation of the development and implementation of programs

As a nurse leader working with Indigenous leaders and communities, it is important to refer to the First Nations Wholistic Policy and Planning Model (Reading, Kmetic, & Gideon, 2007), which was created to better understand the policy structure, planning, and interventions associated with performance indicators that are realistic for communities. This model attempts to capture the complexity of working with Indigenous communities from an Indigenous perspective. This model has the following key characteristics (p. 30):

- community at its core;
- four components of the Medicine Wheel (spiritual, physical, emotional, and mental);
- four cycles of the lifespan (child, youth, adult, and Elder);
- four key dimensions of First Nations self-government (self-government/jurisdiction, fiscal relationships/accountability, collective and individual rights, and capacity/negotiations);
- social determinants of health; and
- three components of social capital (bonding, bridging, and linkage).

Essential Learning Activity 3.4.1

For more information on the First Nations Wholistic Policy and Planning Model, refer to p. 5 of *First Nations' Wholistic Approach to Indicators*, a document submitted by the Assembly of First Nations (Canada) at the Aboriginal Policy Research Conference held in Ottawa, Ontario, March 22–23, 2006. The report was prepared for the Meeting on Indigenous Peoples and Indicators of Well-Being at the conference.

Once you've reviewed the document provided in the link above, describe how the medicine wheel is related to the full diagram on p. 7 of the *First Nations' Wholistic Approach to Indicators*.

3.5 RECOMMENDATIONS FOR WORKING WITH INDIGENOUS COMMUNITIES

Ethics and Research Guidelines

Indigenous communities and people have a history of being over-studied and "tokenized" when non-Indigenous people engage and elicit their help (Campbell, 2014; First Nations Centre, 2007). This has led research organizations such as the Canadian Institutes of Health Research (CIHR) (2007), Social Sciences and Humanities Research Council (2015), and the First Nations Centre (2007) to develop guidelines for anyone researching Indigenous people. The first set of principles developed by CIHR (2007) provide a collective set of guidelines to "assist researchers and institutions in carrying out ethical and culturally competent research involving Aboriginal people" (p. 259). According to Ramsden et al. (2017), the guidelines state:

> engaging with FN communities is in Chapter 9 of the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* . . . where research projects involving First Nations, Inuit, and Metis peoples and their communities are to have a role in shaping and co-creating all research that affects them. (p. 2)

This certainly respects the autonomy of Indigenous clients, their families, and communities who participate in research opportunities (Campbell, 2014).

The First Nations Centre (2007) developed a set of principles referred to as OCAP (Ownership, Control, Access, and Possession). Ownership challenges the academic notion of intellectual property and describes the community ownership of data. The concept of control challenges the academic notion of control of the research process. The principles that guide community access and possession require that the community has full access to and possession of the research information. In leadership positions, it is important to understand how to apply these principles to work and initiatives involving Indigenous people.

Essential Learning Activity 3.5.1

Read the CIHR *Guidelines for Health Research Involving Aboriginal People* (2007–2010), then answer the following questions:

1. Why was it important for CIHR to develop these guidelines?
2. What is participatory research and why is it important?
3. What does "collaboration" mean to you?

In addition to the guidelines described above, researchers have identified the importance of issues that are raised while working with other cultures (Clandinin & Connelly, 2000; Ermine, 2007). Ermine (2007) discusses the importance of creating a respectful research relationship and asks researchers to consider the **ethical space of engagement**:

> The "ethical space" is formed when two societies, with disparate worldviews, are poised to engage each other. It is the thought about diverse societies and the space in between them that contributes to the development of a framework for dialogue between human communities. The ethical space of engagement proposes a framework as a way of examining the diversity and positioning of Indigenous peoples and Western society in the pursuit of a relevant discussion on Indigenous legal issues and particularly to the fragile intersection of Indigenous law and Canadian legal systems. (p. 193)

He argues that researchers must examine the influence of Western perspectives on their understanding of the world and recognize that their perspectives often provide only one viewpoint. A broader examination of cultural, social, and political factors is important when working with and caring for Indigenous persons. It is essential for researchers to recognize and critique the historical relationships between Indigenous worldviews and Western thought (Barlow, 2009; Ermine, 2007; Patterson, Jackson, & Edwards, 2006).

Research Note

Ramsden, V., Rabbitskin, N., Westfall, J., Felzien, M., Braden, J., & Sand, J. (2017). Is Knowledge translation without patient or community engagement flawed? *Family Practice*, *34*(3), 259-261.

Purpose

The purpose of this article is to begin the discussion on "authentic engagement" in developing manuscripts and presentations that evolve from research that has engaged particularly Indigenous patients, individuals, or communities.

Discussion

In Canada, it is outlined in the *Tri-Council Policy Statement* that First Nations, Inuit, and Métis peoples have a role in shaping and co-creating the research that affects them.

Application to practice

As nurse leaders we need to take heed of research frameworks such as those mentioned above (CIHR, OCAP) and ensure that these principles are adhered to so as to maintain the ethical and meaningful involvement of Indigenous people in Canada in both research and practice.

Truth and Reconciliation Commission of Canada

It is well documented that Indigenous culture and identity has been lost as a direct result of residential schools and institutionalization (Adelson, 2000; Barlow, 2009; Comack, 2008; King, Smith, & Gracey, 2009; Laliberte et al., 2000; Truth and Reconciliation Commission of Canada, 2015). Adelson (2000) argues that if colonialism and neocolonialism created disenfranchisement and attempts to eradicate cultural history, then "reconstitution and reaffirmation of identity" (p. 30) may be what is needed to counteract those acts. The Truth and Reconciliation Commission of Canada (2015) offers a detailed document that provides not only a history of the effects of colonialism in Canada, but also a call for action to address the assimilation attempts on Canadian Indigenous people by churches and governments. The document provides "calls to action" to "redress the legacy of residential schools."

Research Note

Sasakamoose, J., Bellegarde, T., Sutherland, W., Pete, S., & McKay-McNabb, K. (2017). Miýo-pimātisiwin Developing Indigenous Cultural Responsiveness Theory (ICRT): Improving Indigenous Health and Well-Being, *The International Indigenous Policy Journal*, 8(4), 1–16.

Purpose

The purpose of this article is to describe the theoretical development of the Indigenous Cultural Responsiveness Theory (ICRT) to improve Indigenous health and well-being.

Discussion

The article draws upon the document entitled *Cultural Responsiveness Framework* developed by the Federation of Sovereign Indigenous Nations (FSIN) and draws upon the knowledge of Indigenous leaders, knowledge keepers, scholars, and health care practitioners to look at a model that discusses and reinforces the importance of having Indigenous communities, scholars, and individuals involved when addressing any work done with Indigenous people. As a nurse leader it is important to be aware and understand your own perspectives and biases and compare it to those you are engaged with.

Application to practice

The Truth and Reconciliation Commission of Canada calls upon those who can effect change within Canadian systems to recognize the value of Indigenous healing practice and to collaborate with Indigenous healers, Elders, and knowledge keepers where requested by Indigenous Peoples. . . . Decolonizing practices include privileging and engaging in Indigenous philosophies, beliefs, practices, and values that counter colonialism and restore well-being. The ICRT supports the development of collaborative relationships between Indigenous Peoples and non-Indigenous allies who seek to improve the status of First Nations health and wellness. (Sasakamoose et al., 2017)

SUMMARY

Nurse leaders need to learn to work effectively within Indigenous communities and with Indigenous leaders. The first step is to be open and willing to understand Indigenous worldviews. This understanding requires nurses to acknowledge the history of Indigenous people in Canada and how the leadership and decision-making structures in Indigenous communities are unique. Finally, with an openness to working with Indigenous leaders and community members, nurses can build respectful, ethical, and meaningful relationships that will ultimately benefit the health of all people.

After completing this chapter, you should now be able to:

1. Identify the differences between your own worldviews and Indigenous worldviews.
2. Critique how different worldviews affect leadership decisions.
3. Recognize Indigenous leadership structures within Indigenous communities.
4. Describe the advantages of working with Indigenous community members.

Exercises

1. Imagine yourself as a non-Indigenous leader who wants to effect a change in an Indigenous community. Read Ermine's (2007) concept of ethical space and discuss with your classmates how you would respectfully negotiate the work that you want to do with the community leadership team.
2. Read the Executive Summary of the *CIHR Guidelines for Health Research Involving Aboriginal People* (2007–2010) and explore and discuss with your classmates how the 15 articles in the document can be applied to a leadership setting.
3. In the Truth and Reconciliation Commission's summary of its final report, *Honouring the Truth, Reconciling for the Future*, locate the section on health (pp. 205-211) and discuss with your classmates how you can make these calls to action come alive in your future work as a nurse leader.
4. Research how many treaties exist in Canada. Which treaty had negotiated the treaty right to health?

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4. The Role of Nurse Leaders in the Development of the Canadian Health Care System

JOAN WAGNER

> *Nurses interact every day with Canadians seeking assistance to maintain and improve their health. As a result, nurses can identify trends in population and public health. They know the strengths and the weaknesses of Canada's health system. They see, first hand, the issues related to accessibility of services. Nurses witness the need to integrate health services with other aspects of social development policy. They work with change in the form of emerging research, knowledge and new technology.*
>
> –CNA presentation to the Senate Standing Committee on Social Affairs, Science and Technology (Calnan & Lemire Rodger, 2002)

INTRODUCTION

The World Health Organization (WHO) set 17 sustainable development goals (SDGs) for world health in 2015. These 17 SDGs include human activities across the economic, social, and environmental dimensions of health. Dr. Margaret Chan, Director-General of the WHO, stressed that universal health coverage (UHC) is the "linchpin of the health development agenda, not only underpinning a more sustainable approach to the achievement of the other health targets, but allowing for a balance between them" (WHO, 2015, p. iii). UHC is regarded, at an international level, as a "tested and proven" framework that guides progressive health care transformation within individual countries. Canada pioneered UHC for the world. This chapter will trace the role of nurse leaders in the development and provision of health care in Canada from the time of the first settlers through to the development, implementation, and ongoing refinement of UHC. The chapter will also include a brief overview of demographic and social forces that exerted a significant impact on both nursing leadership and the Canadian health care system.

Much of the historical information within this chapter is based upon the Canadian Nurses Association (CNA) history book, *One Hundred Years of Service* (CNA, 2013). For a more detailed account of the historical role of Canadian nurse leaders, you can access the full book here.

Learning Objectives

1. Review historical events related to Canadian health care and the role of early nurse leaders in those events.
2. Identify how health care responsibilities have been divided among federal, provincial, and territorial governments.
3. Describe how demographic forces and social forces impact nurse leadership within the Canadian health care system.

4.1 EARLY NURSE LEADERS IN CANADIAN HEALTH CARE

Nurses have played an important role in the health of Canadians for over 400 years. The history of nursing in Canada began with Marie Rollet Hébert, the wife of an apothecary from Europe who settled in what is now Quebec City. She assisted her husband in providing care for the early settlers from 1617 until her death in 1649. Gregory and colleagues describe how she consulted with Indigenous peoples regarding healing methods (Gregory, Raymond-Seniuk, Patrick, & Stephen, 2015). They also recount how she educated Indigenous children and quickly became known as "Canada's first teacher."

The first Hôtel-Dieu in New France, still in existence today, was established in 1639 by three sisters of Augustines de la Miséricorde de Jésus in Quebec City to care for both the spiritual and physical needs of their patients. Jeanne Mance, known as Canada's first lay nurse (CNA, 2013), had both medical and surgical skills. She arrived on Montreal Island from France in 1642 and established a hospital the following year (Gregory et al., 2015). In 1659, she recruited three sisters from the Hospital Sisters of Saint-Joseph in France to assist with running the Hôtel-Dieu de Montréal (Noel, 2008). She is credited with co-founding the city of Montreal.

The founding of the Hudson's Bay Company accelerated the growth of commerce and trade between the Europeans and the Indigenous population of Canada. However, the Europeans brought much more than traders, settlers, and education to Canada. During the seventeenth century, a small pox epidemic killed almost half of the Huron people (CNA, 2013) and the services of the European lay nurses were in great demand.

In 1747, Marie-Marguerite (Dufrost de Lajemmarais) d'Youville led a lay group of women to take charge of the bankrupt Hôpital Général de Montréal. They turned it into a hospice for aged men and women, orphans, and "fallen" women. This group of women became known as the Grey Nuns

in 1755 (Jaenen, 2008). Marie-Marguerite d'Youville was the first Canadian to be canonized and was named a saint in 1990 (CNA, 2013).

The nineteenth century was a time of rapid advances in both health care and nursing education. Almost concurrently with the publication of Florence Nightingale's *Notes on Nursing* in 1859, Louis Pasteur published a paper suggesting that human and animal diseases are caused by micro-organisms (CNA, 2013). Canadian nursing expertise grew rapidly as the first graduates from the Nightingale Training School began working in 1865 and the first Canadian graduates from the Mack Training School for Nurses started working in 1878. The first two professional male nurses in Canada graduated from the Victoria General Hospital School of Nursing (Halifax) in 1892 (CNA, 2013).

Rapid changes to the North American frontier also took place during the nineteenth century. The British North America Act formally established the Dominion of Canada, composed of Quebec, Ontario, Nova Scotia, and New Brunswick, with John A. Macdonald elected as the first prime minister in 1867. Between the years of 1870 and 1898, Manitoba, British Columbia, Prince Edward Island, the Northwest Territories, and the Yukon Territory joined Canada. The completion of Canada's first transcontinental railway in 1885 linked these vast expanses of land together as one country and brought settlers into the open lands of the west.

The rapid opening of the Canadian west to settlement brought to light a shortage of health care providers and hospitals in the isolated western communities. Lady Ishbel Aberdeen, wife of Canada's Governor General, wrote about the "pathetic stories" she heard, "where young mothers and children had died, whilst husbands and fathers were traveling many weary miles for the medical and nursing aid, which might have saved them" (VON Canada, 2017). Lady Aberdeen was asked by the National Council of Women to establish an order of visiting nurses to travel to areas without medical or health services and establish small "cottage" hospitals. This order of nurses was to be founded in honour of the sixtieth anniversary of Queen Victoria's ascent to the throne. Amazingly, parliamentary support for the order wavered because of opposition from Canadian doctors.

However, Lady Aberdeen accepted the challenge and, despite resistance, The Victorian Order of Nurses (VON) was established in late 1897, with Lady Aberdeen the inaugural president.

Figure 4.1.1 Lady Aberdeen Established VON to Provide Health Services in Rural and Remote Communities

[May 1897], "Countess of Aberdeen in Queen's U Robes Topley," by William James Topley (1845-1930), photo courtesy of Library and Archives Canada under the reproduction reference number PA-027869 and under the MIKAN ID number 3194681, released in the Public Domain, via Wikimedia Commons. About this photo: The Countess of Aberdeen (née Ishbel Maria Marjoribanks) in the robes which she wore when she received an honorary L.L.D. from Queen's University, the first time an honorary degree was conferred on a woman by a Canadian university.

The VON's first tasks included the provision of visiting nursing services to areas without medical facilities and the establishment of small "cottage" hospitals in isolated areas of the west. The VON Canada nurses were immediately dispersed to rural and remote areas across Canada. In 1898, four VON Canada nurses travelled with military and government officials to the Klondike in the

Yukon where during the gold rush many prospectors were suffering from a typhoid epidemic. VON Canada sites were opened in Ottawa, Montreal, Toronto, Halifax, and Kingston, and the first "cottage" hospital was established in Regina to care for the early prairie settlers.

Figure 4.1.2 The First Hospital in Regina, Saskatchewan

[1889], photo courtesy of the Provincial Archives of Saskatchewan, Photographic Services Collection, collection number R-B10796, is released in the Public Domain. About this photo: Regina's first hospital was in the home of Mary Truesdell, located on 11th Avenue and McInytre Street.

Essential Learning Activity 4.1.1

For further insight into the response of physicians to the establishment of the VON, watch this short Heritage Minutes video on "Cottage Hospitals" (2:00), produced by Historica Canada.

4.2 HEALTH CARE AND NURSING HIGHLIGHTS OF THE FIRST HALF OF THE TWENTIETH

CENTURY

The early years of the twentieth century saw the establishment of 43 additional VON hospitals in rural and isolated areas of Canada. The VON services were funded through community fundraising led by prominent community members such as Lady Minto (the wife of another Canadian Governor General). The responsibility for running these hospitals was eventually placed in the hands of the communities, with the last VON Canada–run hospital handed over to the community in 1924. However, VON nurses have remained involved with community nursing to the present day.

In good times and bad, VON Canada served as a catalyst for building a sense of community—creating opportunities for people to work together to meet their needs and those of friends and neighbours. Prenatal education, well baby clinics, school health services, visiting nurses, and coordinated home care programs all had their earliest origins with VON Canada (VON Canada, 2017).

The establishment of the International Council of Nurses in 1899 and the service of Canadian troops in the Boer War in South Africa heralded an increased Canadian nursing involvement in international affairs. Canadian nurses left their mark in the Boer War as Georgina Fane Pope was the first Canadian awarded the Royal Red Cross for her extraordinary service as a nurse in the Boer War.

The *Canadian Nurse* journal was first published in 1905. The intention of the journal was to "unite and uplift the profession, and protect the public through work such as advocacy for nurse registration legislation" (CNA, 2013, p. 203). Journal articles dealt with issues similar to those that we continue to deal with today. One early article, a discussion on patient safety in the operating room, reported that a pair of forceps had been left in a patient, and the author made a recommendation that "forceps should be counted in operating rooms" (CNA, 2013, p. 203). The author of another article noted that "Canadian nurses are highly valued abroad" (CNA, 2013, p. 204) and she despaired that 50 to 75 per cent of graduate nurses from smaller Ontario cities had moved to the United States to work. As early as 1907, the editor of the *Canadian Nurse* was requesting "improved hours of work, workload and general working conditions for nurses" (CNA, 2013, p. 204).

This growing concern for patient safety and the need for an organized nursing voice led to the establishment of the Canadian National Association of Trained Nurses, which eventually became the Canadian Nurses Association, in 1908. Mary Agnes Snively was the founding president of the organization. In addition, by 1914, all existing provinces except Prince Edward Island had their

own provincial nursing associations. By 1922, all nine existing provinces had some form of nursing registration legislation.

World War I began in 1914. Approximately 2,000 "trained Canadian nurses, with 27 matrons and a reserve of 203 for special hospital service were enlisted" ("The War Years," 2005, p. 39). Nurses were eager to volunteer to serve in the armed forces. "For example, when a call was made in January 1915 to fill 75 positions, 2,000 nurses applied" ("The First World War's Nursing Sisters," 2016, p. 17). Nurses in the Canadian army received a higher income than the enlisted men and were accorded authority as a lieutenant. Lieutenant Colonel (retired) Harriet (Hallie) Sloan further explains the reasons for this rush of nurses to enlist:

> From the time of the Boer War, Canadian nurses had officer status, with the same rank, pay and privileges of army lieutenant. They also had the power of command over those working under them, such as orderlies. . . . Among the Allied forces in both world wars, Canadian nurses were the only ones to enjoy equality with officers. ("The War Years," 2005, p. 39)

Canadian nurse Margaret MacDonald, appointed matron-in-chief of the Canadian army nursing service, was the first woman given the rank of major in the British Empire, while medals or decorations were awarded to 660 Canadian nurses. However, in addition to the many positive aspects of nursing service in the military, 47 Canadian nurses lost their lives in World War I (CNA, 2013).

Essential Learning Activity 4.2.1

To find out more about military nurses in World War I, watch this short Heritage Minutes video called "Nursing Sisters" (1:00).

World War I, combined with the Spanish Flu epidemic (1918–mid-1920s), hit healthy young adults hard and left many nurses as the sole supporters of their families. In addition, the stock market crash of 1929 started the Great Depression, leading to further hardships. Hospital nursing work was difficult to find and since private duty nursing was more abundant and offered shorter hours and better pay than hospital nursing, many nurses worked private duty (CNA, 2013). However,

overall poor pay and scarcity of work culminated in deprivation for countless nurses and their dependents throughout this time period.

World War II started in 1939 and over 4,000 nurses enlisted. Many enlisted because they would be assured of a good wage. Their services were greatly appreciated by the soldiers, as Pauline Siddons describes: "I have memories of halls lined with stretcher patients waiting for a bed, while more loaded ambulances continued to arrive" (Bassendowski, 2012, p. 91).

Figure 4.2.1 Historical Picture of Nurses Leading Disaster Response

[1940s-50s], photo courtesy of the Saskatchewan Health Authority (formerly Regina Qu'Appelle Health Region) collection number 1999.79-1855, is licensed under a Creative Commons Attribution 4.0 International License.

Military service provided independent decision-making opportunities for Canadian nurses and prepared them for future leadership positions. One nursing veteran recalls:

> It was during this bloody war that one learned and dared to be a nurse of the future. As nursing sisters in front line units, we gave intramuscular injections, administered intravenous solutions . . . removed sutures, did major dressings. . . . On our way to Italy . . . malaria added greatly to our workload. We learned

> to do blood smears, determine from all our findings the type of disease, and initiate intravenous treatment where indicated. (Pepper, 2015, p. 8)

Thirteen Canadian nursing sisters lost their lives in World War II.

During World War II, a severe shortage of trained civilian nurses led to a search for a new source of nursing personnel within the hospitals. The CNA advised the provinces to develop a course for nursing assistants. To support the provinces in this pursuit, the CNA developed the first curriculum for nursing assistants in 1940.

Recommendations coming from a 1943 National Health Survey focused on providing salaries and working conditions for nurses "comparable to those prevailing in other occupations requiring similar preparation" (CNA, 2013, p. 218). However, hospitals were "unable or unwilling to capitalize on nursing sisters' demonstrated abilities in expanded technological roles or their increased autonomy. Instead, hospitals relied heavily on student labour, with limited roles for 'specially trained' graduate nurses" (Toman, 2007, p. 202). Upon return to civilian life following the end of World War II, most nursing sisters resisted conventional hospital roles and sought alternate careers. The following statement from Mary Tweddell helps explain the dilemma of the nursing sisters: "We'd been living the army life—I'd been four years over there—and it was a different life entirely. You came back here and you'd be amazed how hard it was to get back" (Bassendowski, 2012, p. 48).

4.3 HEALTH CARE AND NURSING HIGHLIGHTS OF THE SECOND HALF OF THE TWENTIETH CENTURY

During the decades following World War II, access to health care became a Canadian public priority. However, the nursing shortage continued. Increased responsibilities and poor working conditions in hospitals led nurses to demonstrate an interest in collective bargaining. The first nursing union was formed in British Columbia in 1945.

The 1948 federal grants program offered money for health surveys, public health research, infectious disease control, and grants for hospital construction (when matched with provincial funding). The building of new hospitals created a further shortage of health care personnel. Nursing schools could not graduate registered nurses in adequate numbers to meet the demands. Auxiliary workers, such as nursing assistants, were hired by hospitals to assist the RNs.

Universal Health Care Coverage

Public apprehension about access to health care dominated the Canadian health care landscape for the last half of the twentieth century. The first Canadian health region was established in Swift Current in 1946. For less than $20 per person per year, residents received "doctor services, hospitalization, children's dental care, and a professional public health service including nurse, immunization programs and health inspectors" (Matthews, 2006, para 3).

Two of the significant outcomes of this "experiment" were (1) an increase in doctors in the Swift Current Health Region from 19 in 1946 to 36 in 1948; and (2) as a direct result of the work of the nurses and access to doctors, a drop in the infant mortality rate to the lowest in Saskatchewan. The Saskatchewan Medicare system, based on the Swift Current model, was introduced to the entire province of Saskatchewan in 1962. The Swift Current Health Region, the first universal hospital and medical care program in North America, was a harbinger of international health care priorities in the twenty-first century (WHO, 2017).

Essential Learning Activity 4.3.1

Saskatchewan nurses have been very involved in the Canadian health care system. To find out more about the history of nursing in Saskatchewan, watch this video titled "The Role of Canadian Nurses during WW1 & WW2" (5:19) by Dr. Sandra Bassendowski, Professor, College of Nursing, University of Saskatchewan.

The introduction of UHC coverage to Canadians was a multi-step process, commencing with the passing of the national Hospital Insurance and Diagnostic Services Act (1957), which covered the cost of inpatient treatment, laboratory services, and radiology diagnostic services in acute care hospitals throughout Canada. In 1966, the Medical Care Act extended health coverage for Canadians to help cover the costs of physicians' services outside hospitals. Canada's national health insurance program was structured to ensure that every Canadian received medical care and hospital treatment, which was paid for by taxes or compulsory health insurance premiums. Costs were shared between the federal and provincial governments, providing the provinces met the principles of accessibility, universality, comprehensiveness, portability, and administration (CNA, 2013; Dunlop, 2006).

Health care costs spiralled after the implementation of Medicare, and a review of the publicly funded insurance programs was conducted in 1979 by Justice Emmett Matthew Hall. Dr. Helen Mussallem, then executive director of the CNA (and a World War II veteran), presented the CNA's brief, "Putting Health Back into Health Care" to the review. This document highlighted the CNA's belief that:

> insured health-care services should be extended to include more than just acute care, that nursing services should be covered and serve as an entry point to the health-care system and that all extra premiums such as extra-billing and user fees should be banned. (CNA, 2013, p. 105)

Dr. Ginette Lemire Rodger assumed the position of executive director of the CNA following Dr. Mussallem's retirement in 1981. Dr. Lemire Rodger conducted extensive lobbying to support the recommendations set out in "Putting Health Back into Health Care." The Canada Health Act passed in 1984 included several of the revisions recommended by the CNA. Nursing leaders, including Dr. Lemire Rodger and Dr. Helen Preston Glass (CNA president) had been "unable to convince parliamentarians to extend coverage to services outside hospitals and other medical institutions, but they did manage to have the description of potential providers of insured services broadened to include health-care practitioners and not just physicians" (CNA, 2013, p. 106). Opening the door to funding of insured nursing services was the catalyst that promoted the presence of nurse practitioners in outpatient and nursing clinics.

Essential Learning Activity 4.3.2

Answer the following questions as you review the Canada Health Act:

1. What are the five standards that the provinces and territories must meet?
2. What are the responsibilities of the provinces and territories for health care?
3. What services do the provinces and territories fund?
4. What are the responsibilities of the federal government for health care?
5. What services does the federal government fund?
6. How does the federal government fund and work with First Nations and Inuit people?

To understand more about health care services for First Nations and Inuit people, visit the First Nations and Inuit Health web page on the Health Canada website. Then answer the following questions:

1. What is Jordan's principle?
2. If a First Nations child is not receiving services and supports, who is to be contacted?

Auxiliary Workers

The federal government's plan provided grants that were to be matched by provincial money and provided momentum for rapid hospital construction and renovation. By 1950, money had been approved for almost 20,000 additional hospital beds throughout Canada. These grants, combined with other state-sponsored health focused programs, increased the public's demand for health care. A new category of auxiliary workers was introduced to meet these demands. The CNA was supportive of these auxiliary workers, having already developed a curriculum for nursing assistants in 1940. The provinces began to create courses and bring the licensing of this new classification of auxiliary workers under their control.

Figure 4.3.1 First Graduating Class from the University of Saskatchewan, 1943

[n.d], "Nursing Students," photo courtesy of the University of Saskatchewan Archives and Special Collections, collection number A-2636, is licensed under a Creative Commons Attribution 4.0 International License. About this photo: Visit the College of Nursing website, for more information on the history of the College of Nursing at the University of Saskatchewan.

Nursing education was a focus of Canadian nurse leaders for the last half of the twentieth century. Nursing students had become indispensable care providers for patients within the hospitals and were frequently overworked by the hospital administration. Nurse leaders became increasingly alarmed about the quality of education provided to these students who learned on the job by providing much of the patient care. In 1946, Evelyn Mallory, president of the Registered Nurses Association of British Columbia questioned the state of nursing education:

> Are we going to continue to compromise, to muddle along with nursing education and nursing service hopelessly confused, not only in the minds of the public, but in the minds of nurses as well, as has been the case for years? Or were nurses at long last going to do some really constructive planning in relation to the preparation of professional nurses, frankly recognizing that we

> must have more nurses and better nurses if the needs of the community are to be met? (cited in CNA, 2013, p. 72)

In an attempt to improve the education of nurses, the CNA piloted an accreditation program for schools of nursing. The 1960 pilot accreditation project report on the Evaluation of Schools of Nursing revealed that 21 out of 25 schools failed to meet the standards. As stated by Dr. Helen Mussallem, "the students were not students, they were indentured labour" (CNA, 2013, p. 81).

Dr. Mussallem was the first Canadian nurse to complete a PhD in nursing. Her research, which focused on the development of nursing education in general educational systems, received extensive attention from both professionals and the general public. She recommended a complete revision of Canada's nursing education system. Following publication of her research, the *Globe and Mail* described nursing training in the following words:

> The hospital system of training nurses is closely akin to the army system of training soldiers . . . that deprives her of some of her civil rights—she must submit to curfews, to a considerable control of her leisure time, even to dictates about her personal grooming . . . and not even be able to insist on the most basic of rights—the right to be treated as a reasonable, responsible adult in a free society. (CNA, 2013, p. 85)

Dr. Mussallem's research brought the need for a change in nursing education to the forefront of Canadian nursing and served as a catalyst for the movement of nursing education out of the hospitals and into Canadian colleges and universities.

Figure 4.3.2 Saskatchewan Collaborative Bachelor of Science in Nursing (SCBScN)

[January 8, 2016] "IMG_0074," photo courtesy of the Saskatchewan Registered Nurses Association, is licensed under a Creative Commons Attribution 4.0 International License. About this photo: Pinning Ceremony. At the podium is Grace Onwuka with Dean david Gregory (University of Regina) and Dean Netha Dyck (SaskPolytechnic). Nursing students began their studies in the SCBScN program in fall 2011.

Nursing Research

Nursing leader Dr. Ginette Lemire Rodger fought against strong gender, age, occupational, and academic prejudices within the Medical Research Council (now the Canadian Institutes of Health Research) when she joined the council in 1986 and worked to move research funding beyond bench scientists and physicians. Due to her persistence, financial support was found for both nursing research and nursing research infrastructure. Linked to this awareness of the need for nursing research, the first fully funded PhD program was opened at the University of Alberta in 1991. Dr. Lemire Rodger soon became the first graduate from a Canadian nursing PhD program. As Canadian nurses acquired the university graduate credentials required for teaching and research, they began to develop a unique body of Canadian research centred upon the discipline of nursing.

Research Note

Northern Saskatchewan is home to many Indigenous people, who live in small, often isolated, settlements. The economic conditions in the north were abysmal during the twentieth century. The first nursing stations were established in Ile-a-la-Crosse in 1927 and Cumberland House in 1929. Nursing was the backbone of health care in the North.

Following the 1944 election of the Co-operative Commonwealth Federation (CCF) in Saskatchewan, an emphasis was placed on "integration of the underprivileged of society" (McBain, 2015). This initiative was funded by taking advantage of wealth generated through the exploitation of abundant natural resources, such as uranium, found in this region. Nine additional nursing stations were established between 1941 and 1955. Only two of these stations were federal—those in Lac La Ronge and Pelican Narrows. Because small settlements were scattered across the North, it was difficult to develop the resources required to provide good medical care in the local communities. Consequently, air ambulances were established to fly patients from the nursing stations to larger centres, where they would receive the required services.

Provincial nurses attended to the non-treaty population in the North. The few federal nurses present in the North attended to the status Indian population. Numerous jurisdictional issues arose between provincial health care and federal health care. During the latter half of the twentieth century, many provincial nurses were reprimanded for providing care to status Indians. This jurisdictional issue continues to the present day. However, the nurses never refused to provide care; they always found a way to meet the needs of the patient, regardless of treaty status.

In this YouTube video (53:00), titled "Place and Nursing in Remote Northern Communities: A Historical Perspective," Dr. Lesley McBain discusses historical research conducted with northern Saskatchewan nurses. The research described in this video illustrates some of the challenges faced by outpost nurses while providing care to northern Saskatchewan citizens. In letters to their supervisors, individual nurses bring attention to substandard working environments, which limit their ability to deliver professional care while also having a negative impact upon the welfare of their patients.

After watching the video, answer the following questions:

1. According to this research, has the Canada Health Act had an impact on northern communities?
2. What changes would you recommend to improve health care in the North?
3. How did the frequent relocation of northern nurses impact their "moral proximity," as described by Malone's theory of distal nursing discussed in the video?
4. If you were a provincial northern nurse, what would you do to ensure that *all* people receive good care?

Essential Learning Activity 4.3.3

To understand how the development of nurses' working professionalism over the past 60 years has been linked to changes in societal attitudes, watch this video of Margaret Scaia presenting "Working Professionalism: Nursing in Calgary and Vancouver 1958 to 1977" (51:00).

SUMMARY

Nurses pioneered the provision of holistic health care to Canadians, starting as early as 1617 with Marie Rollet Hébert, who provided care to the early settlers and the Indigenous people. Over the next four centuries, the societal attitudes displayed toward nurses, and their subsequent working conditions, led to nursing shortages. These shortages resulted in the emergence of auxiliary health personnel within the health care workplace.

As nursing education transitioned to universities, nurse researchers and leaders created a unique body of nursing knowledge designed to be used by nurses within their individual practices. This nursing knowledge requires modern nurses to deliver evidence-informed care. Nurses are expected to analyze "practice problems and identify the research that will help them answer questions about how they should go about delivering care" (Lieb Zalon, 2015, p. 425). As holistic practitioners, nurses appraise research and make rational care-provider decisions based on their knowledge of the patient and the health care environment (Rycroft-Malone, 2008).

Many issues identified in the early history of Canadian health care continue to have a significant impact on Canadian nurses today. Understanding nursing's past will help today's nurses move forward as they deal with current issues, such as nursing shortages/supply-and-demand issues; health care funding cutbacks with hospitals replacing nurses with lesser skilled workers; blurring of distinctions between licensed practical nurses and registered nurses; implementation of extended nursing practice that allows nurses to realize their full potential; implementation of primary health care; increasing employment of nurse practitioners; development of nursing informatics; focus on self-regulation; reform of nursing curriculum and education delivery; and finally, the constant need to pay close attention to the appropriate compensation of nurses and provision of quality health care work environments. Lessons acquired throughout Canadian history encourage the vigilance of nurse leaders as they build the future for nursing and health care in Canada.

After completing this chapter, you should be able to:

1. Identify historical events related to Canadian health care and the role that early nurse leaders played in those events.
2. Identify how health care responsibilities have been divided among federal, provincial, and territorial governments.
3. Describe how demographic forces and social forces impact nurse leadership within the Canadian health care system.

Exercises

1. What are the responsibilities of the federal government under the Canada Health Act? Discuss the impact of dividing the responsibilities for health care between the provincial, territorial, and federal governments.
2. Discuss how social forces have had a significant impact upon the roles of nurses in Canadian health care. Provide at least three examples of social forces.
3. What changes would you recommend to the Canada Health Act?

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5. Providing Nursing Leadership within the Health Care System

JOAN WAGNER

> *Something unforeseen and magnificent is happening. Health care, having in our time entered its dark night of the soul, shows signs of emerging, transformed.*
>
> –Barbara Dossey and Larry Dossey (cited in Porter-O'Grady & Malloch, 2011, p. 433)

INTRODUCTION

As the health care system responds to changes in the environment, nurse leaders refine and adapt leadership tools and care processes. Leadership tools such as organizational mission, vision, and value statements, which guide both administration and patient care providers through their daily work, are routinely reviewed and modified. "Delegation of care" or transfer of responsibility from one classification of care provider to another is an example of an important health care process adaptation that has occurred in response to rapid system-wide changes. Nurse leaders play an important role within this complex adaptive system as they retain a focus on maintaining a strong care provider culture that supports quality care and improved patient outcomes, regardless of unending change.

Learning Objectives

1. Apply systems theory to health care.
2. Identify the relationships between organizational culture, leadership, cultural intelligence, and change.
3. Identify the importance of the vision, mission, and value statements of an organization.
4. Conclude that relational leadership and empowerment play an important role in organizational cultural change.
5. Examine the standards for delegation of care established by the Saskatchewan Registered Nurses' Association (SRNA) from RN to unregulated care providers and from physician to RN.

5.1 SYSTEMS THEORY AND HEALTH CARE

In Chapter 1, we discussed complexity science and complex adaptive systems in nursing. It is important to realize that causality in a complex adaptive system is not linear, meaning that it is difficult to predict the end result of a specific employee- or patient-focused intervention. As nurses we know that the success of our patient-centred care interventions is dependent upon many factors. All too often, despite extensive planning and hard work, a patient care intervention fails to lead to the intended results. Factors beyond our control, and often beyond our knowledge, change the intended outcomes. This is typical of events in a complex adaptive system.

So how can we be successful leaders if we cannot predict what will happen when we attempt to guide others? Perhaps a review of the first two principles of the complex adaptive system, discussed in Chapter 1, will provide an answer to this question. The first principle, which is focused on using the **lens of complexity**, and the second principle, which describes **good enough vision**, provide us with clues on how to lead others within the complex adaptive health care system. Organizations and nurse leaders acknowledge that they cannot control change, and thus they do not try to control every aspect of organizational change. Successful health care leaders attempt to give a general sense of direction to employees, rather than focus on specific details. Next, leaders also encourage employees to develop innovative responses that best meet their individual strengths and needs and meet the health care system's ultimate goal of quality patient care. Leaders cannot predict all the factors that will influence the final results of change activities, but by following these principles, they know that the final response will be what is best suited to the environment, or health care system, and the needs of the individual.

Essential Learning Activity 5.1.1

What are we talking about when we speak about systems theory in a health care organization? For a deeper understanding, watch this video titled "System Theory of Management" (7:37) by Nguyen Thanh Thi, then answer the following questions:

1. What are the three basic system types? Describe each type.
2. What type of system is a hospital?
3. What is synergy? What is entropy?

There are three fundamental concepts that, when applied to our individual organizations, can transform the way we provide health care. For additional information, watch this video titled "Systems Thinking and Complexity in Health: A Short Introduction" (5:02), then complete the following exercises:

1. List the three fundamental concepts that can transform the way we provide health care.
2. Define these three concepts and give an example of how they can make a difference to health care provision.

Finally, watch the video "Interview with Judith Shamian on International Nurses Day 2016" (4:44) as she speaks about inviting citizens to work with nurses in creating a positive health care system. Judith Shamian is President of the International Council of Nurses.

5.2 ORGANIZATIONAL VISION, MISSION, AND VALUES

Organizational leaders provide a sense of direction and overall guidance to their employees through the use of organizational vision, mission, and values statements. An organization's **vision statement** defines why the organization exists, describes how the organization is unique and different from similar organizations, and specifies where the leaders hope the organization is going (Sanders, 2013). The **mission** describes how the organization will fulfill its vision and establishes a common course of action for future endeavours. Finally, **values** are developed to assist with the achievement of the vision and mission and provide strategic guidelines for decision making, both internally and externally, by members of the organization (Hibberd, Doody, & Hennessey, 2006). The vision, mission, and value statements are expressed in a concise and clear manner that is easily understood by all the members of the organization. The vision, mission, and values provide guidelines for every person participating in all activities occurring within the organization, encouraging them to "walk the talk."

Canadian health care is an open system that is undergoing constant change while responding to the surrounding environment. Complexity science requires leaders and staff to handle this rapid change in a thoughtful manner. As health care continues to evolve and new models of care are introduced, managers need to consider innovative approaches that meet the needs of change while complying with their individual organization's vision, mission, and values. According to Porter–O'Grady and Malloch, "the language of leadership must reflect the requisites of embracing the mission, identifying how individual work effort contributes to it, and ensuring that work outcomes advance the organization's mission and purpose" (2011, p. 233). Leaders look through the lenses of the vision, mission, and values statements for guidance when determining appropriate responses to critical events and unforeseen challenges, common in a complex system. Successful organizations require each employee to be committed to following these strategic

guidelines during the course of their work activities. Employees who understand the relationship between their own work and the mission and purpose of the organization will contribute to a stronger health care system that excels in providing first-class patient care. The vision, mission, and values provide a common organization-wide frame of reference for decision making for both leaders and staff (Kotalik et al., 2014).

An organization's mission, vision, and values do not remain static and unchanging over the years, thus the strategic organizational guidelines are regularly reviewed and adapted. This revision process ensures that the services offered by an organization meet the needs of its consumers or patients. Evidence of this process of revision is discussed by Conger, Knuth, and McDonald (2014), who describe a health care response to the design and implementation of an electronic health records system. The implementation of this system eventually led to the refreshment of the health care agency's vision, a redefinition of its goals, and, finally, the reinvention of its performance measurement and reporting system. Transformations, sparked by changes in the external technological environment, met the health care agency's mission and vision to engage, enroll, and empower care providers, and led to the development of a "culture of transparency and clinical excellence" (Conger et al., p. 55).

Essential Learning Activity 5.2.1

Watch this video "How to Write a Mission Statement" (4:00), presented by M3 Planning, then answer the following questions:

1. What is a mission statement?
2. What are five characteristics of a mission statement?
3. Who needs to be involved in writing a mission statement?
4. What information do you need to write a mission statement?
5. What should the process of writing a mission statement involve?

5.3 ORGANIZATIONAL CULTURE AND NURSING LEADERSHIP

Organizational culture can be described as "the implicit knowledge or values and beliefs within the organization that reflect the norms and traditions of the organization" (Mancini & Wong, 2015, p. 152). Schein (cited in Ko, Murphy, & Birdman, 2015) further describes organizational culture as "the pattern of shared basic assumptions . . . as the correct way to perceive, think and

feel" (p. S676). Organizational vision, mission, and values, established by leadership, provide the foundation for the establishment's culture. Since individual organizations have their own vision, mission, and value statements, each organization has a different culture. Not surprisingly, when there are conflicts between the mission and vision of various institutions, collaboration in providing services to the patient or consumer can also lead to disagreements (Ko et al. 2015). With the increasing emphasis upon collaboration between health care organizations, it is essential to understand how to overcome the challenges of cultural differences that may impede group efforts.

An example of the important role that organizational culture plays may be found in the recent United Kingdom (UK) health crisis. Shock waves spread across the UK's National Health Service foundation health trusts in response to the 2013 Francis investigation into the unnecessary deaths of up to 1,200 people between January 2005 and March 2009. The first Francis report (2010) spotlighted flaws of the system, which was focused on cost savings rather than the provision of safe and effective patient care. The second report (Francis, 2013) advocated for patient-centred culture where patients take priority over all system and employee concerns. The Francis report stressed the important effect of leadership upon organizational culture and ultimately, upon the quality of patient care: "Truly, organizational culture is informed by the nature of its leadership. The Department of Health has an important leadership role to play in promoting the change of culture required throughout the health care system" (Francis, 2013, p. 64).

Research Note

Hung, D., Chung, S., Martinez, M., & Tai-Seale, M. (2016). Effect of organizational culture on patient access, care continuity and experience of primary care. *Journal of Ambulatory Care Management*, 39(3), 242–252.

Purpose

To examine the relationships between organizational culture and patient-centred outcomes in a large medical practice.

Discussion

This American study was conducted in a large physician group practice setting of 357 physicians, 41 primary care departments, and nearly a million patients. Organizational culture was found to be significantly associated with "patient access to care, continuity of care, and reported experiences with care delivery" (Hung et al., 2016, pp. 245–246).

