

## Nursing Leadership in a Changing World

With the rapid changes in health care today, nursing leadership is more important than ever. In the last 10 years, while health care has become increasingly complex, 5,500 Canadian nursing management positions have been lost (Canadian Nursing Advisory Committee, 2002). Novice nurses find themselves without adequate support and supervision. The public, the health service organizations and nurses themselves feel the critical loss of nursing leadership at a time when it is sorely needed.

Growing concerns over patient safety underscore the need for effective leadership. Canadian research released in 2004 revealed that 7.5 per cent of hospital admissions are associated with an adverse event<sup>1</sup> (Ross Baker, et al., 2004). While this figure is in line with research in other countries, governments and the health care community are discussing and developing national strategies to address the issue. Among these strategies is a call for greater leadership.

But considering the worsening nursing shortage, where will nursing leaders come from? The last of the baby boom generation will retire in 5 to 8 years. Who will support the next generation to take on leadership roles? Who can provide the expertise and guidance to nurses entering the workforce or changing jobs? To answer these questions, we need to change the way we look at leadership. This paper will discuss the fluidity of the concept of leadership and explore ways nurses can take initiative and become leaders in their current roles.

### What is leadership?

If you were asked to name a nursing leader, who would it be? Perhaps it would be the person to whom you report, or an admired educator or researcher. You might cite someone in an official leadership position locally, nationally or internationally. But would you name one of your peers, another nurse or fellow nursing student, for instance? Would you name yourself? If not, why not?

Leadership is not reserved for a few charismatic individuals, say leadership researchers James Kouzes and Barry Posner. Instead, they call it “a process ordinary people use when they are bringing forth the best from themselves and others” (2002, p. xxiii).

Researchers have studied leadership and attempted to define it by describing traits, behaviours, personalities and situations. With so much attention to the subject, it remains difficult to arrive at one simple definition. Still, prevalent themes emerge from the literature on the nature of leadership (Ferguson-Paré, Mitchell, Perkin, & Stevenson, 2002; Goleman, 2000; Kotter, 1996; Kouzes & Posner, 2002; Porter-O’Grady, 2003a, 2003b). These themes include:

- courage;
- change;
- vision and goal-setting;
- enabling and inspiring;
- enlisting others to get things done;
- relationships;
- honesty and integrity; and
- fostering leadership in others.

<sup>1</sup> In this document, an *adverse event* refers to an unexpected and undesirable incident resulting in injury or death, that is directly associated with the process of providing health care to the client (Hébert, Hoffmann, & Davies, 2003).

Both formal and informal leadership models exist, complicating the attempt to define what exactly leadership is. Formal leadership is generally associated with a particular title or position – a chief nursing officer, union president or nursing school director, for example. Ideally, formal nurse leaders enable, inspire and demonstrate leadership in their professional relationships.

However, if we look at leadership as simply an ability to influence others, then each nurse can lead, regardless of position or title. Nurses everywhere can initiate or seize learning opportunities, choose to make a positive contribution, or inspire others despite the difficulties of the health care system (Gillis, 2003). These actions can be described as informal leadership.

Whether formal or informal, the characteristics most closely associated with leadership remain consistent. After more than 20 years of research in this area, and the administration of over 75,000 questionnaires worldwide, Kouzes and Posner say that their findings have been strikingly similar. Their data show that for people to follow someone *willingly*, the majority of constituents must believe the leader is honest, forward-looking, competent and inspiring – characteristics that communications experts together define as credibility (2002).

### **Today's environment**

Leadership development is a hot topic in nursing, as in the rest of society. According to the Ottawa Hospital's Vice President, Professional Practice, and Chief Nursing Executive, Ginette Lemire Rodger, leadership is the most pressing issue for the profession

to act on (in press). She believes that leadership is central to creating a new reality, one that will incorporate a new health care and nursing environment.

What, then, is our current reality? In the big picture, society is in transition from the industrial age to the information age. Indeed, we are experiencing a full-scale social revolution, one that future-thinker Alvin Toffler predicted in his 1980 book *The Third Wave*. This accelerating wave of change is in part characterized by a shift from physical to knowledge work, manufacturing to service economies, and cultural sameness to greater diversity (as cited in Weisbord, 2000). Technological advances have led to faster communication, volumes of information at our fingertips, networks that connect people globally, and more knowledgeable consumers and workers.