Application to practice

When introducing change to an organization, it is essential to recognize the underlying organizational culture. Acknowledging and leveraging this aspect of collective behaviour while targeting specific patient-centred care goals will lead to improved care.

You may ask what the UK National Health Service leaders did to promote cultural change that supported patient safety and quality care. One of the many steps they took to generate discussion and foster learning across professional disciplines was to encourage organizations from all over the UK to establish "Schwartz rounds." These rounds supported all disciplines from across the organization to reflect on the emotional aspects of their work, enhance their communication with each other, and improve their relations with patients (Muls et al., 2015). Quality relationships among staff were recognized as being essential for the provision of quality care to clients.

Leaders know that employees frequently resist change and innovation in their workplace using the argument that "it has always been this way." Leaders play a pivotal role in inspiring change. When introducing innovation or transformation, it is important to recognize that cultural change cannot be commanded, but can only be inspired. Effective leaders understand both implicit and explicitly stated cultural norms and traditions when they introduce change into the organization. As emphasized in the UK health literature, leaders set an example for the staff through sharing values of a "culture of zero tolerance for substandard care" (Muls et al., 2015).

Research with magnet hospitals in the United States reinforced the need for a health care environment that is focused on the provision of quality patient care. This necessity has also been identified in the UK. When caregivers are provided with adequate resources, support, and respect, there is evidence of increased job satisfaction and reduced patient morbidity and mortality (Aiken, Clarke, Sloane, Lake, & Cheney, 2008).

Holistic leadership approaches, which include a focus on relational leadership and staff empowerment, foster a strong and robust care provider culture within the organization. When supportive care provider cultures are present, improved health is likely to be evident for both care providers and patients (Wagner, Cummings, Smith, Olson, & Warren, 2013). Research indicates that successful and effective nurse leaders have a positive impact upon the well-being of nurses, which converts into improved patient–client outcomes (Cummings, 2004).

Essential Learning Activity 5.3.1

Watch this podcast "Spirit at Work Can Make a Difference!" (20:00) by Dr. Joan Wagner on research regarding resonant leadership, empowerment and SAW, then answer the following questions:

1. What is spirit at work?
2. What are the four dimensions that make up spirit at work? Describe them.
3. Does resonant leadership have an effect on structural empowerment? On psychological empowerment? On spirit at work?
4. How can spirit at work research contribute to the development of healthy workplaces?

5.4 DELEGATION OF CARE

Significant changes in health care over the past century have included implementation of a universal health care system, a rapidly aging population, technological advances, and scientific discoveries, and have culminated in increased stress upon the system and rapidly escalating costs. Health care leaders searched for ways to meet the increasing demands placed on the system. One solution that has been successfully implemented over the past 20 to 30 years, in response to these pressures on health care, is **delegation of care**. Delegation of care refers to "the transfer of responsibility for a task when it is not part of the scope of practice or scope of employment of the care provider" (SRNA, 2015, p. 8). Delegation of care most often occurs between an RN and an unregulated care provider or between a physician and an RN. Guidelines have been established to ensure the quality of patient care throughout the delegation process.

Delegation and Assignment of Nursing Care

Assignment

The RN is responsible for the coordination of patient care, which may include assessment, assignment, care planning, supervision, ongoing monitoring, decision making, and evaluation of care (SRNA, 2015). The RN assigns provision of the client's care to the most appropriate care provider based on the previously completed RN assessment.

> Assignment occurs when the required care falls within the scope of practice (i.e., LPN [licensed practical nurse], RN, RPN [registered psychiatric nurse]) or the job description (i.e., UCP [unregulated care provider]) of the care provider

> who accepts the assignment from the RN. . . . The RN at the point of care retains the overall accountability for the appropriate assignment and oversight of client care. This responsibility cannot be delegated. (SRNA, 2015, p. 8)

Delegation

Delegation of nursing care is different than assignment since it refers to "the transfer of responsibility for a task when it is not part of the scope of practice or scope of employment of the care provider" (SRNA, 2015, p. 8). It is important to remember that only the task can be delegated; the RN retains the responsibility for coordination of patient care. Nurse leaders must ensure the following delegation principles (SRNA, 2015, p. 9) are present in their organization before delegation takes place:

1. Formal processes and policies must be in place to support the delegator (the one who does the delegating) and delegatee (the one who receives the delegation);
2. At no time should the safety of the client be compromised by substituting less qualified workers to provide care and/or perform an intervention when the competencies and scope of the RN's knowledge, skill and judgment are required;
3. A delegated task cannot be sub-delegated; and
4. The delegating RN is accountable for appropriate delegation of tasks and for the overall assessment, care planning, intervention and care evaluation. (SRNA, 2015, p. 9)

This accountability requires the RN to monitor the performance and completion of the delegated tasks by the unregulated care provider. Regular communication with the unregulated care provider is required during the initial delegation of the task, throughout the performance of the task, and when the delegated task is completed.

Essential Learning Activity 5.4.1

The five rights of delegation provide an excellent mental checklist for RN delegation of patient care. They include right task, right circumstances, right person, right direction/communication, and right supervision/evaluation. Read more about the five rights of delegation on pages 21–23 of the "SRNA Interpretation of the RN Scope of Practice."

Delegation by Physician to RN

In September 2014, The Medical Profession Act, 1981, was amended to give the College of Physicians and Surgeons of Saskatchewan (CPSS) "the authority to adopt bylaws that can allow physicians to delegate activities described in the College bylaw to other health care professionals" (CPSS, 2015, p. 7). Consequently, the CPSS bylaws were changed to allow physicians to delegate certain activities to RNs. The transfer of medical function (TMF) allows RNs "to perform complex, highly-skilled activities which are outside the scope of registered nursing and within the scope of the practice of medicine" (SRNA, 2016, p. 1).

CPSS principles for delegation include the following:

1. Delegation will be from a particular physician to a particular registered nurse. Delegation will not be by "category";
2. The activities which may be delegated are specified in the [CPSS] bylaw;
3. When there is a specific program which is identified (such as the Neonatal Intensive Transport Team, the RN Pediatric Transport Team or Air Ambulance), it is not necessary to identify the specific procedures that may be provided by an RN as part of the program;
4. It will be the responsibility of the physician who delegates the activity to assess the RN's skill and knowledge to determine if, in the physician's opinion, the RN has the appropriate skill and knowledge to perform the delegated activity;
5. Delegation must be done in writing, except in the case of an emergency;
6. The physician who delegates the authority to the RN must have a process in place to provide appropriate supervision. (CPSS, 2015, pp. 7–8)

Essential Learning Activity 5.4.2

RN Evolving Scope of Practice

Read pages 9–13 of the "SRNA Interpretation of the RN Scope of Practice," then answer the following questions:

1. Why is RN scope of practice evolving?
2. Describe RN speciality practices. What standards is RN speciality practice built upon?
3. What is the scope of practice for the RN with "additional authorized practice"? What is required for a nurse to assume the role of an RN with "additional authorized practice"?

Collaboration between RNs, RPNs, and LPNs in Saskatchewan

Read "Collaborative Decision-Making Framework: Quality Nursing Practice" (approved by the Saskatchewan Association of Licensed Practical Nurses, SRNA, and the Registered Psychiatric Nurses Association of Saskatchewan on September 9, 2017), then answer the following questions:

1. What factors should patient care assignments be based on?
2. What are the four main factors that influence scope of practice? Outline what nurses are educated and authorized to do.
3. The Continuum of Care model on page 11 requires an analysis of which three factors when making decisions about the most effective utilization of LPNs, RNs, and RPNs?

SUMMARY

This chapter addresses the relationship between nursing leadership and the larger health care system. Understanding this relationship requires that we look at our health care system as a complex adaptive system with multiple relationships between different aspects of it that impact both the system and the health of the individuals within it. Health care organizations define their role and describe how they will fulfill this role within the greater system through their vision, mission, and value statements. Members of the organization look through the lens of these guiding statements and principles when making decisions. These guided decisions promote the development of an organizational culture, or common system of beliefs and behaviours for all employees. However, in complex adaptive systems, organizational culture may be influenced by factors other than the vision, mission, and values, leading to undesirable outcomes, as demonstrated in the UK. But even in complex adaptive systems, leaders can inspire change through a focus on relational leadership and empowerment.

Delegation of care is one recent solution to the issues of our rapidly changing complex adaptive health care system. *Delegation* may refer to RNs delegating care provision tasks to unregulated care providers; in this case, the delegating RN retains the role of coordinator of patient care with all the associated responsibilities throughout the delegation process. Delegation may also refer to physicians delegating specific medical tasks to RNs. In this case, the delegating physician retains the responsibilities of assessment and supervision of the RN throughout the performance of the delegated medical activity.

After completing this chapter, you should now be able to:

1. Apply systems theory to health care.
2. Identify the relationships between organizational culture, leadership, cultural intelligence, and change.
3. Identify the importance of the vision, mission, and value statements of an organization.
4. Describe the important role that inspiring relational leadership and empowerment play in organizational cultural change.
5. Explain the standards for delegation of care established by the Saskatchewan Registered Nurses' Association from RN to unregulated care providers and from physician to RN.

Exercises

1. Does the health care system in your local community function as an open, closed, or subsystem? Please explain why you have chosen this type of system to describe your local community.
2. Chose one aspect of health care in your local community that you would like to change. Apply one or more of the fundamental concepts of systems theory, interrelationships, perspectives, and boundaries to this aspect of health care provision that could ultimately lead to improved patient care.
3. You are a home care nurse. An elderly diabetic client has been admitted to your caseload. You conduct an assessment on this client and determine that, due to neuropathy of the hands, this client requires assistance with eye drops for glaucoma. You decide to delegate the process to an unregulated care provider. Develop a care plan for delegation of the care of this client using the five rights of delegation.
4. As a nurse manager you will be assigning care providers to care for clients with different levels of acuity and care needs. Develop two separate client care scenarios, paying special attention to the specific skills required to care for each client. How are Scenario A and Scenario B clients different? (a) Scenario A has a client who can be cared for by an LPN, RN, or RPN. (b) The client in Scenario B requires either an RN or an RPN to provide care.

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6. Primary Health Care

Interprofessional Leadership, Collaboration, and Teamwork

COLLEEN TOYE AND JOAN WAGNER

> *The complexity of delivering effective health and social care means that not one profession can meet the needs of patients in the 21st century – a new and more flexible approach to the delivery of care is required.* (Reeves, Macmillan, & van Soeren, 2010, p. 262)

INTRODUCTION

Welcome to the world of teams and collaboration! In this chapter, you will begin to understand the importance of effective multidisciplinary relationships with respect to optimal client health outcomes in the community, and in turn, the necessity of interprofessional leadership in negotiating these relationships. No matter the population served, the need for collaborative practice is critical in our health system today.

Learning Objectives

1. Describe the increasing complexity of health care needs in the community and the implications of that complexity within our current health system.
2. Explore the need for interprofessional collaboration in community care.
3. Examine the importance of client and family engagement in their care.
4. Identify parallels between leadership characteristics or styles and interprofessional leadership within collaborative practice.
5. Determine specific skills and practices that support interprofessional leadership and collaboration.
6. Recognize cornerstone components that can lead to successful collaboration.
7. Explore relational dynamics of positive teams.

Note: *Client* is used throughout the chapter when referring to an individual in need of health care. *Patient* may be used when citing another author's work.

6.1 BACKGROUND: WHY THE NEED FOR INTERPROFESSIONAL COLLABORATION?

Primary Health Care

The urgent need for the implementation of primary health care throughout the world was given international recognition at the World Health Organization (WHO) conference in Alma-Ata, USSR in 1978. **Primary health care** was described as "a community-based health care service philosophy that is focused on illness prevention, health promotion, treatment, rehabilitation, and identification of people at risk" (Howse & Grant, 2015, p. 132). The Canadian Nurses Association (CNA) issued a position statement strongly supporting the five essential principles of primary health care: "accessibility, active public participation, health promotion and chronic disease prevention and management, the use of appropriate technology and innovation, [and] intersectoral cooperation and collaboration" (CNA, 2015, p. 1). Collaboration and teamwork across the professions and health care sectors are required to meet the five principles inherent within the primary health care service philosophy adopted at Alma-Ata. These principles are the catalyst for interprofessional and inter-sectoral health care collaboration in the provision of comprehensive health care to the public.

Figure 6.1.1 Public Health Nurse in Action

"Public Health, 2009" by the Saskatchewan Union of Nurses is licensed under a CC BY 4.0 International License.

Providing Primary Health Care: Complex Client Needs and the Shift to Care in the Community Sector

Worldwide, the population of persons over the age of 65 is growing, and in most developed countries the increase is most striking in those aged 80 and older (Kwan, Chi, Lam, Lam, & Chou, 2000). The demographics of Canada are changing rapidly. The population of seniors in Canada is expected to grow from 3.5 million people in 1996 to an estimated 6.9 million by 2021 (Statistics Canada, 2015). By 2021, approximately 18.7 per cent of the population will be over the age of 65 (Health Canada, 2010). In 2014, seniors accounted for approximately 14 per cent of the population and 40 per cent of hospital resources (CNA, 2016). As the population grows older, the incidence of chronic illness will also rise (Government of Canada, 2015). Accordingly, the ability to respond to the health needs of older persons in a clinically (professional) and fiscally responsible manner has become a critical challenge of the current health care system (Canadian Institute for Health Information, 2010; Hirdes, Ljunggren, et al., 2008; Kwan et al., 2000). As stated by Leung, Liu, Chow, and Chi (2004) "even though aging is not synonymous with frailty, elderly people are major consumers of health care" (p. 71).

Moreover, Bernabei, Landi, Onder, Liperoti, and Gambassi (2008) and Hirdes, Ljunggren, et al., (2008) suggest that health care systems are increasingly confronted with older clients who are: affected by complex interactions of physical, social, medical, and environmental factors; receiving multiple and frequently interacting medications and treatments for an array of clinical con-

ditions; and often limited in terms of financial resources and support systems to meet increasing health needs.

Even though current health systems have evolved to provide sophisticated acute care, these systems continue to be challenged by complex geriatric clients with chronic medical, psychological, and social needs. The responsibility for their care, once the domain of the hospital and long-term care facilities, has shifted to the community (Bernabei et al., 2008). A systematic review of the literature documenting outcomes from home-based primary care (HBPC) programs for homebound older adults indicated that "specifically designed HBPC programs . . . can reduce hospitalizations and long-term care admissions while improving individual and caregiver quality of life and satisfaction with care" (Stall, Nowaczynski, & Sinha, 2014, p. 2249). Community health services play an increasingly prominent role in the health care system with the aim of minimizing inappropriate hospitalizations and/or admissions into long-term care (Gray et al., 2009; Hirdes, Poss, & Curtin-Telegdi, 2008).

Special attention must be paid to the Canadian Indigenous senior population. Many have complex health needs, but live in areas where it is more challenging and expensive to provide care. In 2006, almost 5 per cent of Indigenous people were aged 65 or older (Health Council of Canada, 2013). The social conditions on many reserves reflect the historical and political neglect that Canada has shown toward people of Indigenous ancestry (see Native People Social Conditions). Many Indigenous seniors are "isolated and struggling due to multiple factors in their lives and communities; they need more intensive support than non-Aboriginal seniors" (Health Council of Canada, 2013, p. 28). In addition, they may be intimidated by the institutionalized health care system. This intimidation may be attributed to care provider approaches similar to those described in a recent research study in which Indigenous patients "reported stories of bullying, fear, intimidation and lack of cultural understanding" (Cameron, Carmargo Plazas, Salas, Bourque Bearskin, & Hungler, K., 2014, p. E1). Health care providers who incorporate culturally appropriate practices into their care provide a welcoming environment that encourages the use of health care services by Indigenous people.

At least one million Canadian seniors are currently living with a mental illness (CNA, 2011). Neill, Hayward, and Peterson (2007) argue that there is a dire need to provide access to wellness care that supports healthy aging, noting that "the population of individuals over 60 is expected to increase to almost two billion internationally by 2050" (p. 425). However, clients of all ages suffer with chronic mental health issues. These individuals can be among the most disadvantaged groups in Canada. They are often living with multiple intersecting health and societal issues that potentiate reliance on a range of services (Schofield et al., 2016).

Research Note

Mitchell, L. A., Hirdes, J., Poss, J. W., Slegers-Boyd, C., Caldarelli, H. & Martin, L. (2015). Informal caregivers of clients with neurological conditions: Profiles, patterns and risk factors for distress from a home care prevalence study. *BMC Health Services Research*, 15, 350. doi:10.1186/s12913-015-1010-1

Purpose

The purpose of this project was to provide a profile of caregivers of home care clients with neurological conditions. The study also examined prevalence of caregiver distress and the association between neurological conditions and other client and caregiver characteristics with distress.

Discussion

The study population included home care clients in Winnipeg, Manitoba and the province of Ontario. Neurological conditions included in the study were Alzheimer's disease and related dementias, multiple sclerosis, amyotrophic lateral sclerosis, Parkinson's disease, Huntington disease, epilepsy, muscular dystrophy, cerebral palsy, traumatic brain injury, spinal cord injury, and stroke. Home care client characteristics and caregiver characteristics were collected and analyzed for each neurological condition. Risk factors associated with caregiver distress were identified.

Results

Many home care clients were found to have one or more of the neurological conditions (38.8 per cent to 41.9 per cent). Caregiver distress was twice as prevalent among caregivers of clients with neurological conditions (28.0 per cent). "The largest associations with caregiver distress were the amount of informal care hours provided in a week and the MAPLe algorithm, an indicator of a client's level of priority for care" (p. 350). Huntington disease was the neurological condition most strongly associated with caregiver distress. However, clients' clinical characteristics and the number of informal care hours were more strongly associated with caregiver distress. The provision of formal home care services from the community reduced caregiver stress.

Application to practice

Many informal caregivers providing care to these clients with neurological conditions experience distress. Multi-component support strategies are required for informal caregivers of the complex clients.

A report by the Commission on the Future of Health Care in Canada (Romanow, 2002) advocated for a strengthening of the Canadian health care system by inclusion of post-acute care, palliative care, and mental health home care services under a revised Canada Health Act, with these services covered by Medicare. In turn, Shamian (2007) stated:

> If policy makers are serious about ensuring the sustainability and quality of our health care system they must turn their attention to the role that home

> and community care plays. Failing to do so will result in a fragmented, weakened health care system. (p. 296)

A heightened and fundamental role of community services in the provision of health care across Canada is required to meet the growing number of clients in the community with complex and chronic medical, psychological, and social needs. As institutions have downsized and/or closed, the acuity and chronicity of client care has escalated in the community, both in home care and community mental health. Furthermore, the client's and the family's desire to remain in the home and to be cared for in the community has become a significant factor as client- and family-centred care evolves.

Yet this brings challenges for the clients, their families, health care providers, and the health care system. How can the complex needs these clients experience be optimally met, keeping quality, safety, and efficiency in mind? How do we as nurses ensure a client- and family-centred approach? How can we as health care providers optimize recovery, wellness in chronicity, and prevention as we provide care in the community?

Complexity, Community Care, and Collaborative Practice: The 3 "C's"

The increasing prevalence of chronic conditions in Western societies and ensuing need for non-acute quality client care bring the need for collaborative practice to the fore (Xyrichis & Lowton, 2008). Xyrichis and Lowton (2008) suggest that multidisciplinary teamwork will lead to an integrated approach to population health promotion and maintenance, while improving the efficacy and outcomes of client care.

Furthermore, community care encompasses medical, psychological, and social care, as well as health promotion and illness prevention strategies. For such an all-encompassing service to be delivered, an array of professionals and skills are required in a team approach (Xyrichis & Lowton, 2008). Neill et al. (2007) argue that a collaborative interprofessional client care model supports the comprehensive delivery of quality care through the integration of multiple professions.

Essential Learning Activity 6.1.1

Read the Canadian Nurses Association's "Position Statement on Interprofessional Collaboration" and identify the four principles that facilitate collaboration.

Diversity among the multidisciplinary team encourages cultural relevancy, bringing creativity to comprehensive client care. Nonetheless, Naylor (2012) found there is often inadequate communication among multidisciplinary teams and insufficient engagement with the client and family members. However, Naylor duly noted that in order to interrupt patterns of high health care utilization by the chronically ill and address the negative effects of this usage on quality and costs, innovative solutions to improve professional collaboration and client and family engagement have emerged in many health care settings. An example of such an innovative solution is **telenursing**, which assists the care providers to overcome difficulties raised by geographical distance and transportation problems (Souza-Junior, Mendes, Mazzo, & Godoy, 2016). Recognition of the client perspective, along with the engagement and participation of the client and family in that client's care planning and implementation, has led to quality care in many health care settings in Saskatchewan.

Essential Learning Activity 6.1.2

Watch this video "How does interprofessional collaboration impact care: The patient's perspective" (7:45) by Dr. Maria Wamsley, about the client- and family-centred approach, then answer the following questions:

1. What do we mean by patient-centred care?
2. What is disease-centred care?
3. Which professionals are on a patient-centred care team?
4. Why is it important to have multiple professionals on a patient-centred team?

From the Field

Canadian Nurse, a publication of the Canadian Nurses Association, will often highlight a Canadian nurse in the "Nurse to Know" portion of the journal. The following quotes are excerpted from these personal profiles, where the nurse is presented with questions at the end of his or her interview. Their responses reflect the discussion in the *background of this chapter*, as these leaders reflect on their own experiences as nurses within the Canadian health care system, including what they see as challenges and/or changes needed.

(a) What do you like least about being a nurse?

"The lack of true teamwork in inter-professional teams." —Marion Rattray (Eggertson, 2016, p. 37)

(b) What is your biggest regret?

"Trying to tell a resident at Massachusetts General that he was wrong and that I had a better idea. I should have just offered him cookies." —Gina Browne (Geller, 2015a, p. 35)

(c) Name one change you would like to make to the health system.

"I'd increase services such as youth centres and food and clothing banks that promote community health and well-being." —Julie Francis (Geller, 2013, p. 35)

(d) Name one change you would like to make to the health system.

"I would remove all borders." —John Pringle (Cavanaugh, 2013, p. 35)

(e) What is the best thing about your current job?

"Having the autonomy to make a tangible difference in people's lives." —Helen Boyd (Jaimet, 2013a, p. 35)

(f) Name one change you would like to make to the health system.

"I'd enhance services for those living with addictions and mental health issues." —Helen Boyd (Jaimet, 2013a, p. 35)

"That it's not such a 'system'; it should be about what's best for the patient." —Hazel Booth (Jaimet, 2013b, p. 33)

"I'd reduce fragmentation in health-care services." —Angelique Benois (Geller, 2015b, p. 27)

"I would like to see more use of integrated health-care information systems to improve care coordination and reduce duplication and redundancies." —Manal Kleib (Geller, 2014, p. 37)

These notable reflections are a snapshot from the many exemplary nurse leaders (frontline and administrative) across Canada. They speak to the importance of the centrality of the client and family; seamless care from one service to another; collaboration and teamwork; and community care and systems integration to optimize care, safety, and efficiencies.

6.2 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 (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.

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).

6.3 COLLABORATION AND TEAMWORK

Collaborative Practice

"Many leadership theorists and practitioners have recognized the value of teams in decision making and in accomplishing the work of the organization" (Sanford & Moore, 2015). Collaboration refers to a collective action focused on achieving a common goal "in a spirit of harmony and trust" (Franklin, Bernhardt, Lopez, Long-Middleton, & Davis, 2015, p. 2). The question is what makes this process successful, and what potentiates the synergistic influence?

Essential Learning Activity 6.3.1

1. Click here to read "Ten Lessons in Collaboration" (Gardner, 2005). While Gardner (2005) is an older publication, the author provides a thorough portrayal of collaborative practice and, more importantly, a comprehensive exploration of ten important lessons to consider in collaborative relationships and practice. The discussion reflects the many components of collaboration that have been integral to nursing practice in interprofessional teamwork and leadership.
2. The Canadian Nurses Association commissioned a paper titled "Interprofessional Collaborative Teams" in 2012. Read the document, then answer the following questions:
   (a) Name five different types of interprofessional collaborative teams.
   (b) Which ones have you experienced during your clinical practice?
   (c) Provide at least one recommendation to enhance interprofessional teamwork, based on your experience.
3. For a brief overview, watch the following video "Interdisciplinary Collaboration in Health Care Teams" (10:01) with Alanna Branton, then answer the following question: What are the barriers and enablers to interdisciplinary collaboration found in Canadian health care teams?

Dynamics of Teamwork

One must acquire an understanding and develop a sense of when it is important to be the leader, the collaborator, and indeed, at times, the follower. Likewise, a keen understanding of being a mentee, and when to transition from a mentee to a mentor, is critical. Ultimately one moves back and forth between these roles over the course of a relationship, including the relationship with the client and relationships within interprofessional collaborative teams. The videos in the following activity illustrate the relational dynamics of successful teams.

Essential Learning Activity 6.3.2

For more information on teamwork, watch the following videos, then answer the questions that follow:

1. Tom Wujec's TED Talk titled "Build a Tower, Build a Team" (7:22).
   (a) Which team performed consistently well?
   (b) Which team did the very best?
   (c) Why are administrative assistants important to the CEO team?
   (d) Do financial incentives contribute to success?
2. Praveen Verma's video on teamwork titled "Motivational Video on Teamwork, Smart Work" (6:38).
   (a) What is the moral of this story?

SUMMARY

Given the increasing complexity of client needs and the shift to community care, leadership and interprofessional collaboration are paramount in our current health system. Sound interprofessional leadership and collaborative practice should be the cornerstone of any nursing leadership practice, whether one is working with or mentoring a group of employees, or engaged with a multidisciplinary team in a complex client's care.

Client and family engagement has never been more important in our health care system than it is today. As health care providers and nurse leaders, our ultimate role is to meet our client needs with a client- and family-centred philosophy, which aims to understand "where the client is at." As a registered nurse, make this engagement happen—promote it and nurture it. It is the client's right, and indeed the client can be one of your greatest resources in determining a plan of care for successful client outcomes.

Leadership and interprofessional collaboration are strengthened with the knowledge and skill set of emotional intelligence, reflective practice, shared leadership, appreciative inquiry, and with the ten lessons in collaboration so eloquently outlined by Gardner (2005). Healthy and positive team dynamics are essential for optimal interprofessional collaborative relationships. It is critical to identify and understand any challenges related to these dynamics and to have transparent team discussions about such challenges early on in your team relationships.

Always seek to understand others, place your focus on strengths, and continuously reflect and learn when things do not go as expected. With these, your nursing world will open to endless possibilities, for the client, for your team, and for you personally.

Additional resources on interprofessional collaboration can be found on the Canadian Nurses Association website.

After completing this chapter, you should now be able to:

1. Describe the increasing complexity of health care needs in the community and the implications of that complexity within our current health system.
2. Illustrate the need for interprofessional collaboration in community care.
3. Explain the importance of client and family engagement in their care.
4. Identify parallels between leadership characteristics or styles and interprofessional leadership within collaborative practice.
5. Describe specific skills and practices that support interprofessional leadership and collaboration.
6. Recognize cornerstone components that can lead to successful collaboration.
7. Describe relational dynamics of positive teams.

Exercises

1. Discuss a client situation in which an interprofessional collaborative approach could be helpful.
2. In the above scenario, discuss how you would set the stage for interprofessional collaboration, including client and family engagement.
3. Identify the elements of appreciative inquiry and how appreciative inquiry supports nurse leaders in community practice.
4. Discuss what reflective practice means to you and how it has or will help you in your nursing practice.

5. Create a scenario where some or all of the ten lessons in collaboration (Gardner, 2005) could support a complex client situation.
6. What did you learn from the "Build a Tower, Build a Team" video? How do team dynamics impact the team and its success?

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7. Leadership in Quality Management and Safety

JOAN WAGNER

> *The symptoms or the sufferings generally considered to be inevitable and incident to the disease are very often not symptoms of the disease at all, but of something quite different.*
>
> —Florence Nightingale (1860, p. 12)

INTRODUCTION

This chapter will focus on quality management (QM) and the maintenance of safety within health care management. You will read about recent significant events related to quality management that have occurred in the United Kingdom and the United States, bringing international attention to patient safety issues. Finally, Lean, a QM strategy, and the plan-do-study-act cycle (PDSA) will be introduced to familiarize you with QM terms and techniques often used in the province of Saskatchewan.

Quality management refers to "the philosophy of a health care culture that emphasizes patient satisfaction, innovation and employee involvement" (Folse, adapted by Wong, 2015, p. 392). **Quality assurance (QA)** refers to the regular monitoring and evaluation of services to ensure that they meet the established standards of practice. **Quality improvement (QI)** refers to the ongoing work required to support optimum health for patients, through continued review and revision of processes and procedures according to best practices, emphasizing patient satisfaction, innovation, and employee involvement (Folse, adapted by Wong, 2015).

Figure 7.1 Rigorous Training Ensures Highest Quality Health Care and Outcomes for Patients

[n.d.], "Infusion Protocol Display," photo courtesy of the Saskatchewan Health Authority (formerly Regina Qu'Appelle Health Region) collection number 2003.8-1304, is licensed under a Creative Commons Attribution 4.0 International License.

QI is a fundamental responsibility of all health care providers. Florence Nightingale, one of the first QI experts, changed the provision of health care throughout the world. Her vision of nursing in hospitals "foreshadowed what, more than a century later would be designated a Magnet hospital" (Shiller, 2013, p. 1).

Learning Objectives

1. Describe the key issues leading to the development of Magnet hospitals.
2. Identify how Magnet hospitals changed health care in the United States.
3. Describe the key issues leading to the publication of the Francis report in the UK.
4. Describe the features of "a culture of safety."
5. Appraise the use of Lean in health care.
6. Appraise the plan-do-study-act (PDSA) cycle as a basis for QI work.
7. Identify your leadership imperative to create safe work environments and support QI work.

7.1 MAGNET HOSPITALS

Emergence of Magnet Hospitals

Hospitals are a vital health care resource for our communities. Community members usually spend the first and last days of their lives in these buildings, and they regard the hospital as an important health resource that will support them should they be injured or become critically ill. Thus, when hospitals are forced to shut down beds and deny admission to sick people, it becomes a community crisis. Such a crisis occurred in the United States during the 1980s and 1990s when many hospital beds were closed due to a shortage of nurses. However, not all hospitals faced calamity. Some hospitals were fully staffed and remained untouched by the nursing shortages. In 1982, a research team from the American Academy of Nursing identified 41 such hospitals that were not experiencing nurse employment or retention issues. These hospitals became known as **Magnet hospitals**.

A review of the Magnet hospitals (McClure, Poulin, Sovie, & Wandelt, 1983) revealed 14 attributes or "forces of magnetism" (Goode, Blegen, Park, Vaughn, & Spetz, 2011) that were unique to Magnet hospitals. These "forces" or environmental influences were associated with higher levels of nurse job satisfaction and reduced nurse burnout (McHugh et al., 2013). Magnet hospitals also displayed improved patient outcomes, such as lower patient fall rates, overall reduced mortality rates, and lower mortality rates for very low birth weight infants (McHugh et al., 2013).

The Magnet Recognition Program, formalized in the 1990s, required hospitals desiring Magnet status to demonstrate evidence of organizational reform of nurses' work environment that would facilitate the achievement of desired patient outcomes. The 14 forces of magnetism described by McClure et al. (1983) had evolved into five goals: (1) transformational leadership; (2) structural

empowerment; (3) exemplary professional practice; (4) new knowledge and improvements; and (5) empirical outcomes that are embedded in each of the four previous domains (McHugh et al., 2013). There are presently 389 hospitals in the United States that have demonstrated reform of nurses' work environment and achieved Magnet hospital status.

Essential Learning Activity 7.1.1

Watch this video titled "Magnet Recognition Program Overview" (5:55) by Mouayad Mohtar, to find out more about the five requirements of Magnet hospitals, then answer the following questions:

1. What are the five components of the Magnet model?
2. What are the main characteristics of each of the five components?

Patient Outcomes and Magnet Hospitals

The Magnet hospital model was originally developed to improve RN recruitment and retention. As researchers studied Magnet hospitals, they soon came to the realization that improved patient outcomes were a direct positive outcome of the organizational reform of the nurses' work environment. A meta-analysis of the literature from 2006 to 2012 by Krueger, Funk, Green, and Kuznar (2013) indicated that there are eight categories of nurse-related variables (nurse hospital work environment, Magnet status, nurse–physician communication, job demands, staffing, education, years of experience, and certification) that have an impact on patient outcomes. Sixteen studies retained in the review revealed that there are significant relationships between these nurse-related variables and three patient outcomes: patient adverse advents (infections, pressure ulcers, prolonged length of stay, mortality rates, failure to rescue, medication errors, patient falls, post-operative hemorrhage, acute myocardial infarction, congestive heart failure, stroke, and craniotomy); cost of patient care; and expected patient outcomes (self-care and readiness for discharge) (Krueger et al., 2013). Review of the Magnet hospital research indicated that staffing was the most stable nurse variable predictor of patient outcomes (Krueger et al., 2013). Magnet hospital research from 2006 to 2015 successfully demonstrated the association between improved nurse variables and successful nurse and patient outcomes. Additionally, a comparison of Magnet hospitals and non-Magnet hospitals demonstrated significantly greater improvements in work environment and nurse and patient outcomes for Magnet hospitals (Kutney-Lee et al., 2015).

Research Note

Ma, C., & Park, S. H. (2015). Hospital Magnet status, unit work environment and pressure ulcers. *Journal of Nursing Scholarship*, 47(6), 565–573.

Purpose

To identify how organizational nursing factors at different structural levels (i.e., unit-level work environment and hospital Magnet status) are associated with hospital-acquired pressure ulcers (HAPUs) in US acute care hospitals (Ma & Park, 2015, p. 565).

Discussion

Cross-sectional observational study used responses from 33,485 RNs to measure work environments.

The unit of analysis was the nursing unit, and the study included 1,381 units in 373 hospitals in the US.... Both hospital and unit environments were significantly associated with HAPUs, and the unit-level work environment can be more influential in reducing HAPUs (Ma & Park, 2015, p. 565).

Application to practice

Investment in the nurse work environments at both the hospital level and unit level has the potential to reduce HAPUs, and in addition to hospital-level initiatives (e.g., Magnet recognition program), efforts targeting on-unit work environments deserve more attention (Ma & Park, 2015, p. 565).

7.2 THE FRANCIS REPORT

A public inquiry into poor care at the Mid Staffordshire NHS Foundation Trust in the UK documented the unnecessary deaths of up to 1,200 people between 2005 and 2009 (Francis, 2013). The first report (Francis, 2010) coming out of the inquiry described an organization that was focused on saving money and creating efficiencies in the system rather than on providing safe quality care to patients. The second report (Francis, 2013) advocated for the organizational culture to be changed to a culture where patient safety and well-being would be the primary focus of management and staff (Muls et al., 2015). Shock waves swelled throughout the UK as news regarding the abusive care spread to the public. Major regulatory organizations and all trusts in the UK reviewed their policies, procedures, and actual processes for provision of care. Action plans were developed to create change and ensure that organizations had a culture responsive to patients' needs and preferences, with an emphasis on patient safety.

Essential Learning Activity 7.2.1

Watch this video of Catherine Foot interviewing Robert Francis QC (chair of the Francis inquiry) titled "Catherine Foot in conversation with Robert Francis" (9:47), then answer the following questions:

1. Describe one of the patient stories that Francis shared. Why did the board or coroner not hear about this patient?
2. Why did staff not come forward with examples of poor patient care?

Watch a short video titled "Diane Eltringham: Nurses responses to the Francis Report" (3:04), then answer the following questions:

1. What happened to care delivery after the Francis report?
2. How has the organizational culture changed?
3. What was the change that made the biggest difference to patient care?

7.3 PATIENT SAFETY CULTURE

Health care systems around the world have come to the realization that the presence of a positive patient safety culture within each organization is essential for high-quality and compassionate patient care (Institute of Medicine, 2000; WHO, 2008). Improvement of patient safety is also considered to be a cost-effective intervention since it reduces costs associated with iatrogenic illnesses. Medication error is one documented example of a cost that may be lowered by placing an emphasis on patient safety. In the United States, medication errors cost approximately $19.5 billion and led to 2,500 excess deaths in 2008 (Shreve et al., 2010, as cited in Saleh, Darawad, & Al-Hussami, 2015). Ulrich and Kear (2015) summarize patient outcomes found in safety literature by stating that there is mounting empirical evidence demonstrating a direct link between patient safety culture and patient outcomes, financial outcomes, patient satisfaction, health care clinician behaviours, and the safety of health care professionals. In other words, for a health care organization to be successful, it must exhibit a positive patient safety culture.

Definition of a Patient Safety Culture

An initial review of the literature indicates that the term *patient safety culture* has emerged recently from the work on health care quality improvement. Saleh, Darawad, and Al-Hussami (2015) suggest that the concept of a safety culture first appeared in response to the Chernobyl nuclear reactor accident (1986), which was a direct outcome of human action rather than

mechanical breakdown. A culture of safety is defined by the European Society for Quality in Healthcare as

> The integrated pattern of individual and organizational behavior, based upon shared beliefs and values that continuously seek to minimize patient harm, which may result from the processes of care delivery. (European Union Network for Patient Safety, 2010, p. 4)

Insights into Patient Safety Cultures

The 2013 Francis report emphasizes the need for organizations to keep alive a culture that is responsive to patients, or *patient-centred*. The UK Department of Health developed and publicized "**6 C's**" that were to guide their vision and strategy for leadership in nursing, midwifery, and care staff. These 6 C's, consisting of care, compassion, competence, communication, courage, and commitment, were not new; however prioritizing them as principles to guide the organizations was new (Muls et al., 2015).

Essential Learning Activity 7.3.1

Watch the video "6 C's in Nursing" (3:32) to find out more, then answer the following questions:

1. List and describe the 6 C's in nursing that lead innovation and change in the patient care environment in the UK.
2. Do you think these 6 C's are present in the Canadian health care environment? Please discuss.

Health care organizations around the world are striving to strengthen their safety cultures. Cultures do not change easily; instead they adapt to existing conditions and tend to mirror their environment. Many different aspects of an organization play a role in the development and maintenance of a safety culture. Sammer et al. described a safety culture as consisting of "seven subcultures, including leadership, teamwork, evidence-based practice, communication, learning, just (a culture that identifies errors as systems failures rather than individual failures) and patient-centred" (as cited in Saleh et al., 2015, p. 340).

One example of how these subcultures interact, or fail to interact, may be found in a recent study centred on the patient safety culture in nephrology practice settings across the US. This study revealed gaps between how nurses perceive patient safety and how managers and administrators perceive it. Research results illustrated a need for further discussion between care providers and managers regarding patient safety and a need for overall transparency and open communication throughout the organization (Ulrich & Kear, 2015).

Nursing attributes, such as burnout and sense of coherence, are also known to have a direct association with the patient safety culture. A Norwegian study supported this connection by indicating that there was "an association between a positive safety culture and absence of [RN] burnout and high ability to cope with stressful situations" (Vifladt, Simonsen, Lydersen, & Farup, 2016, p. 33).

Essential Learning Activity 7.3.2

Explore the tools and resources on the Leader page of the Canadian Patient Safety Institute website.

Explore the proposed framework titled "The measurement and monitoring of safety" published in 2014 by the UK's National Health Service.

Now answer the following questions:

1. What are the five dimensions required to measure and monitor safety?
2. How would you measure each dimension of the proposed framework in Canadian hospitals?

7.4 LEAN

Lean arose from the Toyota success story of the 1960s. It is a management strategy used to evaluate organizational processes, identifying those that add value to the business, eliminating waste, and improving the flow with a focus on creating better value for time and money (Crema & Verbano, 2015; Johnson, Smith, & Mastro, 2012). Crema and Verbano (2015) maintain that this strategy emphasizes standardization of process in order to facilitate the identification of unexpected events that can be fixed quickly.

The Lean approach has been used in the following areas of health care: recruitment and hiring, nursing informatics, laboratory functions, patient care environment, radiology, patient safety,

trauma care, and cost reductions. In addition, Lean has contributed to process improvements with regards to clinical procedures, appointment compliance, patient flow, referrals, wait and discharge times, and re-hospitalizations. Johnson, Smith, and Mastro (2012) highlight the fact that Lean is being used more and more frequently as a system-wide operating framework.

The Lean approach was introduced to all Saskatchewan health care organizations in 2010 by the provincial government as a quality improvement approach. Lean has faced many challenges over the past years. However, despite these challenges, it has continued to provide health care leaders with excellent tools and processes that support continuous QI.

Essential Learning Activity 7.4.1

To see an example of Lean in action, watch this YouTube video "Advanced Lean in Healthcare" (3:08) from Lucile Packard Children's Hospital at Stanford, then answer the following questions:

1. What does Lean aim for?
2. How is patient flow improved?
3. Who or what is at the centre of Lean?

Lean focuses on resource optimization rather than on excellence or quality of patient care. Concerns have been voiced about the Lean emphasis on "doing more with less" and the need for significant changes. There also has been evidence of anxiety within the health care community regarding misplaced priorities and the safety of patients in a Lean health care environment.

Provision of patient-centred care comes from the specialized knowledge base in concrete ways that nurses practise in their varied roles, from management to direct care. While Lean methods of improving efficiency and cost-cutting strategies are important for hospitals and governments, some health care leaders and researchers believe that Lean methods ignore the actual work of nurses (Wagner, Brooks, & Urban, 2018, p. 22).

However, many researchers, such as Simons et al. (2015), believe that Lean management has the potential to contribute to a patient safety culture. Lean, with its inherent philosophy of quality management, places the patient at the centre and Lean tools are used to motivate employees and increase the efficiency of the organization while also improving patient care quality and patient

safety. Other researchers, such as Crema and Verbano (2015), suggest that Lean, a business management strategy with an ability to analyze, design, and manage processes, is an excellent tool to strengthen medical error avoidance. Finally, Kaplan, Patterson, Ching, and Blackmore (2014) emphasize that Lean tools are not the sole answer to an organization's concerns and are best employed as part of a comprehensive management system with commitment to organizational change and innovative leadership.

Johnson, Smith, and Mastro (2012) advocate that nurses are the ideal leaders of groundbreaking Lean and QI work. Nurses combine experience leading interdisciplinary teams, systems knowledge, and strong assessment skills with a focus on patient advocacy and a commitment to quality patient care. These combined attributes are required to steer an organization toward QI changes that are focused on both cost efficiency and maintenance of a strong patient safety culture. Health care requires nurses, with their versatile skills, knowledge, and experience, to take leadership of QI innovations.

7.5 PLAN, DO, STUDY, AND ACT

The plan-do-study-act (PDSA) cycle is one of several quality improvement tools or techniques used to improve care. It is easily used at all levels of the organization and focuses on the development, testing, evaluation, and implementation of quality improvement solutions. The PDSA cycle consists of *plan* (decide on the change to be tested), *do* (perform the change), *study* (look at the data before and after the change and determine what has been learned), and *act* (plan another change cycle with required modifications or move to full implementation). Large-scale changes are implemented only after a PDSA cycle consisting of rapid small-scale sequential or parallel tests has been conducted to investigate the proposed changes and determine if they work (Gillam & Siriwardena, 2013). PDSA has been described as a tool that can be used to evaluate current service delivery and to test and develop innovative ideas (Byrne, Xu, & Carr, 2015).

Essential Learning Activity 7.5.1

Watch these two videos for more detailed information on how to use PDSA: "PDSA Part 1" (4:45) and "PDSA Part 2" (3:45).

SUMMARY

This chapter introduced the philosophy of QM in health care and highlighted events across the international health care environment that have put a focus on patient safety culture, such as the development of Magnet hospitals in the US and the Francis inquiry in the UK. In addition, common QI approaches such as Magnet hospitals and Lean were described and discussed, with a focus on their contribution to patient safety. Finally, PDSA, a prevalent QI tool, was introduced.

After completing this chapter, you should now be able to:

1. Describe the key issues leading to the development of Magnet hospitals.
2. Identify how Magnet hospitals changed health care in the United States.
3. Describe the key issues leading to the publication of the Francis report in the UK.
4. Describe the features of "a culture of safety."
5. Appraise the use of Lean in health care.
6. Appraise the plan-do-study-act (PDSA) cycle as a basis for QI work.
7. Identify your leadership imperative to create safe work environments and support QI work.

Exercises

1. Apply the proposed 2014 NHS framework for measuring and monitoring safety to a hospital where you have had a clinical placement. Can you see areas for improvement in measurement and monitoring of safety?
2. You are the director of nursing for a long-term care facility. When an elderly woman falls out of her bed during the night and breaks her hip, you look at recent incident reports and notice that there has been an increase in residents' nighttime falls. Use the PDSA QI tool to find a solution that will reduce the nighttime falls of residents.

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8. Leaders and Evidence-Informed Decision Making

MAURA MACPHEE

> *Evidence-based practice can only occur if leaders plan for and provide the organizational structures and processes. Success lies in making these structures and processes "transparent" and part of normal daily business for clinicians.*
>
> —R. P. Newhouse (2007, p. 21)

INTRODUCTION

This chapter will demonstrate how leaders influence those around them to make evidence-informed decisions and deliver evidence-informed care. Evidence-informed care is associated with positive outcomes for patients, such as lower rates of injury and mortality, and less burnout and turnover for nurses. Within health care settings, leaders influence organizational culture by promoting the use of evidence and critical thinking. Their quest for evidence-informed excellence is often challenged by competing concerns, such as finances, which can put patients and nurses at risk. Brave leaders are those who seek out evidence and use the best available evidence to guide them.

Learning Objectives

1. Justify the importance of evidence-informed practice to nursing.
2. Explain how evidence-informed leaders contribute to quality, safe patient care delivery.
3. Identify barriers to use of evidence within health care organizations.

8.1 EVIDENCE-INFORMED LEADERSHIP

Let's begin with a review of evidence-informed practice, also known as evidence-based practice. Whether you are a student, a practicing nurse, or a nurse leader with formal authority within a health care setting, you are expected to use evidence to inform your decisions and your actions.

Essential Learning Activity 8.1.1

Read the Canadian Nurses Association's Position Statement titled "Evidence-Informed Decision-Making and Nursing Practice," then answer the following question:

1. What types of evidence should nurses and nurse leaders use when making decisions?

The CNA Position Statement indicates that it's important to evaluate the quality of evidence. Nurses and nurse leaders need to know where to locate different types of evidence; they need to determine whether or not it is trustworthy evidence (i.e., valid, reliable); and they need to know how to use it in their practice—whether caring for patients or leading within a health care setting. Schools of nursing, in their undergraduate and graduate programs, include critical thinking and assessment and use of evidence as important learner competencies.

8.2 INNOVATION, LEADERSHIP, AND CLUSTERS OF INFLUENCE

Essential Learning Activity 8.2.1

Watch the following YouTube videos:

1. "What is Evidence-Based Practice?" with Ann Dabrow Woods (3:27)
2. "Evidence-Informed Practice" by the Ontario Centre of Excellence for Child and Youth Mental Health (4:14)

In the first video, Dabrow states that the Joanna Briggs Institute is a great source for health care evidence. Look at the Institute's website. Resources like this are vital to evidence-informed nurse leaders. The speaker in the first video describes how McMaster University in Canada actually coined the term *evidence-based practice*.

The second video reinforces the importance of using best available evidence in service provision.

After watching both videos, answer the following questions: What should organizational leaders do to promote evidence-informed practice? What should individual nurses do to optimize use of evidence in their practice?

Regardless of whether you are a student nurse or are a leader in a formal role (e.g., unit manager, facility director, chief nursing officer), your decisions need to be informed by evidence. And yet, as emphasized in the first video, only a small proportion (20 per cent) of the decisions made in health care are based on evidence. Furthermore, Dabrow Woods states, "It takes 15 to 20 years to get evidence into practice." What is going on?

Essential Learning Activity 8.2.2

Read Dr. Donald Berwick's 2003 paper titled "Disseminating Innovations in Health Care." This classic paper discusses why innovation, or positive change, is difficult to integrate within health care settings.

According to innovation experts such as Dr. Donald Berwick, "failure to use available science is costly and harmful; it leads to overuse of unhelpful care, underuse of effective care, and errors in execution" (2003, p. 1969). For nurses and doctors, our errors can cost injury and even loss of life. Dr. Berwick asks the following set of questions:

> Why is the gap between knowledge and practice so large?
>
> Why do clinical care systems not incorporate the findings of clinical science or copy "best known" practices reliably, quickly, and even gratefully into their daily work simply as a matter of course? (p. 1969)

For successful innovation uptake and use, there are three basic clusters of influence that need to be addressed by leaders at all levels of a health care organization: perceptions of the innovation, composition of staff, and contextual information.

Perceptions of the Innovation

The first cluster is perceptions of the innovation. Leaders need to thoughtfully consider how to introduce a new policy or protocol or a new piece of technology or medicine: first impressions count. Leaders need to consider five characteristics of an innovation by asking the following questions before introducing that innovation to their staff:

1. Will staff perceive the innovation as a *benefit* to them?
2. Does the innovation fit with staff's *current needs*? (e.g., Will the innovation enhance care delivery?)
3. Is the innovation easy to understand? Is it simple to do? Complexity (e.g., multiple parts, steps) slows down innovation. *Simplicity* promotes "spread."
4. Is it possible to do a small-scale pilot? *Trialability* improves the rate of innovation.
5. Is it possible for staff to observe the innovation in progress, to learn about it and answer any questions or concerns they may have? *Observability* and *trialability* often work well together.

Leaders, therefore, need to plan in advance for how they will influence staff's first impressions of an innovation. Change is frightening to people; we typically resist proposed changes because change often involves extra effort, resources, and time. With the busyness in our lives, we need to know, from leaders, that they are making evidence-informed decisions about proposed changes. Why should we change the status quo?

Composition of Staff

The second cluster of influence that leaders need to think about is the composition of their staff. Leaders cannot impose innovation on their own; they need the right staff helping them out. Without the right complement of helpers, their attempts at innovation will fail. Take a look at Figure 2 in the Berwick paper (2003, p. 1972). For innovation to succeed, you need: innovators, early adopters, and an early majority.

Innovators are the source of proposed positive changes. They are those individuals within an organization that read scientific journals, attend conferences, and keep informed about best

practices. They are well connected with sources of evidence outside the organization, and they bring ideas back to the organization.

Early adopters are well connected within the organization. They are the leaders who have influence and authority. They can make things happen, given their formal power within the organization. These leaders believe in the value of innovation, and they support their innovators. As one example, an early adopter leader provides release time and financial support for a nurse educator to attend a conference on medical-surgical practice innovations. The nurse educator brings back great ideas and presents them to the leadership and staff.

Once an early adopter leader recognizes the potential of an innovation, the leader gets to work, planning for how to present the innovation to staff (i.e., how to make the first impression). The leader proposes a pilot and asks for staff volunteers to help. Those staff who step forward to trial the innovation make up the **early majority**. In many instances, the early majority consists of new graduate nurses who are eager to try something new.

If the pilot has been successful, the rest of the staff—who have observed the positive outcomes from the pilot—will readily adopt the innovation. These staff comprise the **late majority**. And lastly, there are some staff, the **laggards**, who remain resistant to change. Leaders should listen to their concerns, but ultimately, if some staff members are uncomfortable with the change, it may be time for them to look for another unit or place of employment. The laggards typically represent only a small number of staff (16 per cent), and yet leaders often get sidetracked trying to convince them to change. The fact is that they may never change.

Leaders, therefore, should focus their energies on the initial 20 per cent of staff at the beginning of the innovation curve (i.e., innovators, early adopters, early majority) who need leadership support: they are the critical mass for positive change.

Contextual Information

The third cluster of influence consists of contextual factors that facilitate or impede innovation within the organization. The leadership and the organizational culture both have major influence over innovation spread. You need evidence-informed leaders (i.e., early adopters) throughout the organization who: (1) promote staff interactions, discussions, and networking across the organization (remember observability?); (2) trust and enable their staff to adapt new ideas to their needs; (3) invest essential resources, supports, and time in innovation; and (4) "walk the talk" or champion the innovations themselves. As Dr. Berwick (2003) wrote about Captain James Cook, an early explorer and innovator and early adopter: "James Cook had to eat his own sauerkraut, and health care leaders who want to spread change must change themselves first" (p. 1974).

Essential Learning Activity 8.2.3

Answer the following questions:

1. What kind of leaders would you like to work with? Why?
2. What kind of organization would you like to work in? Why?

From the Field

Let's take a look at what happens when you do not have evidence-informed leadership.

In England, there is a single payer system, the National Health Service (NHS), which is very similar to our health care system in Canada. The NHS is made up of health regions known as trusts. Over a period of several years, evidence around safe staffing was ignored by the leadership within one NHS trust, the Mid Staffordshire Trust. To balance their budget, the trust's leadership began replacing nurses with unlicensed care aides. After a public outcry by the loved ones of patients who were harmed or died due to negligent care, an independent inquiry was conducted by the NHS to find out what was going on in the Mid Staffordshire Trust. The inquiry revealed appalling care conditions due to nurse understaffing. The NHS was "shamed" by this inquiry and vowed to enforce policies and procedures in place throughout all trusts to restore quality, safe public health care delivery.

The Mid Staffordshire Trust leadership chose to ignore over two decades of safe staffing research evidence. For example, the numbers (patient to nurse ratios) and the types of nurses (skill mix) are directly linked to rates of patient morbidity (e.g., hospital acquired infections, preventable falls, and pressure ulcers), patient mortality, and failure to rescue. Heavy nurse workloads, characterized by high patient to nurse ratios (e.g., 10 patients per nurse) results in adverse patient events and nurses' inability to detect changes or deterioration in patients' status (Berry & Curry, 2012). Richer skill mix, with proportionally more RNs among direct care staff, is associated with better patient outcomes (Needleman, 2016).

The NHS was puzzled: what went wrong? Why didn't the Mid Staffordshire leadership use the evidence to inform their staffing decisions? Dr. Berwick, who wrote a 2003 paper on innovation, is considered an internationally renowned expert on quality and safety. Dr. Berwick was asked by the NHS to review the inquiry report and to recommend quality and safety policy changes. Dr. Berwick's recommendations are set out in a document titled "A Promise to Learn—A Commitment to Act." What he recognized, right away, was that the Mid Staffordshire Trust had a culture of secrecy and oppression, as well as a significant lack of leadership throughout the organization. In fact, doctors and nurses were afraid to speak up. There was evidence of leaders bullying and threatening doctors and nurses who complained about unsafe work conditions.

Based on information from "Valuing Patient Safety: Responsible Workforce Design" (MacPhee, 2014).

One of Dr. Berwick's key recommendations to the NHS (discussed in the From the Field textbox) was about leadership. Leaders are essential for creating an open, transparent culture of learning, where everyone is expected to use the evidence to ensure best practice and best possible delivery of care to patients. Leaders are essential for modelling the way for others and providing the necessary information, resources, and supports so that all nurses and other staff have the means to provide quality, safe care to patients. Leaders are essential for promoting a culture of continuous learning, openness, and transparency toward sharing and using evidence to make a difference—what is known as a **learning organization**.

Take a look at the following table, from Dr. Berwick's "Promise to Learn." Under his recommendations on leadership, he identifies the overarching responsibility of all staff and leaders.

Table 8.2.1 Who and What for Staff and Leaders (*Data Source: Table based on material from Berwick, 2013, p. 16.*)

Who	What
All staff and leaders of NHS-funded organisations	Every person working in NHS-funded care has a duty to identify and help to reduce risks to the safety of patients, and to acquire the skills necessary to do so in relation to their own job, team, and adjacent teams. Leaders of health care provider organisations, managers, clinical leaders . . . have a duty to provide the environment, resources, and time to enable staff to acquire these skills.

All members of an organization, staff and leaders alike, are expected to contribute to a learning organization culture.

Essential Learning Activity 8.2.4

Watch the following three videos on learning organizations, then answer the questions that follow:

"What is a Learning Organization?" (4:56) by the Ontario Centre of Excellence for Child and Youth Mental Health

"Introduction to Organizational Learning" (3:13) by Peter Senge

"Learning Organisation" (2:01)

1. Imagine you are a nurse within a learning organization, such as the Ontario Centre of Excellence for Child and Youth Mental Health. Describe how you will contribute to the culture of continuous learning.
2. The Ontario Centre of Excellence for Child and Youth Mental Health adopted core values associated with learning organizations and continuous learning. Why do you think they chose these core values?

8.3 RESEARCH SUPPORTS A HEALTHY ORGANIZATION

Research on organizations from all different sectors (including industry, business, and health care) has shown that organizations that promote practices associated with learning organizations have significantly better outcomes, such as improved quality, efficiency, and effectiveness. Organizations and their leadership, therefore, are making wise investments when they support cultures that promote continuous learning (Robbins, Garman, Song, & McAlearney, 2012).

As you may have surmised by watching the video by Peter Senge, organizations do better when they expect everyone within the organization to "make a deep commitment to learning." In his presentation, "high leverage" refers to the ability to make positive changes, to be innovative. When we get stuck in one way of thinking and one way of doing things (habit), we miss opportunities to improve and enhance the way we work together. Senge urges us to break out of our old "mental models" and to "triangulate" or bring our knowledge and ideas together with others—to gain multiple perspectives. He also emphasizes that it takes time to "develop, adapt and apply." Evidence-informed leaders need to "walk the talk." Leaders have to constantly challenge the status quo and invite diverse perspectives from their staff, from patients and families, and from their colleagues to explore better ways for delivering quality, safe care within their organizations.

Let's return to the Mid Staffordshire Trust. Within the trust, leaders ignored evaluation data that reported adverse events, and they ignored patient complaints and staff complaints. They focused almost exclusively on financial targets set by the government to produce balanced budgets. The NHS finally commissioned a public inquiry of Mid Staffordshire Trust after a whistleblower group of families went to the media with stories of terrible injury to their loved ones. Julie Bailey, one of the organizers of the movement, lost her mother. The public and the media were responsible for government action.

Essential Learning Activity 8.3.1

Watch this Channel 4 News video titled "Mid Staffs: Julie Bailey and Jeremy Hunt" (7:51). The reporter interviews Julie Bailey, one of the organizers of the public movement (who lost her mother), and Jeremy Hunt, the Minister of Health. The video is dated February 6, 2013, shortly after the release of the Francis report on the Mid Staffordshire Trust.

In the video, Ms. Bailey concludes that "we need a leader" to make the changes necessary to ensure quality, safe care delivery. Ms. Bailey also asserts that change will not happen without new leadership. The reporter, however, challenges whether or not the resignation of the current leader will take care of the problem. What do you think?

Essential Learning Activity 8.3.2

Read the 2017 "Position Statement on Harm Reduction" from the British Columbia Nurses' Union (BCNU). The background of the position statement highlights how evidence-informed harm reduction approaches represent nursing principles. Identify those concepts of harm reduction that are associated with nursing professional standards and codes of ethics.

For more information on injectable drugs and risks that influence evidence-informed nursing, see the World Health Organization's web page on HIV/AIDS.

8.4 EVIDENCE-INFORMED NURSING: LEADING THE WAY

In British Columbia, illicit drug overdose deaths topped 914 in 2016, and in Alberta, there were 343 deaths in 2016 from fentanyl overdoses (Canadian Press, 2017). This opioid crisis in Canada and the US has spurred policy-makers and health care providers to seek guidance from research on mental health and addictions treatment.

Position statements are typically evidence-based documents that can be found on websites of professional organizations, regulatory colleges, unions, and the government. Although these documents are often referenced and fact-checked, they may also include guiding principles that reflect their organization's mission, vision, and values. It's important for nurses, therefore, to seek guidance from organizations that reflect professional nursing standards and codes of

ethics. For students, these documents are great resources, which also provide an introduction to the professional principles that define who we are as nurses.

The BCNU position statement referenced in the Essential Learning Activity above begins with bulleted principles, including "The BC Nurses' Union believes that harm reduction policies and programs can provide support for people coping with the effects of substance use" (BCNU, 2017). Note the references and the use of research evidence to describe key evidence-based harm reduction strategies. A number of recent research studies are included in this position statement. You'll see that the references include qualitative, quantitative, and economics (cost-effectiveness) research.

What does this mean from a leadership perspective? As nurses, we need to lead the way with respect to knowing the research evidence on topics that affect our patients, and more broadly, Canadian public health and well-being. Harm reduction is significant to nurses at local, provincial, and national levels—even globally. If you are interested in doing further exploration on harm reduction, see the World Health Organization's global perspective on reducing harm for anyone who uses injectable drugs here.

Research Note

The Study to Assess Long-Term Opioid Medication Effectiveness (SALOME) was a clinical research trial in Vancouver to determine whether a legally prescribed opioid, hydromorphone, could be an effective substitute for illicit injectable heroin. Another component of the study compared the efficacy of injectable heroin and hydromorphone to oral versions of these two opioids.

An interdisciplinary team of physicians, nurses, social workers, and counselors were involved in this study. This study demonstrated that injectable heroin could be substituted with injectable hydromorphone, an opioid with less social stigma than heroin. Oral versions of both medications were not effective in curbing illicit drug use. Supervised injection sites, managed by care teams with nurses, now have a variety of evidence-based treatment options (e.g., methadone, suboxone, hydromorphone) to offer individuals with chronic addictions—legal options that reduce potential harm, even death to some of our society's most vulnerable members.

An overview of harm reduction research can be found at SALOME Clinical Trial Questions and Answers.

SUMMARY

Return to the quote at the beginning of this chapter, rethinking it in terms of everything you have just read.

> *Evidence-based practice can only occur if leaders plan for and provide the organizational structures and processes. Success lies in making these structures and processes "transparent" and part of normal daily business for clinicians.*
>
> —R. P. Newhouse (2007, p. 21)

Evidence-informed leaders are early adopters who seek out the best available evidence and promote evidence-informed practices among their staff. These leaders provide the structures and the processes necessary to spread the use of evidence and innovation throughout their organizations. Evidence-informed leaders do not only seek out the best available evidence, but they use it to drive their decisions—that is to say, they "walk the talk." Moreover, evidence-informed leaders promote learning organization cultures of transparency and continuous learning.

Leaders who ignore the evidence are often the greatest barriers to quality, safe care delivery. As illustrated in the Mid Staffordshire Trust tragedy, there's more to evidence-informed leadership than having access to evidence or even use of evidence. Sir David Nicholson, the head of the NHS at that time, had access to lots of evidence, but he chose to focus on financial evidence, and the leaders under him focused almost exclusively on financial targets. Leaders influence how others interpret and share evidence, depending on other leadership attributes they possess. As discussed throughout this book, it takes other leadership attributes, such as authenticity, moral integrity, and effective use of power, to make a great leader.

After completing this chapter, you should now be able to:

1. Defend the importance of evidence-informed practice to nursing.
2. Explain how evidence-informed leaders contribute to quality, safe patient care delivery.
3. Identify barriers to use of evidence within health care organizations.

Exercises

Debate the following question with your classmates: When a leader ignores available evidence and allows serious quality or safety breaches to happen under his or her leadership, should he or she be given another chance to lead the organization?

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9. Common Change Theories and Application to Different Nursing Situations

SONIA UDOD AND JOAN WAGNER

> *Leaders take us to places we've never been before. But there are no freeways to the future, no paved highways to unknown, unexplored destinations. There's only wilderness. To step into the unknown, begin with the exploration of the inner territory. We continue to discover that the most critical knowledge for all of us—and for leaders especially—turns out to be self-knowledge.* (Kouzes & Posner, 2007, p. 346)

INTRODUCTION

Change is an essential component of nursing practice. Leading change is a challenge for nurse leaders amid the complexities and challenges of evolving health care environments in providing quality patient care. This chapter is designed to provide nurse leaders with guidance through various theories and frameworks to effectively support the change process in shaping healthy work environments. Additionally, you will learn about resistance to change and how to respond constructively to change. This chapter focuses on providing guidelines for nurse leaders on behaviours and practices for encouraging and facilitating change in the health care setting.

Learning Objectives

1. Explain why nurses have the opportunity to be change agents.
2. Identify how different theorists explain change.
3. Discuss how the nursing process is similar to the change process.
4. Discuss the medicine wheel as a change model.
5. Describe the nurse leader's role in implementing change and the call to action.
6. Differentiate among change strategies.

7. Recognize how to handle resistance to change.

The rapid pace of change in Canada's health care system provides opportunities for nurse leaders to refine and advance their leadership and management skills for advancing change. Various forces that drive change in health care include rising costs of treatment, new technologies, advances in science, workforce shortages, and an aging population. Change initiatives must always be implemented for good reason within the context of advancing institutional goals and objectives. Balancing change is a key challenge within a patient- and family-centred model to provide safe and reliable patient care (Stefancyk, Hancock, & Meadows, 2013; Saskatchewan Ministry of Health, 2011).

9.1 THE NURSE LEADER AS CHANGE AGENT

Nurse leaders must ensure the day-to-day operation of their unit(s) in a rapidly evolving health care system. Nurse leaders are often called upon to be agents of change and are often responsible for the success of a project. Yet the literature suggests that leaders continue to struggle with change despite the frequency with which they are involved in leading change (Gilley, Gilley, & McMillan, 2009; Quinn, 2004). A **change agent** is an individual who has formal or informal legitimate power and whose purpose is to direct and guide change (Sullivan, 2012). This person identifies a vision and rationale for the change and is a role model for nurses and other health care personnel.

Nurse leaders' behaviours influence staff actions that contribute to change (Drucker, 1999; Yukl, 2013). The significant number of changes that nurse leaders face require new ways of thinking about leading change and adapting to new ways of working. Moreover, leaders work closely with frontline care providers to identify necessary change in the workplace that would improve work processes and patient care. As such, nurse leaders must have the requisite skills for influencing human behaviour, including supervisory ability, intelligence, the need for achievement, decisiveness, and persistence to guide the process (Gilley et al., 2009). Effective change management requires the leader to be knowledgeable about the process, tools, and techniques required to improve outcomes (Shirey, 2013).

9.2 THEORIES AND MODELS OF CHANGE THEORIES

Knowledge of the science of change theory is critical to altering organizational systems. Being conversant with various change theories can provide a framework for implementing, managing, and evaluating change within the context of human behaviour. Change theories can be linear or non-linear; however, even linear theories do not unfold in a systematic and organized pattern. In the following section, we identify the role of leader and the typical pattern of events that occur in a change event.

Force Field Model and The Unfreezing-Change-Refreezing Model

Kurt Lewin (1951) is known as a pioneer in the study of group dynamics and organizational development. He theorized a three-stage model of change (unfreezing-change-refreezing model) in order to identify and examine the factors and forces that influence a situation. The theory requires leaders to reject prior knowledge and replace it with new information. It is based on the idea that if one can identify and determine the potency of forces, then it is possible to know the forces that need to be diminished or strengthened to bring about change (Burnes, 2004).

Lewin describes behaviour as "a dynamic balance of forces working in opposing directions" (cited in Shirey, 2013, p.1). The force field model is best applied to stable environments and he makes note of two types of forces: driving forces and restraining forces. **Driving forces** are those that push in a direction that causes the change to occur or that facilitate the change because they push a person in a desired direction. **Restraining forces** are those that counter the driving force and hinder the change because they push a person away from a desired direction. Finally, change can occur if the driving forces override or weaken the restraining forces.

This important force field model forms the foundation of Lewin's three-stage theory on change (1951) (see Figure 9.2.1). **Unfreezing** is the first stage, which involves the process of finding a method to assist individuals in letting go of an old pattern of behaviour and facilitating individuals in overcoming resistance and group conformity (Kritsonis, 2005). In this stage, disequilibrium occurs to disrupt the system, making it possible to identify the driving forces for the change and the likely restraining forces against it. A successful change ultimately involves strengthening the driving forces and weakening the restraining forces (Shirey, 2013). This can be achieved by the use of three methods: (1) increase the driving forces that direct the behaviour away from the existing situation or equilibrium; (2) decrease the restraining forces that negatively affect the movement away from the current equilibrium; or (3) combine the first two methods.

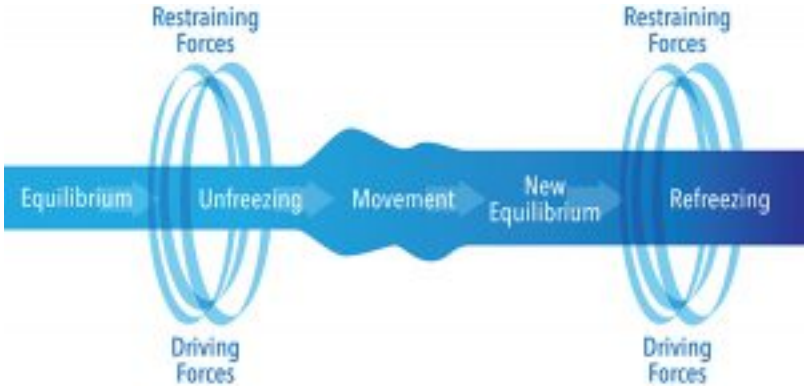
The second stage, **moving** or **change**, involves the process of a change in thoughts, feelings, and/or behaviours. Lewin (1951) describes three actions that can assist in movement: (1) persuading

others that the status quo is not beneficial and encouraging others to view a problem with a fresh perspective; (2) working with others to find new, relevant information that can help effect the desired change; and (3) connecting with powerful leaders who also support the change (Kristonis, 2005). This second stage is often the most difficult due to the fact that there is a level of uncertainty and fear associated with change (Shirey, 2013). Therefore, it is important to have a supportive team and clear communication in order to achieve the desired change.

Lastly, stage three, which Lewin called **refreezing**, involves establishing the change as a new habit. The third stage is necessary to ensure that the change implemented (in the second stage) will "stick" over time (Kristonis, 2005). Success at this stage will create a new equilibrium state known to be the new norm or higher level of performance expectation (Shirey, 2013).

Although Lewin's model on change is well known and widely accepted in health care settings, it is often criticized for being too simplistic and linear. Change is often unpredictable and complex, and an effective leader must be aware of many change models.

Figure 9.2.1 The Steps of the Unfreezing-Change-Refreezing Model



"The Steps of the Unfreezing–Change–Refreezing Model" by Sonia Udod and Joan Wagner, designed by JVDW Designs, is licensed under a CC BY 4.0 International License.

9.3 PLANNED CHANGE

Lippitt, Watson, and Westley (1958) focus more on the role and responsibility of the change agent than on the process of the change itself. Their theory expands Lewin's model of change into a seven-step process and emphasizes the participation of those affected by the change during

the planning steps (Kritsonis, 2005; Lippitt et al., 1958). The seven steps of the planned change model include: (1) diagnosing the problem; (2) assessing the motivation and capacity for change in the system; (3) assessing the resources and motivation of the change agent; (4) establishing change objectives and strategies; (5) determining the role of the change agent; (6) maintaining the change; and (7) gradually terminating the helping relationship as the change becomes part of the organizational culture (see Table 9.3.1).

The steps in this model place emphasis on those affected by the change, with a focus on communication skills, rapport building, problem-solving strategies, and establishing mechanisms for feedback (Kritsonis, 2005; Lehman, 2008).

Phases of Change

Ronald Havelock (1973) also modified Lewin's model of change to include six phases of change from planning to monitoring (see Table 9.3.1). It is believed that Havelock further developed the unfreezing-change-refreezing model to address two social forces that were gaining momentum in society at the time: "the explosion of scientific knowledge, and the increasing expectation by policy-makers, governments, business and society that scientific knowledge should be useful to society" (Estabrooks, Thompson, Lovely, & Hofmeyer, 2006, pp. 29–30). Havelock argued that adapting Lewin's change model to include knowledge building, which focused on a systematic integration of theories rather than disjointed approaches, would respond more effectively to real-life situations in managing change (Estabrooks et al., 2006).

The six phases of Havelock's model are as follows:

1. **Building a relationship**. Havelock regarded the first step as a stage of "pre-contemplation" where a need for change in the system is determined.
2. **Diagnosing the problem**. During this contemplation phase, the change agent must decide whether or not change is needed or desired. On occasion, the change process can end because the change agent decides that change is either not needed or not worth the effort.
3. **Acquire resources for change**. At this step, the need for change is understood and the process of developing solutions begins as the change agent gathers as much information as possible relevant to the situation that requires change.
4. **Selecting a pathway for the solution**. A pathway of change is selected from available options and then implemented.
5. **Establish and accept change**. Individuals and organizations are often resistant to change, so careful attention must be given to making sure that the change becomes part of new routine behaviour. Effective communication strategies, staff response strategies, educa-

tion, and support systems must be included during implementation.

6. **Maintenance and separation**. The change agent should monitor the affected system to ensure the change is successfully stabilized and maintained. Once the change has become the new normal, the change agent can separate from the change event. (Tyson, 2010)

Innovation Diffusion Theory

Rogers' five-step theory explains how an individual proceeds from having knowledge of an innovation to confirming the decision to adopt or reject the idea (see Figure 9.3.1) (Kritsonis, 2005; Wonglimpiyarat & Yuberk, 2005). A distinguishing feature of Rogers' theory is that even if a change agent is unsuccessful in achieving the desired change, that change could be resurrected at a later, more opportune time or in a more appropriate form (Kritsonis, 2005). Roger also emphasizes the importance of including key people (i.e., policy-makers) interested in making the innovation happen, capitalizing on group strengths, and managing factors that impede the process. The five stages to Rogers' theory are as follows:

1. **Knowledge.** The individual is first exposed to an innovation but lacks information about the innovation.
2. **Persuasion.** The individual is interested in the innovation and actively seeks related information and details.
3. **Decision.** The individual considers change and weighs the advantages and disadvantages of implementing the innovation.
4. **Implementation.** The individual implements the innovation and adjusts the innovation to the situation. During this stage the individual also determines the usefulness of the innovation and may search for further information about it.
5. **Confirmation.** The individual finalizes the decision to continue using the innovation. (Rogers, 1995)

Essential Learning Activity 9.3.1

Watch the video "Lewin's 3-Stage Model of Change: Unfreezing, Changing & Refreezing" (8:06) by Education-Portal.com for more about Lewin's change model.

Watch the video "Rogers Diffusion of Innovation" (3:15) by Kendal Pho, Yuri Dorovskikh, and Natalia Lara (Digital Pixels) for more about Rogers' theory of innovation.

Figure 9.3.1 The Five Steps of the Innovation Decision Process

"The Five Steps of the Innovation Decision Process" by Sonia Udod and Joan Wagner, designed by JVDW Designs, is licensed under a CC BY 4.0 International License.

Rogers' innovation diffusion theory explains how, why, and at what rate new ideas are taken up by individuals. Rogers defines five-categories of innovation adopters. **Innovators** are willing to take risks; they are enthusiastic and thrive on change. They play a key role in the diffusion of innovation by introducing new ideas from the external system (Rogers, 1995). **Early adopters** are described as being more discreet in adoption choices than innovators. They are cautious in their adoption of change. The **early majority** are those people who take a significantly longer time to adopt an innovation as compared to the innovators and early adopters. The **late majority** comprise individuals who have a high degree of skepticism when it comes to adopting a change. Finally, the **laggards** are those who are last to adopt a change or innovation. They typically have an aversion to change and tend to be focused on traditions and avoid trends (Rogers, 1995).

Table 9.3.1. Comparison of Traditional Change Models and Theories

Traditional Change Models and Theories	Process
Nursing Process	• Assessment • Planning • Implementation • Evaluation
Lewin	• Unfreezing • Movement • Refreezing
Lippitt, Watson & Westley	• Diagnose problem • Assess motivation and capacity for change • Assess change agent's motivation and resources • Select progressive change objectives • Choose appropriate change agent role • Maintain change • Terminate helping relationships
Havelock	• Build a relationship • Diagnose problem • Acquire resources • Choose the solution • Gain acceptance • Maintain and Separate
Rogers	• Knowledge • Persuasion • Decision • Implementation • Confirmation

9.4 NON-LINEAR CHANGE MODELS

Most organizations have viewed change as sequential and linear occurring in a step-by-step fashion. However, nursing has begun to explore non-linear models as a way of guiding more unpredictable change, as these models do not follow an orderly and predictable pattern.

Chaos Theory

Chaos theory, considered to be a subset of complexity science, emerged from the early work of Edward Lorenz in the 1960s to improve weather forecasting techniques. Non-human-induced responses in the environment indicate there is some predictability in random patterns (Thietart & Forgues, 1995; Wagner & Huber, 2003). Lorenz found that even small changes of randomness in a system that constantly changes can dramatically affect the long-term behaviour of that system and make it difficult to predict future outcomes. Interestingly, this non-linear model refers to a controlled randomness, which may be associated with recognizable and somewhat predictable patterns.

Chaos theory may be another way to structure change processes in a highly complex and evolving health care environment. Despite the best of intentions to improve organizational function and improve quality and safety of patient care, contextual factors may not be fully explored or considered in the change process. For example, instituting a care delivery model on a unit may not work well if staff have not been appropriated the necessary resources to provide care. Knowing how non-linear theories work can advance organizational functioning in health care organizations and systems in the twenty-first century.

Essential Learning Activity 9.4.1

Watch Claire Burge's TEDx Talk titled "The Future of Work is Chaos" (13:43) for a more in-depth understanding of chaos theory.

Essential Learning Activity 9.4.2

Cindy is an RN with three years' experience working on a busy surgical unit in a large urban hospital. Cindy enjoys her job and is keen to pursue an intensive care course after which she plans to work in the intensive care unit of the same hospital. She has received a one-year grant to establish a cardiac program for patients and caregivers. This project will be evaluated at the end of one year. Cindy, as the change agent, is tasked with

implementing the change. Stephanie, the nurse manager, is highly supportive, but some of the nurses don't have time and are not willing to help make the program a reality.

How should Cindy proceed with the change process? Could Lewin's change theory be used to guide the change? If so, how would you envision the change occurring?

How can she persuade other nurses to buy into the change? What effective leadership and followership strategies could she implement in the change process?

9.5 THE NURSING PROCESS AS THE CHANGE PROCESS

The change process can be related to the nursing process and is described by Sullivan (2012) in four steps. **Assessment**, the first step, entails identifying the problem. It involves collecting and analyzing data. Pinpointing the problem enables individuals affected by a proposed change to have a clear and accurate understanding of the problem.

Once the problem is identified, the change agent collects external and internal data as needed (e.g., patient satisfaction questionnaires, staff surveys). A critical analysis of the data supports the need for change, at which point the change agent determines resistance, identifies potential solutions, and begins to develop consensus regarding change. Assessing the political climate by determining who will benefit from the change, accessing resources, and having credibility with and respect of the staff will enhance the leader's ability to increase the driving forces and reduce the restraining forces (Lewin, 1951). Sullivan (2012) recommends converting data into tables or graphs, thus making the results easier for administration and frontline providers to understand, and perhaps accept, the change.

Planning requires the participation of staff that will be affected by the change. Relationships among staff may be altered if structures, rules, and practices are modified. This in turn alters workforce requirements, which may then lead to hiring new people with different skills, knowledge, attitudes, and motivations (Sullivan, 2012). It is anticipated that less resistance will be encountered if staff are involved at the planning stage, since attitudes, ways of thinking, and behaviours need to shift to accommodate a new way of working.

Weiss and Tappen (2015) recommend three tactics that can be used to unfreeze members or staff. First, **sharing information** is a way to help staff understand the rationale for a proposed change. Second, **disconfirming currently held beliefs** is a way to demonstrate that a current goal of the target system is inadequate, incorrect, or inefficient and therefore needs to be modified. Third, **providing psychological safety** is a tactic that minimizes risk by affording sufficient security to staff. This tactic is highly valuable as it generates a feeling of security and facilitates

members' ability to trust and accept the change. These three tactics decrease anxiety about the change. Establishing target dates and time frames to determine progress and providing opportunities for members to offer feedback will support the change.

In the **implementation** stage, plans are put into action. The change agent sets the tone for a positive and supportive climate, and methods are used to continue persuading members toward the change (providing information, training, assisting with personnel changes). Strategies are used to change the group dynamics to encourage members to act based on group decisions.

During **evaluation**, indicators are monitored to determine whether goals have been met, and what, if any, undesirable outcomes occurred and how to respond to unintended consequences. Once the desired outcome is reached, the change agent terminates the role by delegating responsibilities to members. Policies and procedures may be necessary to stabilize the change as part of everyday practice. The leader, as energizer and supporter, continues to reinforce behaviours through ongoing feedback.

9.6 THE MEDICINE WHEEL AS A CHANGE MODEL

The medicine wheel, drawn as a circle with four quadrants, represents a **holistic** set of beliefs encompassing the **mind**, **body**, **emotions**, and **spirit**, which is foundational to the human being. These beliefs have been embraced by Indigenous cultures across the world for thousands of years (McCabe, 2008). Carl Jung and others emphasized this dialogue between the four aspects of the human being as a way to understand self and maintain health (McCabe, 2008). Psychologists recognize the medicine wheel as "the Jungian mandala—a symbol of wholeness" (Dapice, 2006, p. 251).

Figure 9.6.1 Medicine Wheel

"Medicine Wheel as a Change Model" by Joan Wagner, designed by JVDW Designs, is licensed under a CC BY 4.0 International License.

The medicine wheel is found in the teachings of individual Elders in over 500 Indigenous nations across Canada. Teachings are similar between the nations; however there are slight differences regarding the location of the four dimensions on the wheel (Clarke & Holtslander, 2010). The medicine wheel is manifested within the community as a "process (healing), a ceremony (sweats, sharing circles) and teachings (a code for living)" (McCabe, 2008, p. 34). The Indigenous people consider the community participation in ceremonies to be an important part of the healing process (McCabe, 2008). The medicine wheel assists community members to connect with each other, while also supporting balance and harmony across the four dimensions of mind, body, emotions, and spirit for the individual and the extended community (Clarke & Holtslander, 2010).

Recent literature focuses on the use of the medicine wheel to recover from illness and regain health. The medicine wheel guides healthy change and can be **individualized** to the specific needs of the client or community, taking into account the context of culture, socioeconomic status, family situation, disease process, and other significant factors, culminating in balance, healing, and growth in all four aspects. Research literature documents the use of the medicine wheel in diabetes education (Kattelmann, Conti, & Ren, 2010), end-of-life care for Aboriginal people (Clarke & Holtslander, 2010), substance abuse prevention programs (Walsh-Buhl, 2017), adoles-

cent group counselling (Garner, Bruce, & Stellern, 2011), and development of a retention program for diverse nursing students (Charbonneau-Dahlen, 2015). The medicine wheel provides a guide to holistic change for both the individual and the collective community.

Essential Learning Activity 9.6.1

Watch the video "Medicine Wheel: Beyond the Tradition" (9:20), for an explanation and overview of the Lakota (Sioux) medicine wheel, according to Don Warne, then answer the following questions:

1. What does the medicine wheel represent?
2. How does the use of the medicine wheel extend from traditional to modern times?
3. Which gifts come from each of the four directions?

9.7 THE NURSE LEADER'S ROLE IN MANAGING ORGANIZATIONAL CHANGE

The nurse leader's role as change agent is complex and varied in nature, and it represents significant leadership challenges. Innovative organizational change can be effectively managed with proven leadership strategies and tools (MacPhee, 2007). The change agent has two main responsibilities: to change oneself and to build capacity in others. Stefancyk et al. (2013) introduced the idea of a **change coach**, which builds upon the traditional role of a nurse leader. A change coach or leader uses coaching behaviours that include guidance, facilitation, and inspiration (Stefancyk et al., 2013). The leader uses guidance to set behavioural expectations for staff performance and provides feedback on performance in the change project. As a facilitator, the change coach encourages staff to share in decision making, thereby creating and nurturing a culture that supports input from others, facilitates creative thinking, and enhances the process of finding the best solutions to address challenges. The leader takes on an inspirational role, expressing confidence and recognizing staff as providing meaningful contributions to the change process.

Building partnerships with staff that include two-way communication, both internally and externally, is critical to building trust and teamwork (Gilley et al., 2009; Yukl, 2013). Communication strategies can include informing those affected by the change how the change will affect their job, and providing information in a timely manner to help them make effective decisions. Nurse scholars (MacPhee, 2007; Morjikian, Kimball, & Joynt, 2007; Stefanyk et al., 2013) suggest that developing trust is a component of communicating effectively, and that this can be accomplished

through demonstrating approachability, building rapport, listening, and restating the opinions of others (even when the leader disagrees with the opinion). Listening to staff also means being aware of **change fatigue**, a condition experienced by individuals subjected to unrelenting and overwhelming change in their work environments (Bowers, 2011). Leadership and management skills and behaviours can positively influence the execution of change initiatives (Gilley et al., 2009).

A call to action means the leader knows when strategies for change need to be altered to foster effective followership. Navigating complex organizational structures through formal and informal power networks is foundational to setting the stage for a successful change. Organizational agility requires the leader to know and understand how the organization works and to be familiar with key policies, practices, and procedures.

9.8 CHANGE STRATEGIES

According to the classic model developed by Bennis, Benne, and Chinn (1960), three strategies can be used to facilitate change. The characteristics of the change agent and the amount of resistance encountered will determine which of the following strategies should be used.

1. **Power-coercive** strategies are based on the application of power through legitimate authority (Sullivan, 2012). Little effort is used by the nurse leader to enforce change, and staff has no ability to alter the course of the change process. Power-coercive strategies can be used when change is critical, time is limited, there are high levels of resistance, and there may be little or no chance of reaching organizational consensus (Sullivan, 2012).
2. **Empirical-rational** strategies assume that providing knowledge is the most powerful requirement for change (Sullivan, 2012). This strategy assumes that people are rational and will act in their own self-interest when they understand that change will benefit them. It can work well if the change is perceived as reasonable or beneficial for individuals.
3. **Normative-reeducative** strategies assume that individuals act in accordance with social norms and values that influence their acceptance of change (Sullivan, 2012). The nurse leader focuses on individual's behavioural motivators such as roles, attitudes, feelings, and their interpersonal relationships as an effective way to implement change in the health care environment.

9. 9 RESPONSE AND RESISTANCE TO CHANGE

Several factors can influence resistance to change. It is not uncommon for staff to state that they were not involved in the decision making regarding changes in their practice and, as a result,

be highly resistant to change. While not everyone will embrace change, individuals respond on a continuum that ranges from a lack of enthusiasm to overt sabotage (Gaudine & Lamb, 2015). Resistance may involve a personal loss, feelings of inadequacy, lack of competence, and lack of confidence to perform (Austin & Claassen, 2008). Leaders who can help members psychologically own the change are more likely to see the change initiative sustained and embedded in practice.