Knowledge has become the new currency, changing the traditional relationship between worker and employer, writes nurse-author Tim Porter-O'Grady (2003b). What people know and how they translate it into the innovations and practices of work are critical to the continuing viability of the organization, he writes.

As a result of the shift to the knowledge economy, many changes in the workplace have eroded formal nursing leadership. Since the early 1990s, health care organizations, both large and small, have cut costs, downsized, re-engineered and created new business models. Such initiatives have translated to the casualization of nursing work, increased workloads and spans of control, and reduced practice supports. All too often, these changes have negatively affected nursing care and client

outcomes, and can, in part, explain the emergence of patient safety as a key concern (Registered Nurses Association of British Columbia, 2004).

The changes have also had a direct impact on nurses themselves: many Canadian work environments are burning out experienced nurses and discouraging new recruits (Baumann, et al., 2001). As part of this picture, older baby boom nurses are beginning to retire, raising questions about who will step in to teach and mentor younger generations of nurses.

Given these conditions, recruiting nurses into formal leadership roles poses a challenge. Sometimes this challenge is a numbers game, reflecting the demographic realities within nursing. Sometimes it is related to the health care environment and the enormity of the task at hand. As Porter-O'Grady points out, clinical and structural shifts in health care occur so swiftly that leading in their presence is overwhelming (2003a). The Academy of Canadian Executive Nurses (ACEN) observes that leadership positions seem less attractive with their multiple work life challenges and long work hours (Ferguson-Paré, Mitchell, Perkin & Stevenson, 2002).

It is also becoming more challenging to recruit and retain deans and directors of nursing programs (Gregory & Russell, 2002). This shortfall has implications for the preparation of a workforce of future leaders. The next generation of nurse researchers faces retirement over the next 10 to 20 years, raising important questions about how to secure the future of nursing research in Canada (Health Canada, 2002). In all domains of nursing, succession planning is a critical issue.

## **Toward a new model**

To help sustain the profession, new models of nursing leadership advocate a combination of accountability, teamwork and initiative. ACEN suggests that we move away from a traditional style of leadership toward new structures where leaders see nurses as knowledge workers. Formal leaders must create an environment that allows nurses at all levels to exercise some degree of leadership. ACEN advocates a shared leadership model, one with "...nurses leading nurses, nurses leading nursing practice and nurses leading client-centred, interdisciplinary teams" (Ferguson-Paré, Mitchell, Perkin & Stevenson, 2002, p. 6).

Sharing leadership requires nurse executives and managers to ensure that the right environment and resources are available for direct care nurses to make the most of their own knowledge. For example, chief nursing officers, who are context experts, must create networks in which they regularly and actively seek input from direct care nurses, who provide expertise on the content of nursing practice. Because of their firsthand knowledge, direct care providers continuously advance nursing by contributing to decisions that support professional practice settings (2002).

Lemire Rodger takes this point further by proposing that clinical nurses guide corporate decision-making related to clinical practice. She notes that we teach students to be critical thinkers and agents for change and encourage each nurse to use leadership skills, yet we fail to take advantage of these skills. Even today, when we think of leadership, we refer mostly to formal positions (personal communication, December, 2003).

She stresses that strict procedures, such as those in program management models that emphasize the bottom line, risk turning nurse leaders into generic executives. Instead, Lemire Rodger supports an evolving model that replaces top-down hierarchies and linear reporting structures with teams of individual professionals who work in a fluid matrix (Lemire Rodger, in press).

For example, educators, researchers and clinical nurses may collaborate for a short period to improve processes and services, allocate resources or study how effective a change in process has been. The teams may work on a single project or periodically regroup to study a series of issues, adapting the way they work to the uniqueness of the services they provide. Such teams may work across regions, organizations and professions. Lemire Rodger urges all nurses to play a leading role in interprofessional teams to keep the nursing profession visible and active in decisions for client care (in press).