We offer the following strategies to counter resistance:

- Understand that resistance is a natural part of the process but must be constructively addressed for change to progress.
- Learn why an individual is resisting the change. Perhaps the resistance may be related to the lack of understanding in how the change process unfolds, which calls for supporting their ability to adjust to the change.
- Link some of the old ways of working with the new change as a way to bridge the old with the new and bring some familiarity to new practices (Austin & Claassen, 2008).
- Identify people who are willing to try new practices, which can reduce the possible resistance from others when change is introduced (Bowers, 2011).
- Assist staff in identifying with and valuing how the change will affect their practice (i.e., help them to assume ownership for the change) in order to ensure that the change is embraced and sustained.
- Communicate a clear vision of the benefits to be gained from the change (Yukl, 2013). Structured and transparent communication aids the participation and involvement of staff.

SUMMARY

One of the most difficult activities for the nurse leader is leading change in an organization. The nurse leader needs to have excellent leadership skills, be conversant with change theories, and be able to partner and work effectively with staff in achieving the vision. Being a change coach involves navigating change, generating and mobilizing resources toward innovation, and improving outcomes.

After completing this chapter, you should now be able to:

1. Explain why nurses have the opportunity to be change agents.
2. Identify how different theorists explain change.

3. Discuss how the nursing process is similar to the change process.
4. Discuss the medicine wheel as a change model.
5. Describe the nurse leader's role in implementing change and the call to action.
6. Differentiate among change strategies.
7. Recognize how to handle resistance to change.

Exercises

1. How do you normally respond to change in your personal life? How did you respond to your first clinical situation?
2. Identify the leadership skills that a nurse leader must apply when implementing change.
3. Identify a change occurring in your workplace. Using one of the change theories presented in this chapter, analyze how well the change process is working.
4. What are some of the contributing factors to the failure of change projects?
5. Reflect on how you as a follower can be a positive asset to a change process.

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10. Using Advocacy to Galvanize Ethics into Action

JOAN WAGNER

> *For me, this beautiful, rich and energetic country of ours can become a model of the just society in which every citizen will enjoy his fundamental rights.*
>
> —Pierre Elliott Trudeau, 1968

INTRODUCTION

The Canadian Nurses Association Code of Ethics is meant to guide Canadian nurses throughout their nursing practice. According to that code, "Nursing ethics is concerned with how broad societal issues affect health and well-being. This means that nurses endeavour to maintain an awareness of aspects of social justice that affect the social determinants of health and well-being and to advocate for improvements" (CNA, 2017, p. 3). The first part of the Code of Ethics describes the core ethical responsibilities central to nursing practice. The Code of Ethics is grounded in nurses' professional relationships with persons receiving care as well as with students, nursing colleagues, and other health care providers. The seven primary values are:

1. Providing safe, compassionate, competent, and ethical care
2. Promoting health and well-being
3. Promoting and respecting informed decision making
4. Honouring dignity
5. Maintaining privacy and confidentiality
6. Promoting justice
7. Being accountable

The second part of the CNA Code of Ethics "describes activities nurses can undertake to address social inequities. Ethical nursing practice involves endeavouring to address broad aspects of social justice that are associated with health and well-being" (CNA, 2017, p. 3). A brief overview of the ethical responsibilities of a nurse leader will then lead to a focus on the advocacy–driven by the CNA Code of Ethics–required to promote the optimal health of citizens throughout the world.

Learning Objectives

1. Identify the importance of ethics to nursing leadership.
2. Describe advocacy.
3. Compare the advocate approach to the paternalistic approach in addressing health inequities.
4. Investigate how the nurse leader uses advocacy to introduce change that addresses health inequities.
5. Identify the different types of power.
6. Recognize the role nurse leaders can have in political action.
7. Reflect on your own response to change.

10.1 INTEGRATING ETHICS INTO NURSE LEADERSHIP

It is the nurse leader's responsibility to integrate professional guidelines (e.g., CNA Code of Ethics) with the ethics of their health care organization (e.g., mission, vision, values) in order to offer ethical guidance to care providers. Simultaneously, the nurse leader is required to critically analyze situations and take appropriate action with regards to practices that may threaten a patient's health and safety. Nurse leaders model the just and caring behaviours that promote the common good for care recipients as well as students, nursing colleagues, and other health care providers. The following quote stresses the link between ethics and patients: "The ultimate goal of nursing ethics is to promote the wellbeing of patients through the delivery of good nursing care" (Johnstone, 2017, p. 19). Ethical nursing care and good nursing care are, by definition, similar terms that describe the actions required to achieve quality health care outcomes.

Recent research conducted in Australia investigated the ethical principles that guide the leadership practices of clinical nurse leaders (Mannix, Wilkes, & Daly, 2015). This research revealed three main principles that shape day-to-day clinical practices. These principles are relevant for nurses and nursing practice around the world. The principles discussed in the research are:

1. Nurses remain true to their beliefs, by embodying principled practice;
2. Nurses recognize that not all practices fit every patient, offering ethical leadership in ambiguous situations;
3. Nurses are open to people's concerns and provide fair and just solutions. (Mannix et al., p. 1605)

These principles convey a sense of pride in nursing practice, a willingness to advocate for practices that meet the needs of patients, and an understanding of how to facilitate change by listen-

ing to people and empowering them to engage in change. Nurse leaders, by virtue of their Code of Ethics and the ethical principles that shape their daily practice, are obliged to advocate on behalf of their professional colleagues and the general public for healthy living conditions within healthy communities.

10.2 ADVOCACY

Figure 10.2.1 Student Advocacy Outside the Saskatchewan Legislature

"Photo Students Legislative Building, Nursing Education 2004" by Saskatchewan Registered Nurses Association is licensed under a CC BY Attribution 4.0 International License.

Advocacy is defined in the online Merriam–Webster dictionary as "the act or process of supporting a cause or proposal [or] the act or process of advocating something." For a deeper understanding of the professional nurse's responsibility to advocate, we need to look at how the CNA describes advocacy:

> Advocacy involves engaging others, exercising voice and mobilizing evidence to influence policy and practice. It means speaking out against inequity and inequality. It involves participating directly and indirectly in political processes and acknowledges the important roles of evidence, power and politics in advancing policy options. (CNA, 2018)

For more on advocacy, see the CNA's webpage Policy and Advocacy.

Awareness

The short but comprehensive description of advocacy by the CNA requires the professional nurse to be aware of inequity and inequality within patient practice, among professional colleagues, and within local, national, and international communities. A simple example of inequity or unfair treatment within patient practice may include violations of best practice. For example, care of a complicated chronic ulcer demands a specialized dressing; however, a health care institution may not have the required dressing due to cost restrictions. Consequently, a less costly dressing is used and the healing of the patient's wound is delayed. The knowledgeable and ethical nurse leader understands the consequences of inappropriate wound care and is prepared to take appropriate actions to foster best practice.

The nurse leader is aware of the need for positive staff morale and spirit at work in the health care workplace. Contrary to the actions described in the phrase "nurses eat their young," a successful nurse leader mentors new graduates, by including them as part of the team and working with other team members to support new team members in developing their full potential as professional nurses.

The nurse leader's awareness of health, well-being, and social justice extends beyond the health care workplace to his or her local, national, and global communities. The leader works to support healthy lives and well-being for people of all ages as stated in the United Nations sustainable development goals (WHO, 2015). The nurse leader may not work directly with every community; however, she or he can impact all communities indirectly through health-focused actions and communications within the local community.

Community, Communication, and Evidence-Informed Action

Advocacy requires the engagement or participation of multiple people. It is not a solitary act. It requires the nurse leader to communicate with others and involve the community in the development of plans and potential solutions to health-related problems. The nurse leader's skills in accessing relevant research ensure that advocacy initiatives are constructed upon a foundation of evidence that provides strength to the community action.

Essential Learning Activity 10.2.1

The CNA conducted an environmental scan in 2016 to identify the health care concerns of Canadians. Environmental scans capture key trends and issues that may impact the policy work and programs of CNA and its members, and thereby create awareness for Canadian nurse leaders. The findings are intended to inform the CNA board's strategic decision making.

Read the CNA's executive summary of that environmental scan "June 2016 Environmental Scan Summary" and review the key health care trends and issues of Canadians.

1. Identify and describe one trend or issue under each of the following categories:
   - Political
   - Economical
   - Social
   - Technological
   - Management
2. Select three themes from the CNA Environmental scan that you believe will have the greatest policy impact on the CNA. Justify why you chose these three themes.

10.3 CLIENT CARE ADVOCACY: THE THIN LINE BETWEEN ADVOCACY AND PATERNALISM

Advocacy and change are irrevocably linked. In fact, the term *advocacy* suggests that individuals and communities are working to promote change. Additional insights into patient care advocacy can be obtained from the patient advocacy literature.

Virginia Henderson described advocacy as providing health care for people that they would do for themselves, if they had the "strength, will or knowledge to care for themselves" (Halloran, 1996, p. 18). However, other theorists such as Kohnke (1982) suggested that the nurse advocate's primary role is to inform and support the patient in making decisions. Gadow (1980) and Curtin (1979) cautioned care providers, stating that professionals cannot decide what is in the best interests of the patient unless they understand the individual patient's values. Zomorodi and Foley (2009) further advised that the "thin line between advocacy and paternalism may be crossed" (p. 1748) when patients are unable to communicate or practice autonomy due to illness or intimidation.

Paternalism is defined as "intentional overriding of one person's known preferences or actions by another person, where that person justifies the action with the goal of benefiting or avoiding harm to the person whose will is over written" (Johnson, as cited in Zomorodi & Foley, 2009,

p. 1747). Paternalism is contrary to the values expressed by the World Health Organization in the Ottawa Charter for Health Promotion (WHO, 1986), including that which affirms that every person has the right to control all factors that contribute to his or her health. Recent authors stress that patients have the right to make their own decisions, even when professional caregivers believe that the decisions are wrong (McKinnon, 2014; Zomorodi & Foley, 2009; Griffith, 2015; Risjord, 2013). This debate between autonomy and paternalism has raged over the centuries, with John Stuart Mill voicing clear support for autonomy almost two centuries ago:

> The only purpose for which power can be rightfully exercised over any member of a civilized community against his will is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. (as cited in McKinnon, 2014, p. 677)

10.4 SOCIAL JUSTICE AND ADVOCACY

The CNA Code of Ethics supports the principle of social justice, requiring that all peoples, without discrimination, "have the right to live in dignity and freedom and to enjoy the fruits of social progress and should, on their part, contribute to it" (Office of the United Nations High Commissioner for Human Rights, 1969, Part 1, Article 1).

Ethical nursing addresses aspects of social justice that are considered essential for the health and well-being of individuals, communities, and populations throughout the world. According to the CNA,

> Advocacy refers to the act of supporting or recommending a cause or course of action, undertaken on behalf of persons or issues. It relates to the need to improve systems and societal structures to create greater equity and better health for all. Nurses endeavor, individually and collectively, to advocate for and work toward eliminating social inequities. (CNA, 2017, p. 5)

Nurse leaders working to ensure the health of all, will advocate for the presence of the fundamental resources essential for health, regardless of the dominant social, cultural, or economic system. Fundamental resources required by all people include: peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice, and equity (Government of South Australia and World Health Organization, 2017).

It is important to remember that healthy people contribute to the social and economic development of the community or nation. Advocacy for health encourages political, economic, social, cultural, environmental, behavioural, and biological factors that favour health rather than sup-

press health. The control of factors that determine the individual's health will support all people to reach their fullest health potential (WHO, 2017).

Essential Learning Activity 10.4.1

Advocating for social justice requires us to look at social inequities, both within Canada and across the world. There are many groups experiencing social inequities within Canada. Indigenous people, for example, have been the victims of colonization throughout the centuries. Only recently have Canadians come to realize the problems created by residential schools.

Please watch Dawn Tisdale's TedX Talk titled "The Impact of Residential Schools on Aboriginal Healthcare" (13:04).

After you have viewed the video, answer the following questions while looking through the lens of social justice:

1. What impact do you think the residential school system had on Indigenous health?
2. What steps have been taken to resolve health issues arising from the residential school system?
3. What additional steps would you recommend?

10.5 POWER AND ADVOCACY

What is Power?

Academics from many disciplines have studied the elusive concept of power. Hokanson Hawks (1991) provided two different meanings for power: (1) power to, or the ability to get things done, and (2) power over, or the ability to influence the behaviour or decisions of others. The definition of power, commonly found in leadership research, is "the ability to get things done, to mobilize resources, to get and use whatever it is that a person needs for the goals he or she is attempting to meet" (Kanter, 1993, p. 166). Power is a force that is inherent and personal and it comes into play when clinicians are influencing the health care decision making of others (Milton, 2016). When power is defined as the ability to get things done, it is a significant resource for nurses, and as such, warrants further in-depth discussion.

Sullivan (2013) adapted the classical description of social power to fit the nursing perspective. The five types of nursing social power, as described by MacPhee (2015) are: (1) "personal power based on one's reputation and credibility; (2) expert power [referring to the possession of skills

and knowledge] that are needed by others" (p. 188); (3) position power that is a result of your position in the organization or group; (4) perceived power resulting from your status as a powerful person; and (5) connection power ensuing from your association with, or links to, powerful people. Understanding these versions of social power, which have been adapted for nursing, will provide the nurse leader with a basic understanding of the power dynamics that influence decision making within the workplace.

However, the increasing complexity of our health care organizations requires the nurse leader to look at power from additional perspectives. Some authors look at power as situated within a relationship (Davidson, 2015). Davidson states that, by the very nature of being human, people are always in relationships where power dynamics are at play. Stacey (2006, as cited in Davidson, 2015) stresses the importance of relationships as both an enabling and a constraining power:

> In order to form and stay in a relationship with someone else, one cannot do whatever one wants. As soon as we enter into relationships, therefore we constrain and are constrained by others . . . we also enable and are enabled by others. (p. 134)

Udod (2008) uses the work of Michel Foucault in her research exploring empowerment for staff nurses. Foucault's work also emphasizes that power is not owned, but rather is a "relation or situation. . . . When power is exercised in relation to others, it causes reactions and effects" (cited in Udod, p. 81). Power is regarded as a strategy, suggesting that nurses develop tactics on how to comply with power, rather than fight it. Finally, power is not present solely in the actions of leaders; it is also present in the actions of people who resist (e.g., whistle-blowers). In summary,

> nurses need to work with power rather than against it, recognizing that their task is not to overcome more powerful others . . . but to understand how power and its effects operate in order to enhance their sense of empowerment and hence, their practice. (Udod, 2008, p. 88)

Essential Learning Activity 10.5.1

Read the following article to learn more about power, then answer the following questions.

Davidson, S. J. (2015). Shifting the balance: Relationship as power in organizational life. *Nursing Forum*, 50(4), 258–264.

1. What are three assumptions that the rationalist/positivist makes about power?
2. What are the limitations of studying power from the rationalist/positivist approach?
3. What is the main assumption about power in using the complex responsive process analysis?
4. Why should we examine and call attention to patterns of power relations within organizations?

Power and Health Care for Indigenous People

Recognition of the impact of colonization and residential schools on the health and well-being of Indigenous people requires the nurse leader to take a closer look at the relationship between power and diverse populations and, more specifically, at the relationship between power and the Indigenous population. Foucault's work demands that we acknowledge "how power relations shape the production of truth" (Macias, 2015, p. 225) and how "discourse defines and limits the subject's freedom" (p. 231). Foucault also suggests that changing discourse can produce freedom.

Madeleine Dion Stout (2015), a Cree speaker from Alberta who became an RN approximately 46 years ago, worked to improve the health of Indigenous people by changing the discourse of power in just such a way. She addressed the need for Indigenous people to develop their own determinants of health, rather than accept the values of the colonizer society. She stated very eloquently in both Cree and English how the Indigenous people will move forward to reclaim their health and well-being. In her words:

> *kaskitamasowin miýw-āyāwin* is health and wellness we have conjured up and created for ourselves. *kaskitamasowin miýw-āyāwin* means achieving health status that we wish upon ourselves and for our families, communities and nations. We achieve *kaskitamasowin miýw-āyāwin* with our own will and abilities and with the resources we have at our immediate disposal. *kaskitamasowin miýw-āyāwin* comes from our inner strength, inner forces, and inner voices. (p. 145)

Changes in ownership of Indigenous health and well-being are rapidly becoming evident in the relationship between Health Canada and the Indigenous population. In accordance with the wishes of the Canadian Indigenous people for a health plan that meets their needs, the Government of Canada developed the First Nations and Inuit Home and Community Care (FNIHCC) 10-Year Plan (2013–2023) (Health Canada, 2015). This plan provides a template for collaboration with First Nations and Inuit partners in health care. It will be updated yearly or as needed. The plan is envisioned as responsive to the unique needs of the Indigenous people, representing "a

continuum of home and community care services that are comprehensive, culturally safe, accessible, effective, and equitable to that of other Canadians and which respond to the unique health and social needs of First Nations and Inuit" (Health Canada, 2015, p. 1).

Figure 10.5.1 First Indigenous Nurse in Northern Saskatchewan

[January 1958], photo courtesy of the Provincial Archives of Saskatchewan, Photographic Services Branch Collection, collection number R-B6805, is used with permission. All rights reserved. About this photo: Jean (Cuthand) Goodwill was the first Indigenous nurse in Northern Saskatchewan. This photo was taken at the Indian Health Nursing Station in La Ronge, Saskatchewan. Jean Goodwill and her colleague Jocelyn Bruyere went on to develop a registry of Indigenous nurses, which eventually became the Registered Nurses of Canadian Indian Ancestry, laying the foundation for the formation of the Canadian Indigenous Nurses Association in 1975.

10.6 EMPOWERMENT AND ADVOCACY

Discussion of nurse empowerment within the health care workplace is evident throughout worldwide nursing literature. **Empower** is defined as "to give official authority or legal power to [or] to promote the self-actualization or influence of" (Merriam-Webster, n.d.). To understand empowerment further we turn to the definition by Conger and Kanungo (1988): "a process of

enhancing feelings of self-efficacy among organizational members through the identification of conditions that foster powerlessness and through their removal by both formal organizational practices and informal techniques of providing efficacy information" (p. 474). Many nurse researchers have investigated empowerment in an attempt to further understand this relationship between empowerment, the workers, and the workplace.

Essential Learning Activity 10.6.1

There are numerous studies conducted on workplace empowerment by nurse researchers. Dr. Heather Laschinger from the University of Western Ontario played an important role in many of these studies.

Search the term "structural empowerment" and the author "Laschinger" in the Cumulative Index to Nursing and Allied Health Literature. How many studies can you find?

Dr. Laschinger passed away in 2016. Search for articles published after 2016 by Canadian nurse researchers that are focused on empowerment of patient care providers such as nurses, occupational therapists, and health care aides. How many studies can you find?

Structural Empowerment

Considerable research on empowerment in recent nursing literature has focused on Kanter's ethnographic work (1993) on structural empowerment. This work focuses on the contextual or social-structural aspects of the organization that facilitate empowerment. Structural empowerment involves the sharing of power and the eventual transference of pertinent decision-making power from managers to lower levels of the organizational hierarchy. The applicability of the shared power to the needs of the employees is the key to the success of structural empowerment, enabling employees to make decisions related to their job or role (Spreitzer, 2008).

Structural empowerment consists of four dimensions (Havens & Laschinger, 1997). Employees of an organization have structural empowerment when they have access to: (1) opportunities (advancement or new experiences); (2) information (knowledge about the organization required to be effective); (3) resources such as equipment, supplies, and staffing required to carry out their daily work; and (4) support (from colleagues and superiors as required to complete their work and make decisions). Access to structural empowerment is gained through formal power (one's position in the organization) and informal power (networks and alliances with supervisors, peers, and colleagues, both within and without the organization). Presence of the structural

dimensions of opportunity, information, resources, and support leads to an empowered workforce with increased job satisfaction and retention (Wagner et al., 2010).

Psychological Empowerment

Psychological empowerment is another perspective on empowerment found in the recent literature. It is more micro in nature than structural empowerment, focusing on the individual's psychological empowerment or perceptions of power; Spreitzer (2008) refers to the "individual's reactions to the structures, policies, and practices they are embedded in" (p. 55). Psychological empowerment does not focus on sharing a manager's organizational power, but rather concentrates on how employees experience their work. Components of psychological empowerment include: (1) meaning (a fit between job requirements and the individual's own ideals or standards); (2) competence (individual's confidence in his or her ability to do a good job of the required work); (3) self-determination (sense of control over work); and (4) impact (the sense of being able to influence important outcomes at work) (Spreitzer, 2008).

Essential Learning Activity 10.6.2

Structural empowerment and psychological empowerment are believed to be strongly linked within the health care workplace. Leaders who understand and implement changes based on structural empowerment theory can make positive changes to their workplace. Read the following systematic review for a more in-depth understanding, then answer the questions that follow.

Wagner, J., Cummings, G., Smith, D. L., Olson, J., Anderson, L., & Warren, S. (2010). The relationship between structural empowerment and psychological empowerment for nurses: a systematic review. *Journal of Nursing Management*, 18(4), 448–462.

1. What is the relationship between structural empowerment and psychological empowerment?
2. Why do the authors of this systematic review believe that there is no relationship between the psychological empowerment subscale of competence and overall structural empowerment in the example of Ontario staff nurses?
3. Why does the author recommend "delegation or decentralization of formal power" by leaders?

Critical Social Theory and Empowerment

Nursing leaders are also aware of the importance of critical social theory to empowerment in nursing. Critical social theory strives to create an awareness of how culture and the norms of everyday life constrain or disempower people. It strives to remove oppressive barriers, which are revealed in exchanges that contain hidden values and norms; these values and norms change, depending on the situation and the participants (Sumner & Danielson, 2007). According to Clune and Gregory, "A person who challenges the status quo in the social world is taking a critical social approach" (2015, p. 202).

Manias and Street (2000) describe four main theoretical areas of critical social theory:

1. **Theory of false consciousness** shows how a group of people may have a common set of false beliefs (e.g., people with non-white skin are inferior to white people).
2. **Theory of crisis** requires people to look at how their dissatisfaction threatens the cohesion of a society (e.g., ISIS terrorist actions).
3. **Theory of education** in which individuals receive benefit from education (e.g., information regarding the impact of terrorism upon the well-being of individuals).
4. **Theory of transformative action**, which involves making plans for change (e.g., the WHO's development of sustainable development goals).

Critical social theory is important to nurses who are involved in caring relationships with patients where the communication is from the nurse to the patient. Much of the nursing literature speaks about the patient's expectations of the nurse; however "what is rarely, if ever examined, are the human needs of the nurse that need to be met in the patient–nurse relationship" (Sumner & Danielson, 2007, p. 30). Perhaps it is time to look at the power structure of these unidirectional relationships between nurse and patient. In a similar manner, as aspiring nurse leaders, it is necessary to look critically at the nurse leader's relationships with followers and with the overall health care organization. Critical social theory provides the opportunity to look at the nurse's needs and think about how these needs may be met, while reflecting on the inherent asymmetry of the relationships (Sumner & Danielson, 2007).

Critical race theory, **queer theory**, and **feminist theory** are examples of well-known critical social theories. Another important critical social theory that is crucial to the profession of nursing is associated with **oppressed groups**. MacPhee (2015) states that nurses are considered by sociologists to be an oppressed group, or a group "whose freedoms and rights are restricted by socially imposed inequalities" (p. 189). MacPhee stresses that members of an oppressed group do not realize that their powerlessness is a socially constructed situation and can be challenged. Not surprisingly, members of oppressed groups tend to dominate or oppress others (bul-

lying and horizontal violence). However critical social theory can assist members of oppressed groups, such as nurses, to gain insight into their behaviour through reflection and education. This new understanding may motivate them to engage in transformative action that challenges their socially conditioned powerlessness.

10.7 WHISTLE-BLOWING AS ADVOCACY

Whistle-blowing refers to "a conscious act of disclosure about organizational or individual practices and behaviours to those who could achieve possible change" (Jackson et al., 2011, p. 656). The CNA Code of Ethics supports the act of whistle-blowing when there are ethical violations, stating, "Nurses support a climate of trust that sponsors openness, encourages the act of questioning the status quo and supports those who set out in good faith to address concerns (e.g., whistle-blowing)" (2017, p. 16). However, whistle-blowing can be very difficult for the individual nurse since it involves a public accusation, which can cause the nurse to be perceived as disloyal to the organization. Despite these difficulties, nurses have a responsibility to speak up and report to their leaders when patients are at risk of harm or when they observe a poor-quality experience due to an inadequate patient care environment.

How organizational leaders respond to the concerns about ethical violations is often dependent on the organization. Nurses may be concerned that employment contracts with confidentiality clauses prioritize organizational issues over the concerns of staff and patients (Jackson et al., 2011). These confidentiality clauses sometimes lead to secrecy and the withholding of risky, or potentially stigmatizing, disclosures (Ellenchild Pinch, 2000). Perceived lack of response to client concerns by organization leaders and managers can force the nurse to take the issues to individuals in positions of power outside the organization. The employee who takes the issues outside the organization may violate confidentiality and risk negative consequences in order to address concerns of patient and staff well-being. Whistle-blowing is always a last resort (Reid, 2013).

Essential Learning Activity 10.7.1

For more information on whistle-blowing, review the following legislation designed to protect those who speak out to address concerns in good faith.

From the Criminal Code of Canada:

"**425.1(1)** No employer or person acting on behalf of an employer or in a position of authority in respect of an employee of the employer shall take a disciplinary measure against, demote, terminate or otherwise adversely affect the employment of such an employee, or threaten to do so,

(a) with the intent to compel the employee to abstain from providing information to a person whose duties include the enforcement of federal or provincial law, respecting an offence that the employee believes has been or is being committed contrary to this or any other federal or provincial Act or regulation by the employer or an officer or employee of the employer or, if the employer is a corporation, by one or more of its directors; or

(b) with the intent to retaliate against the employee because the employee has provided information referred to in paragraph (a) to a person whose duties include the enforcement of federal or provincial law." (Criminal Code, 1985)

From the preamble of the Public Servants Disclosure Protection Act:

". . . confidence in public institutions can be enhanced by establishing effective procedures for the disclosure of wrongdoings and for protecting public servants who disclose wrongdoings, and by establishing a code of conduct for the public sector." (Public Servants Disclosure Protection Act, 2005)

The Government of Saskatchewan's website states that "The Public Interest Disclosure Act protects employees of the Government of Saskatchewan from reprisal for making a disclosure of wrongdoing in the workplace" (Government of Saskatchewan, 2013). Visit the Government of Saskatchewan's website to read the Public Interest Disclosure Act in full.

Research Note

Jackson, D., Peters, K., Hutchinson, M., Edenborough, M., Luck, L., & Wilkes, L. (2011). Exploring confidentiality in the context of nurse whistle blowing: Issues for nurse managers. *Journal of Nursing Management*, 19(5), 655–663.

Purpose

"The aim of this paper is to reveal the experiences and meaning of confidentiality for Australian nurses in the context of whistle blowing" (Jackson et al., p. 655).

Discussion

"Despite the ethical, legal and moral importance of confidentiality within the health-care context, little work has addressed the implications of confidentially related to whistle-blowing events.

The study used qualitative narrative inquiry. Eighteen Australian nurses, with first-hand experience of whistle blowing, consented to face-to-face semi-structured interviews. Four emergent themes relating to confiden-

tiality were identified: (1) confidentiality as enforced silence; (2) confidentiality as isolating and marginalizing; (3) confidentiality as creating a rumour mill; and (4) confidentiality in the context of the public's right to know.

The interpretation and application of confidentiality influences the outcomes of whistle blowing within the context of health-care services. Conversely, confidentially can be a protective mechanism for health-care institutions." (Jackson et al., p. 655)

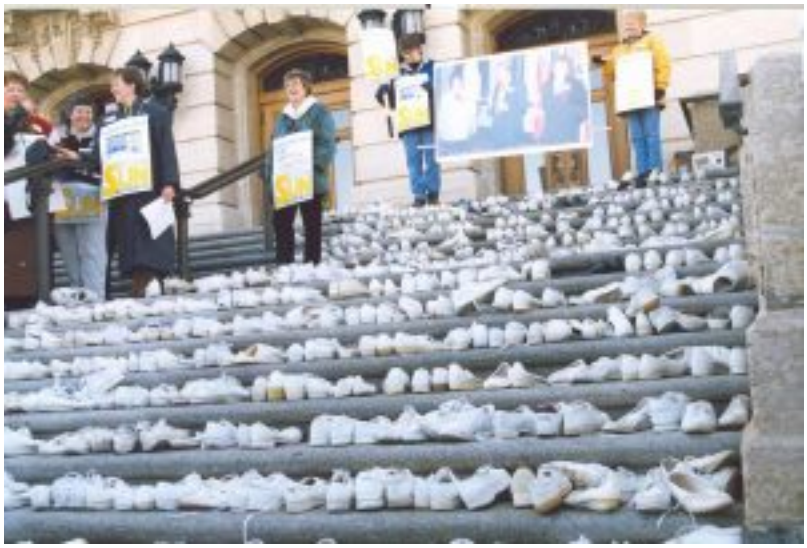
Application to practice

"It is beholden upon nurse managers to carefully risk manage whistle-blowing events. It is also important that nurse managers are aware of the consequences of their interpretation and application of confidentiality to whistle-blowing events, and the potentially competing outcomes for individuals and the institution." (Jackson et al., p. 655)

10.8 POLITICAL ACTIVISM AS ADVOCACY

The online Merriam–Webster dictionary defines **activism** as "a doctrine or practice that emphasizes direct vigorous action especially in support of or opposition to one side of a controversial issue." Political activism directs action toward creating change related to the making of government policy. Throughout this chapter we have discussed the requirement for nurse advocacy on behalf of patients. Our discussion of empowerment within the health care workplace suggests that there is also a need for advocacy on behalf of nurses to confirm their distinction as professional health care providers and knowledgeable patient advocates.

Figure 10.8.1 99 Shoe Campaign



"99 Shoe Campaign, 1999" by the Saskatchewan Union of Nurses is licensed under a CC BY 4.0 International License.

Advocating for the individual patient is an important part of ensuring quality health care. Nurses may respond to the social, political, and economic context of their environment to advocate for their patients and families through invisible political activism. This invisible activism is linked to strong partnerships with the public, local residents, government, and other power structures. Ongoing communication with community groups, including the government and media, is required to maintain these partnerships (Paterson, Duffet-Leger, & Cruttenden, 2009). This work of maintaining positive relationships with the community can remove the individual nurse from client-centred health care responsibilities. Therefore, it is important to consider that collective advocacy, through the auspices of professional associations and unions, can "extend the reach of individual nurses in order to address systemic problems in health care institutions and bureaucracies" (Mahlin, 2010, p. 247). Mahlin stresses that many of the difficulties faced by individual patients are the direct result of system-wide issues and problems related to inappropriate health resource allocation—such as costly medications that patients cannot afford after discharge from hospital—and inadequate and unsuitable levels of health care provider staffing. Taking action and finding solutions to these system issues are frequently beyond the reach of the individual nurse, but definitely within the scope of health care professional groups.

SUMMARY

This chapter focuses on the ethical responsibilities of nurse leaders to advocate for health. A leader who understands how to use power is more likely to be a successful advocate. Building on Foucault's work, we know that we must look at the relationship between health, power, and diverse populations. In Canada a focus on the Indigenous populations is required if we are to make a difference.

Nurse leaders must also look at the workplace and examine how the presence or absence of structural empowerment and psychological empowerment for care providers impacts patient care. Critical social theory suggests that reflection upon the roles of nurses in health care systems empowers nurses to be effective advocates. Nurse leaders, intent on advocating for health, can join other nurses in political action directed at changing existing health care practices. When no other solution is available to advocate for the health of vulnerable people, whistleblowing may be employed as a last resort.

After completing this chapter, you should now be able to:

1. Identify the importance of ethics to nursing leadership.
2. Describe advocacy.
3. Compare the advocate approach to the paternalistic approach in addressing health inequities.
4. Determine how the nurse leader uses advocacy to introduce change that addresses health inequities.
5. Identify the different types of power.
6. Recognize the role nurse leaders can have in political action.
7. Verbalize your own response to change.

Exercises

1. Pick a shift from one of your most recent clinical rotations. Examine the actions of nurses during your shift and look for examples of the five different types of nursing power. Did you or your fellow nursing students exhibit personal power, expert power, position power, perceived power, or connection power? What types of power did your preceptor exhibit? What about Staff nurses? The charge nurse? Which nurse do you think was the most powerful on your unit? Why?

2. Review the CNA's "June 2016 Environmental Scan Summary" which was discussed in Essential Learning Activity 10.2.1. Select an issue identified in the environmental scan that you believe will have a serious impact on the health of Canadians when you graduate in one to two years. Develop a plan to advocate for the health of Canadians using the advocacy tools provided on the CNA website.
3. Read the research article "Exploring confidentiality in the context of nurse whistle blowing: issues for nurse managers" (Jackson et al., 2011) on whistle-blowing (outlined in the Research Note earlier in this chapter). Identify how confidentiality was used to silence and isolate nurses.
4. Think of the commonly heard phrase "Nurses eat their young." What theory explains this phrase? As a graduate nurse, what steps will you take to ensure that people will not describe you as a nurse who "eats her young"?

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11. Identifying and Understanding How to Manage Conflict

DISPUTE RESOLUTION OFFICE, MINISTRY OF JUSTICE (GOVERNMENT OF SASKATCHEWAN)

> *Peace is not absence of conflict, it is the ability to handle conflict by peaceful means.*
>
> —Ronald Reagan (1982)

INTRODUCTION

The information included in Chapter 11 represents a synthesis of theory and practical experience in the fields of dispute and conflict resolution, facilitation, interest-based negotiations, and collaborative problem solving. The information presented in this chapter draws on the experience of mediators from Saskatchewan's Ministry of Justice Dispute Resolution Office; CDR Associates (Boulder, Colorado); the Oregon Mediation Association; the Justice Institute of British Columbia; Kilmann Diagnostics; and the Center for Congregational Health. The model of conflict resolution that we present has been used by informal and formal nurse leaders in many Saskatchewan health care environments. This chapter describes the model and helps the reader understand conflict and the five different approaches to managing conflict. Each approach is then applied to hypothetical nursing situations or environments, to help the reader see the practical use of the theory in nursing. A review of the evidence concludes the chapter.

Note: Chapter 11 is contributed by Stacy Muller and Amanda Willcox of the Dispute Resolution Office, Ministry of Justice (Government of Saskatchewan).

Learning Objectives

1. Describe the different causes of conflict.

2. Analyze the different approaches to managing conflict.
3. Recognize how conflict escalates.
4. Adapt your approach to conflict.

11.1 THE THEORY OF CONFLICT

> ***Conflict***: *to struggle, clash, be incompatible.* (Oxford Dictionary, n.d.)

For centuries, people accepted adversarial disputes and harsh conflict as a by-product of human nature. This acceptance caused people to analyze only how conflict could be resolved, that is, how they could make it go away. In the past decade or two, many people have started to also ask, "Why is conflict resolved in that way?" and, "Might there be a better way?"

If we are to make progress toward better conflict resolution, it is imperative that we understand why conflicts arise and how people traditionally have reacted to conflict situations. When we are able to analyze more clearly the causes of disputes, we will be able to determine better what processes need to be implemented to produce a more positive outcome to the conflict.

11.2 FOUR MAJOR TYPES OF CONFLICT

In order to analyze how to transform destructive conflict into a dispute with a positive outcome, let us begin by exploring the four major types of conflict (categorized by cause): data conflicts, relationship conflicts, value conflicts, and structural conflicts.

Data Conflicts

Data conflicts occur when people lack the information necessary to make wise decisions, are misinformed, disagree over which data are relevant, interpret information differently, or have competing assessment procedures. This type of conflict is usually the simplest to overcome, by adopting a process to ensure both parties perceive the data in the same way.

Relationship Conflicts

These problems often result in what have been called unrealistic or unnecessary conflicts since they may occur even when objective pre-conditions for conflict, such as limited resources or

mutually exclusive goals, are not present. They occur due to the presence of strong emotion (e.g., jealousy, mistrust, hatred) and are created from perceptions, poor communication, stereotypes, and so on. Relationship conflicts often fuel disputes, causing them to escalate.

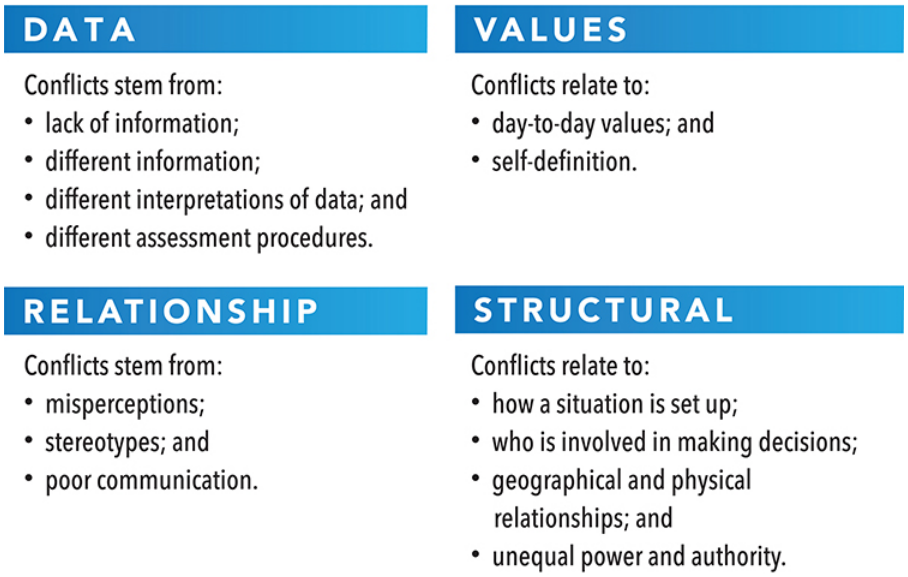
Value Conflicts

This type of conflict is caused by perceived or actual incompatible value systems. Values are beliefs people use to give meaning to life and to explain what is good, bad, right, or wrong. Value conflicts occur only when people attempt to force one's set of values on another or lay claim to exclusive value systems, which do not allow for divergent beliefs.

Structural Conflicts

Structural conflicts are caused by oppressive patterns of human relationships. These patterns are often shaped by forces external to the people in dispute. Often, the disputants have no reason to be in conflict other than the structural problem that is imposed on their relationship. Often, these conflicts can be overcome by identifying the structural problem and working to change it. Acceptance of the status quo can perpetuate structural conflict.

Figure 11.2.1 Types of Conflict



"Types of Conflict," content by the Dispute Resolution Office, Ministry of Justice (Government of Saskatchewan), designed by JVDW Designs, is licensed under a CC BY 4.0 International License.

It is important to understand what type of conflict (data, value, relationship, or structural) you are dealing with before you can effectively work toward a resolution. The solution for each type of conflict will be different and must suit the type of conflict you are addressing. For example, it would be unlikely that you would resolve a relationship problem with a data solution.

Data and structural conflicts have external sources of conflict and are typically easier to resolve; this is done by changing something in the external environment. Conversely, relationship and value conflicts relate to internal sources of conflict and can be much more difficult to resolve. Understanding relationship and value conflicts requires a deep internal awareness and empathy for others. Resolving relationship and value conflicts may significantly challenge an individual's personal perspectives, which generally makes the process more difficult. Typically, when we are under stress or in an escalated conflict we reach for data or structural solutions to resolve the conflict as these solutions require less time and effort.

11.3 DEALING WITH CONFLICT—DIFFERENT APPROACHES

Every individual or group manages conflict differently. In the 1970s, consultants Kenneth W. Thomas and Ralph H. Kilmann developed a tool for analyzing the approaches to conflict resolution. This tool is called the Thomas-Kilmann Conflict Mode Instrument (TKI) (Kilmann Diagnostics, 2017).

Essential Learning Activity 11.3.1

For information on the Thomas-Kilmann Conflict Mode Instrument, see the Kilmann Diagnostics website.

Thomas and Kilmann suggest that in a conflict situation, a person's behaviour can be assessed on two factors:

1. **Commitment to goals or assertiveness**—the extent to which an individual (or a group) attempts to satisfy his or her own concerns or goals.
2. **Commitment to relationships or cooperation**—the extent to which an individual (or a group) attempts to satisfy the concerns of the other party, and the importance of the relationship with the other party.

Thomas and Kilmann use these factors to explain the five different approaches to dealing with conflict:

avoiding	competing	accommodating	compromising	collaborating

There is an appropriate time to use each approach in dealing with conflict. While most people will use different methods in various circumstances, we all tend to have a more dominant approach that feels most comfortable. One approach is not necessarily better than another and all approaches can be learned and utilized. To most effectively deal with conflict, it is important to analyze the situation and determine which approach is most appropriate.

Let's take a closer look at each approach and when to use it.

Avoiding

An avoidance approach demonstrates a low commitment to both goals and relationships. This is the most common method of dealing with conflict, especially by people who view conflict negatively.

Table 11.3.1 Avoiding

Types of Avoidance	Results	Appropriate When
• Physical flight • Mental withdrawal • Changing the subject • Blaming or minimizing • Denial that the problem exists • Postponement to a more appropriate time (which may never occur) • Use of emotions (tears, anger, etc.)	• The dispute is not resolved. • Disputes often build up and eventually explode. • Low satisfaction results in complaining, discontentment, and talking back. • Stress spreads to other parties (e.g., co-workers, family).	• The issue is trivial or unimportant, or another issue is more pressing • Potential damage outweighs potential benefits • Timing for dealing with the conflict is inappropriate (because of overwhelming emotions or lack of information)

Application to Nursing—Avoidance

When might avoidance be an appropriate approach to conflict in a hospital or clinic setting?

In a hospital or clinical setting, there may be times when it is appropriate to avoid conflict. For example, on a particularly busy day in the emergency room, when a patient in life-threatening condition has just been received, the attending doctor may bark directions at the assisting nurses to get equipment. The nurses may feel offended by the doctor's actions; however, it may be appropriate for the nurses to avoid the conflict at that moment given the emergency situation. The nurse, if he or she felt it was inappropriate behavior by the doctor, could then deal with the conflict after the patient has been stabilized.

When might avoidance be an inappropriate approach to conflict in a hospital or clinic setting?

Avoiding the conflict may be inappropriate if that same doctor continues to bark directions at the nursing staff in non-emergency situations, such as during debrief of a surgery, or when communicating non-emergency instructions. When the nurses and doctor have to continue a working relationship, avoiding the continuing conflict will no longer be appropriate.

Competing

A competing approach to conflict demonstrates a high commitment to goals and a low commitment to relationships. Individuals who use the competing approach pursue their own goals at the other party's expense. People taking this approach will use whatever power is necessary to win. It may display as defending a position, interest, or value that you believe to be correct. Competing approaches are often supported by structures (courts, legislatures, sales quotas, etc.) and can be initiated by the actions of one party. Competition may be appropriate or inappropriate (as defined by the expectations of the relationship).

Table 11.3.2 Competing

Types of Competing	Results	Appropriate When
• Power of authority, position, or majority • Power of persuasion • Pressure techniques (e.g., threats, force, intimidation) • Disguising the issue • Tying relationship issues to substantive issues	• The conflict may escalate or the other party may withdraw. • Reduces the quality and durability of agreement. • Assumes no reciprocating power will come from the other side; people tend to reach for whatever power they have when threatened. • Increases the likelihood of future problems between parties. • Restricts communication and decreases trust.	• There are short time frames and quick action is vital. • Dealing with trivial issues. • Tough decisions require leadership (e.g., enforcing unpopular rules, cost cutting, discipline).

Application to Nursing—Competing

When might a competing approach to conflict be appropriate in a hospital or clinic setting?

A completing approach to conflict may be appropriate in a hospital or clinic setting if you recognize that another nurse has made an error in how much medication to administer to a patient. You recognize this mistake prior to the nurse entering the patient's room so you approach the nurse, take the medication out of his or her hands, and place the correct dosage. The goal of patient safety outweighs the commitment to the relationship with that nurse in this case.

When might a competing approach to conflict be inappropriate in a hospital or clinic setting?

It would be inappropriate to continue to be competitive when you debrief with the nurse about the dangers of medication errors and the system of double checking dosage amounts. The goal at this point is to enhance the learning of that nurse as well as to build trust in your relationship as colleagues. A different approach is needed.

Accommodating

Accommodating demonstrates a low commitment to goals and high commitment to relationship. This approach is the opposite of competing. It occurs when a person ignores or overrides their own concerns to satisfy the concerns of the other party. An accommodating approach is used to establish reciprocal adaptations or adjustments. This could be a hopeful outcome for those who take an accommodating approach, but when the other party does not reciprocate, conflict can result. Others may view those who use the accommodating approach heavily as "that is the way they are" and don't need anything in return. Accommodators typically will not ask for anything in return. Accommodators tend to get resentful when a reciprocal relationship isn't established. Once resentment grows, people who rely on the accommodating approach often shift to a competing approach because they are tired of being "used." This leads to confusion and conflict.

Table 11.3.3 Accommodating

Types of Accommodating	Results	Appropriate When
• Playing down the conflict to maintain surface harmony • Self-sacrifice • Yielding to the other point of view	• Builds relationships that will allow you to be more effective in future problem solving • Increases the chances that the other party may be more accommodating to your needs in the future • Does not improve communication	• You are flexible on the outcome, or when the issue is more important to the other party. • Preserving harmony is more important than the outcome. • It's necessary to build up good faith for future problem solving. • You are wrong or in a situation where competition could damage your position.

Application to Nursing—Accommodation

When might accommodation be an appropriate approach to conflict in a hospital or clinic setting?

It may be appropriate to use an accommodating approach when, for example, one of the nurses on your shift has a particularly difficult patient who is taking up a lot of time and effort. Seeing that the nurse is having dif-

ficulty, you take on some of her or his tasks. This increases your workload for a period of time, but it allows your colleague the time needed to deal with the difficult patient.

When might accommodation be an inappropriate approach to conflict in a hospital or clinic setting?

This approach may no longer be appropriate if that same nurse expects you to continue to cover his or her tasks after the situation with the difficult patient has been resolved.

Compromising

A compromising approach strikes a balance between a commitment to goals and a commitment to relationships. The objective of a compromising approach is a quick solution that will work for both parties. Usually it involves both parties giving up something and meeting in the middle. Compromising is often used in labour negotiations, as typically there are multiple issues to resolve in a short period of time.

Table 11.3.4 Compromising

Types of Compromising	Results	Appropriate When
• Splitting the difference • Exchanging concessions • Finding middle ground	• Both parties may feel they lost the battle and feel the need to get even next time. • No relationship is established although it should also not cause relationship to deteriorate. • Danger of stalemate • Does not explore the issue in any depth	• Time pressures require quick solutions. • Collaboration or competition fails. • Short-term solutions are needed until more information can be obtained.

Application to Nursing—Compromise

When might compromise be an appropriate approach to conflict in a hospital or clinic setting?

You are currently on shift with another nurse that does the bare minimum and rarely likes to help his or her colleagues out. It is two hours since lunch and one of your hyperglycemic patients have not received their

lunch tray. You approach your colleague and ask him or her to go look for the tray while you draw blood from a patient for them. The other nurse agrees as he or she has been having difficulty with the patient that needs a blood draw.

When might a compromise be an inappropriate approach to conflict in a hospital or clinic setting?

It would be inappropriate to continue to ask the nurse to do tasks for you that are less appealing than the tasks you take on.

Collaborating

Collaborating is an approach that demonstrates a high commitment to goals and also a high commitment to relationships. This approach is used in an attempt to meet concerns of all parties. Trust and willingness for risk is required for this approach to be effective.

Table 11.3.5 Collaborating

Type of Collaborating	Results	Appropriate When
• Maximizing use of fixed resources • Working to increase resources • Listening and communicating to promote understanding of interests and values • Learning from each other's insight	• Builds relationships and improves potential for future problem solving • Promotes creative solutions	• Parties are committed to the process and adequate time is available. • The issue is too important to compromise. • New insights can be beneficial in achieving creative solutions. • There is a desire to work through hard feelings that have been a deterrent to problem solving. • There are diverse interests and issues at play. • Participants can be future focused.

Application to Nursing—Collaboration

When might collaboration be an appropriate approach to conflict in a hospital or clinic setting?

It may be appropriate to use collaboration in a hospital or clinic setting when discussing vacation cover off with team members at a team meeting. During a team meeting, time is available to discuss and focus on what is important for each member of the team.

When might collaboration be an inappropriate approach to conflict in a hospital or clinic setting?

Collaboration would be inappropriate in a discussion of a new policy that has been put in place if the team has little influence in making adjustments.

11.4 WHAT DOES EACH APPROACH NEED?

There are times when others may take an approach that is not helpful to the situation. However, the only person that you can control in a conflict is yourself. It is important to be flexible and shift your approach according to the situation and the other people with whom you are working. When someone else is taking an approach that is not beneficial to the situation, it is critical to understand what needs underlie the decision to take that approach. Here are a few examples:

Avoiders may need to feel physically and emotionally safe. When dealing with avoiders, try taking the time to assure them that they are going to be heard and listened to.

Competitors may need to feel that something will be accomplished in order to meet their goals. When dealing with competitors, say for example, "We will work out a solution; it may take some time for us to get there."

Compromisers may need to know that they will get something later. When dealing with compromisers, say for example, "We will go to this movie tonight, and next week you can pick." (Be true to your word.)

Accommodators may need to know that no matter what happens during the conversation, your relationship will remain intact. When dealing with accommodators, say for example, "This will not affect our relationship or how we work together."

Collaborators may need to know what you want before they are comfortable sharing their needs. When dealing with collaborators, say for example, "I need this, this, and this. . . . What do you need?"

Essential Learning Activity 11.4.1

Take an online test by Bacal and Associates from their webpage Conflict Quizzes and Assessments to find out your preferred approach to conflict.

All approaches to conflict can be appropriate at some times, and there are times when they can be overused. It is important to take the time to consider which approach would be most beneficial to the situation in question. Taking the wrong approach can escalate conflict, damage relationships, and reduce your ability to effectively meet goals. The right approach will build trust in relationships, accomplish goals, and de-escalate conflict.

Everyone has the capacity to use each approach to conflict and to shift from his or her natural style as needed. We react with our most dominant style when we are under stress, but other styles can be learned and applied with practice and self-awareness. When dealing with others who may not have developed their capacity to shift from their preferred style of conflict, it is important to listen for their underlying needs. By understanding the needs that exist beneath the surface of the conflict, you can work with the other person toward a common goal.

11.5 HOW CONFLICT ESCALATES

Note: The information in this section has been adapted from Speed Leas' Levels of Conflict, published by the Center for Congregational Health.

Many academics and conflict resolution practitioners have observed predictable patterns in the way conflict escalates. Conflict is often discussed as though it is a separate entity, and in fact it is true that an escalating dispute may seem to take on a life of its own. Conflict will often escalate beyond reason unless a conscious effort is made to end it.

The following is an example of an escalating conflict. Most people will recognize their own actions in the description.

A conflict begins . . .

- The parties become aware of the conflict but attempt to deal with it sensibly. Often, they will attribute the problem to "a misunderstanding" and indicate that "they can work it out."
- The parties begin to slide from cooperation to competition. ("I'll bend but only if they will first.") They begin to view the conflict as resulting from deliberate action on the part of the other. ("They must have known this would happen.") Positions begin to harden and defensiveness sets in, which creates adversarial encounters. Parties begin to take actions to strengthen their positions and look to others for support. ("Don't you feel this is reasonable?" "Do you know what that idiot is doing to me?")
- As communication deteriorates, parties rely more on assumptions about the other and attribute negative motives to them. ("I'll bet they are going to . . . ," "Those sorts of people would . . . ," "Their thinking is so muddled, they must . . .") Groupthink often takes over as each disputant seeks support from others. ("We have to appear strong and take a united front.") Parties begin to look for more evidence of other problems—their beliefs feed their observations.
- Parties soon believe that cooperation cannot resolve the problem because of the actions of the other, and aggressive actions are planned. ("I've tried everything to get them to see reason." "It's time to get tough with them." "I'm going to put a stop to this.")
- Parties begin to feel righteous and blame the other for the whole problem. Generalizing and stereotyping begin. ("I know what those people are like. . . . We can't let them get away with this.") Parties begin to be judgemental and moralistic, and believe they are defending what is right. ("It's the principle of the matter." "What will people say if we give in to this?")
- The conflict becomes more complicated but also more generalized and personalized. Severe confrontation is anticipated and, in fact, planned for, thus making it inevitable. The parties view this as acceptable as the other has, in their mind, clearly shown they are lacking in human qualities. ("He's just a jerk; we'll have to really hit him hard.")
- All parties appears now to believe that the objective of the conflict is to hurt others more than they are being hurt. ("I'll make you pay even if we both go down over this.") The dispute is beyond rational analysis; causing damage to the other, even at your own expense, is the main focus. ("Whatever it takes . . ." "There is no turning back now." "They won't make a fool out of me.")
- Finally, destruction of the other, even if it means self-destruction as well, is the driving force. ("If it takes everything I have, for the rest of my life . . .")

Figure 11.5.1 is called the **conflict escalation tornado**. It demonstrates how conflict can quickly escalate out of control. By observing and listening to individuals in dispute, it is often possible to determine where they are in the escalation process and anticipate what might occur next. In doing so, one can develop timely and appropriate approaches to halt the process.

Figure 11.5.1 Conflict Escalation Tornado

"Conflict Escalation Tornado," by the Dispute Resolution Office, Ministry of Justice (Government of Saskatchewan), redesigned by JVDW Designs, is licensed under a CC BY 4.0 International License.

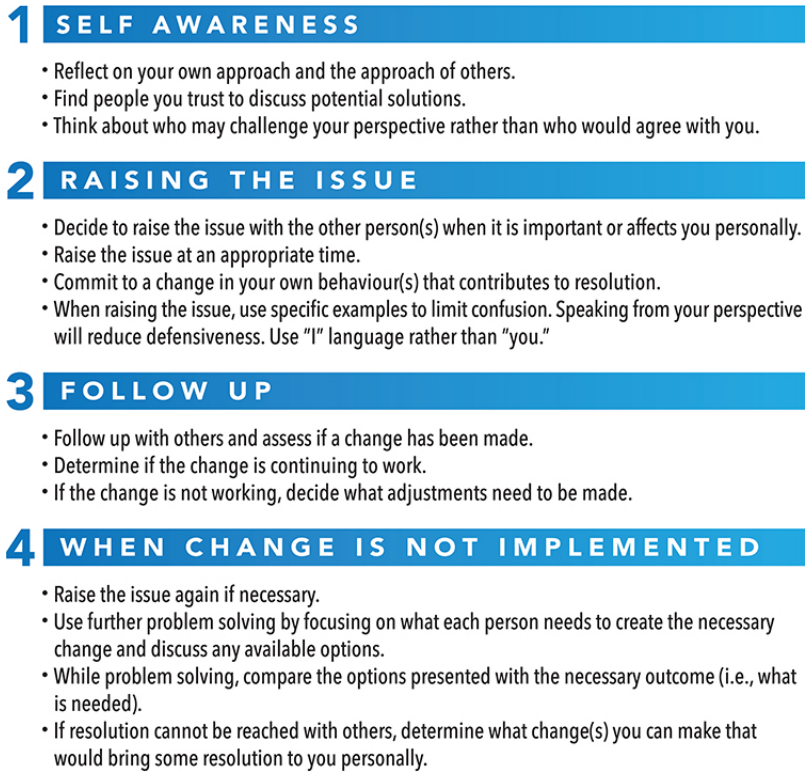
11.6 HOW TO GET OFF THE SPIRAL: STOPPING ESCALATION

An appropriate level of risk must be taken by the individuals involved to de-escalate the conflict. Taking these risks can be scary as it requires people to be vulnerable and express emotions. A nurse leader's emotional intelligence plays an important role in the de-escalation of conflict. By taking risks to de-escalate conflict, whether the result is successful or unsuccessful, the nurse leader sends a message of wanting to rebuild trust, respect, and effective communication. Risk taking can also provide an opportunity to make necessary change by learning and developing new behaviours and capacities to work effectively as individuals and as work units.

Typically, when conflict is not de-escalated and resolved appropriately, it results in more conflict in the relationship. The relationship continues in a state of heightened sensitivity to actions, and assumptions can be formed quickly. Actions that may previously have been viewed as innocent

or acceptable may be perceived as threatening. Every unresolved conflict reduces the time it takes to get to the top of the tornado because of this heightened sensitivity. The following steps are suggestions for use at every stage of conflict escalation. The ability to harness fear and be vulnerable is a critical step for de-escalation.

Figure 11.6.1 Steps to De-Escalate Conflict



"Steps to De-Escalate Conflict," content by the Dispute Resolution Office, Ministry of Justice (Government of Saskatchewan), designed by JVDW Designs, is licensed under a CC BY 4.0 International License.

Research Note

Amestoy, S. C., Bakes, V. M. S., Thofehrn, M. B., Martini, J. G., Meirelles, B. H. S., & Trindade, L. L. (2014). Conflict in nursing management in the hospital. *Revista Gaúcha de Enfermagem*, 35(2). 79–85. doi:10.1590/1983-1447.2014.02.40155

Article review

The study outlined in this article takes a qualitative, descriptive approach, which includes case studies used as an investigational strategy to determine the main conflicts experienced by nurse leaders in the hospital environment, as well as the strategies adopted for dealing with such. The study included 25 nurses in three hospitals in Florianopolis, Santa Catarina, Brazil. Semi-structured interviews, non-participant observations, and dialogical workshops were used to collect data. A thematic analysis was undertaken to analyze the data gathered. What the study found was the most prevalent conflict that emerged in the health sector stemmed from the interpersonal relationships of those working in the health field. The study also put an emphasis on the power dynamics that could relate to the interpersonal conflicts in the health sector.

The study found that management of these interpersonal conflicts is necessary, as are strategies to deal with them. Management of these interpersonal conflicts is critical to the health sector because of the paralysis or overwork that can accompany conflict in nursing teams, and between nurses and other health professionals, such as physicians. The best strategy outlined in this study for dealing with interpersonal conflict is a democratic, involved style where team members are included in decision making. The impact this will have on the field of nursing is encouraging. The authors recognize a limitation of this study: the fact that the availability and shift patterns of nurses make it difficult to perform the involved kind of research undertaken in this study. What is hoped is that this information will encourage the integration of interpersonal conflict management training into the work and training materials provided to nurses through their education.

SUMMARY

Conflict is inevitable, especially for leaders. Effective nurse leaders invest time understanding the causes of conflict and learn how to manage and resolve it. The first step to managing conflict is to reflect on your own experiences and understand your personal approach to conflict. After learning their own preferred style, good leaders learn to understand the styles of others and adapt their approaches accordingly. They observe and practice de-escalating situations and coaching people toward resolution. Fortunately, managing conflict is not something to be feared; rather, it is something that can be learned and practised. It just takes time.

> *Change the way you think about disagreements, and how you behave during conflict. Be willing to listen, engage directly, constructively, and collaboratively with your colleagues.*
>
> —Cloke and Goldsmith, 2011

After completing this chapter, you should now be able to:

1. Describe the different causes of conflict.
2. Verbalize the different approaches to managing conflict.
3. Recognize how conflict escalates.
4. Adapt your approach to conflict.

Exercises

1. Read this scenario and answer the questions that follow.

> Jill and Neil are both nurses working the same shift. Jill is responsible for patients in rooms 1–6 and Neil is responsible for patients in rooms 7–12. Over the course of their shift, both nurses routinely visit their patients' rooms to take vitals and deliver medication.
>
> On one of his rounds, Neil attends to his patient in room 8. He reads the chart and notices Jill's initials signaling that she had already checked on this patient. A bit confused, he continues on to his next patient. After another hour goes by, Neil returns to room 8 and again notices Jill's initials on the chart. Neil thinks to himself, "What is she doing? I've got it covered. She's checking my work. She must think I'm incompetent." Neil decides to approach Jill and see what is going on.

Questions:

a) What might have been the initial cause of the conflict?

b) What kind of conflict did it turn into?

c) If Neil provides Jill with a copy of the room assignments, would that resolve the conflict?

2. Read this scenario and answer the questions that follow.

> A nursing team is having a routine meeting. One of the nurses, Stephen, is at the end of a 12-hour shift and another nurse, Tanya, is just beginning hers. Tanya is a senior nurse in the unit with over ten years' experience on this specific unit. Stephen is new to the unit with less than three years' experience in nursing. Tanya has been asked to present information to the team about effective time management on the unit. During Tanya's presentation, Stephen is seen rolling his eyes and talking to other members of the team. Tanya breaks from her presentation and asks "Stephen, do you have anything to add?" Stephen replies, "No, I just don't know why we need to talk about this again." Tanya chooses to avoid engaging with Stephen further, and finishes her presentation. Stephen continues to be disruptive throughout the presentation.

After the meeting concludes, Tanya approaches Stephen and asks if he had anything to add from the meeting. Stephen replies, "No, I don't have anything. I just think we all know what the procedure is because we just learned it all during orientation training. Maybe if you don't remember the training, you should take it again." Tanya is shocked by his reply and quickly composes herself. She states, "Stephen, I have worked on this unit for over ten years. I was asked to present that information because there are current issues going on among the staff. Next time please respect my authority and listen to those who come before you."

Questions:

a) What types of conflict are present?

b) What will need to happen to resolve this issue between Tanya and Stephen?

3. Take a moment to think about what your preferred approach to conflict may be. How might you adapt your approach to conflict when working with others?

4. Read this scenario and answer the questions that follow.

Connie, the head nurse on Unit 7, is a respected member of the team. She has been working on this unit for a number of years and is seen by the other nurses as the "go to" person for questions and guidance. Connie is always thorough with patients and demonstrates excellence and quality in her work. Dr. Smith is a well-respected member of the medical profession and an expert in his field of medicine. He has a reputation for excellent bedside manner and is thorough in his approach with patients.

Connie is four hours into her 12-hour shift when she is approached by Dr. Smith. He asks, "Connie, why has the patient in room 2 not received his blood pressure medication over the past few days? I was not notified about this!"

Connie, trying to find a quick solution, replies, "I didn't know that patient had been missing medication. I'll go check on it and get back to you."

Dr. Smith is persistent, saying, "You don't need to go check anything. I know this patient and should have been informed about the withholding of medication and the reasons why."

Connie, again attempting to find a resolution, states, "Well, there must be some communication about this change somewhere . . ."

"There isn't!" Dr. Smith interrupts.

Connie becomes upset and decides to leave the conversation after declaring, "Fine, if you know everything then you figure it out, you're the one with the medical degree, aren't you?" She storms off.

Connie makes her way to the nurses' station where Dan and Elise are assessing charts and says to them, "You will not believe what Dr. Smith just said to me!"

Dan and Elise look shocked and ask "What?"

Connie explains, "Well, he thinks I don't do my job, when really we nurses are the ones that keep this unit going. Who is he to question my ability to look after patients? I am the most knowledgeable person on this unit!"

Dan and Elise don't know how to reply and decide to avoid the interaction with a simple "Oh yeah."

Meanwhile, Dr. Smith has made his way to the doctor's lounge and finds his colleague Dr. Lee. Dr. Smith tells him, "That head nurse on Unit 7 is useless. She doesn't know what she is doing and doesn't understand that we must be informed about changes to our patients' medications, does she?" Dr. Lee nods quickly and returns to reviewing his file.

About three hours later, Connie and Dr. Smith have each spoken to several people about the interaction. Connie bumps into another nurse, Jessie, one of her best friends. Connie pulls Jessie aside and says, "You will not believe what I just saw. I was going into the admin office to file my holiday requests and out of the corner of my eye, I see Dr. Smith lurking around the corner, pretending to look at a chart, spying on me!"

"What? Are you serious? That's not safe," replies Jessie.

Connie is relieved that Jessie is taking her side—it makes her feel like she is not going crazy. "Yeah, I'm really getting worried about this. First that creep is accusing me of not doing my job, then he is wasting his time spying on me. What a loser! Maybe what I should do is file a complaint. That'll show the "big man" that he isn't that big around here and maybe take him down a notch."

When Jessie gives her an apprehensive look, Connie continues, "Oh Jessie, don't worry. I have a perfect record and this won't affect me. Even if it does, I will have done something good for all the other nurses around here. It is the principle of the matter at this point."

Meanwhile, Dr. Smith has run into an old classmate of his, Dr. Drucker, and says, "Wow! You got hired! So happy to have you in the hospital. I do need to tell you though to be careful of the head nurse on Unit 7 . . ." Dr. Smith describes his troubles with Connie and adds, "She's a real snitch! She makes trouble out of nothing. I was reviewing a chart down the corridor from the admin office, minding my own business and actually getting my work done, when I saw her slip into the admin office to squeal about me to the top bosses! This is something that needs to be watched! We can't have people reporting doctors to administration over nothing. I think I'm going to write her up and get a black mark on that perfect record of hers. I will be fine—everyone knows I'm right. There will be consequences for her."

Questions:

a) Using the scenario above, identify the stages of the conflict escalation tornado.

b) What suggestions might you give to Dan, Elise, Jessie, Dr. Lee, and Dr. Drucker about how to respond to Connie and Dr. Smith?

c) How do you think this conflict will be resolved?

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12. Responsibility and Authority of Nurse Leaders

LISA LITTLE, JOAN WAGNER, AND ANNE SUTHERLAND BOAL

> *Let whoever is in charge keep this simple question in her head (not, how can I always do this right thing myself, but) how can I provide for this right thing to be always done?*
>
> –Florence Nightingale (1860, p. 37)

INTRODUCTION

According to the Canadian Nurses Association, "Nursing leadership is about critical thinking, action and advocacy–and it happens in all roles and domains of nursing practice." It exists across all domains of nursing (clinical, academic, administration, research, and policy) in every setting and at various levels. Leadership can occur in formal, appointed positions or in informal roles that nurses assume. In administration, it is

> about innovative and visionary administrators from the first level to the most senior nurse executives–leaders who understand and hold themselves accountable for creating vibrant, exciting practice settings in which nurses can deliver safe, accessible, timely and high-quality care for the Canadians they serve. (CNA, 2009a, p.1)

This chapter will focus on the tools and resources required to support the first-level manager (nurse manager) and builds on the ethical nursing practices and professional nursing values discussed in Chapter 10.

Learning Objectives

1. Recognize the role of nurse leaders, and nurse managers in particular.

2. Integrate the role of the professional nurse into the role of the nurse leader or manager.
3. Illustrate the importance of examining personal, professional, and organizational values in nursing practice.
4. Describe how the CNA's Code of Ethics can be used in your nursing practice to deal with environmental threats.

12.1 NURSING LEADERSHIP

"Nursing leadership plays a pivotal role in the immediate lives of nurses and it has an impact on the entire health system and the Canadians it serves" (CNA, 2009a, p.1). Perhaps nowhere does nursing leadership play a more pivotal role in the immediate lives of nurses than in the case of the nurse manager. A nurse manager is responsible and accountable for the day-to-day operations of the workplace. This includes employee selection, hiring, orientation, staff development and evaluation, resource allocation and management, risk management, patient safety, and financial accountability, among others. Nurse managers are also expected to provide inspiration, guidance, and direction to nurses and other health care providers. They supervise and influence the professional practice of the largest number of frontline nurses, and by that, the largest groups of health care providers in the health system. In 2015, more than 80 per cent of Canada's nurses worked as staff nurses (CIHI, 2016). On average nurse managers have 56.9 direct reports, with many managers overseeing over 100 staff members (OHA, 2011). Those with a self-reported wide span of control are more likely to have:

- more than 80 staff members reporting to them;
- responsibility for three or more units (physical spaces, which can exist across multiple geographical sites);
- budgetary responsibility; and
- budgets exceeding $7 million.

As such, nurse managers have the greatest opportunity to instill the principles of professional nursing in the nursing workforce. The importance of the relationship between nurses and their leaders began to be explored in US hospital studies in the early 1980s, which found that achieving Magnet status results in higher nurse satisfaction and high-performing work environments with positive patient outcomes. The Magnet Recognition Program® recognizes health care organizations that (1) transform their work environments to create a culture that values excellence in

nursing care and professional practice and (2) demonstrate the ability to attract and retain professional nurses.

Nurse managers are also expert knowledge brokers. They translate organizational policy directives into action at the forefront of health care while also bringing information regarding the delivery of health care and practice requirements to senior management to inform organizational policy. In this role, nurse managers are an essential intermediary. Without nurse managers, the knowledge translation of organizational directives would not occur. However, this unique position can be very challenging. It can be demanding, trying to meet organizational demands and priorities while also managing resources to enable staff to provide the highest quality of care. Nurse managers are constantly balancing their responsibilities and accountabilities between their staff and the senior leadership they report to. Increasing job satisfaction, decreasing nurse turnover, managing a multigenerational workforce, supporting research, and meeting quality targets are among the many functions they perform set against a backdrop of continuous quality improvement and, often, fiscal restraint.

12.2 HEALTH SYSTEM TRANSFORMATION

Institute for Healthcare Improvement Triple Aim Framework

Health care is in a constant state of change, often with multiple change initiatives of various scales occurring simultaneously. Some are more successful than others, but all are designed to find solutions to complex problems facing the health care system. Many of these changes are aligned with the Institute for Healthcare Improvement's Triple Aim framework, which has as its goals: (1) improving the patient experience, (2) improving the health of the population, and (3) reducing the per capita cost of health care (IHI, n.d.) This set of goals is often referred to as better care, better health, and better value and was the framework for the National Expert Commission's inquiry and its final report, *A Nursing Call To Action: The Health Of Our Nation, The Future Of Our Health System* (2012). The Commission set out to discover the most efficient, effective, and sustainable ways to meet the changing and pressing health needs of Canadians in the twenty-first century. According to the Commission,

> Registered nurses are deeply engaged in system transformation because they care about human health and about delivering responsible health care. But more than caring, it is the professional and social responsibility of nurses to take a strong leadership stand on behalf of Canadians. (p. 1)

Policy- and decision-makers, spurred on by the Triple Aim framework, have recognized that a large-scale transformation of the health system is required to meet the desire to achieve sustainable and high-quality health care for Canadians.

Transformation of the Canadian Health Care System (Major Foci)

Concerns over the financial sustainability of the health care system, as well Canada's declining health care system performance among Commonwealth countries and growing need for health care services, have prompted governments to begin to transform the system through various funding, structural, and programming policies. Seven key elements of the transformation are set out below.

Primary health care. The paradigm of care is beginning to shift to one premised on primary health care and the social determinants of health. In 1978, the WHO adopted the primary health care approach as the conceptual basis for effective health care delivery. The five principles of primary health care are:

1. accessibility,
2. public participation,
3. health promotion,
4. appropriate technology, and
5. intersectoral cooperation.

Community. Efforts are underway to gradually shift health care services from the hospital setting to the community, with care being provided closer to home.

Delivery of health services. The nature of health care delivery is also changing. Canada's current social policies, with a focus on marginalized populations and the recommendations of the Truth and Reconciliation Commission, require increased inclusivity, which will have an impact on the delivery of care.

Interprofessional practice. Nurses are increasingly practising within, and leading, interprofessional teams.

Establishment of professional boundaries. Participation in interprofessional teams requires nurses and nurse leaders to practise within their professional boundaries and to clearly define such boundaries to other professionals. Canadian nurses' professional boundaries are explicitly described within their provincial legislation for registered nurses (see, for example, The Registered Nurses Act, 1988), standards and competencies documents (see, for example, SRNA, 2013).

Registered nurses are also "accountable to the Standards of Practice and nursing values outlined in the Code of Ethics" (SRNA, 2018).

Chronic disease management. Chronic disease management has become a priority given the rising rates of chronic disease and an aging population. Seniors experienced rising rates of cancer, diabetes, and high blood pressure between 2003 and 2009 (CIHI, 2011). Studies have shown that high-cost users of health care represent only a small proportion of the population but consume a large proportion of health care funding. For example, "approximately 1.5% of Ontario's population, represented by the top 5% highest cost-incurring users of Ontario's hospital and home care services, account for 61% of hospital and home care costs" (Rais et al., 2013). Predictably seniors account for the majority of high-cost users and health care costs.

Technology. Technology, used by both health care providers and the general population, is altering the way in which people and their health care providers interact within the system. It also enables the provision of big data analytics to support evidence-informed decision making.

From the Field

Big data provides new opportunities to store and index previously unusable, siloed, and unstructured data for use by health care stakeholders. Analytics creates new business value by transforming previously unusable data into new predictive insights and actionable knowledge.

For more information on big data, see the Canada Health Infoway white paper titled "Big Data Analytics in Health."

Essential Learning Activity 12.2.1

For more information on primary health care, watch this video titled "The Five Elements of Primary Health Care" (2:45), then answer the following question:

1. What are the five elements of primary health care?

For additional examples of primary health care, watch two more videos and answer the questions that follow.

"Hand in Hand: Interdisciplinary Teams in Community Health Centres" (13:45)

1. What is at the centre of interdisciplinary care?
2. What is the health promoter's role?
3. How can you ensure that communication occurs within an interdisciplinary team?

"Teams Manage Chronic Disease in Canada" (5:00)

1. Why is Ross a "lucky man"?

12.3 LEADING AND MANAGING IN TODAY'S HEALTH CARE ENVIRONMENT

To lead effectively in this constantly evolving environment requires visionary, contemporary, and energetic nurse managers. "Exerting good management skills is part of being a good leader—and leadership skills are necessary for good management" (CNA, 2009a, p.2). While nurse managers must develop strong organizational and management skills, effective leadership skills are needed to navigate today's challenging work environments confronted with human, fiscal, time, and other resource constraints. Nursing leadership is

> about innovative and visionary administrators from the first level to the most senior nurse executives—leaders who understand and hold themselves accountable for creating vibrant, exciting practice settings in which nurses can deliver safe, accessible, timely and high-quality care for the Canadians they serve. (CNA, 2009a, p.1)

Various resources exist to define and shape nursing leadership. The Registered Nurses' Association of Ontario (2013) has developed a best practice guideline on how to develop and sustain nursing leadership. Further, Huston (2008) suggests eight skills that will be essential nurse leader competencies for 2020.

Huston's eight essential nurse leader competencies for 2020 include:

1. A global perspective or mindset regarding health care and professional nursing issues;
2. Technology skills, which facilitate mobility and portability of relationships, interactions, and operational processes;
3. Expert decision-making skills rooted in empirical science;
4. The ability to create organizational cultures that permeate quality health care and patient and worker safety;

5. The ability to understand and appropriately intervene in political processes;
6. Highly developed collaborative and team building skills;
7. The ability to balance authenticity and performance expectations; and
8. The ability to envision and proactively adapt to a health care system characterized by rapid change and chaos.

Various leadership theories and approaches have emerged over the years, in response to various contexts and societal and generational values. Leadership has become less hierarchical, less focused on tasks and more on relationships with collaborative frameworks for leadership evolving over the years (see Chapter 1). Nurse leaders, including nurse managers, must actively demonstrate the same professional, evidence-informed, innovative, collaborative, compassionate behaviour they expect of their staff nurses. This begins with clarifying their personal, professional, and organizational values. Leaders must find their own voice, then clearly and distinctively give voice to their values. Professional values can be drawn from the CNA Code of Ethics (2017a), which is applicable to nurse leaders in all domains (see Chapter 10). Nurses, including nurse managers, can find themselves in ethical distress as they try to manage and lead within an environment of constant change and resource constraint. Demonstrating ethical leadership is critical to their role as professional nurses. The next two sections outline the nurse leader's ethical responsibilities in safe nurse staffing and in medical assistance in dying (MAID).

Safe Nurse Staffing

One of the key functions of a nurse manager is to manage resources, including budgets and personnel. Appropriate, evidence-informed, safe nurse staffing is a key responsibility of nurse managers, one that can often result in moral distress. Safe nurse staffing is critical to patient, provider, organizational, and system outcomes (Berry & Curry, 2012). The CNA and the Canadian Federation of Nurses Unions (CFNU) have developed an online, evidence-based safe nurse staffing toolkit made up of four modules. It is designed to provide nurse managers—or any nurse who has the responsibility and authority for staffing—with the knowledge, tools, and resources required to fulfill that responsibility in a variety of settings.

Figure 12.3.1 Safe Nurse Staffing–Nurses with Critically Ill Patient

[n.d.], "Hospital Staff Tending to Patient," photo courtesy of the Saskatchewan Health Authority (formerly Regina Qu'Appelle Health Region) collection number 2003.8-1578, is licensed under a Creative Commons Attribution 4.0 International License.

The CNA/CFNU approach to safe nurse staffing calls for attention to be given to the following:

- real-time assessment of patient needs;
- nursing care delivery models;
- staff mix decisions;
- workload measurement;
- quality practice environments; and
- retention and recruitment.

From the Field

Ethical (or moral) distress arises in situations where nurses know or believe they know the right thing to do but, for various reasons (including fear or circumstances beyond their control), do not or cannot take the right

action or prevent a particular harm. When values and commitments are compromised in this way, nurses' identity and **integrity** as moral agents are affected and they feel moral distress.

See the following sites for key tools and resources related to evidence-informed staffing:

CNA's Position Statement on Clinical Nurse Specialist

CNA/CFNU's Evidence-based Safe Nurse Staffing Toolkit

RNAO's report titled "Developing and Sustaining Safe, Effective Staffing and Workload Practices"

CNA's Position Statement on Interprofessional Collaboration

CNA's Position Statement on Patient Safety

The RN/RPN Utilization Toolkit (part of the HHR Demonstration Project in Ontario)

CNA's report titled "Staff Mix Decision-making Framework for Quality Nursing Care"

CNA's Position Statement on Taking Action on Nurse Fatigue

CNA's Position Statement on the Nurse Practitioner

CNA's Certification Program webpage

Medical Assistance in Dying

June 2016 saw amendments to the Criminal Code that made it possible for eligible persons to receive medical assistance in dying (MAID) in Canada. Canada's nurses have a significant role in providing high-quality, person-centred end-of-life care, which includes palliative care and natural death and, in some jurisdictions, MAID. This is a key area of nursing practice in which nurses and nurse managers will draw on their personal and professional values and ethics. Nurse managers may be responsible for the operational aspects such as policy development, coordination, and management of the delivery of MAID on their unit or work setting. They may also serve as an ethical resource for their staff nurses as they choose whether or not to participate in MAID. The Canadian Nurses Association has released a National Nursing Framework on MAID that includes seven core values and responsibilities derived from the CNA Code of Ethics; these values and responsibilities are meant to be used as an initial lens through which all ethical guidance and decisions for MAID are viewed.

The framework serves many purposes including, but not limited to, the following:

- to reinforce sound ethical nursing practice;
- to outline the role of nurses (i.e., nurse practitioners as compared to registered nurses, licensed practical nurses, and registered psychiatric nurses) in MAID and to support nurses in their practice as they work with clients receiving MAID, as well as their families and

interprofessional health care teams (in alignment with regulatory direction in relevant jurisdictions); and
- to be a resource that supports nurse regulators, clinical nurse leaders, administrators, employers, and interprofessional health care teams in developing policies, guidelines, processes, and services that use the knowledge and skills of nurses appropriately to provide or aid in MAID.

In 2016, the Saskatchewan Registered Nurses' Association issued a Guideline for RN Involvement in Medical Assistance in Dying, which outlines the different roles of RNs and RN(NP)s who are involved in MAID.

Research Note

Makaroff, K., Storch, J., Pauly, B., & Newton, L. (2014). Searching for ethical leadership in nursing. *Nursing Ethics*, *21*(6), 642–658.

Purpose

The aim of the study was to investigate how frontline nurses and formal nurse leaders (FNLs) envision ethical nursing leadership.

Discussion

The researchers used a meta-ethnography methodology to guide their analysis and synthesis of four studies conducted with 601 participants in Canada (from 1999 to 2008) that explored the notion of ethical nursing leadership. The intent was to determine what frontline nurses in practice expect of their formal nurse leaders regarding ethical leadership, and importantly, how formal nurse leaders perceive ethical leadership. Two main themes are reflected in the four studies. First, ethical nursing leadership must be responsive to practitioners and to the contextual system in which they and FNLs work. Second, ethical nursing leadership requires receiving and providing support to increase the capacity to practise and discuss ethics in the day-to-day context. This work draws attention to the important, and somewhat neglected, need for FNLs to have organizational support in order to enact ethical leadership.

Application to leadership practice

Frontline nurses do not necessarily perceive FNL as visible, responsible, and supportive. This highlights a gap between perceptions and actions that requires more attention. FNLs may face challenges in their ability to enact ethical nursing leadership. Ethical leadership is an important aspect of creating an ethical climate in which both nurse and patient outcomes are enhanced. Yet FNLs may find themselves caught in the tension between enacting ethical obligations of the profession and working within the priorities and needs of their health care organizations and governments. Chief among these challenges is navigating the current health care environment in which values related to quality of care may be of second priority to business and market-

oriented values of efficiency and cost effectiveness. Organizational resources such as vision, mission, values, and codes of ethics can be utilized by FNLs to enact the responsibilities and competencies associated with ethical nursing leadership. There is a need to focus on and develop the ethical competencies of FNLs as part of organizational leadership. A key rationale for strengthening ethical nursing leadership is to support ethical nursing practice as part of excellence in patient care.

The Institute for Healthcare Improvement (2017) has identified four main responsibilities of leaders to achieve safe, reliable, and effective operational excellence. These four responsibilities correlate with newer, empowering leadership styles such as transformational and authentic. One might add that ensuring value alignment also requires the application of professional values such as those found in the CNA Code of Ethics.

Guarding the learning system. Fully engaging in the work of self-reflection that leads to transparency; understanding and applying improvement science, reliability science, and continuous learning; and inspiring that work throughout the organization.

Creating psychological safety. Making sure that anyone in the organization, including patients and families, can comfortably voice concerns, suggestions, and ideas for change.

Fostering trust. Creating an environment of non-negotiable respect, ensuring that people feel their opinions are valued, and any negative or abusive behaviour is swiftly addressed.

Ensuring value alignment. Applying organizational values to every decision made, whether in service of safety, effectiveness, patient-centredness, timeliness, efficiency, or equity.

From the Field

Review the following CNA ethics-related resources for nurse managers:

Ethical Distress in Health Care Environments

Ethical Issues Related to Appropriate Staff Mixes

Ethics, Relationships and Quality Practice Environments

E-Learning Modules on CNA Code of Ethics (E-learning Modules, accessible to CNA members)

12.4 LEADING AND PROMOTING ENVIRONMENTAL HEALTH

Visionary nurse leaders are also responsible for strengthening the presence of the determinants of population health, both internal and external to their health care organizations. The 2017 CNA Code of Ethics guides nurses in providing leadership through individual and community health interventions directed at eliminating environmental threats and improving our health worldwide. As expressed in a 2009 joint position statement put out by the CNA and the Canadian Medical Association, "the physical environment is an important determinant of health" (CNA, 2009b). Each of us has a responsibility for the environment at an individual, community, national, and international level. Health care providers can offer leadership in advocating for environmentally responsible practices and policies. Leadership and advocacy include actions such as:

- "assessing and communicating risks of environmental hazards to individuals, families and communities;
- advocating for policies that protect health by preventing exposure to those hazards and promoting sustainability; and
- producing nursing science, including interdisciplinary research, related to environmental health issues." (CNA 2009c, p. 1)

Nurses are encouraged to provide leadership in environmental health throughout all areas of nursing practice.

12.5 LEADERSHIP DEVELOPMENT

Leadership development can take many forms including self-reflection, networking, education, training, and coaching. Many universities, including the DeGroote School of Business at McMaster University, offer health care leadership development courses and programs. The Kouzes and Posner leadership model is the basis for many leadership development programs, including that offered by the Dorothy Wylie Health Leaders Institute offered in collaboration with the CNA. Established in 2001, this unique Canadian leadership program was originally designed to strengthen nursing leadership, but has since evolved to include health care leaders from all disciplines across the country. More than 75 per cent of Institute alumni said their experience had a positive or profound impact on their personal life and career with attendance at the Institute described as a catalyst for change (Purdy, 2016).

Nurse managers have various resources available to them, including the opportunity to network, connect, collaborate with, and learn from their peers and colleagues. Networking resources include:

- the Academy of Canadian Executive Nurses, which represents the voice of nursing leadership in Canada, offering a forum for discussion and sharing of strategies and opportunities for coalitions and partnerships; and
- the Canadian College of Health Leaders, which is a national, member-driven, non-profit association dedicated to ensuring that the country's health care system benefits from capable, competent, and effective leadership.

SUMMARY

In this chapter, the responsibilities of a nurse manager and leader are examined and identified through various lenses. A nurse manager is responsible for the day-to-day operations of a workplace in addition to providing inspiration and direction to other nurses and health care professionals. Nurses, including nurse managers, may find themselves in workplace moral and ethical distress. The CNA Code of Ethics is a valuable resource to support nurse managers in demonstrating ethical leadership in situations related to safe nurse staffing, medical assistance in dying (MAID), and environmental health. Numerous resources and networking opportunities exist across Canada to support nursing leadership development. Nurse leaders– in particular nurse managers–play a key role in the immediate lives of nurses, as well as in the health care system and the health of Canadians.

Some key takeaways from this chapter include:

- Know your own personal, professional, and organizational values.
- The application of personal and professional values is particularly relevant in the practice of empowering, collaborative leadership styles, such as transformational leadership (see Kouzes and Posner, 2012) and authentic leadership.
- Nursing leadership is "about innovative and visionary administrators…who understand and hold themselves accountable for creating vibrant, exciting practice settings in which nurses can deliver safe, accessible, timely and high-quality care for the Canadians they serve" (CNA, 2009a, p.1).
- Nurse managers are in a key position to influence the professional practice of staff nurses through the creation of professional practice environments.
- While nurse managers must develop strong organizational and management skills, effective leadership skills are needed to navigate today's challenging work environments confronted

with human, fiscal, time, and other resource constraints.