The innovation of such team-based models can provide nurses with the opportunities to grow professionally. In many cases, however, we are still fighting to create better health care settings and coping with a loss of stability and an increased workload. In larger health care organizations especially, we are seeing the emergence of more autonomous units of operation, little standardization and fewer points of control (Lemire Rodger, in press). Despite the toll such changes have taken on nurses, it is often up to us to develop ways to cope. We may suddenly find ourselves without guidance and must fill leadership gaps by quickly developing new skills. In short, whether we are adapting to

new leadership models or simply coping with a lack of stability, we are being asked to become the leaders we need.

Rethinking approaches to leadership also means thinking about how to prepare nurses for their roles as future leaders. And it means thinking about how to align leadership with the vision nurses have of health system renewal based on the principles of primary health care. Each one of us should engage in this kind of creative thinking and not just leave it to schools of nursing, health care agencies or nursing associations and unions. By sharing and debating our ideas and bringing them into the policy arena, we also demonstrate a vital aspect of leadership.

## **Growing our leadership**

To actively participate in decision-making for client care and to address concerns over patient safety, nurses should make leadership development a priority throughout their careers. Nursing associations, unions, specialty nursing groups and the Canadian Nursing Students' Association have been valuable training grounds for leadership over the years. In addition, the Canadian Nurses Association (CNA) has supported the exchange of ideas on leadership through discussion papers, policy statements, think tanks and its co-sponsorship of two national conferences: the Nursing Leadership Conference and the Health Care Middle Management Conference. CNA also dialogues at the international level through its linkages with the global nursing community. Professional associations in provincial and territorial jurisdictions have likewise published policy and discussion documents on leadership. Many have hosted leadership events.

Globally, the International Council of Nurses supports leadership development through projects like the *Leadership for Change* action-learning program (International Council of Nurses, n.d.). This initiative focuses on enhancing nurses' effectiveness in areas that include planning and policy development, contributing within broader health and management teams and influencing curricula changes.

The Canadian Health Services Research Foundation (CHSRF) offers another example of leadership training. Nurses and professionals from other disciplines can be funded to participate in the Executive Training for Research Application (EXTRA) program to learn how best to apply their research.

Despite these examples, few programs on leadership development are described in the nursing literature. This was the finding of a partnership of consultants and the Nursing Effectiveness, Outcomes and Utilization Research Unit at the University of Toronto site as they pioneered the development of the Dorothy M. Wylie Nursing Leadership Institute (Simpson, Skelton-Green, Scott, & O'Brien-Pallas, 2002). With leadership development now a priority across the profession, however, this information gap may soon be addressed.

Formal training programs aside, nurses are often left to develop leadership skills through their own experience and initiative. According to Canadian nurse educator Angela Gillis, individual leadership begins with personal accountability (2003). Unlike the notion of management holding an employee accountable, *personal accountability* means that individuals hold themselves accountable for their thoughts and actions.

Borrowing from John Miller's personal accountability framework, Gillis provides examples of what such accountability might look like. In the face of disruptive change, writes Gillis, it means asking ourselves, "How can I improve the situation?" instead of "Why is this happening to me?" It means asking "What can I do to find the information we need here?" instead of "Why don't the managers give us the information we need to do this?" And it means taking action – through advocacy and a commitment to learning. In this way, we turn our focus away from factors we cannot control towards those we can (as cited in Gillis 2003).

This approach helps us deal positively with change and improve the quality of our work life. According to Gillis, we choose to be leaders. "We can practise personal accountability and contribute, regardless of our role, level or title within an organization," she writes. "Each of us has the ability to assert or diminish nursing" (2003, p. 35).

To build leadership in the nursing profession, nurses are guided by the CNA *Code of Ethics for Registered Nurses* (2002a), which expresses the values and responsibilities central to ethical practice. It also deals with nurses' professional relationships with individuals and families. Nurses participate in revising the code every five years, reflecting changes in social values. They also consider conditions that affect the health care system and that create new challenges and opportunities for the ethical practice of nursing.

Just as the code evolves with the times, so must we if we are to lead. That means staying attuned to the context in which we function, building strategic relationships across disciplines and keeping up with advances in knowledge.

It was in this spirit of leadership that master of nursing students at Dalhousie University in Halifax created the Graduates United in Dialogue for Excellence forum – an informal monthly opportunity for idea-sharing with peers and guests from related disciplines and the community (Price, MacConnell, & Forgeron, 2003). The forum allows students to tap into the skills and resources of experienced colleagues, build leadership skills and pave the way for collaboration in research and practice. Within a learning environment, they created learning opportunities for themselves and others.