After completing this chapter, you should now be able to:

1. Recognize the role of nurse leaders, in particular, nurse managers.
2. Integrate the role of the professional nurse into the role of the nurse leader or manager.
3. Illustrate the importance of examining personal, professional, and organizational values in nursing practice.
4. Describe how the CNA's Code of Ethics can be used in your nursing practice to deal with environmental threats.

Exercises

1. Linda is a nurse manager on a critical care unit. It has been brought to her attention that it is common practice for the nurses working on the night shift to sleep in the visitors' lounge. Linda is planning to discuss this with the nursing staff. What elements of the CNA Code of Ethics could Linda apply to inform her discussion with the nurses?
2. Define a clinical or management issue that requires action. Assume that you have six weeks to make a difference. Create a high-level plan that demonstrates effective leadership.
3. How is data, information, and research to inform management decision making?
4. As a nurse manager, you have a small group of staff nurses with a keen interest in diabetes care who offer to revise the diabetic foot care policies and procedures. What actions might you take to empower these nurses?
5. A diabetic client, living on a ranch in rural Saskatchewan, has a leg ulcer that appears to be infected. The local physician has advised her to wash the ulcer with Sunlight soap every day to dry out the exudate. You have just made a home visit to the client and you know that this treatment is not best practice for wound care. What are your next steps? Describe how your next steps fall within the professional boundaries of authorized registered nursing practice.

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13. Emergency Preparedness and Response

YVONNE HARRIS

> *We see all comers, from the worried well to the critically ill; from birth to death; and with conditions involving all parts of the mind, body, and spirit; from brain trauma to ingrown toenails. Our patients come to us trusting that we will respect their concerns and that we will provide care for them. As emergency nurses, we have a responsibility to respect that trust and provide our patients with the skill and expert knowledge required for their care.*
>
> –Jean Proehl (2009, p. xi)

INTRODUCTION

Emergency nurses see it all. Disasters have claimed millions of lives and cost billions of dollars worldwide in the past few decades. Goodwin Veenema suggests that there is, on average, a disaster requiring international assistance every week (2013). Tragedies such as the September 11th World Trade Center attacks, Hurricane Katrina, and the 2010 earthquake in Haiti have led heath care providers to critically review their processes in order to deal with such events.

Figure 13.1 Waiting to be Rescued after Hurricane Katrina, New Orleans

"Photograph by Jocelyn Augustino taken on 08/30/2005 in Louisiana" by Jocelyn Augustino, FEMA / FEMA Photo Library is released in the Public Domain, via Wikimedia Commons. About this photo: New Orleans, LA, Aerial views of damage caused from Hurricane Katrina the day after the hurricane hit.

Nurses need to be familiar with their role in emergency preparedness and disaster planning as they frequently have wide-ranging leadership responsibilities for community- and hospital-level disaster preparedness and response. This chapter discusses the definition of a disaster, either natural or anthropogenic (caused by humans), disaster preparedness and planning, and the disaster response.

Learning Objectives

1. Discuss the four areas of focus in emergency and disaster planning—mitigation, preparedness, response, and recovery.
2. Describe the core preparedness actions.
3. Recognize situations that may call for additional comprehensive planning.

13.1 DISASTER

Disasters are defined in many ways. The World Health Organization (WHO, n.d.) defines *disaster* as "a situation or event, which overwhelms local capacity, necessitating a request to the national or international level for external assistance." The United States Department of Homeland Security (USDHS) defines it as an emergency that "requires responsive action to protect life or property" (USDHS, 2008, p. 138). Hammond, Arbon, Gebbie, & Hutton (2012) summarize these definitions in their statement that

> A disaster is a serious disruption of the functioning of a community or a society involving widespread human, material, economic or environmental losses and impacts, which exceeds the ability of the affected community or society to cope using its own resources." (p. 236)

Simply put, a disaster is a catastrophic event that overwhelms available resources. Disasters can be natural or anthropogenic (caused by human activity). In May 2016, a fire in Fort McMurray, Alberta, destroyed 2,400 structures in the area, forcing more than 90,000 people to evacuate the region.

> The fire grew so much that at one point it was creating its own weather and required firefighting reinforcements from across the country. All the stores and amenities in Fort McMurray were closed . . . and residents were told to boil their water. (Morgan, 2016)

Figure 13.1.1 Highway 63 near Fort McMurray, Alberta, May 3, 2016

"Landscape view of wildfire near Highway 63 in South Fort McMurray," by DarrenRD, is licensed under a CC BY-SA 4.0 International License, via Wikimedia Commons.

Natural disasters such as tornadoes, earthquakes, floods, and extreme winter conditions occur more frequently than anthropogenic disasters such as civil unrest, terrorism, and armed conflict; in 2015, there were 376 naturally triggered disasters registered (Guha-Sapir, Hoyois, & Below, 2015). Disasters are typically considered "low probability, high impact" events (Saunderson Cohen, 2013, p. 21).

Planning for any type of disaster requires consideration of common elements including mitigation, preparedness, response, and recovery. Canada's Emergency Management Act recognizes the roles that all stakeholders must play in Canada's emergency management system including "coordinating emergency management activities among government institutions and in cooperation with the provinces and other entities" (Emergency Management Act, 2007).

13.2 DISASTER MITIGATION

Disaster mitigation measures are those that eliminate or reduce the impacts and risks of hazards through proactive measures taken before an emergency or disaster occurs. It begins with identifying the risks. Health care leaders need to evaluate potential emergencies or disasters that could impact the demand for their services and supplies, then develop a plan that will address those needs. Public Safety Canada describes the Red River Floodway as an example of disaster mitigation.

> The building of the Floodway was a joint provincial/federal undertaking to protect the City of Winnipeg and reduce the impact of flooding in the Red River Basin. It cost $60 million to build in the 1960s. Since then, the floodway has been used over 20 times. Its use during the 1997 Red River Flood alone saved an estimated $6 billion. The Floodway was expanded in 2006 as a joint provincial/federal initiative. (2015)

Hendrickson & Horowitz, (2016) explain that hospital facility planners and health leaders should address those disasters that are most likely to occur in their community and geographic area and perform a **hazard vulnerability analysis** to determine the likely vulnerabilities that may arise in their facility from those disasters.

A hazard vulnerability analysis (HVA) is defined as a systematic approach that:

- identifies all hazards that may affect a community;
- determines the probability of the hazard;
- determines the consequences of the hazard; and
- analyzes the findings to determine what hazards are of priority (Saunderson Cohen, 2013; Hendrickson & Horowitz, 2016).

For example, industrial sites that store large volumes of potentially harmful chemicals pose a hazardous material threat that could require mass decontamination. Area hospitals would need to have functional decontamination units, as well as an abundant supply of ventilators, oxygen, and specific antidotes that are not typically available in large quantities. Natural disasters often result in increased numbers of homeless or displaced persons whose everyday medical needs may be exacerbated by limited access to routine health care. This may result in emergency departments experiencing an influx of patients seeking medication, treatments, and assessments.

The results of an HVA can be used to develop and streamline disaster plans. These plans should be designed using an interdisciplinary approach, including partners from local police, emergency, and fire services. HVAs should be conducted on an annual basis, or whenever there are demographic or infrastructural changes that may impact the potential of a disaster.

Figure 13.3.1 Medical Crew Conduct Mass Casualty Scenario Drill

"Mercy conducts mass casualty exercise during Pacific Partnership 2015 [Image 12 of 12]", by Mayra Conde, identified by DVIDS, is released in the Public Domain, via Wikimedia Commons. About this photo: PHILIPPINE SEA (July 16, 2015) Crew members on board the hospital ship USNS Mercy (T-AH 19) conduct a mass casualty drill during Pacific Partnership 2015.

The goal of disaster preparedness is to plan a response that will decrease the damages and support the recovery from a disaster (Stopford, 2007). Nurses, with their expertise in primary health care, extensive experience with interdisciplinary teamwork, and strong collaborative skills are the ideal leaders in disaster preparedness. The first step in preparing for a disaster is developing a strategic emergency management plan (SEMP) (Public Safety Canada, 2016) in anticipation not only for those disasters that are most likely to occur in a specific geographical area, but also those that are unexpected (Saunderson Cohen, 2013).

The SEMP is a broad scope document that guides and informs partners internally and externally on how to respond to disasters. It includes specific processes for:

- the main goals of the plan and the method for attaining those goals;
- obtaining information on threats; and
- planning standard response to threats.

Essential Learning Activity 13.3.1

For detailed information on SEMP, refer to Annex A of the *Emergency Management Planning Guide, 2010–2011*, published by Public Safety Canada.

Stopford (2007) provides a comprehensive list of additional processes including:

1. **Determining a command and control plan.** When determining a line of command, it is essential to ensure you have both a command person and a second-in-command, should the situation arise that the primary commander is unable to fulfill the role. The control plan must also include the designation of a specific location for the command centre.

2. **Identifying the functional roles and responsibilities of internal and external agencies.** Internal and external department need to have a clear understanding of both their roles and responsibilities and other parties' roles and responsibilities during a disaster. Contact information of emergency personnel, along with their roles should be readily available. Additionally, essential service staff should be defined, thus ensuring that there is consistent emergency staff coverage during the disaster.

3. **Determining a communication system.** A standard process of communication must be developed to address the possibility of system failure. The contingency process should include the use of land lines, cellphones, and radios as standard communication equipment.

4. **Confirming a legal basis for response to include isolation strategies as needed for infection control.** Disaster preparedness must include details for the processes of isolation, infection control, and allocation of medications such as vaccines, antibiotics, and antiviral agents should they become short in supply. Additionally, should there be a need for facility lockdown and controlled facility access, legal and ethical concerns need to be considered when developing this portion of the plan.

5. **Developing an infectious disease plan.** Standard process needs to address the potential for an infectious disease outbreak or pandemic. Different illnesses require different levels of isolation and personal protective equipment (PPE). Disaster preparedness addresses the possibility of high-level isolation equipment requirements and ensures adequate supplies and equipment are readily available. Emergency care providers should be familiar with clinical signs of different

diseases, and a surveillance methodology plan should be in place to address possible advancement of the disease process.

6. **Obtaining and maintaining emergency facilities, equipment, and supplies.** Emergency preparedness requires a standard process for obtaining and maintaining emergency equipment and supplies. This includes a standard maintenance schedule, a tracking schedule of where equipment is located, and details where to obtain additional equipment and supplies.

7. **Providing disaster preparedness training for emergencies.** Training may involve

- educating personnel to understand their role in an emergency;
- donning and doffing PPE;
- decontamination procedures; and
- triage.

Training should occur on a regular basis and should be included in regional orientation for all personnel. Individual facilities require additional planning on the steps to take if a disaster disrupts their day-to-day facility operations. This planning is directed at facility leadership and personnel and provides a standard process for ensuring facilities can continue to provide regular essential services (Saunderson Cohen, 2013). Additional considerations suggested by Stopford (2007) include planning for a lockdown of the facility. Staff may be required to remain in the facility, and if so, they need to be trained to develop a contingency plan for family emergency planning.

13.4 DISASTER RESPONSE

The first step in responding to an incident is recognizing the event is occurring and initiating the plans that were developed in the preparedness phase. External responses may include activities such as search-and-rescue operations, firefighting, and building shelters for displaced persons. Nurses need to have a good understanding of the disaster plan, as well as a concrete awareness of the events surrounding the incident, to provide the best care for their patients. As an example, during the 2016 Fort McMurray fire, surrounding hospitals were required to be prepared to care for high numbers of patients with burns and respiratory compromise. This included not only the citizens, but also firefighters and first responders.

Efficient internal facility responses to disasters include disaster triage and casualty distribution (Saunderson Cohen, 2013). Nursing during a disaster often focuses on providing care to an influx of patients to a care centre, and it requires an understanding that these patients may have varying degrees of illness and injury as well as emotional stress from the event. Disaster triage is the

process of "doing the greatest good for the greatest number of casualties" and has been characterized as the "keystone to mass casualty management" (Saunderson Cohen, 2013, p. 26).

Treatment priorities may vary according to available supplies and resources, as well as the type of disaster (Stopford, 2007).

Various disaster triage systems have been designed for use in mass casualty incidents; therefore, it is important for facilities to determine in advance which system they will use. One method of disaster triage is the simple triage and rapid transport (START) tool. This system was developed in the 1980s in Orange County, California, and has been adopted throughout many countries (Saunderson Cohen, 2013, p. 27).

When the triage nurse is using the START tool, patients are rapidly assessed (less than one minute) and determined to be either red, yellow, green, or black.

Figure 13.4.1 Assessing Patients Using the START Tool (*Data Source: Table based on material from Saunderson Cohen, 2013.*)

RED	Immediate care required. These patients are in a priority treatment category with illnesses or injuries that could result in loss of life or limb.
YELLOW	Urgent care required. This category of patient requires urgent treatment but can wait until the red-tagged patients have been stabilized.
GREEN	Minimal care required. These patients require care but are deemed stable enough to wait several hours for treatment.
BLACK	End-of-life care required. Black-tagged patients are deemed to be beyond the ability of the care team to provide lifesaving care. They are in a state of impending death or already lifeless.

Essential Learning Activity 13.4.1

Mass casualty incidents involving high numbers of pediatric patients use the JumpSTART system. Read about the process of triaging pediatric patients using the JumpSTART Pediatric Triage Algorithm from the US Department of Health and Human Services.

13.5 DISASTER RECOVERY

Figure 13.5.1 Gratitude to Nurses

"Assiniboia flag raising flag signing" by Saskatchewan Registered Nurses Association is released under a CC BY Attribution 4.0 International License.

Disaster recovery follows the response phase and is defined by the short-term and long-term actions required to return the community to a normal state. Short-term recovery includes returning vital life support systems to an operational state and repatriation of patients. Establishing a protocol for the safe transport of patients back to their designated facility as soon as possible helps to alleviate the psychological trauma of family separation. Additionally, it eases the burden on the alternate care facilities and staff called into action during the disaster (Assid, 2014).

Long-term recovery includes such actions as restoring damaged infrastructure and damaged property, and providing physical and psychological support for victims, families, and responders (Upton, 2013). Physical damage is an easily identifiable visual cue of disaster, but it is not always present (Saunderson Cohen, 2013). Pandemics, bio- and cyber-terrorism are examples of disasters that leave minimal or no visual footprint. However, the psychological impact may last for years, for both patients and the health care team. Individuals who experience a traumatic event are at risk of suffering long-term effects, which. may be physical, emotional, spiritual, or mental. Characteristics of these responses include:

- emotional reactions to events;
- loss of ability to function;
- feeling overwhelmed; and
- increased use of resources.

Essential Learning Activity 13.5.1

Canada has had a number of major disasters over the past few years.

1. Nurses played significant leadership roles during the Fort McMurray fires (mentioned earlier in this chapter) and in the follow-up recovery. Go to the links below, then answer the questions that follow.

"'We got the job done': Nurse describes Fort McMurray hospital evacuation" by Rob Drinkwater (*Canadian Press*, May 5, 2016)

"A year after the fire, Fort McMurray residents report an uneven recovery" by Keith Gerein (*Edmonton Sun*, April 25, 2017)

(a) What were the major issues facing nurses who evacuated the hospitals in Fort McMurray?

(b) What are the major health issues facing Fort McMurray residents as they recovered from the fire?

2. Read the following articles on the Lac-Mégantic train derailment titled "The public health response during and after the Lac-Mégantic train derailment tragedy: a case study," then answer the questions that follow.

Généreux, M., Petit, G., Maltais, D., Roy, M., Simard, R., Boivin, S., Shultz, J. M., & Pinsonneault, L. (2014). The public health response during and after the Lac-Mégantic train derailment tragedy: A case study. *Disaster Health*, 2 (3–4), 113–120. doi:10.1080/21665044.2014.11031

(a) Describe the seven lessons learned by public health professionals.

(b) Why do public health actions continue long after emergency response operations have concluded?

3. Read the following sources for information on the role that nurses played during the 2003 SARS pandemic in Toronto, and the role that nursing leadership played in preventing further spread of the illness, then answer the questions that follow.

"Lessons learned from SARS" by Melissa Di Costanzo (*Registered Nurse Journal*, May/June 2013)

"SARS, 10 years later: One family's remarkable story" by Amy Dempsey (*Toronto Star*, March 2, 2013)

(a) What were some of the long-term effects that nurses reported following the traumatic event?

(b) What were the primary lessons learned?

Research Note

Goodwin Veenema, T., Andrews, D, Losinski, S., Newton, S. M., & Seal, S. (2016). Exploration and development of standardized nursing leadership competencies during disasters. *Health Emergency and Disaster Nursing*, 4, 26–38.

Nash, T. J. (2016). A guide to emergency preparedness and disaster nursing education resources. *Health Emergency and Disaster Nursing*, 4, 12–25.

Canadian Nurses Association. (2010). Evidence-informed decision-making and nursing practice. [Position statement] Retrieved from http://cna-aiic.ca/~/media/cna/page-content/pdf-en/ps113_evidence_informed_2010_e.pdf

Imagine you are just finishing your day shift in the emergency department when the EMS radio patches in that a tornado has touched down in a community 50 kilometres outside the city. Numerous homes and businesses have been completely destroyed. EMS, fire, and police are on scene and have begun transporting patients to your ED. Are you prepared? Do you have the knowledge to provide the best care for the victims?

Evidence-based practice has always been part of the nursing lexicon; over the last few decades it has taken a more prominent role in nursing education (CNA, 2010). A broad scope of knowledge is needed to be an effective emergency nurse, which requires keeping current on the latest research about nursing and health care. However, research has shown that many nurses do not have the basic understanding or knowledge to prepare for a disaster. A literature review done by Nash (2016) suggests that nurses do not feel comfortable responding to disaster situations due to scarcity of emergency preparedness resources (p. 12). The challenge lies in the lack of current literature related to emergency nursing and disaster preparedness. Additional literature reviews strengthen this argument and contend that evidence-based leadership research is minimally available (Goodwin Veenema, Andrews, Losinski, Newton, & Seal, 2016, p.36). Clinical research in emergency nursing underpins the development of practice guidelines, such as door-to-needle and door-to-balloon times for treatment of acute coronary syndromes and family presence during resuscitation. Research in emergency preparedness is no exception.

The inevitability of future disasters, both natural and anthropogenic, combined with the currently limited resources related to education and training, means that there needs to be a greater focus on disaster preparedness education in nursing curricula. There is an opportunity for nursing education to forge the way for continued research, thereby meeting this continuing challenge.

SUMMARY

Disasters are unpredictable and can occur anywhere, at any time. Nursing during a disaster requires a coordinated effort among professionals throughout the health care, public, and private service sectors.

Today's nurses are faced with the challenges of responding to natural, anthropogenic, and technological disasters. Strong leadership is required to address the unique set of challenges and necessary preparation for such events. "When a disaster strikes a community—whether a bus accident, a tornado, a hurricane, or terrorist attack—nurses will be on the front lines helping those who are in need" (Knebel, as cited in Goodwin Veenema, 2013, p. xxvi). As the frequency, magnitude, and variety of disasters, both anthropogenic and natural, continue to escalate, nursing leaders will need to respond with "awareness, preparedness, political prowess…and most of all, teamwork on all levels" (Ford, as cited by Goodwin Veenema, 2013, p. xxix).

After completing this chapter, you should now be able to:

1. Discuss the four areas of focus in emergency and disaster planning—mitigation, preparedness, response, and recovery.
2. Describe the core preparedness actions.
3. Recognize situations that may call for additional comprehensive planning.

Exercises

1. Watch this video titled "START Simple Triage and Rapid Treatment" (18:19) on START triage basics, then read the following simulated scenario:

You are on a ride-along with EMS and are first on the scene to a multi-vehicle collision on Highway 1 involving five passenger vehicles and one semi carrying non-hazardous materials. There are ten victims in various stages of crisis.

Triage the following victims using the START adult triage categories: green, yellow, red, and black.

(a) Female, 77 years, scalp avulsion, no spontaneous breathing

(b) Male, 45 years, ambulatory, RR 20, bleeding noted from scalp, asking if he can help

(c) Male, 30 years, no spontaneous breathing, impaled pipe through chest

(d) Male, 55 years, gasping respirations RR 32, bleeding from both arms

(e) Female, 27 years, non-ambulatory, RR 18, obeys commands

(f) Male, 23 years, RR 28/minute, large laceration to head, decreased LOC, not obeying commands

(g) Female, 44 years, limping, complaining of left knee pain, painful left arm. Obvious deformity of left arm, cap refill < 2 seconds, RR 24/minute

(h) Male, 79 years, walking between vehicles, calling for his wife, no obvious injuries

(i) Female, 19 years, ambulatory, c/o feeling dizzy, RR 16, no obvious injuries

(j) Female, 18 years, ambulatory, crying, RR 22, bleeding from nose

2. Several city hospitals create a network of policies and agreements governing the redirection of patients should one emergency department become overwhelmed beyond ability to respond. Which phase of the emergency management plan does this action exemplify?

(a) mitigation

(b) preparedness

(c) response

(d) recovery

3. Choose the statement which best describes the mitigation phase of a disaster event.

(a) Establishing a protocol for the safe transport of patients back to their designated facility as soon as possible occurs during the mitigation phase.

(b) The mitigation phase of disaster encompasses assessing physical and structural damages.

(c) Mitigation begins with identifying the risks.

(d) The mitigation phase of a disaster is the final phase of a disaster experience.

SOLUTIONS

1. (a) Female, 77 years, scalp avulsion, no spontaneous breathing (black)

(b) Male, 45 years, ambulatory, RR 20, bleeding noted from scalp, asking if he can help (green)

(c) Male, 30 years, no spontaneous breathing, impaled pipe through chest (black)

(d) Male, 55 years, gasping respirations RR 32, bleeding from both arms (red)

(e) Female, 27 years, non-ambulatory, RR 18, obeys commands (yellow)

(f) Male, 23 years, RR 28/minute, large laceration to head, decreased LOC, not obeying commands (red)

(g) Female, 44 years, limping, complaining of left knee pain, painful left arm. Obvious deformity of left arm, cap refill < 2 seconds, RR 24/minute (yellow)

(h) Male, 79 years, walking between vehicles, calling for his wife, no obvious injuries (green)

(i) Female, 19 years, ambulatory, c/o feeling dizzy, RR 16, no obvious injuries (green)

(j) Female, 18 years, ambulatory, crying, RR 22, bleeding from nose (green)

2. (b) Preparedness. **Rationale**: Establishing inter-hospital agreements and coordination arrangements prior to a disaster, constitutes a preparedness phase action.

3. (c) Mitigation begins with identifying the risks. **Rationale**: Disaster mitigation measures are those that eliminate or reduce the impacts and risks of hazards through proactive measures taken before an emergency or disaster occurs. It begins with identifying the risks.

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14. Nursing Leadership through Informatics

Facilitating and Empowering Health Using Digital Technology

SHAUNA DAVIES

> *Twitter is not a technology, it's a conversation—and it's happening with or without you.*
>
> —Charlene Li (2014)

INTRODUCTION

Information plays a vital role in the nursing process. As nurses, we collect information about our clients, use this data to develop nursing care plans, implement the plan, and communicate our findings with other health care providers. Advances in information technology allow nurses and nursing students to access vital information with the click of a button. For example, in hospitals and clinic offices, health care providers have access to electronic health records, which provide access to private and confidential client health information in a secured environment. Services such as telehealth provide a means for client education, as well as medical and health care services such as health monitoring or clinical diagnosis. Social media is also being used in health care to provide a means for clients to share experiences with one another or learn more about their medical condition.

Now more than ever, nurses have the opportunity to communicate and plan care more effectively, in collaboration with clients and other health care providers, due to advances in technology. This chapter will provide you with a deeper understanding of nursing informatics and technology. Additionally, the nurse's role in relation to electronic health records, telehealth, telehomecare, and social media will be discussed.

Learning Objectives

1. Define the terms *nursing informatics*, *e–Health*, and *m–Health*.
2. Develop an understanding of the risks and benefits of using electronic health records.
3. Develop an appreciation for standardized terminologies.
4. Develop an understanding of telehealth and telehomecare.
5. Differentiate between telehealth and telehomecare.
6. Develop an understanding of various web 2.0 tools used in health care.
7. Discuss the role of nurses in developing clients' health literacy.
8. Describe the necessary steps to ensure privacy and security of personal health information.

14.1 HEALTH INFORMATICS

Nursing Informatics

Health information systems specialize in storing, managing, capturing, and transmitting information about the health of individuals along with all activities within the health care organization (CASN, 2012). **Nursing informatics** is a specialty that incorporates nursing care with the use of computers and information science to provide information about nursing care delivery. The Canadian Association of Schools of Nursing (CASN) developed a resource that outlines the competencies required by nursing students upon graduation (see CASN, 2012). When entering the workforce, graduate nurses are expected to (1) use information to support safe, effective, and evidenced-informed care for their clients; (2) follow workplace, professional association, and regulatory bodies' standards with respect to information and communication technologies; and (3) be able to use information and communication technologies in practice. Required skills include, but are not limited to, searching for credible and reliable health information online and assisting clients and their families in finding and evaluating the credibility and reliability of online health information.

From the Field

Understanding principles related to nursing informatics is important for student nurses who will both observe and experience countless examples of clients' use of technology throughout their careers. Examples include:

- working in a rural setting and using telehealth for a client's appointment with a specialist;
- using electronic health records in daily practice; and
- using a medical app to assist in delivering safe, effective client care.

e-Health

e-Health is a term used by Health Canada to describe the information and communication technologies used in health care, which includes a range of services such as electronic patient administration systems, lab and diagnostic tests, information services, and telehealth and telehomecare monitoring devices (including remote vital sign monitoring).

m-Health

Mobile technology has changed the way health care providers communicate, monitor, and connect with clients, families, and other health care providers. Any mobile device with smartphone capabilities allows for downloading apps, which are self-contained computer programs that run directly on the device's home screen. This **m-Health** technology includes many different types of medical- and health-related apps, currently available either free of charge or for a fee.

Health and fitness apps are generally intended for daily individual use and are related to monitoring or informing about a variety of healthy activities such as calorie counting or exercise (Aungst, Clauson, Misra, Lewis, & Husain, 2014; Martinez-Pérez, de la Torre-Diez, & López-Coronado, 2013). Medical apps focus more on health care practices and may assist in communication or pictorial representation of a medical condition or may help to record blood pressure or blood sugars in clients with hypertension or diabetes.

The use of m-Health technology may have potential security issues. Many health apps currently available require the client to input personal health information (Cummings, Borycki, & Roehrer, 2013). The developer informs the user of the terms of use (including use of personal health information) by requiring a confirmation agreement before the app can be used. If the client agrees to the terms of use, users must be informed of who has access to any personal information placed

within the app. Clients also need to be informed if this information will be monitored by their health care provider or if someone else outside the circle of care will have access to this health information, such as the app developer. All health care providers must follow HIPA (Health Information Protection Act) when using apps with multiple clients so that any personal information is de-identified. If more than one client is accessing a mobile device during a hospital stay or health consult, it is also important to develop privacy policies to prevent clients from accessing another client's health information entered into the app.

Infection control procedures must be developed based on the type of devices in use within the health care setting. Health care providers must consider infection control procedures when devices are shared between clients.

When choosing health care apps for clients, providers must consider factors such as the client's age, the cost of the app, and app-specific features (e.g., email, messaging, or support groups) to determine if they will meet the needs of the client (Ristau, Yang, & White, 2013). If the client is to use the app upon discharge or at home, it must be cost effective. Some apps require an internet connection, so the client will need to have regular or intermittent access to the internet. The app must also be easy to use and updated regularly to provide current, reliable information.

Essential Learning Activity 14.1.1

For more information on nursing informatics, see CASN's report titled "Nursing Informatics: Entry-to-Practice Competencies For Registered Nurses," then answer the following questions:

1. What three entry-to-practice informatics competencies does CASN set out?
2. Select one of these competencies and list the indicators.

For more information on privacy, review the sites below, then answer the questions that follow:

Health Insurance Portability and Accountability Act for Professionals, US Department of Health and Human Services

1. Can health information be shared in a severe disaster?
2. Who has the right to consent with respect to whether a covered entity may electronically exchange a minor's protected health information to or through a health information organization?

Your Personal Health Information and Privacy (Government of Saskatchewan)

1. Who are the trustees under the Health Information Protection Act?
2. What rights do you have with respect to your personal information?

How do I get access to information? (Office of the Saskatchewan Information and Privacy Commissioner)

1. How do you access the type of information you need from the Office of the Saskatchewan Information and Privacy Commissioner?

14.2 RISKS AND BENEFITS OF ELECTRONIC HEALTH RECORDS

Electronic Health Records

Electronic health records systems are used in various hospitals, community health settings, and doctor's offices to enter and view client information. Unique client identifiers are used to ensure that information about the client is linked with the correct health care provider, the client's most recent results of laboratory and diagnostic tests, and an updated list of currently prescribed medications. Information about the client's vaccination history, allergies, consults, operative reports, and discharge information is also provided. A benefit of using electronic health records is that health care providers have quick access to medical information. Clients benefit as they receive improved management of chronic diseases, such as when health care professionals can receive reminders of follow-up tests. Electronic health records also reduce unnecessary repetition of laboratory and diagnostic testing, which ultimately saves money. A risk of electronic health records is that people not within the circle of care may access confidential information. Regional health authorities have taken measures to monitor for such risks. These measures include providing limited access and monitoring who is viewing any confidential health information.

Electronic health records may also include the use of standardized evidenced-based protocols for nursing care. Nurses can access the most current evidenced-based protocol to see potential nursing interventions, which can serve to improve documentation of assessments and interventions by providing reminders to chart specific symptoms or to chart the administration of PRN medications.

Standardized Terminologies

Overview

Electronic health systems use standardized clinical terminologies so that all health care providers can communicate findings and share client information within their specific practice settings. Standardized clinical terminologies refer to a set of common terms that describe health conditions, treatment plans, and necessary interventions. Two examples of commonly used standardized clinical terminologies include the **Systematized Nomenclature of Medicine–Clinical Terms (SNOMED CT)** and **Canadian Health Outcomes for Better Information and Care (C-HOBIC)**. Standardized clinical terminologies facilitate the measuring and recording of nursing care and data in a way that can be understood by other health care providers. Monitoring the length of time it takes to perform a nursing procedure is an example of recorded data that can then be used to help organize care. This recorded data can also be used to describe specific nursing activities, and their impact on client outcomes, including the client's progression toward discharge.

Benefits of Standardized Clinical Terminologies for Nursing

Nursing practice guidelines, developed by the Registered Nurses' Association of Ontario, are based on the results of systematic reviews, an expert panel, and stakeholder review. These nursing practice guidelines can be embedded electronically into any nursing plan of care to reduce variation in care based on a specific medical condition. By using a common terminology and following a specific plan of action, researchers will be more effective in using the information and comparing results with other information globally. These nursing interventions can then be described and understood by other health care providers as the client transitions from the hospital to community or home setting.

From the Field

It is important to maintain client confidentiality and follow the policies of workplace and regulatory bodies when using information and communication technologies.

Essential Learning Activity 14.2.1

Read Canada Health Infoway's webpage about Electronic Health Records, then answer the following questions:

1. Explain why digital records need to be available to all authorized health care providers.
2. What are the challenges to and solutions for providing a comprehensive framework for sharing health information across the country?
3. The 2016 Digital Health Blueprint identified ten computing environments. What are they?
4. When determining how to implement a particular digital health solution, designers have many decisions to make. List three of these decisions.

14.3 TELEHEALTH AND TELEHOMECARE

Telehealth is an information and communication technology that allows for health services to be delivered over a distance using electronic or telecommunication devices. The benefit of using telehealth technology is that health care is accessible to all persons no matter where they reside. For example, the client may access this service in their community instead of travelling to see a specialist in a larger community. A nurse is available to the client throughout the appointment and provides care to the patient in various forms such as assessment or education. The nurse may perform a physical assessment and relay the results to the physician using telehealth technology. The nurse–client relationship continues as the nurse becomes involved with any education and support of the client throughout the assessment, planning, implementation, and evaluation stages. All care is documented according to agency protocol. Client safety is an important consideration throughout each interaction. Nurses working with the client must follow standards and competencies of the professional association in the province in which they are located, regardless of where the client is situated. If the client is receiving long distance care, extra consideration and high level assessment skills are required as the nurse does not directly perform the physical assessment on the client. Thus, there is an increased safety risk related to incomplete assessments. Following agency protocol, privacy, and confidentiality are maintained throughout the nurse–patient interface.

Telehomecare is similar to telehealth. The difference between telehomecare and telehealth is that telehomecare refers to services provided to clients in their own homes. Clients receive devices and training to monitor their own vital signs at home. These vital signs are relayed to a health care provider through a phone line or the internet. Health care providers watch for trends in the data to alert the physician or nurse practitioner about the need for follow-up. The

main benefit of telehomecare is that clients and caregivers are provided with additional supports, which lead to a greater sense of independence, fewer emergency department visits, and reduced flare-ups.

Essential Learning Activity 14.3.1

1. How can telehomecare help you care for your patients?
2. How can telehomecare assist family caregivers in caring for family with COPD or heart failure?

14.4 SOCIAL NETWORKING

Types

Social networking refers to any web-based or mobile platform that allow users to create and share conversations or content with other users or the public. Many types of social networking tools, such as Facebook and Twitter, focus on communicating with an established group of people, often those who are already known to each other. Another form of social networking, LinkedIn, helps to expand professional contacts as users make new connections online. Other popular social networking tools, such as YouTube, allow users to upload videos for public viewing. Each of these tools is presently being used in health care to: (1) connect clients with other clients dealing with the same health condition, (2) connect health care providers with other health care providers, or (3) connect health care providers with clients and families. For example, health care providers can use Twitter to monitor epidemics (e.g., searches can be performed to monitor tweets about influenza). YouTube can be used to educate clients about diet or even help them prepare for a surgery. These are only a few examples of how social networking can benefit client care.

Privacy Concerns

It is important to consider the legal and ethical obstacles–along with any associated risks and responsibilities–of incorporating social media into nursing practice. Social networking technology must be used appropriately, respectfully, and safely. Registered nurses must reflect on the CNA's Code of Ethics for Registered Nurses (2017) which states that registered nurses must

"safeguard the privacy and confidentiality of persons and other colleagues" (p. 21). Nurses must be aware of any applicable federal and provincial legislation such as the right to privacy and confidentiality of personal and health information (Sewell, 2016). In Saskatchewan, the Health Information Protection Act (HIPA) discusses the protection of electronic health information (Government of Saskatchewan, 2003).

Significant breaches of confidentiality have occurred when nurses posted comments, pictures, or videos that contain sufficient detail to identify a patient. Health care providers need to realize that posting anonymously or under a pseudonym does not protect the user against a breach of confidentiality or defamation of character (CNPS, 2012). Furthermore, nurses need to respect professional boundaries when becoming a "friend" or communicating health information, which may lead to personal liability if the nurse identifies him or herself as a nurse.

Research Note

Davies, S. (2016). Online Social Support in the Saskatchewan Heart Failure Network: An Interpretative Description Approach (Doctoral dissertation). University of Saskatchewan: Saskatoon.

Abstract

The management and prevention of cardiovascular disease is a significant challenge to the health care system, both nationally and internationally. Web-based tools are used by many health care professionals and health care organizations to communicate with patients, to collaborate with other health professionals, and to provide health information. This interpretive description research study explored the factors that have influenced and will continue to influence or contribute to caregivers' use of social networking as a form of social support when a family member is learning to live well with heart failure. The researcher created, designed, and developed a social networking site for caregivers. Following focus group sessions with health care professionals, the Living Well with Heart Failure NING site was reviewed and approved for use. Six caregivers participated on the website and were interviewed before and after participation.

The results of this research study have implications for regional health authorities, health care professionals, and caregivers of patients living with heart failure. Health care professionals are encouraged to provide caregivers and patients with a variety of teaching materials both in print and electronically. Health care professionals should be encouraged to participate in web-based forums to share their experiences and learn from other health care professionals, caregivers, and patients living with heart failure. Such experiences can help new graduate nurses learn from more experienced nurses as regional health authorities can develop networks related to specific areas of practice. This will have many benefits as health care professionals can share medical research with each other as well as caregivers and patients.

SUMMARY

Information technology has advanced the delivery of health care services. There are many benefits, including quick access to up-to-date medical information, accessibility for clients who may otherwise have to travel long distances to meet with a specialist, and availability of information 24 hours a day, 7 days a week at the click of a button. Nurses must consider legal and ethical challenges related to the use of technology in health care in order to provide safe, efficient, and effective care to all clients either virtually or in person.

After completing this chapter, you should now be able to:

1. Define the terms *nursing informatics*, *e–Health*, and *m–Health*.
2. Identify the risks and benefits of using electronic health records.
3. Recognize the need for standardized terminologies.
4. Verbalize the role and importance of telehealth and telehomecare.
5. Differentiate between telehealth and telehomecare.
6. Recognize and understand the various web 2.0 tools used in health care.
7. Discuss the role of nurses in developing clients' health literacy.
8. Describe the necessary steps to ensure privacy and security of personal health information.

Exercises

1. Review your current social media presence then describe the risks and benefits of using social media in a professional setting. Reflect on what you found. Now consider any risks and benefits related to your nursing image and professionalism.
2. Review the Health on the Net (HON) code principles for medical and health websites. Find three websites that relate to your area of clinical interest. Would you recommend these websites to your clients? Why or why not?
3. Reflect on a situation where a member of a health care team was reprimanded for posting information on social media. How will you ensure that you are maintaining confidentiality using social media?
4. Review HIPA, HIPAA, and FOIP guidelines. How do you ensure that you are maintaining health information confidentiality in the clinical setting? What steps are taken by a health care organization to ensure confidentiality of health information? What information can a client request to see before, during, or after receiving medical care? What steps must be taken by the client to receive their personal health information?

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US Department of Health & Human Services. (n.d.). Health Information Privacy. Retrieved from: https://www.hhs.gov/hipaa/index.html

15. Regulation, the Law, Labour Relations, and Negotiations

BEVERLY BALASKI

> *Education is a human right with immense power to transform. On its foundation rest the cornerstones of freedom, democracy and sustainable human development.*
>
> –Kofi Annan, former UN Secretary–General (1999)

INTRODUCTION

As you complete a four-year baccalaureate degree in nursing and enter the profession of registered nursing, there are several organizations that will play a significant role in supporting your practice. Provincially, these include the professional regulatory body and the nursing union. Nationally, there is the Canadian Nurses Association (CNA), the Canadian Federation of Nurses Unions (CFNU), and the Canadian Nurses Protective Society (CNPS). In addition, the Canadian Indigenous Nurses Association (CINA) works to improve the health of Indigenous people through support of Indigenous nurses. The mandates and initiatives of these organizations are all focused on supporting and engaging registered nurses in the development of a strong profession.

This chapter will discuss the role of each organization and the role you possess in being an informed, participating member in these organizations that have a direct impact on your profession and your ability to deliver safe, quality nursing care.

Learning Objectives

1. Identify the mandates of the provincial professional regulatory body, the union representing registered nurses, and the four national organizations (CNA, CFNU, CNPS, and CINA).
2. Compare and contrast each organization's mission and approach to supporting Registered Nurses (RNs)

and the delivery of quality nursing care.
3. Generate conclusions as to the current relevance of each organization.
4. Appraise how trends in health care are impacting the viability of these organizations.
5. Compare and contrast how these organizations are maintaining their current missions and roles or evolving to encompass new missions and roles.

15.1 ENTRY INTO THE PROFESSION OF REGISTERED NURSING

In order to practise as an RN, you must complete a program of study, and write and pass a national exam, both of which must be recognized by the regulatory body for RNs in your province. Currently, in most provinces and territories in Canada, this requires completing a four-year degree program at the university level and passing the National Council Licensure Examination for RNs (NCLEX-RN). Following this, you must register to be licensed with a provincial regulatory body before you can call yourself an RN and proceed to work within the role.

15.2 REGULATION

Professional Self-Regulation

In Canada, registered nursing is a **self-regulated** profession. It is through the framework of professional self-regulation that RNs in Canada have long enjoyed the ability to inform and influence the creation and implementation of health policies, thus ensuring the provision of quality patient care. Self-regulation is generally understood to mean that the profession regulates itself through creation of a **regulatory body**, rather than being managed by government (CNA, 2007) and "is based on the belief that the profession has the specialized knowledge necessary to set standards of practice and to evaluate the conduct of its members through peer review" (Storch, 2010, p. 201).

Legislation governing registered nursing is found in provincial and territorial statutes that may be specific to nursing, such as an RN Act, or encompassed within "umbrella" legislation that applies to several different health care providers (CNA, 2007). It is this legislation that gives RNs the authority to practise, and provides the framework for governance of the profession. In professional self-regulation agreements, governments delegate the responsibility for appropriate and effective enactment of this legislation to the regulatory body, thus transferring the legal

authority to regulate members in the public interest based on the legislative requirements. One important aspect of professional self-regulation is to ensure title protection for its members–this caveat is usually contained in profession-specific legislation. The protection of title is important in ensuring the public is able to identify which professions possess which skills.

The main responsibility of any professional self-regulatory body is always to ensure protection of the public. Therefore, the professional regulatory body must carry out activities and govern regulated members in an effective manner to protect and serve the public interest; otherwise, it risks having the privilege of self-regulation revoked. Protection of the public is achieved through the principles of promoting good practice, preventing poor practice, and intervening in unacceptable practice (CNA, 2007). Regulatory bodies achieve this mandate by ensuring that RNs are safe, competent, and ethical practitioners through a variety of regulatory activities. This requires the regulatory body to "define the practice and boundaries of the nursing profession, including the requirements and qualifications to practise" (CNA, 2007).

The main functions of a regulatory body include: (1) setting requirements for individuals to enter the profession; (2) setting requirements for the practice of the profession; (3) setting up an investigation and disciplinary process; and (4) setting up a process to evaluate the continuing competence of members (Randall, 2000).

Another important aspect of establishing standards for a profession is the recognition of the unique and defined body of knowledge possessed by its members. This is achieved through specified and specialized education and cannot overlap significantly with another occupational group. If a large part of the body of knowledge of the profession is already possessed by other occupational groups, it becomes impractical to set standards of practice for the profession (Randall, 2000).

From the Field

The Saskatchewan Registered Nurses' Association (SRNA) has the following accountabilities as a regulator:

- establishes requirements for licensure;
- registers and renews licences;
- establishes, monitors, and enforces practice standards, the code of ethics, and a continuing competence program;

- provides practice advisement and support to members;
- approves nursing programs; and
- establishes and maintains a professional conduct process. (SRNA, 2015)

In 2017, the SRNA celebrated its 100th Anniversary.

Figure 15.2.1 SRNA Celebrates 100 Years

"100th Announcement, 2017" by the Saskatchewan Registered Nurses Association is licensed under a Creative Commons Attribution 4.0 International License. About this photo: Joanne Petersen, President SRNA, and Carolyn Hoffman, Executive Director SRNA, stand in front of the Saskatchewan Legislature with the Honorable David Marit, the Honorable Lyle Stewart, and the Honorable Greg Ottenbreit.

It is important to understand that professional self-regulation is beneficial to both parties. In this relationship, the government still has some control over the practice of the profession through its ministerial accountability and approval of professional bylaws, but does not have to maintain the expense and specialized expertise required to safely govern a profession of which they have little knowledge. For the professions, self-regulation is an exceptional privilege,

showing that government trusts the profession to safely provide the services in the best interest of the public (Human Resources Professionals Association, 2016).