### **How to grow as a leader**

- seize opportunities created by change
- enable others to influence change
- support each other, especially younger nurses
- practice personal accountability
- put the *Code of Ethics for Registered Nurses* to work every day
- apply research; participate in research
- embrace lifelong learning
- build strategic relationships
- cultivate flexibility and innovation
- advocate for improved client care

As the examples here demonstrate, openness to learning, formally or informally, is integral to leadership. In fact, writes Harvard Business School leadership professor John Kotter, leaders must embrace lifelong learning and the mental habits that support it. He defines these habits as risk-taking, humble self-reflection, opinion-seeking, careful listening and openness to new ideas (1996). The simplicity of these habits suggests that we learn from anyone under almost any circumstances. However, taking the initiative to develop these habits is, in itself, an expression of leadership.

## Leadership through strategic partnerships

Experience, initiative and continuous learning help individuals develop leadership skills, but these efforts become most effective when combined with a commitment to advocacy. Nurses are well placed to advocate for quality professional practice environments in today's health care system. Seasoned nurse researchers have shown leadership, for example, by methodically collecting evidence to show policy-makers the damaging effects of today's workplace on nurses and patients. Mounting evidence suggests that making the work environment better helps recruit and retain the best nurses and produces healthier and more satisfied patients (Canadian Nursing Advisory Committee, 2002). Through strategic partnerships with practical and psychiatric nurses, Health Canada and the Canadian Council for Health Services Accreditation (CCHSA), CNA succeeded in having nursing quality work life indicators included in Canada's system of accreditation.

When the federally appointed Commission on the Future of Health Care in Canada examined the current state of health care, nurses were there. Nurses and nursing students from across Canada, some representing professional associations and unions, understood the importance of speaking out from their experience. They provided their perspective, emphasizing the interrelatedness of professional practice environments, quality care and the sustainability of the health care system.

New health professionals are also taking initiative by developing their advocacy skills early in their careers. The Canadian Nursing

Students' Association, together with the Canadian Association of Pharmacy Students and Interns and the Professional Association of Interns and Residents of Ontario has recently formed the New Health Professionals Network (NHPN). The purpose of NHPN is to advocate for the strengthening of medicare. As the new providers of health services, they are participating in the national debate over health care reform in Canada, which demonstrates exemplary leadership (New Health Professionals Network, 2004).

Finally, an innovative project to reduce wait times, implemented by nurses at the Southwest Community of Calgary Health Region, provides a wonderful example of effective leadership. The project includes using a web-based bed management system that facilitates the transfer of patients between units. Pre-admission lab work is now done in the community before day surgery, eliminating a step in OR preparation. Standardizing consent completion has reduced delays for booked surgery due to incorrect or incomplete consent forms. Nurses also use a tracking system to chart conditions that affect the frequency and duration of peaks in demand. As a result of these efforts, patient flows have been streamlined and are measurably more effective, efficient and timely (Wasylak, 2004).

### Towards tomorrow

Succession planning doesn't have to mean identifying an individual nurse to groom for a particular role. It can simply mean offering encouragement to the next generation. We know that successful preceptorship and mentoring improves job satisfaction and increases nurse retention. So it is

up to each of us to offer support to new nurses in our fields without expecting them to be exact replicas of ourselves. By focusing on our shared values, we can work with them, encourage them but let them take on their own new leadership styles.

Nurses can take a commanding role in shaping the future of nursing and the future of health care. If we are to succeed, however, we must never lose sight of who we are – a strong collectivity of knowledgeable, caring and committed individuals, each of whom holds the power to, as Gillis (2003) says, "choose leadership." Or not.

What will *you* choose for the road ahead?

### Resources and further reading

- ✓ *Excellence in Professional Practice: A Guide to Preceptorship and Mentoring* (CNA, 2004)

This updated guide supports the development of leadership skills for nurses in clinical roles and succession planning within the profession. Competencies for preceptors and mentors have been included.

- ✓ *Code of Ethics for Registered Nurses* (2002a)

The code sets out the ethical behaviour expected of registered nurses in Canada. It includes a description of, and the responsibility statements for, the eight primary values identified.