Essential Learning Activity 15.2.1

View the links below to learn more about self-regulation and the necessary components of licensure, then answer the questions that follow.

SRNA's Position Statement on Profession-Led Regulation

SRNA's document "Our Role in the Public Interest"

1. Why is self-regulation so important for the profession of nursing?
2. Who do you think would regulate the nursing profession if nurses did not regulate it?

Trends in Nursing Regulation

Traditionally, regulatory bodies encompassed both the **college** role (regulation of the profession) and the **association** role (advocacy for supporting RNs to inform and influence health care), balancing the administrative management of the profession with the need to advocate for environments, policies, and practices that allow members to meet their required accountabilities and responsibilities. Generally speaking, the difference in the purpose and function of each regulatory body lies largely in whether or not legislation combines the self-regulatory arm of nursing (the college function) and the professional advocacy arm of nursing (the association function), or if these functions are maintained separately (Schiller, 2014).

In recent years, governments, stakeholders, and the public have begun to question the benefit of one body holding responsibility for both regulatory administration and advocacy. Some believe separation of these functions is a positive change, removing any perceptions of bias, self-promotion, or impropriety; others see it as a move to weaken the voice of the profession and enable the passing of poor policies without challenge.

While membership in a college is mandatory, involvement in an association is voluntary. In this regard associations rely on RNs to understand the importance of the advocacy role and choose to be involved through paid membership. Thus, the separation of the regulatory process from the advocacy role results in a mandatory college model where the regulatory aspects are

administered, while the advocacy role is fulfilled by RNs willing to form an association. If RNs are not willing to form such an association, advocacy, an important aspect of the profession, is unfulfilled.

Essential Learning Activity 15.2.2

To learn how SRNA governs, operates, and informs, see their webpage About the SRNA. Ensure that you click on the "Read More" boxes under each section, then answer the following questions:

1. How are council members selected?
2. What does a student nurse have to do in order to observe a council meeting?

Read about the SRNA's strategic plan, then answer the following questions:

1. What are the key themes in the SRNA draft strategic plan?
2. Do you think one key theme is more important than the others? Why?

As discussed above, the SRNA has two main roles. Read "Our Role in the Public Interest" to learn more about the regulation and association roles, then answer the following questions:

1. What are their regulatory initiatives?
2. What are their association initiatives?
3. What are the deliverables for public and member engagement?

Many believe that a highly effective profession cannot be achieved through regulatory administrative functions alone, while others see the dual responsibility of regulation and advocacy as being at odds with the overarching mandate. The International Council of Nurses (ICN) declares that "Empowering the profession through professional self-regulation is legitimate only if the primary purpose of regulation is concerned with improving the service and protecting the public" (2013). In this regard, improving the service requires the ability for RNs to identify issues, inform policy development, and ensure the fulfillment of professional accountabilities and responsibilities.

Similarly, the Association of Registered Nurses of British Columbia (ARNBC) identifies the significant detrimental effect RNs experienced during the transition from an association to a college. With the dissolution of The Registered Nurses Association of British Columbia, "the profession no longer had mechanisms through which to engage with government on issues of concern to nurses or advocate for health and public policy matters affecting British Columbians

during a time of significant health care system restructuring" (Duncan, Thorne, & Rodney, 2012, p. 5). As a result the creation of an association was embarked on, with the purpose to rebuild BC nursing's public policy voice in order to (1) represent the professional perspective of nursing in current health policy debates; (2) ensure that the talents of nursing are effectively deployed in the solution of major challenges, such as primary care reform and continuing care expansion; and (3) regain a meaningful place for their profession at government and other public policy processes, provincially, nationally, and internationally (Duncan et al., 2012, p. 8).

While the literature is scarce on which model is most beneficial in protecting the public and ensuring the development of effective health policies, it is clear that registered nursing requires a strong, united voice in order to effectively participate in health care debates and contribute to decisions. With the separation of regulatory functions from advocacy roles, there is an overwhelming feeling by RNs that their voice has been lost and silenced. With the loss of that united voice, three questions have emerged:

1. How will RNs utilize their leadership to have the courageous conversations that will inform key decisions on the future of their profession?
2. How will RNs develop and continue to contribute to the organizational structures that best serve the profession's current and future mandates?
3. How will RNs know if current and future organizational transitions are contributing to the advancement of the profession, in the public interest? (Duncan et al., 2012)

Regardless of which model registered nursing ascribes to, or is mandated to function under, it is clear that a mechanism to ensure the voices of RNs are heard is essential to the delivery of quality patient care. According to the ARNBC,

> We take as a fundamental premise that nursing will thrive as a profession in the public interest if it is well supported by effective regulatory college, professional association and union functions, and we are convinced that the demise of one will ultimately lead to the weakening of the others. (Duncan et al., 2012, p. 3)

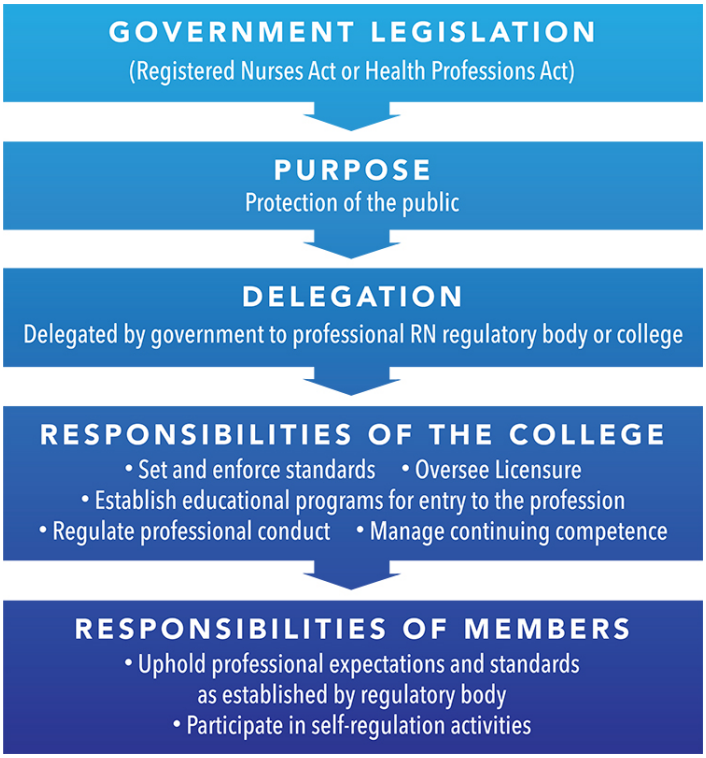
A profession is more than an occupation; it is a career with specialized knowledge and functioning. It is through the knowledge and service of a profession that the public has come to trust that members of a profession will be competent and ethical. It is through this trust that professional self-regulation is granted. RNs must therefore recognize the tremendous benefits that self-regulation brings but also the responsibilities expected of each and every one of us in upholding standards and providing quality care.

Essential Learning Activity 15.2.3

Read more about the Canadian Nurses Association's position on self-regulation in "Framework for the Practice of Registered Nurses in Canada," then answer the following questions:

1. How do practising nurses participate in self-regulation?
2. Describe one way in which nurses in Canada are regulated.

Figure 15.2.2 Professional Self-Regulation



"Professional Self-regulation" by Beverly Balaski, designed by JVDW Designs is licensed under a CC BY 4.0 International License.

15.3 UNIONS

Unionization of Registered Nurses

Labour unions are organizations that represent workers in their negotiations with employers. Unions are based on a simple concept: working women and men joining together to gain strength in numbers and presenting a united voice to address issues of concern and create safe work environments. Unions provide their members with many benefits and supports. The primary purpose of a union is to engage in **collective bargaining** with the employer to determine issues related to wages, terms and conditions of work, and worker security, and to support workers during conflict.

Collective bargaining is a process whereby members of a profession, supported by their union, meet with representatives for the employer and discuss and negotiate agreements on key issues and concerns. This collective bargaining culminates in a product called a **collective bargaining agreement** (CBA). The overall goal of a CBA is to ensure that mutual agreement on issues of employee safety and fair treatment on the job are defined and enacted. In short, a union works to ensure overall better working conditions for its members, thus contributing to care environments where safe, quality nursing care can be provided.

In addition to the role it plays in negotiating an agreement and ensuring the day-to-day administrative requirements of the CBA are upheld, the union has two other relevant functions. Unions lobby and work with governments to improve labour and occupational health and safety legislation (as safe working conditions contribute to the safety of patients and workers). Unions also assist in ensuring standards are upheld. For instance, some people believe that workers' rights are already protected by the employment standards legislation. Although there is legislation in place to provide minimum standards in the workplace, violations of these standards are very difficult to enforce. In situations of a worker challenge (e.g., when standards are not being met), employers have a financial advantage in that they are able to hire lawyers to represent their organization through the process of investigation. Employees, on the other hand, are often left to represent themselves. Unions help to level the playing field by assisting employees through processes negotiated between the workers and the employer. Employees are often entitled to paid time to attend meetings and hearings pertaining to their concern and are afforded representation throughout their dealings with the employer.

In-Scope and Out-of-Scope Positions

Upon graduation most RNs will enter into roles that are categorized as **in-scope** positions. An in-scope designation refers to positions that are unionized. These roles usually apply to all direct care providers including registered nurse educators, resource nurses, etc. This is in contrast to **out-of-scope** positions, which usually apply to management and senior administrative roles and do not fall within the category of unionization. Therefore, they are not part of the CBA and are not afforded the benefits and protections of such an agreement. In determining if a position should be out-of-scope, one considers the responsibilities of the work. Traditionally positions that are responsible for hiring, firing, and disciplining workers are classified as out-of-scope.

Collective Bargaining Agreement

The collective bargaining agreement (CBA) essentially contains the "rules" that direct the workplace. Often a CBA is thought to be a document belonging solely to the members and its representative union. This is not so—in fact, the CBA is a joint agreement between the members of the union and the employer. In this regard, the agreement affects all members of the union, as well as having an equal effect on the employer. Therefore, enforcement of the CBA is essential to upholding the terms of the agreement and resolving issues in a standardized, agreed-upon approach. Allowing the employer or members to violate any of the terms and conditions erodes application and utilization of the agreement for all involved and jeopardizes the cohesiveness and administration of the workplace.

Collective Bargaining Accomplishments

Prior to the unionization of nursing, RNs were paid very low wages and worked extremely long hours in unsafe environments. Some of the advances unions have made for RNs include:

- a set, predictable work week;
- limitations on being required to work more than a set number of shifts or hours in a row;
- recognition that hours or shifts worked in excess of the set agreement must be paid at overtime rates;
- premiums for in-charge responsibilities, weekend shifts, etc.;
- the right to scheduled breaks;
- vacation, statutory holidays, and leaves of absence;
- the right to representation in disputes with employers;
- wage parity with comparator male-dominated groups (e.g., police officers, firefighters);

- parental leaves; and
- pension and benefits.

In addition, CBAs often include language to assist in addressing:

- grievances and arbitrations;
- professional practice support and nursing advisory;
- health and safety of members; and
- continuing education, orientation, mentorship, and professional development.

Saskatchewan Context

The Saskatchewan Union of Nurses (SUN) was created in 1974 and represents registered nurses, registered nurse (nurse practitioners), and registered psychiatric nurses. SUN's mission is to enhance the social, economic, and general well-being of its members, and to protect high-quality publicly funded and delivered health services. Members of a union also have a role—that being **solidarity** and active engagement, as a union is only as strong as the membership who engage in it.

Figure 15.3.1 An Early SUN Meeting, 1974

"An early SUN meeting, 1974" by the Saskatchewan Union of Nurses is licensed under a CC BY 4.0 International License.

Inclusion of Professional Practice Supports

In addition to the foundational role of collective bargaining, SUN has been innovative in developing additional ways to support its members. This includes acknowledging that many of the issues facing RNs were beyond the terms of the CBA. Concerns around workload, staffing, and the inability to uphold professional standards as developed by the professional regulatory body were not directly identified in the CBA. In this regard, the need for professional practice support was recognized. SUN created a professional practice arm of its union to work in conjunction and collaboration with the labour relations side of the organization. This includes utilization of RNs to assist members in meeting their professional standards. The professional practice team often meets with members and employers to discuss the requirements of the professional regulatory body and works to find ways to support professional practice, once again focusing on patient safety and quality outcomes.

SUN has also developed collaborative partnerships with many stakeholders including government, regional health authorities, and educational institutions in order to influence policy and health care decisions, implement best practice guidelines, and work on innovations to more effectively provide health care services. Some of the successes include implementation of patient care acuity assessment tools, nursing models of care, patient flow and utilization models, and initiatives aimed at reducing overtime utilization of RNs.

Impact of Unions

It is a common myth that unions and their members are solely interested in increasing salaries. Research shows that wages are often not within the top three priorities of collective bargaining (Akyeampong, 2005). This is also true of RNs in Saskatchewan. Over the last number of collective bargaining sessions, items such as safe staffing, manageable workloads, and ability to uphold professional standards have been the main priorities of members.

Figure 15.3.2 SUN signs Partnership Agreement with Saskatchewan Government, 2008

"SUN signs Partnership Agreement with Saskatchewan Government, 2008" by the Saskatchewan Union of Nurses is licensed under a CC BY 4.0 International License.

Nursing unions have significant impact on members, patients, and society as a whole and the benefits of unionization extend well beyond those of perceived simple self-interest. In fact, research has shown that the higher the number of unionized employees in a workplace, the better the overall health of workers and the lower the poverty rates, for both union and non-unionized workers (Mishel, 2012; Raphael, 2006). Nursing unions ensure safe practice environments; this translates into better care for patients (Twarog, 2005). Standards established in CBAs result in increased productivity for the employer through better training, less turnover, and longer tenure of the workforce (Yetwin, 2016).

One of the greatest benefits for patients is that registered nursing unions provide a consistent collective voice for RNs in the workplace. They empower RNs to actively participate in shaping health care reform and care delivery, affording them the protected right to stand up and speak out for their patients, their practice, and their profession. There is no greater patient advocate than a unionized registered nurse. Ultimately the work of the union is aimed at giving RNs a *collective voice* to advocate for themselves and for their patients, thus benefitting society as a whole.

Essential Learning Activity 15.3.1

For more information, see the comparison chart of union and non-union benefits hosted on the Massachusetts Nurses Association's webpage Union Rights and Benefits, then answer the following question:

Would you prefer to work in an organization where the nurses are unionized or non-unionized? Explain your answer.

15.4 SIMILARITIES AND DIFFERENCES BETWEEN PROFESSIONAL SELF-REGULATION AND UNIONIZATION

Mandates

As previously discussed, the mandate of the professional regulatory body and that of the union are vastly different and yet they have one common goal: the delivery of safe patient care through supporting registered nurse practice. Nursing standards cannot be met if environments do not have the appropriate leadership, policies, staffing, and workloads to allow RNs to enact their legislated, professional role. Therefore, the mandates of the regulatory body and the union cannot be realized if such issues are not addressed.

For the regulatory body, protection of the public is not possible if their members are faced with unsafe and unsupportive work environments that do not use research and best practice guidelines as the foundation of care provided. For the union, CBAs alone cannot resolve issues of professional practice. Unions also vigorously promote the use of best practice research as this not only establishes quality workplaces for members, but also ensures a safe environment in which patients are provided care. In this regard, individual RNs need to be keenly aware of the initiatives of these two important organizations and become active and engaged.

This engagement can be achieved through running for council and board positions, becoming involved in organizational committees, and attending annual general meetings, where items directly impacting practice, and of interest to members, are raised, discussed, voted on, and enacted. In addition, members must keep up to date on organization news, correspondence, and projects. Members must also be willing to communicate directly with the professional body and the union regarding concerns and obstacles to meeting professional standards; this communication is an important and effective way of raising and working to resolve issues. This participation cannot be left to others, as the profession cannot support itself without the empowerment and voice of individual RNs.

Essential Learning Activity 15.4.1

For more information follow the link to the comparison chart of the "Three Pillars of Registered Nursing" supports: Regulatory Body, Professional Association and Union. Published by the College of Registered Nurses of Manitoba. *Nurse Link*, Winter 2017, (p. 10).

Answer the following questions:

1. Describe the difference in mandates for each group.
2. Which group would you approach for information on nursing standards?

15.5 OTHER ORGANIZATIONS

Canadian Nurses Association

The Canadian Nurses Association (CNA) is the national professional voice for registered nurses, representing almost 139,000 RNs. Membership in CNA varies according to provincial and territorial requirements. Members include provincial and territorial nursing associations and colleges, independent RNs from Ontario and Quebec, retired nurses, Canadian Nursing Students' Association, and Canadian Network of Nursing Specialties.

CNA works to advance nursing excellence in order to (1) achieve positive health outcomes in the public interest;(2) promote profession-led regulation in the public interest; (3) act in the public interest for Canadian RNs, providing national and international leadership in nursing and health; and (4) advocate in the public interest for a publicly funded, not-for-profit health system.

Figure 15.5.1 SRNA Represents Saskatchewan RNs at the National Level

"IMG_2484," by the Saskatchewan Registered Nurses Association is licensed under a Creative Commons Attribution 4.0 International License. About this photo: Joanne Petersen, President of SRNA, participates at the CNA meeting, 2017.

In Saskatchewan, RNs are members of CNA through registration with the SRNA. A portion of your annual membership fee is directed to CNA on your behalf. One of the benefits of being a member of CNA is representation in CNA's national advocacy and policy advancements. See the CNA's webpage CNA on the Hill for more information on the advocacy and policy initiatives CNA is pursuing.

Essential Learning Activity 15.5.1

Read more about the CNA on the About Us and Member Benefits sections of its website, then answer the following questions:

1. What are the CNA's objectives and goals?
2. What are the benefits of being a member of CNA?

Canadian Federation of Nurses Unions

The Canadian Federation of Nurses Unions (CFNU) is another organization representing nurses, with the mandate to protect nurses and speak on behalf of the profession. It is made up of

provincial unions and includes almost 200,000 nurses. Through membership with your provincial union, you are represented by the CFNU. CFNU provides a national voice for issues and concerns of Canadian nurses and supports provincial union activities. CFNU works hard to advance solutions to improve patient care and working conditions and advocates for the maintenance of a strong publicly funded health care system. The organization also engages in the development, utilization, and dissemination of evidence to inform policy decisions. It also works as an information resource, keeping nurses aware of current issues and advocating for viable solutions.

Essential Learning Activity 15.5.2

Read more about the CFNU's advocacy on their website, then answer the following question:

What are the political action initiatives of CFNU?

Canadian Nurses Protective Society

The Canadian Nurses Protective Society (CNPS) is a not-for-profit society that offers legal advice, risk management services, legal assistance, and liability protection to eligible RN members. In Saskatchewan, membership with CNPS is facilitated through your SRNA license.

The mission of CNPS is to "exist so that Canadian nurses are enabled to effectively manage their professional legal risks, and are appropriately assisted when in professional legal jeopardy" (2018). CNPS provides advice on foundational and arising issues facing RN practice through various publications, webinars, workshops, and presentations. Resources are available to address general nursing topics as well as emerging trends that affect RN functioning, such as medical assistance in dying (MAID) and medical marihuana.

Essential Learning Activity 15.5.3

Learn more about the CNPS's mandate, services, and publications. For more information, see the CNPS info-LAWS bulletins.

Canadian Indigenous Nurses Association

The Canadian Indigenous Nurses Association (CINA), formerly known as the Aboriginal Nurses Association of Canada, is the longest serving Canadian association for Indigenous health professionals. It is a non-profit organization dedicated to improving the health of Indigenous people in Canada. This is achieved through engagement activities related to recruitment, retention, and support of Indigenous nurses and Indigenous nursing knowledge, consultation, research, and education. Its mission is to improve the health of Indigenous people, by supporting Indigenous nurses and by promoting the development and practice of Indigenous health nursing.

Any individual interested in Indigenous nursing or Indigenous health care issues is welcome to become a member of CINA. Voting rights, however, are reserved for those RNs, RN(NP)s, RPNs, and LPNs of Indigenous ancestry.

Essential Learning Activity 15.5.4

Read about the formation of the CINA and answer the following question:

1. What were the visionary goals of Jocelyn Bruyere and Jean Goodwill, two of the organization's founders?

Read more about CINA projects, then answer the following question:

1. Describe some specific CINA Projects.

SUMMARY

A registered nurse's practice is supported by several organizations at both the provincial and national level. Professional regulatory bodies ensure that only members who have met the specified criteria are eligible for registration as an RN, and therefore eligible to practice in this professional capacity. The Canadian Nurses Association acts as a national body representing issues important to registered nursing at the national level. The provincial unions, along with the CFNU, ensure that RNs have a voice and are able to speak about issues without fear of reprisal. The Canadian Nurses Protective Society also serves an important role in supporting registered nurse practice through provision of legal advice and liability coverage.

All combined, registered nurses have an abundance of organizations supporting them to practise within the expectations of their professional responsibilities. It is important that each RN stay informed as to what priority issues these organizations are working on. It is only through active, engaged participation of RNs at each level that professional RN standards and delivery of safe, quality care is possible.

After completing this chapter, you should now be able to:

1. Identify the mandates of the provincial professional regulatory body, the union representing registered nurses, and the four national organizations (CNA, CFNU, CNPS, and CINA).
2. Describe each organization's mission and approach to supporting Registered Nurses (RNs) and the delivery of quality nursing care.
3. Verbalize conclusions as to the current relevance of each organization.
4. Describe how these organizations are maintaining their current missions and roles or evolving to encompass new missions and roles.

Exercises

Union-Focused Questions

1. Should RNs be able to choose if they want to belong to a union?

2. Should unionized workers be able to strike?

Scenario 1

3. It is your first job. There is no union. How do you know what salary and benefits to ask for?

4. You negotiate a salary and benefits and find out it is 50 per cent less than what your coworkers are getting and you work more hours than they do.

(a) How do you feel?

(b) How will this affect morale on the unit?

(c) How will this impact recruitment and retention of RNs on the unit?

(d) How do you go about negotiating an increase in salary?

(e) How do you address the situation?

(f) How will raising the issue affect your future opportunities?

Scenario 2

5. As a nursing unit, you have identified several ongoing issues affecting your ability to fulfill professional standards. These include:

- short staffing,
- replacement of RNs with lesser educated health care providers, and
- excessive overtime and unsafe working conditions.

You have discussed these concerns with your manager and have made every effort to reach a low-level resolution. You have not been successful.

(a) What options do you have to reach an agreement with the employer if you are unionized?

(b) What options do you have to reach an agreement with the employer if you are not unionized?

Scenario 3

6. There is a hospital policy that all RNs must use appropriate turning, lifting, and repositioning principles. Equipment used for heavy lifting is broken and currently the unit is short of staff. The manager directs you to manually move the patient.

(a) What do you do?

(b) What is your recourse if you are unionized?

(c) What is your recourse if you are not unionized?

Scenario 4

7. You are working on a unit that is increasingly not replacing sick time calls or vacation leaves, which leaves the unit short of RNs. You identify your concerns to the unit manager, who tells you that due to short staffing as well as budget restraints she is unable to replace absent RNs.

(a) What do you do?

(b) What is your recourse if you are unionized?

(c) What is your recourse if you are not unionized?

Regulatory-Focused Questions

8. What are the risks and consequences of having registered nurses' professional self-regulation revoked by government?

9. (a) What are the risks or benefits of separating the college function from the association function (i.e., removing the association role of the regulatory body)?

(b) Who would take on the advocacy role? How would this be developed?

(c) How effective do you think it would be in terms of representing RN concerns?

10. What are the risks or benefits of having one regulatory body represent all three categories of nursing providers (RNs, RPNs, LPNs)?

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16. Emerging Nursing Leadership Issues

BRENDALYNN ENS, SUSAN BAZYLEWSKI, AND JUDY BOYCHUK DUCHSCHER

> A *leader these days needs to be a host—one who convenes diversity; who convenes all viewpoints in creative processes where our mutual intelligence can come forth.*
>
> —Margaret Wheatley

INTRODUCTION

Health care in all sectors is changing at a rapid pace. As nursing leadership and nursing management evolve with this change, the need for new leadership approaches, strategies, and ideas to be actioned becomes more evident. This evolution includes two broad critical aspects:

- responsiveness, responsibility, accountability, and engagement of *all nurses* (regardless of position) within the health care system; and
- proactive and strategic, collaborative actions to be taken by nurse managers and others in formal leadership roles to ensure changing health care priorities are managed.

Learning Objectives

1. Recognize rapidly changing approaches to nursing management and leadership within unit-level environments in Saskatchewan, in Canada, and around the world.
2. Assess changing care priorities and turbulent issues within our current health system, and approaches to managing them.
3. Identify the importance of business acumen skills and concepts as expectations for administrative roles.
4. Recognize the importance of, and approaches for, client- and family-centred care and shared decision making as critical concepts for collaborative and effective care management.
5. Determine the importance of the manager or leader's personal journey planning for fruitful and fulfilling career development and professional growth.
6. Recognize transition shock.
7. Describe the five foundational elements of professional role transition for new nurses.

16.1 TRANSFORMATIONAL LEADERSHIP AND CHANGE: THE NURSING MANAGEMENT LANDSCAPE

> *The rate of change is not going to slow down anytime soon. If anything, competition in most industries will probably speed up even more in the next few decades.*
>
> —John P. Kotter (1995)

An Evolving National and Provincial Landscape

Health care environments have evolved over the years to become highly complex with less predictability; they are constantly undergoing change and restructuring. This has been a result of many factors. The most crucial are changes in the health of populations served and their subsequent health needs paired with available resources and capacity of the health system to meet these needs. Additional factors impacting health care over the past two decades include: increases in the use of technology, a rapidly changing multigenerational workforce, changing requirements of management accountabilities, a greater emphasis on performance measurement, the challenge of managing with scarce resources, rapid growth in inter- and intra-professional teams with changes in scope of practice, and higher consumer expectations. These many factors have influenced and impacted the roles of nurse managers and leaders in ways that have not traditionally been experienced in organizations.

In July of 2011, the Canadian Nurses Association and the Canadian Medical Association published "Principles to Guide Health Care Transformation in Canada." In response to health care system transformation and restructuring across Canada, this document was developed to provide a common framework to guide regional and jurisdictional change. It identifies the importance of following the five principles of the Canada Health Act and incorporates the Triple Aim Framework from the Institute for Healthcare Improvement (IHI). The principles in this document are focused around three main themes: (1) enhance the health care experience, (2) improve population health, and (3) improve value for money. These three themes are now a critical focus in nurse managers' work environments today (CNA & CMA, 2011).

A second document published by the Canadian Nurses Association titled "Registered Nurses: Stepping Up to Transform Health Care" (CNA, 2012) outlines many examples of how registered nurses are putting key principles into action based on the three main themes. Illustrations are provided of the innovative ways in which nurses are improving our health system across Canada today. On a national level, both publications serve as guiding framework documents for nurse managers and leaders in today's health care environment pointing to new ways of working together across care boundaries to better meet the health needs of the populations we serve.

On a provincial level, Saskatchewan is now beginning a large-scale transformation of its health care system. In December of 2016, a report on system restructuring titled "Optimizing and Integrating Patient-Centered Care" was released by an appointed Advisory Panel of the Saskatchewan government. This panel released 14 recommendations, with a key recommendation focused on consolidating existing health authorities into one provincial authority to "achieve administrative efficiencies and improvements to patient care" (Saskatchewan Advisory Panel, 2016, p. 3).

Two earlier Saskatchewan reports that continue to influence the nursing management landscape in the province today include the "Primary Health Care Framework Report" (Saskatchewan Health, 2012) and the "Patient First Review" (Saskatchewan Health, 2009), both of which identify transformational opportunities for our health care system and nursing management.

Significance for Management and Leadership

These previously mentioned reports emphasize the need for nurse managers and leaders to employ the necessary skills to manage increased complexity in this changing landscape. Managers are required to think beyond the traditional silos and extend their view to focus on the patient journey along a care continuum. As our evolving Canadian health care system places more emphasis on health promotion, primary care, and community-based care, nurse leaders are also being challenged to move from organizations that have had a more controlling and directive style of management to one where engagement, empowerment, and recognition of the unique strengths of all individuals are essential. Because of system transformations, two key areas of change for nurse leaders in our health care system relate to **workforce impacts** and **management system changes**.

Workforce Impacts

Despite challenges associated with a changing workforce and increased accountability for scare resources, nurse leaders and managers provide a crucial function in creating healthy work environments. There is growing evidence in the nursing literature about the positive impact of a healthy work environment on staff satisfaction, retention, patient outcomes, and organizational performance (Sherman & Pross, 2010).

A key factor in the changing workforce is the **multigenerational** makeup of health care organizations today. Our current workforces consist of mixed generations at all levels. Sherman (2006) identifies four generations with distinct attitudes, beliefs, work habits, and expectations, not-

ing that this age diversity will continue for years to come. Spinks and Moore (2007) reported on Canadian generational diversity along with cultural diversity seen at all levels of organizations.

Another major challenge facing nurse leaders today is creating healthy work environments, keeping staff engaged and effectively retained. Mate and Rakover (2016) examined the concept of sustaining improvement in health care, taking into account changes in the Saskatoon Health Region (now part of the Provincial Health Authority) during this time of transformation, emphasizing the critical role of leadership both at the unit level and on the front line. They emphasize that nurse leaders are local champions who must work directly with staff engagement through coaching, team building, daily communicating, and demonstrating the ability to consistently function and manage the new standard processes in order to sustain achievements.

Another workforce impact is the rapidly changing nature of intra- and interprofessional teams. As health systems transform and more attention is paid to the care continuum and the patient and family journey, there is a heightened focus on effective functioning of all teams in touch with the patient and family. Scope of practice changes required to keep up to the changing population needs have led to changes in health care providers' role on the many teams with whom the patient intersects across the care continuum. The changing nature of teams now requires managers to be attuned to role and scope changes to ensure care is effectively coordinated and integrated during the patient journey.

As early as 1973, in his review of health care in Canada, Robertson recommended the education and deployment of nurse practitioners (NPs) across the health care system, as a way to improve continuity of care and promote efficiency in the system (Stahlke, Rawson, & Pituskin, 2017, p. 488). NPs are "registered nurses who have additional education and nursing experience, which enables them to:

- autonomously diagnose and treat illnesses;
- order and interpret tests;
- prescribe medications; and
- perform procedures." (Canadian Nurses Association, 2016)

Dorothy Pringle (2007) stated that NPs meet the "needs of patients that are not being adequately met by the healthcare system with its current configuration of roles" (p. 5). Their additional education and advanced skill set support them in providing leadership in health care. The role and performance of NPs has been found to be comparable to physicians across many aspects of care (Stahlke et al., 2017). Their study, referenced in the Research Note below, examines patient perspectives on NP care and further identifies the value of the NP within the health care system.

Research Note

Stahlke, S., Rawson, K., & Pituskin, E. (2017). Patient perspectives on nurse practitioner care in oncology in Canada. *Journal of Nursing Scholarship*, 49(5), 487–495. doi:10.1111/jnu.12313

Purpose

"The purpose of this study was to add to what is known about patient satisfaction with nurse practitioner (NP) care, from the perspective of breast cancer patients who were followed by an NP" (Stahlke et al., 2017, p. 487).

Discussion

Nine patients in an outpatient breast cancer clinic were interviewed about their experiences with NP-led care. These experiences were highly consistent among the patients. Patients were initially surprised that they would receive their ongoing care from a NP. However, as care progressed, several of them were relieved to be assigned to the NP, because those assigned to the doctor were the "sicker" people. They were seen by the NP for almost their entire course of treatment. Patients were comfortable and confident in the NP care; however, they continued to believe that the physician was in charge. The NPs were "described as being more 'hands-on' and it was said that 'they look at the bigger picture . . . dealing more with the individual' and tapping into the patient's own strength and resources for healing" (Stahlke et al., 2017, p. 491).

"Despite any initial misgivings or misunderstandings, these patients unanimously felt strongly positive about their NP-led care experiences, explaining that the NP was 'a bonus' (P6). That 'the experience was wonderful' (P5) and 'she was just terrific with me' (P5). One summed up the general sentiment, saying, 'I've just been so fortunate. It was a gift. She's a gift' (P9)" (Stahlke et al., p. 491).

Application to practice

Despite the role ambiguity between the physician and NP, the patients valued the leadership of the NP in their care. Patient satisfaction is documented as being closely linked with better patient outcomes (Thrasher & Purc-Stephenson, 2008) and consequently the value of the NP role has become more evident. "NPs hold the potential to transform the patient experience and offer access to excellent, patient-centred care" (Stahlke et al., p. 492).

Figure 16.1.1 Celebration of the Birth of the Saskatchewan Association of Nurse Practitioners

"Celebration of the birth of the Saskatchewan Association of Nurse Practitioners," by the Saskatchewan Registered Nurses Association is licensed under a CC BY Attribution 4.0 International License.

Focusing on Quality Improvement: Management systems changes

Saskatchewan has been engaged in a transformational approach to management systems through a method of provincial strategy-setting "to set priorities, determine goals for the system, establish plans to achieve the agreed-upon goals locally and provincially, and measure progress toward these goals" (Health Quality Council, 2010). These changes have lead to an increased inclusion of nurses in decision making at various levels. As of 2013, all management staff in Saskatchewan received training on the Lean management system, a quality assurance approach. The training contained a consistent management approach for all leaders and managers in the province with standard processes that cascade up and down the management hierarchy. This approach and increased transparency of organizational direction required managers and leaders to develop and sharpen their communication skills, along with their skills for engaging staff and leading change initiatives. A greater emphasis on performance measurement also required managers and leaders to develop new skills for data collection to monitor various aspects of their unit's performance, to learn how to display data on charts and graphs, and to use this information to tell a story about how the care aligns with and contributes to the overall provincial strategic directions. Inherent in this approach are concrete activities such as visibility

walls, daily huddles at all levels of the organizations, and quarterly and annual reviews. As leaders of these activities, nurse managers and local unit leaders are required to engage staff on a daily basis as they communicate overall direction to their staff and work to build engagement in outcomes. These new processes are highly inclusive of all members of the health care team including patients and families.

Overall Impact on Leadership Styles

Chapter 1 of this textbook described various leadership styles. Strengths-based nursing leadership "redirects the focus from deficits, problems and weaknesses to use strengths that include assets and resources to manage problems and overcome and contain weaknesses" (Gottlieb, Gottlieb, & Shamian, 2012, p. 1). This style is also seen to support an environment of intra-professional teams and is a perspective that places the person and family at the centre of care.

Essential Learning Activity 16.1.1

For additional local information on the role and scope of nursing practice, consult the Saskatchewan Registered Nurses' Association webpage on Nursing Practice Resources.

From the Field

Be able to clearly articulate what the transformed organization will look like to staff by providing concrete information on what you know as a manager, and what you don't know, and regularly getting up-to-date, reliable information during the change.

Increase communication frequency and methods with staff during transformative change, using a variety of methods and communicating the same message a minimum of seven times.

16.2 MANAGING TURBULENT TIMES AND RESPONDING TO COMPETING PRIORITIES

Chapter 1 of this textbook outlined the necessity for nurse leaders and scholars to study and understand the principles of a complex adaptive system (Pangman & Pangman, 2010). Adding to these principles, nurse leaders need to be knowledgeable and responsive to environmental factors and changes affecting or creating turbulence within their local health care realms.

Turbulence Explained

Turbulence can be viewed as any upheaval or change (sudden or gradual) from normal. In health care, it relates to sudden or continuous times of uncertainty, or irregularities in resources, changing budgets, or adjusted strategic priorities. It involves issues impacted by changing political or administrative leadership, policy, or funding models, and by the evolution of care delivery methods, a refocusing on safety or risk issues, the introduction of new technologies or treatments, or staff attrition and adjustments in a facility. For nurse managers and leaders, it can result in competing priorities and complex decision-making processes.

In health care settings, it may be easiest for the nurse leader to consider turbulence as occurring on two separate levels: (1) broader changes at the high levels (i.e., national policy change or impact; national or provincial demographics or statistics); and (2) focused change at the more grassroots levels (i.e., regional, hospital, or unit). A change at the higher levels inevitably (and eventually) affects the grassroots levels over time.

Turbulence often intersects at the broad (federal) and local (regional) levels of health care. Both levels can have significant *direct* and *indirect* impact on local care and decision making for nurse leaders, even if at first glance they appear not to be relevant. Based on need and the span of control, nurse managers may find themselves having to respond promptly by making staffing adjustments, training staff on new skills, purchasing new equipment, decommissioning old or outdated treatments or equipment, re-directing program priorities, changing budget priorities, or even introducing new programs to ensure safety and quality. Decisions during turbulent times need to be thoughtfully and carefully made in a timely way, using the best available research, local data, and consultative sources.

Vigilance about relevant turbulence and knowing who to consult for accurate information and data will assist the nurse leader in being well informed and to anticipate turbulence before it occurs unexpectedly and leads to unanticipated results. Proactive responsiveness will support the development of trust and collaboration with colleagues and staff and ensure seamless transitions of care for clients.

Proactive Responsiveness: Being Well Informed

Being caught off-guard by unexpected turbulence requiring immediate change or a quick decision is never ideal for nurse managers or leaders. Whenever possible, they prefer to avoid having to react quickly and fix a local issue without thoughtful consideration. In order to move from reactive to proactive, nurse leaders and managers should understand both high-level and grassroots issues affecting their local health care environments.

This requires the nurse leader or manager to be well informed and know where to find the best resources. Table 16.2.1 provides credible information on emerging priorities and resources.

Table 16.2.1 Emerging Priorities

Priority	Resources
Changing demographics	The Chief Public Health Officer's Report On The State Of Public Health In Canada 2014—Public Health In The Future (The Public Health Agency of Canada)
First Nations health priorities	An Overview of Aboriginal Health in Canada (National Collaborating Centre for Aboriginal Health) First Nations and Inuit Health Branch (Health Canada)
Emerging drug and device issues	Consumer Health Products Canada (Health Canada) What's New— Drug Products (Health Canada new medication approvals) Canadian Agency for Drugs and Technologies in Health, Common Drug Review (CDR) Joint Statement of Action to Address the Opioid Crisis (Health Canada) Safe Medical Devices in Canada (Health Canada)

Domino Effects of Change

The mere introduction of a single new medical treatment, innovation, or health technology (e.g., device) into one department in a health care system can resonate and spread to other departments within that system rapidly. Hospital services that may be affected (directly or indirectly) include housekeeping, information technology/information management, health records, diagnostic imaging, laundry services, and other clinical departments. Unexpected costs, costly software updates, additional staffing, or process or protocol changes may be required to keep up with what is required from a new treatment introduction. For these reasons, it is critical for ongoing, open communication with other departments to occur in advance of any new changes.

A final turbulent adjustment for many health care systems and managers is the shift away from the focus on disease or illness and toward wellness and preventive strategies (PHAC, 2016). Health care leaders encourage funding models that support preventive programs and services, including screening programs. With limited budgets, managing this shift toward preventive approaches can be costly and must be balanced with urgent acute and long-term care service needs for all clients in the health system (CNA, 2012).

From the Field

Tips

- Know and use appropriate and credible online sources to verify facts, statistics, and data.
- Keep abreast of changing demographics both locally and nationally to anticipate change and need for modifications to service.
- Pay attention to local government priorities for funding to support local program development and respond to shifting priorities (e.g., preventive services).
- Communicate planned changes and new ideas effectively to others to ensure you have collaboration and support to move your new ideas forward. Consult with experts and others who may be affected (directly or indirectly) with planned innovations or changes.
- Refer to the SRNA's "Standards and Foundation Competencies for the Practice of Registered Nurses."

Essential Learning Activity 16.2.1

1. Imagine you are a nurse manager tasked with purchasing a new large piece of equipment for your department. Physicians and nurses from your unit just heard about it at a trade show in England. They would like you to purchase it as soon as possible to try out with patients here in Saskatchewan.

Review "13 Considerations for Making an Evidence-Informed Decision" on the Canadian Agency for Drugs and Technologies in Health website and consider which factors may be most important for you to assess prior to making a decision.

2. What thoughts do you have about the health of seniors in your community and growing old (in general)?

Make a brief list of what you believe about their seniors' health, then read the Myths associated with an aging population section of "The Chief Public Health Officer's Report on the State of Public Health in Canada 2014—Public Health in the Future" on the Public Health Agency of Canada website. How did you compare?

16.3 BUSINESS ACUMEN AND TANGIBLE SKILLS

Traditionally, the head nurse position within a hospital unit was primarily concerned with managing clinical issues and coordination of care with appropriate staff. These roles are changing rapidly as health care and leadership roles are evolving in nursing. Now more than ever, nurse managers may or may not require clinical expertise to fulfill their duties. Instead, they require practical business skills, tools, and tactics for comprehensively managing departments and ensuring personal career success.

To be successful change agents, managers, and leaders must strive to acquire and use business skills and develop **acumen**, the ability to make good judgements in an efficient and well-informed way.

Business Skills and Tactics

Table 16.3.1 highlights specific practical business skills and tactics now required for formal nurse leaders and managers to fulfill their roles effectively. Where appropriate, additional online resources and links have been included for further study.

Table 16.3.1 Important Business Skills

Business Skill	Resources
Understand strategic planning	http://leads.in1touch.org/site/framework?nav=02
Use statistics and data to prove your point	https://www.ahrq.gov/research/data/index.html http://www.hqontario.ca/ http://hqc.sk.ca/ http://www.qp.gov.sk.ca/documents/english/Statutes/Statutes/H0-021.pdf
Critically appraise published research to ensure quality and credibility of supporting data	http://www.casp-uk.net/casp-tools-checklists

Communication at work must reflect an appropriate business writing style befitting professional practice environments. Table 16.3.2 outlines some of the considerations relevant to various methods of communication.

Table 16.3.2 Business Communication Methods

Method of Communication	Factors to Consider
Detailed written report outlining a full plan (multiple pages, including planning processes)	• Essential to outline major changes or to provide annual status updates on services or issues. • Typically received by senior team members. • Often accompanied by an executive summary for quick reference.
Business case or business proposal (maximum 3–4 pages)	• Preferred to present a new idea or concept that will require additional resources (i.e., funding) beyond standard budget needs. • Professional approach to request additional resources to support a new or expanding concept or service.
Outline or business brief (1–page summary)	• Should be short, include only critical elements, and be personalized for particular groups receiving it. • May accompany a presentation or verbal update. • Critical element of ongoing communication and engagement of stakeholders or those affected by evolving changes that will directly (or indirectly) affect them.
Presentation	• Verbal and visual approach to present updates on progress or to outline details associated with new proposals or business cases. • Avoid reading directly off slides or from handout pages. Verbal components of presentations should add additional information to handouts participants receive. As a professional presenter, you must be well versed in the content to reduce reliance on data or information on slides. • Presentations can be a mechanism to ensure inclusiveness of multi-level stakeholders or those directly affected by an evolving change.
Newsletter or memo (half page to 1 page)	• Helpful to convey common messaging across larger groups or across an organization to keep a large number of people updated. • Emphasis should be placed on presenting key messages clearly to avoid assumptions or unnecessary questions being raised due to ambiguity.

Email	• Helpful to convey common messaging across larger groups, but best suited to provide specific extracts from a strategy, plan, or brief. • Most ideal for providing updates or ongoing information on a project. • Helpful to stakeholders with limited or minimal interest in a project and only requiring minimal information. • Cautious use of CAPITAL LETTERS, underlining, and **bolding** as it is difficult to convey tonality via standard email.

From the Field

- Educate yourself on necessary business acumen.
- Educate yourself and plan ahead, even if the future is unpredictable.
- What you do with your budget impacts others. Coordinate and share your budget plans with other similar departments that could be affected by plans you have for change, quality improvement, and enhancement in services and care.
- Focus on patient outcomes. For example, "If I make X change in care in my unit, it will result in a better care experience for the patient and shorter hospitalization times."

16.4 PATIENT AND FAMILY COLLABORATION FOR CARE DELIVERY

As health systems have moved from a disease-oriented approach toward a model focused more on health prevention, promotion, and wellness, so too has the philosophical foundation of how patients and families are engaged in care. Traditionally, patient and family involvement in care was more visible and more accepted by health care providers in specific clinical areas such as pediatrics, obstetrics, oncology, and palliative care. Now this expectation from consumers is being extended to all sectors of the care continuum. A key transformational shift in the health care landscape over the past two decades has been a focus on the concept of **patient- and family-centred care** (PFCC) also known as **person-centred care** (according to the Canadian Partnership Against Cancer), or **client- and family-centred care** (CFCC) (by Accreditation Canada). These definitions are now widely used to define the inclusiveness and collaboration with patients and families in determining their care and outcomes at all touch points of the care continuum. For purposes of this section of this chapter, the terms *patient*, *client*, and *resident* will be used interchangeably.

Definitions

The Institute of Patient- and Family-Centered Care (IPFCC, 2017) defines PFCC as "an approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, patients, and families." The four key concepts espoused by the IPFCC and followed within Canada and Saskatchewan are:

Dignity and respect. Health care practitioners listen to and honor patient and family perspectives and choices. Patient and family knowledge, values, beliefs, and cultural backgrounds are incorporated into the planning and delivery of care.

Information sharing. Health care practitioners communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete, and accurate information to effectively participate in decision making.

Participation. Patients and families are encouraged and supported in participating in care and decision making at the level they choose.

Collaboration. Patients, families, health care practitioners, and health care leaders collaborate in policy and program development, implementation, and evaluation, in research, in facility design, and in professional education, as well as in the delivery of care.

Essential Learning Activity 16.4.1

For a historical perspective on the evolution of PFCC, see "Partnering with Patients and Families To Design a Patient- and Family-Centered Health Care System: A Roadmap for the Future," published by the IPFCC.

The IPFCC's definition is aligned with that of Accreditation Canada, which defines **client and family centred care** (CFCC) as "an approach that fosters respectful, compassionate, culturally appropriate, and competent care that responds to the needs, values, beliefs, and preferences of clients and their family members" (2015). In CFCC, the word **client** also means patients and residents. At the heart of PFCC is the concept of working "with" the patient instead of doing "to" or "for." This key concept puts the client and family at the centre of the care as opposed to a model

where the provider's perspective is dominant, so the health care provider and the client have a true partnership.

Putting Patients First

In 2009, Saskatchewan released its "Patient First Report," which started Saskatchewan on a focused transformational journey to embed PFCC/CFCC into the culture of health care in the province. The key recommendation from this report stated:

> That the health system make patient- and family-centred care the foundation principal aim of the Saskatchewan health system, through a broad policy framework to be adopted system wide. Developed in collaboration with patients, families, providers and health system leaders, this policy framework should serve as an overarching guide for health care organizations, professional groups and others to make the Patient First philosophy a reality in all workplaces. (Saskatchewan Health, 2009, p. 8)

Saskatchewan is now actively engaged in strategic efforts to advance patient- and family-centred care in this province and has set targets and measures to achieve this culture change.

Essential Learning Activity 16.4.2

For more information on specific targets and goals of quality health work in Saskatchewan health care, please review the following websites and documents:

The Saskatchewan Patient- and Family-Centred Care Guiding Coalition's newsletter (Fall 2016), Putting Patients First.

Saskatchewan Health Quality Council's report, "Shared decision making: Helping the system and patients make quality health care decisions."

Changing Effects of Patient- and Family-Centred Care

This new collaborative approach to care delivery has a major impact on how health care providers engage with patients and families in our system, and the subsequent involvement and influence of the nurse manager or leader. One specific area that managers and leaders must pay

attention to is related to the changing expectations of clients and their family members who have increased access to information through technology. This includes expectations for information flow between care providers and increased expectations around shared decision making and meaningful engagement. One of the key tenets of PFCC is "every patient, every time." This culture change involves all levels of health care providers from care providers to support service staff.

Essential Learning Activity 16.4.3

For more information on the changing effects of patient- and family-centered care, see the patient engagement resource hub on the website of the Canadian Foundation for Healthcare Improvement.

Review the following websites and consider how their information impacts local management environments:

Institute for Patient- and Family-Centred Care, Free Downloads—Reports/Roadmaps

For more information on innovations in advancing patient- and family-centered care in hospitals, see the Agency for Healthcare Research and Quality's web page Advancing the Practice of Patient- and Family-Centered Care in Hospitals.

From the Field

- Gain increased knowledge in PFCC as a sound foundation for a leadership role.
- Increase knowledge on specific examples of successful ways that patients and families have collaborated for their care, and work with patients and families to implement change in your work area (e.g., including patients and families during hospital rounds, changing meal times in long-term care to accommodate resident preferences).
- Enhance communication skills for collaboration and engagement with patients and families as individuals and in groups, such as patient councils. Learn the difference in stakeholder roles, in terms of which are input and consultation and which are decision making, and be able to articulate this to patients and family members.
- Develop communication skills to engage patients and families in participating in and improving care. See examples outlined in the Registered Nurses' Association of Ontario's clinical best practice guidelines (2015) for person- and family-centred care.
- Develop skills in coaching and mentoring diverse groups of staff, patients, and family members. Develop

skill in conflict resolution for helping staff handle challenging patient or family issues.
- Be alert to current issues that will impact an increased emphasis on patient and family engagement in care, such as medical assistance in dying and advanced care directives.
- Learn how to educate and direct patients and families to credible resources, particularly on the internet.
- Learn communication processes for appropriate disclosure of errors in an effective manner and include patients as part of quality improvement.
- Ensure that you and your staff understand how to maintain patient privacy and confidentiality with increased family involvement.
- Sharpen skills in measuring patient experience. For example, develop mechanisms to hear routine feedback from patients and families and use this to improve care.

16.5 MANAGING STRESS AND SELF-CARE PRACTICES

Today's nurse manager roles are diverse and constantly changing. Multiple priorities and complex pressures affect nearly every aspect of a manager's day-to-day activities. Urgent and non-urgent considerations often intersect and can negatively impact the time and resources available for efficient, optimal decision making. In some instances, ambiguity and missing data can complicate decision-making processes. Priorities are sometimes set and then re-adjusted based on time-sensitive data, higher-level turbulent issues, or patient care management needs. Leading and managing in this environment is the new health care norm.

Within this chaos and non-stop change, it is critical for the nurse manager or leader to keep top of mind their primary leadership responsibility to organizations and their staff and to ensure proactive and positive oversight and safe, appropriate quality care for patients. Managers need to expect and anticipate change and be able to communicate effectively and collaborate easily with others to move health care forward. The use of complexity theory to explain and provide a framework for the ever-changing environmental priorities was discussed in Chapters 1 and 3.

There is no one best way to manage change in an organization. Pragmatic and logical thinking must be at the forefront of every consideration. Proactively supporting and promoting change is both a demanding and fatiguing task. Without careful consideration of internal strengths, self-awareness, and resilience coping mechanisms, it is easy for nurse leaders to experience negative impacts on their lives and behaviours. Sometimes the deleterious effects such as fatigue may not be realized, but may eventually lead to **burnout**, which may be displayed as emotional exhaustion, cynicism, and personal inefficacy (Laschinger & Fida, 2014).

Now more than ever, self-care is essential for managers and leaders as a proactive and continuing activity. **Self-care** always begins with strategic awareness of strengths, skills, and abilities that you as a manager or leader possess. It has been said that the best leaders do not rely on their positional power, but rather focus on their best attributes and assets to enhance and succeed at their roles (Rath & Conchie, 2009). Similarly, Gottlieb et al. (2012) discussed strengths-based leadership as a multifaceted concept involving the development of not just tangible knowledge and skills but also of an un-anxious mindset that allows individuals to utilize their best developed strengths for problem management, while focusing on development of weaker skills over time. Their theory of strengths-based leadership extends beyond self-assessment to further recognize strengths in others on a team and among those we collaborate with. Additionally, evidence related to how you as a leader think and view the world also impacts your actions and behaviours. Mindfulness and mindset of the manager are critical in navigating this complexity, as discussed in previous chapters.

Connecting to a leadership framework assists in focusing the personal growth of managers. Closely tied to the work of Rath and Conchie (2009) is the management framework of LEADS in a Caring Environment, now supported and endorsed by the Canadian College of Health Leaders. LEADS correlates to: **L**eading self, **E**ngaging others, **A**chieving results, **D**eveloping coalitions, and transforming **S**ystems.

Leading self as the first step in the LEADS framework highlights how essential it is for a manager or leader to consciously embark on a personal journey of self-awareness, introspection, and recognition of their skills, intuitive character strengths, and expertise. It is not an expectation for managers or leaders to be good at everything, but a strategic plan for self-care and personal journey development can begin if they are first aware of their strengths as well as weaker areas to work on.

From the Field

- Consult and complete the leadership and management competency assessment tools from the following two documents to recognize areas of management or leadership strengths, as well as those that may need attention: SRNA's Standards and Foundation Competencies for the Practice of Registered Nurses and CNA's Canadian Nurse Practitioner Core Competency Framework.
- Consider approaches to using emotional intelligence for decision making and for engaging others effectively (Bradberry & Greaves, 2009), and consider your strengths as part of your strengths-based leader-

ship approach (Gottleib et al., 2012).

- Use the results of competency assessment tools to help you set goals for career and professional development learning. Stick to these goals and evaluate them regularly (Echevarria, Patterson, & Krouse, 2017).
- Be aware of physical and mental cues from your body that you may be becoming overwhelmed or need a "time-out" from complex and fast-paced environments. Negotiating for time to ponder and strategically consider options almost always leads to more successful decision making.
- Take care of your personal health by practising healthy lifestyle habits; specifically, pay attention to adequate sleep, healthy eating, exercise, and stress management activities.
- Identify a mentor—someone in a similar or higher management or leadership position who you look up to and aspire to emulate. Consult with your mentor and coordinate a relationship for feedback, advice, and support to guide your personal growth as a manager or leader over time.
- Practise good time management and resource management skills to support efficiencies and streamlined processes. Self-motivation skills and cues are important to ensure you keep on task and that you meet deadlines for reports or commitments.
- Schedule protected time in your work schedule to periodically review your strengths and approaches. Think outside the box in terms of creativity and ways to enhance your personal growth.

16.6 INTERNATIONAL NURSING LEADERSHIP

This chapter has explored critical emerging leadership issues in nursing with a focus on the Canadian, and specifically the Saskatchewan, context. Now it is time to look at nursing around the world. In the following activity, spend time with Dr. Judith Shamian, President of the International Council of Nurses (2013–2017), as she discusses global health and nursing as part of the Global Leadership Series hosted by the Sick Kids Centre for Global Child Health.

Essential Learning Activity 16.6.1

Watch this video "Sustainable Development Goals: Global Health and Nursing" (56:10), which is part of the Global Leadership Series hosted by the Centre for Global Child Health. In this video, Dr. Judith Shamian discusses global nursing and sustainable development goals. Then answer the following questions:

1. How is the Canadian Nurses Association (CNA) linked to the International Council of Nurses (ICN)?
2. Why does Dr. Shamian state that money spent on health care workers is an investment?
3. What are the three "buzzwords" that Dr. Shamian mentions?

4. Identify the sustainable development goals (SDGs) for the world.
5. How can you, as a nurse leader, work to assist citizens of the world to achieve these goals?

16.7 FOUNDATIONAL ELEMENTS OF PROFESSIONAL ROLE TRANSITION FOR NEW NURSES

There are foundational intersecting elements that feed into the new graduate nurse's (NGN) initial experience in the workplace: (1) stability, (2) predictability, (3) familiarity, (4) consistency, and (5) success (Duchscher, 2012). When all is in order, these elements put us in the driver's seat of our own experience.

Figure 16.7.1 Quality Workplace Factors for New Nursing Graduates

"Quality Workplace Factors for New Nursing Graduates" is © 2012 Judy Boychuk Duchscher. All rights reserved, used with permission.

Stability refers to how steady the circumstances and situation are for you during your transition experience; essentially, stability refers to that which is unlikely to change or deteriorate. Stability is a fundamental feature of **homeostasis**, which even from a purely bio-physiologic perspective is something all humans seek. When you think about optimizing stability remember to think personally as well as professionally. Try to consider work that provides you with clinical situations

that are stable, in a context that doesn't constantly change. For this reason, floating (or being on a team that goes from unit to unit on a daily basis) does not provide for stability of patient population. Further to this, contexts where a patient's clinical presentation is highly dynamic, or whose level of illness is such that there is a near certain likelihood of instability or decompensation (i.e., emergency or critical care), are precarious for the NGNs growing knowledge base. The immature pattern recognition capacity of the new practitioner renders the NGNs response to this kind of clinical volatility challenging. Finally, if you feel like your home life is unstable (i.e., things feel chaotic or stressful at home), the stability of your workplace is even more important. The reverse is also true: a stable home life is critical if you lack stability in the workplace.

Predictability for NGNs relates to their ability to know: (1) WHAT they will do (e.g., What level of performance is expected of me now that I am a graduate nurse? What do I need to do in this role? Am I comfortable enough with those in charge to tell them when I am in over my head?); (2) WHERE they will do it (Where am I working? Am I going to the same workplace every shift or floating to multiple units? If I have to start as a casual employee, how can I get enough hours without exposing myself to too many unfamiliar workplaces?); (3) WHEN they will do it (Am I working 8-hour or 12-hour shifts? What is the rotation? When X happens [a code, a death, a distraught patient, a diagnosis of a sexually transmitted infection, a suicide in the community], how do I respond?); (4) WHO will they do it with (Who will I be working with? Who do I go to if I have questions? Who can fire me? Who can I trust?); and (5) HOW they will do it (What are the differences between what I did as a student and what is expected of me now as a graduate nurse? What will I do if I come up against something I have never done before? Are things done differently here relative to where I practised as a student?).

Familiarity speaks to the saying, "I've seen this before," and perhaps even "…and I know what to do about it." If you were privileged to be employed as a senior student or spend your final practicum (or capstone or consolidated learning experience) on the unit or in the practice context where you intend to work as a graduate nurse, the lack of familiarity may not contribute as much to your transition stress. Even knowing where to get what you need to do your work is a relief of transition stress (e.g., where the STD kits are in the clinic or where the special bags of N/S with 20meqK+/L are located on the unit).

Knowing who's who in the practice area is very helpful. While many NGNs experience phenomenal collegiality with their senior counterparts, there are equal numbers who are quickly introduced to, or warned about, those individuals to avoid because they "eat their young." A new workplace is a bit like a minefield—you obviously need to keep moving but no one tells you where the mines are planted (sometimes even they don't know) and not all mines have obvious triggers that you can see before they explode. It is in the area of familiarity that **nursing residency/internship programs** (also sometimes called a graduate nurse program or a transi-

tion facilitation program) or less formal **supernumerary staffing arrangements** have significant impact on a transition experience. Supernumerary staffing means that you work with patients and your colleagues without being given an actual assignment. The advantage of this is that you can move around your new environment, taking advantage of various learning experiences, getting to know your colleagues and the patient demographic without the stress of predetermined workload expectations. **Mentorship or preceptorship programs** constitute another approach to familiarizing you with your roles and responsibilities as a new nurse. The concept of **mentor** usually encompasses a longer-term, more personally professional relationship between a novice and experienced nurse. Conversely, the role of **preceptor** is often associated with the transferring of skill knowledge and therefore is often used in the context of a pairing between a nursing student and a senior nursing guide. Having said that, preceptors can also be expert clinical nurses who are buddied with a new nurse for the purposes of teaching them about the roles, routines, and responsibilities related to their new workplace. Along those lines, it is thought that we can be assigned a preceptor, but that a mentor is someone we choose, as this relationship requires a more personal connection between mentor and mentee.

Consistency is the experience of being exposed to a similarly presenting event, situation, concept, or idea, which affords you a level of familiarity and predictability. From a purely logical perspective, consistency is defined as that which does not contain contradictions. Here are some of the inconsistencies to watch for as you enter professional practice:

- The practice environment is more often than not constructed to ensure efficiency and productivity over effectiveness and quality.
- Health care institutions must function within budgets that are influenced by many competing sociopolitical and economic factors. This means that there will often be tension between the ethics-based, value-driven motivations of health care providers and the fiscal and human resource limitations of the health care system.
- When you graduate from an educational program that encourages independent critical thinking, it is a bit disconcerting to find yourself relatively dependent on the experienced nurses around you. You may feel a sense that you should be independent—you think others are expecting you to perform independently and this is what you often expect of yourself. Confusion reigns when you quickly come to realize that so much of what you are doing and seeing is new. The inconsistency is between what you think people expect of you, what you expected of yourself as a student, and the recognition of your own limitations as a new practitioner.

When experiencing inconsistencies, remember to stay grounded in the fundamental objectives of a NGN:

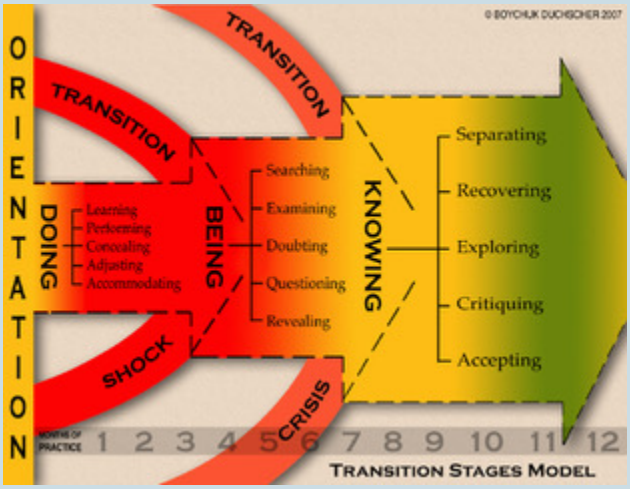
- Gain a sense of the roles and responsibilities of a graduate nurse.
- Create a workload organizational system that works for you.
- Learn how to manage your time within a gradually increased workload complexity.
- Learn the routines of your workplace.
- See and experience a variety of "normal" and "abnormal" situations under controlled conditions.
- Debrief with a trusted experienced colleague, nursing educator, or mentor about clinical situations to gain a depth of understanding of clinical patterns and the relationships between those patterns and the judgements that arise out of them.
- Gain confidence in performing the fundamental skills required of a nurse in the setting where you work. (The skills of an expert nurse are not simply tasks, but a complex and layered portfolio of roles and responsibilities enacted in an infinitely varied set of sequences and combinations and under dynamic, fluid and often intense and risk-laden conditions.)
- Assess patients of increasing complexity at varying levels of stability.
- Learn how to work on a team—and learn about *your* team.
- Get to know the dynamics of your workplace. What is "nursing" to your colleagues and how is nursing valued within your institution and community?
- Pursue a balance between your personal life and professional life.
- Learn who you are (again) now that you are not consumed by studying and academic deadlines.
- Have fun again!

Essential Learning Activity 16.7.1

Watch the video "Duchscher's New Graduate Nurse Transition Stages" (19:53) by Dr. Judy Boychuk Duchscher who discusses new graduate nurse transition stages. Refer also to the following Figures 16.7.2 and 16.7.3. More information on new graduate nurse transition can be found on the Nursing the Future website. Answer the following questions:

1. Describe the stages of transition. What recommendations does Dr. Duchscher give for each stage?
2. Where do the majority of new nurses usually find employment? Why?
3. What is flow? Give an example of flow.
4. What is the difference between accommodating and adjusting?

Figure 16.7.2 Transition Stages Model



"Transition Stages Model" is © 2007 Judy Boychuk Duchscher. All rights reserved, used with permission.

Figure 16.7.3 Transition Shock Model

Enlarge image: Dec10 Transition Shock Model

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SUMMARY

Given the multiple challenges and uncertainty now and into the future, it is imperative for nurse managers and leaders to continue to enhance their leadership effectiveness. Carroll (2006) describes several effective ways to become a nurse leader, regardless of your current training or position. Among these, the following relate directly to nursing management and the journey toward career success:

- Make a commitment to lifelong learning through a self-development plan.
- Find your passion and begin to build and develop your strengths in this area.
- Get involved in the nursing community and keep abreast of changing issues affecting nursing.
- Understand your personal leadership style and how it impacts your work.

After completing this chapter, you should now be able to:

1. Recognize rapidly changing approaches to nursing management and leadership within unit-level environments in Saskatchewan, in Canada, and around the world.
2. Assess changing care priorities and turbulent issues within our current health system, and approaches to managing them.
3. Identify the importance of business acumen skills and concepts as expectations for administrative roles.
4. Recognize the importance of, and approaches for, client- and family-centred care and shared decision making as critical concepts for collaborative and effective care management.
5. Propose the importance of the manager or leader's personal journey planning for fruitful and fulfilling career development and professional growth.
6. Recognize transition shock.
7. Describe the five foundational elements of professional role transition for new nurses.

Figure 16.7.4 Letter from Katherine McKenzie Ross to All New Nursing Graduates

THE TORCH

From the Superintendent of Nurses

To the Graduating Class, 1929.

It seems like the stroke of Fate that the pleasure of contributing an article to your First Book, should devolve upon me, in view of the fact that I have only recently severed my connection with Alma Mater to assume the duties of Superintendent of Nurses.

My pleasure in addressing you is mingled with regrets at your leaving us at a time when I am appreciating more than ever your personal worth and devotion to duty.

Let me, in the beginning, congratulate you upon your success in reaching the Goal of your Ambition,—the passing of your Examinations—entitling you to enter upon the practice of your Profession.

You must remember that yours is an honourable calling and that you take a place beside the Physician and the Priest, and that you are not inferior to either in your Mission.

I would remind you that your first consideration is duty towards your patient, a duty, "Inflexible as Fate, exacting as Necessity and imperative as Destiny."

Be vigilant, trustworthy and faithful, remembering that wonderful gift of impartiality which never allows one to disclose fears or suspicions in time of emergency.

Taciturnity—another excellent virtue—should be one of your mottoes, and you cannot do better than follow the Psalmist's advice, viz.—"I will keep my mouth as it were with a bridle, and if there have heard a word, let it die with them." Sir Thomas Browne, in the 16th Century, said, "I think not Silence the Wisdom of Fools, but rightly the Honour of Wise Men, who have not the talkeativity but the virtue of Taciturnity."

When you have passed the Portals of your Alma Mater I know you will always look back upon the happy days spent there and remember the lessons taught.

Do not think that your education is complete. You have only the General Work, and in order to be abreast of the times you must continue to study and read all you can. If possible, take Post Graduate Classes. Medicine and its branches is a progressive Science and there are at work today, a countless band of investigators who are trying to eliminate the problems in many undetermined subjects.

In saying farewell, I trust you will always carry with you many happy recollections of your student days and that you will always maintain a devoted interest in your Alma Mater, the Regina General Hospital.

KATHERINE McKENZIE ROSS,
Superintendent of Nurses.

"*From the Superintendent of Nurses: To the Graduating Class, 1929,*" *article published in the 1929 edition of The Torch. Photo courtesy of the Saskatchewan Health Authority (formerly Regina Qu'Appelle Health Region) is licensed under a Creative Commons Attribution 4.0 International License.*

Exercises

1. Select a manager you know from one of your clinical sites. Interview this manager to gain insights into the nursing management. Consider asking the following questions: Why did you become a manager? How would you describe your management style? What turbulent changes have you seen in the health system in the past two to five years? How have you adapted to this changing management landscape?
2. What are the key findings of the "Optimizing and Integrating Patient-Centred Care" 2016 report? How do you think these findings will impact managers and leaders in Saskatchewan?
3. What are three key considerations for nurse managers when assisting with the implementation of an electronic health records system in a nursing unit?
4. Review the current age of the patient population in a clinical setting you are or have been in. What are the key health challenges that each age group faces and how are they reflected in your chosen setting? What are you going to do to maximize this engagement in care for this patient group?
5. Assess the current activities underway in each of your clinical settings to promote PFCC.
6. Consider the rapidly changing and emerging uses of wireless devices and the internet in everyday patient care. Do you think that wireless applications in health care settings improve the efficiency of care delivery systems? Why or why not? How could we measure return-on-investment for these wireless delivery systems over the long term?
7. Reflect on your own career path in nursing. What content in this chapter will be useful to you regardless of the type of leader you become in nursing (e.g., bedside, unit leader, manager, director)?
8. Looking back to the Global Leadership Series video by Dr. Shamian, how will you find a "spot at the table"? What is your ten-year plan?

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Amanda Willcox, BHJ

In April 2011, Amanda Willcox joined the Dispute Resolution Office, Ministry of Justice (Government of Saskatchewan) as a mediator. Prior to joining the office, Amanda obtained a Bachelor of Human Justice degree specializing in criminal and restorative justice from the University of Regina. Amanda is responsible for providing conflict resolution services for disputes involving families, farmers and lenders, organizations, municipalities, and civil court cases. She is also involved facilitating group workshops in conflict resolution, mediation, and leadership. Amanda has a passion for empowering people to work through their differences in the most productive way possible.

Anne Sutherland Boal, RN, BA, MHSA

Anne Sutherland Boal is a health care professional with 40 years' experience in progressively senior roles, across three Canadian provinces and in China. She has held a number of positions in academic health care settings including staff nurse, patient care coordinator, director of nursing, vice-president of nursing and programs, and chief operating officer. Anne first joined the Canadian Nurses Association in 2010 as chief operating officer and acted as CEO from December 2013 to May 2017.

Throughout her career, Anne has been successful in carrying out innovative programs and effecting change. At the BC Health ministry, where she was chief nurse executive and assistant deputy minister, Anne oversaw the implementation of the nurse practitioner role and the use of the baccalaureate degree as the entry-to-practice requirement for nurses. As chief operating officer at Vancouver Coastal Health, Vancouver Acute, Anne led the establishment of a collaborative practice model that more fully uses the skills and abilities of RNs, LPNs, and care aides.

Anne obtained her nursing diploma from Foothills Hospital School of Nursing (University of Calgary). She also holds a Bachelor of Arts degree (Brock University) and a master's degree in health services administration (University of Alberta).

Anthony de Padua, RN, PhD

Anthony de Padua is an Assistant Professor for the College of Nursing, University of Saskatchewan, at Prince Albert campus. Prior to his work at the University of Saskatchewan, he

was the Department Head for Indigenous Health, Social Work, and Education and the Director of Health Science at First Nations University of Canada. He is non-Indigenous and has had the privilege to work with a number of Indigenous leaders, Elders, and nurses. He recognizes the differences between non-Indigenous and Indigenous leadership styles and appreciates the importance of understanding and working with Indigenous leaders and perspectives to improve health care for all people. He has worked in a number of nursing areas from medical–surgical wards, pediatrics, intensive care, community health, and correctional nursing.

Beverly Balaski, RN, BN, MN

Beverly Balaski started her nursing career as a certified nursing assistant (now known as an LPN). She returned to school one year later and completed a diploma in registered nursing. Throughout her career she has worked in the domains of direct care, education, research, and policy development.

Beverly has the unique experience of having worked for both the regulatory body of nursing, the Saskatchewan Registered Nurses' Association (SRNA), in the roles of nursing practice advisor and acting director of nursing practice, and for the union representing RNs and RPNs in Saskatchewan, the Saskatchewan Union of Nursing, as a nurse research and practice advisor.

Currently Beverly is employed as the Executive Director for the Registered Psychiatric Nurses Association of Saskatchewan (RPNAS) and has a wealth of knowledge regarding nursing legislation, standards, research, evidence, and best practice guidelines. She is dedicated to the achievement of role clarity for nursing providers and is passionate about promoting RN and RPN practice as unique, knowledge based, and *irreplaceable.*

Brendalynn Ens, RN, MN, CCN(c), HTA(c)

Brendalynn Ens is currently the Director of Knowledge Mobilization, Liaison Officer Program and Partnerships with the Canadian Agency for Drugs and Technologies in Health (CATDH). She is based in Saskatchewan, but manages a national team. In this role, she shares evidence-based information, increases awareness of CADTH services, and supports understanding of evidence for decision making. She has over 25 years' experience as a critical care nurse, cardiac educator, researcher, and nurse manager in various rural and urban hospital settings.

Brendalynn completed a Bachelor of Science in Nursing in 1988, then completed a Master of Nursing (University of Saskatchewan) in 1992. In 2005, she completed a certificate program in Health Technology Assessment from Laval University. She has been a CNA-certified cardiovascular nurse since 2003.

Brendalynn is also a casual instructor with the Colleges of Nursing and Pharmacy and the School of Physical Therapy at the University of Saskatchewan. She teaches occasionally with the Paramedicine and Nurse Practitioner programs at Saskatchewan Polytechnic.

Colleen R. Toye, RN, BSN, MN

Colleen Toye began her career as a diploma-prepared nurse. She went on to obtain a Bachelor of Science in Nursing (Distinction) and a Master of Nursing. Her master's thesis, "Beyond Adoption: Exploring the Utilization and Integration of RAI-HC," was a qualitative study, completed with Saskatchewan Health Region participants. Based on the work of her thesis, she published an article in the peer-reviewed journal *Home Health Care Management and Practice* titled "Normalisation Process Theory and the Implementation of Resident Assessment Instrument–Home Care in Saskatchewan, Canada: A Qualitative Study."

Colleen has had 38 years of nursing experience in acute, chronic, rehabilitative, and palliative care, within rural and urban, institutional and community settings. Nursing care and responsibility has been in clinical, administrative and leadership, and mentoring/teaching roles. No matter the role, Colleen's practice philosophy has been one of client and family centrality, and she has maintained a keen awareness of the need to be adaptive and supportive of colleagues and clients in an ever-changing health care environment.

Colleen has been active in the SRNA as a council member for eight years and was elected into the role of President-Elect/President for a four-year term. During her time as president, Colleen also represented Saskatchewan nurses as a board member of the Canadian Nurses Association. Colleen is a proud and committed registered nurse. She has had the opportunity to work in a variety of settings across Saskatchewan, and indeed feels privileged to work with and learn from an abundance of exemplary nurses.

Joan Wagner, RN, PhD

Dr. Joan Wagner is an Associate Professor of Nursing, University of Regina. She has extensive course development experience and served as curriculum liaison for the Faculty of Nursing, University of Regina, from 2011 to 2014. She is presently the Coordinator, Research and Scholarship for the Faculty of Nursing. Joan is an active participant in many Faculty of Nursing committees and also remains active with her professional association.

Dr. Wagner teaches "Leadership and Influencing Change" to third-year nursing students. She collaborated with nursing colleagues to develop this online leadership course, which she has taught since its inception. She has extensive community and long-term care nursing experience,

including over 12 years of senior leadership and program development experience within the health care community.

Joan's multidisciplinary research focuses on healthy workplaces, spirit at work, workplace empowerment, and leadership within healthcare workplaces. She is presently the principal investigator for a Saskatchewan Health Research Foundation–funded study investigating the use of the synergy tool in the emergency departments in the Regina area. Joan has published her research in *Western Journal of Nursing Research*, *Journal of Nursing Management*, *Canadian Journal of Nursing Research*, *Canadian Journal of Nursing Leadership*, and *Journal of Health Organization and Management*. She has presented widely on her body of research at a local, national, and international level.

Judy Boychuk Duchscher RN, PhD

Dr. Judy Duchscher began her nursing career in 1979 and has committed herself to excellence in education, practice, research, and leadership. As an academic, she has been an active researcher and consultant in the area of new graduate professional role transition–work for which she has received over 20 national and international awards and scholarships. The findings of her research have generated a theory of transition shock and a model of the stages of transition resulting in the publication of more than 18 peer-reviewed articles, two books, and five book chapters and the delivery of over 200 guest lectures throughout Canada, the United States, Australia, and Asia on the topic of new nurse integration. To ensure the translation and dissemination of her work, Dr. Duchscher founded Nursing the Future, an organization that serves as a bridge between the ideals taught in undergraduate nursing education and the realities of the "real" world of professional practice. Dr. Duchscher is currently considered one of the foremost experts on new nurse transition in North America, and fervently maintains that "it is the vision, creativity and passionate commitment of these young professionals, united with the experience and insight of their senior colleagues and mentors that will drive nursing and health care in Canada forward."

Louise Racine, RN, PhD

Louise Racine was born and raised in beautiful Quebec City. She entered the nursing profession in 1978 as an RN and practised for more than 14 years in general surgery, ENT, head and neck surgery, urology, and gynecology. Dr. Racine received her RN diploma from the CEGEP Sainte-Foy and a Certificate in Health Administration from the Université de Montréal in 1991. She received her BSN (1994) and MN (1996) from the Université Laval. In 2004, she received her PhD in nursing from the University of British Columbia. Dr. Racine's research interest is in the area of

immigrant and refugee health. Her program of research also focuses on the delivery of culturally competent and safe nursing care to racialized populations.

Lisa Little, RN, MHS

Ms. Little has over 25 years' experience in health care as a registered nurse. For the past seven years, she has been sole proprietor of Lisa Little Consulting, a health policy consulting organization focusing on health research and policy, as well as consultation, facilitation, and strategy development. She is also a lecturer in the School of Nursing at Queen's University. Prior to this, Lisa spent ten years at the Canadian Nurses Association, including serving as the director of public policy. There she led national research projects, committees, advisory groups, and policy initiatives in the quest to shape healthy public policy.

Lisa graduated with a Bachelor of Nursing Science from Queen's University and a Masters in Health Studies from Athabasca University. She has written and presented both nationally and internationally.

Lisa served on the Winchester District Memorial Hospital from 2007–2015, including as Board Chair. She joined the Rural Healthcare Innovations' Board of Directors in 2012 and was elected to the International Council of Nurses' Board of Directors in 2017.

Maura MacPhee, RN, PhD

Dr. Maura MacPhee is a Professor of Nursing at the University of British Columbia (UBC) in Vancouver. She co-developed the British Columbia Nursing Leadership Institute, a collaborative leadership development model between the Ministry of Health, the province's health regions, and UBC. Between 2005–2010, over 500 novice nurse leaders attended this institute. Dr. MacPhee has adapted the Institute's leadership curriculum for use in other countries, including Taiwan, Hong Kong, and Brazil. Dr. MacPhee's research focus is on healthy work environments for nurses, particularly the influence of nurse leaders on nurses' workplaces. She also studies safe staffing. She is a proponent of staffing tools to help nurses and leaders better evaluate patients' priority care needs: nurse staffing should always be based on patients' care needs. She has done research on safe staffing using the synergy tool. Dr. Maura MacPhee is currently a professor with the Faculty of Nursing, University of British Columbia.

Norma Rabbitskin, RN, BN

Norma Rabbitskin is a fluent Cree speaker from Big River First Nation, Saskatchewan. She is currently employed by Sturgeon Lake First Nation as the senior health nurse, overseeing primary care, community health, and home care programs. Her passion is being of service and supporting the development of community-based programs that are strongly grounded in traditional healing practices. She is equally passionate about parenting skills, traditional life skills, teachings from Elders and knowledge keepers, maintaining the vitality of language in knowledge building, and achieving wellness in one's life.

Shauna Davies, RN, PhD

Shauna Davies is an instructor with the University of Regina. Dr. Davies has a 16-year history in nursing education, teaching in baccalaureate and graduate nursing programs. She has taught clinically in a variety of medical–surgical areas, primarily in general surgery, abdominal, and cardiovascular thoracic. Her classroom teaching has focused on health assessment and medical–surgical classes. Her research interests are primarily in the area of technology as it relates to nursing practice. Dr. Davies has incorporated a variety of medical–surgical simulated scenarios in both the classroom and laboratory settings using high-fidelity mannequins. She also has experience teaching registered nurses how to use the iPad for clinical practice in two health regions. Her doctoral research focused on the use of social media for caregiver support and information. She is currently conducting research on the use of social media in nursing education. Another strong research interest is exploring how technology has improved nursing care.

Stacy Muller, BAdmin, JD

Stacy Muller obtained an undergraduate degree in Business Administration from the University of Regina and a Juris Doctor from the University of Saskatchewan. Stacy is a Crown Counsel for the Government of Saskatchewan and is currently working as the Director of the Dispute Resolution Office with the Ministry of Justice.

Susan Bazylewski, RN, BSN, MCEd

Susan Bazylewski is a registered nurse with a Bachelor of Science degree in Nursing from McMaster University and a Master's in Continuing and Adult Education from the University of Saskatchewan. Susan has worked for over 40 years in the health care system in a variety of settings in acute, long-term, and community care. Her roles have included point-of-care clinical nurse, educator, nurse manager, and various executive roles (most recently, vice-president for

a variety of regional and provincial health programs in Saskatchewan). She is currently working as a health sector consultant and part-time clinical instructor. With a passion for teaching and education and making positive change in our health care system, she is involved in many initiatives, teaching and mentoring managers, leaders, staff, interdisciplinary teams, patients, and families throughout Saskatchewan.

Sonia Udod, RN, PhD

Dr. Sonia Udod's program of research investigates nurses' work environments and health services delivery under the umbrella of Translating Evidence for Nursing LEADership and Health Services (LEAD Outcomes Research Program). Within this program of research, her scholarly interests are health care leadership, nurses' work environments, nurse manager development, and workplace diversity.

The nature of Dr. Udod's program of research focuses on nursing leadership and its effect on the quality of nurses' work environments leading to improved patient, nurse, and organizational outcomes. She focuses on building and disseminating evidence about approaches to nursing and health care leadership that influence outcomes.

Dr. Udod received the Top Researcher in Socio-Health, New Investigator Establishment Grant (2013–14), is a research affiliate with the Manitoba Centre for Nursing Research (College of Nursing, University of Manitoba), and is a member scholar with the International Institute for Qualitative Methodology at the University of Alberta. Dr. Udod teaches leadership and management and advanced qualitative research methodologies. She mentors graduate and undergraduate students interested in leadership and nurses' work environments and other organizational aspects of health care delivery that influence organizational, health care provider, and patient outcomes.

Wendy Whitebear

Wendy Whitebear is a member of the White Bear First Nation located near Carlye, Saskatchewan. The majority of her work and volunteer activities has been focused on the betterment of First Nations communities, people, and youth. Wendy has developed and implemented programs and initiatives that pertain to wellness, personal development, career, and financial planning for First Nations people and community organizations. In 2013, Wendy was the recipient of the Service of Excellence—Spirit Award for her active participation in the University of Regina's Indigenization efforts as well as assisting in a variety of other campus initiatives.

Over the last couple of years, Wendy has been a community producer and co-host for a local Indigenous women's talk show called *The Four*. The show provides a range of stories about First

Nations histories, communities, and aspirations. Wendy is currently the Business Manager at University of Regina Press and is assisting with Indigenous acquisitions and manuscript reviews. She is also a committee member on the Diversity and Inclusion Working Group with the Association of Canadian Publishers to assist in Indigenizing the Canadian publishing industry.

Yvonne Harris, RN, BSN, ENC(c)

Yvonne Harris has over 30 years of clinical nursing and leadership experience primarily in the emergency setting. This passion for emergency nursing and emergency nursing education has culminated in her most recent accomplishment: participating in the development and roll-out of the Emergency Nursing Advanced Certificate program for Saskatchewan Polytechnic.

Yvonne earned her post-RN Bachelor of Science in Nursing from the University of Saskatchewan in 2011 and is currently enrolled in the Masters of Health Studies program through Athabasca University. In 1997, she was successful in writing the Emergency Nursing Certification exam. She successfully rewrote the exam in 2012 and continues to maintain her certification through ongoing education and lifelong learning.

Acknowledgements

For the past four years I have been teaching the “Leadership and Influencing Change” course as an online distance learning course for nurses. When the opportunity presented itself to create an open textbook for the course, it seemed like a natural fit to use the materials that I had developed and refined for the online course. Those materials make up the basis of this textbook.

I would like to thank Dr. david Gregory, Dean of Nursing at the University of Regina, for providing support and encouraging me to undertake this project. Without his willingness to pilot this new area of open educational resource development in the School of Nursing, the creation of this textbook would not have been possible. The process of creating a textbook is no small task; indeed, it takes a community of experts to bring it all together, from nurse leaders who are subject matter experts to editors, designers, and support staff who lead the publication process. I would like to thank all the experts in nursing who have contributed their expertise and time to write chapters for the textbook. They are the heart of this project, and their contributions are a testament to the fact that health care in Saskatchewan is supported by a strong community of nurses and health care experts working together to provide the best in health care for Saskatchewan residents. I encourage students using this textbook to read the biographies of the contributors. They come from diverse academic institutions and nursing organizations in our province and across Canada and bring a wealth of knowledge and perspectives on nurse leadership from different disciplines.

I would also like to thank those nursing experts who generously contributed their time to provide detailed reviews and recommendations for improvement. In particular, I would like to thank Jayne Naylen Horbach. Through her keen eye and passion for nursing and leadership, she has provided a valuable review of the text and has helped to strengthen its content. I would also like to thank Wendy Whitebear, whom I met through our common interest in the Saskatchewan Centre for Patient-Oriented Research. Wendy wrote the foreword to the textbook and brought valuable insight into health care as it relates to Indigenous people.

The staff at URP provided a sure hand in guiding me through the publishing process and providing support throughout the development of the textbook.

Finally, I would like to thank my husband for his support and willingness to listen as I shared my excitement over each chapter as it was “birthed.”

Joan Wagner

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The Open Textbook Publishing Program would not be possible without the support and insight of many different stakeholders at the University of Regina.

- Tom Chase (Provost and Vice-President, Academic)
- Dena McMartin (Past Associate Vice-President, Academic and Research)
- Bruce Walsh (Publisher and Director of University of Regina Press)
- Cara Bradley, Christina Winter, Brad Doerksen, and James Holobetz (University of Regina Library)
- Jermain McKenzie (University of Regina Students' Union)
- Flexible Learning Division
- University of Regina Bookstore
- Elsa Johnston (Open Textbook Publishing Program Manager)

Funding for University of Regina Press's Open Textbook Publishing Program and all publications in this program was generously provided by the Government of Saskatchewan.

Library and Archives Canada Cataloguing in Publication

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Leadership and influencing change in nursing / edited and co-authored by Joan Wagner, RN, PhD (associate professor, Faculty of Nursing, University of Regina).

ISBN 978-0-88977-548-0 (PDF)

1. Nursing services–Canada–Administration–Textbooks. 2. Leadership–Canada–Textbooks. 3. Nursing–Canada–Textbooks. 4. Textbooks. I. Wagner, Joan Irene Joy, 1951-, editor

RT89.L43 2018 610.73068 C2018-903207-3