- ✓ CNA position statement, *Nursing Leadership* (2002b)

This concise document emphasizes that nurses in all domains and at all levels must maximize their leadership potential.

*See reference list for full publication information.*

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Baumann, A., O'Brien-Pallas, L., Armstrong-Stassen, M., Blythe, J., Bourbonnais, R., Cameron, S., et al. (2001). *Commitment and care: The benefits of a healthy workplace for nurses, their patients and the system*. Ottawa: Canadian Health Services Research Foundation.

Canadian Nurses Association. (2004). *Excellence in professional practice: A guide to preceptorship and mentoring*. Ottawa: Author.

Canadian Nurses Association. (2002a) *Code of ethics for registered nurses*. Ottawa: Author.

Canadian Nurses Association. (2002b). *Nursing leadership* [position statement]. Ottawa: Author.

Canadian Nursing Advisory Committee. (2002). *Our health, our future: Creating quality workplaces for Canadian nurses* [final report]. Ottawa: Health Canada.

Ferguson-Paré, M., Mitchell, G., Perkin, K., & Stevenson, L. (2002). Academy of Canadian Executive Nurses (ACEN) background paper on leadership. *CJNL*, 15(3), 4-8.

Gillis, A. (2003). Personal accountability. *Canadian Nurse*, 99(10), 34-35.

Goleman, D. (2000). *Working with emotional intelligence*. Toronto: Bantam.

Gregory, D. & Russell, C. (2002). Reaping what we sow: Nursing education and leadership in Canada and the United States. *CJNL*, 16(1), 38-41.

Health Canada, Office of Nursing Policy. (2003). Pathfinding for nursing science in the 21st century: Where to from here? *CJNL*, 16(1), 75-109.

Hébert, P. C., Hoffman, C., & Davies, J. M. (2003). *The Canadian patient safety dictionary*. Ottawa: Royal College of Physicians and Surgeons.

International Council of Nurses. (n.d.). *Leadership for change*. Retrieved July 20, 2004, from [www.icn.ch/leadchange.htm](http://www.icn.ch/leadchange.htm)

Kotter, J. P. (1996). *Leading change*. Boston: Harvard Business School Press.

Kouzes, J. M., & Posner, B. Z. (2002). *The leadership challenge*. San Francisco: John Wiley & Sons, Inc.

Lemire Rodger, G. (in press). Leadership challenges and directions. In J. M. Hibberd & D. L. Smith (Eds.), *Nursing leadership and management in Canada* (3<sup>rd</sup> Ed.). Toronto: Elsevier Canada.

New Health Professionals Network. (2004). *Statement of purpose*. Retrieved July 23, 2004, from <http://www.futurefaceofmedicare.ca>

Price, S., MacConnell, G., & Forgeron, P. (2003). A forum for graduate nursing students. *Canadian Nurse*, 99(8), 14-15.

Porter-O'Grady, T. (2003a). A different age for leadership, part 1. *JONA*, 33(2), 105-110.

Porter-O'Grady, T. (2003b). A different age for leadership, part 2. *JONA*, 33(3), 173-178.

Registered Nurses Association of British Columbia. (2004). *Nursing leadership and quality care* [policy statement]. Vancouver: Author.

Ross Baker, G., Norton, P. G., Flintoft, V., Blais, R., Brown, A., Cox, J., et al. (2004). The Canadian adverse events study: The incidence of adverse events among hospital patients in Canada. *CMAJ*, 170(11), 1678-1686.

Simpson, B., Skelton-Green, J., Scott, J., & O'Brien-Pallas, L. (2002). Building capacity in nursing: Creating a leadership institute. *CJNL*, 15(3), 22-27.

Wasylyak, T. (2004, April). *Patient flow and safety: How nurses make a difference*. PowerPoint retrieved June 3, 2004, from <http://www.nurses.ab.ca/Archived%20Pages/TracyWasylyak.pdf>

Weisbord, M. R. (2000). Toward third-wave managing and consulting. In W. French, C. Bell, & R. Zawacki (Eds.), *Organization development and transformation: Managing effective change* (5<sup>th</sup> ed.) (pp. 64-79). Toronto: McGraw-Hill.

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