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Leadership and Management in Professional Nursing Practice

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Leadership and Management in Professional Nursing Practice

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Table of Contents

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Chapter 1: Leadership: What is it? Application of Theories

Leadership in Nursing

Given the rapid and continual changes to the healthcare landscape, the integration of innovative technology, and an aging, complex patient population, the way in which care is delivered must be reimagined. In order to address these issues and improve the delivery of care, effective and efficient leadership is vital.

The current healthcare system requires visionary leaders to address the challenges of the current healthcare environment and to become an active player in healthcare reform. The landmark report by the Institute of Medicine (IOM, 2011), *The Future of Nursing, Leading Change, Advancing Health* focuses on transformation of nursing practice, nursing education, and nursing leadership. *The Future of Nursing, Leading Change, Advancing Health* can be found at the **National Academies of Science website**.

All nurses require leadership skills and competencies to in order to partner with physicians and other healthcare professionals, both within and outside of their institution. Nurses play a vital role in transforming healthcare, such as:

- Provision of safe, high quality, patient-centered care
- Primary care services
- Care delivery in the community
- Provision of seamless, coordinated care
- Accessible, affordable healthcare
- Engagement in health information technology (such as EMRs) (IOM, 2011)

In order for nurses to achieve these outcomes, nursing leadership must undergo a radical transformation. Health reform legislation signed by President Obama in 2010 includes a wide range of initiatives including the redesign of the healthcare delivery system. Many of the programs that have been created rely on interventions that inherent in registered nurses' scope of practice, such as care coordination and transitional care.

Being a leader, or a full partner in healthcare reform, means taking responsibility for recognizing problems or needs in the healthcare setting. Nurses at all levels of care must serve as strong advocates for patients and take the initiative to become involved with decision-making and offering suggestions on how to improve the delivery healthcare.

The delivery of high-quality nursing care is at risk during an era of critical transitions. The aging nursing workforce, retirement of nurse leaders, and the current and future nursing shortage requires strong nursing leadership. In order to achieve the vision of transforming the healthcare system, the profession must produce leaders throughout all areas the healthcare system. Leaders must be present at every level of care and across

all settings. Nurses must be accountable for their contribution to providing high-quality care, while working collaboratively with leaders throughout the healthcare system (IOM, 2011).

The nursing workforce struggles with overextended, fatigued staff who are often disenchanted with the current work environment (Van Bogaert & Clarke, 2018). The healthcare system requires nurse leaders who are capable of creating a healthy work environment that instills trust, empowerment, support and encouragement, and a leadership style sustains nurses' health and well-being.

The IOM (2011) explains how an effective leadership style is essential in today's healthcare landscape, adding, "What is needed is a style of leadership that involves working with others as full partners in a context of mutual respect and collaboration" (p. 233). Leadership styles with a focus on respect and collaboration have been associated with improved patient outcomes, reduced medical errors, increased nurse retention and job satisfaction, improved teamwork, reduced lengths of hospital stay, and cost savings (IOM, 2011). Through effective nursing leadership, the nursing profession will continue to grow and evolve, and provide exceptional nursing care to patients who desperately need it.

Scope and Standards of Practice

The Scope and Standards of Practice, developed by the American Nurses Association (ANA, 2015c), serves as a template for professional nursing practice for all registered nurses. Standard 11, Leadership, states, "The registered nurse leads within the professional practice setting and the profession" (ANA, 2010, p. 75). The following is a summary of the competencies of the Leadership standard:

- Contributes to the establishment of an environment that supports and maintains resect, trust, and dignity.
- Encourages innovation in practice and role performance to attain personal and professional plans, goals, and vision.
- Communicates to manage change and address conflict.
- Mentors colleagues for the advancement of nursing practice and the profession to enhance safe, quality health care.
- Retains accountability for delegated nursing care.
- Contributes to the evolution of the profession through participation in professional organizations.
- Influences policy to promote health (ANA, 2015, p. 75)

The goal of both formal and informal nursing leadership roles is to transform the healthcare system, where quality and safety are paramount.

Leadership Concepts and Definitions

Leadership: “a process whereby an individual influences a group of individuals to achieve a common goal” (Northouse, 2018, p. 5)

Note the following concepts within this definition:

- Leadership as a ***process****:* leadership is not a characteristic or trait of an individual, but an event that occurs between a leader and follower or a leader and a group (Northouse, 2018)
- Leadership occurs in ***groups***: leadership occurs within groups, with people who have the same common goals or purpose as the leader (Northouse, 2018)
- Leadership has ***common goals***: leaders and followers have a common goal or purpose. Leaders work with followers to achieve selected goals (Northouse, 2018)
- Leadership involves ***influence***: leadership is focused on *how* the leader affects the followers, and the type of communication between the individuals (Ruben & Gigliotti, 2017)

Formal leaders: individuals who hold a formal leadership position, such as nurse manager.

Informal leaders: individuals who do not hold a position with formal authority, though are recognized as leaders, and have influence over their peers (Pielstick, 2000).

Informal leaders are higher performers with significant skill, they feel responsible for the functioning of their team, which they strengthen by exerting their influence by solving problems for colleagues who are in need (Downey, Parslow, & Smart, 2011).

Followers or subordinates: individuals who are being directed by a leader or manager.

Empowerment

Amundsen and Martinsen (2014) define empowerment as *giving* influence to others, rather than having influence *over*. The central characteristic of a leader who empowers others is one who supports and encourages autonomy. When a nurse manager *gives* influence to a staff nurse, the nurse has more power over decision-making, delegating, etc., which in turn leads to a more autonomous practice. Nurse leaders must use empowerment strategies in order for staff to have the freedom to make patient care decisions, especially in this challenging healthcare landscape (Spencer & McLaren, 2016).

Two types of empowerment:

- **Structural empowerment**: employees work in environments that have structure. When employees have access to opportunities, information, support, and necessary resources, they are able to be effective and achieve goals (Kanter, 1993)
- **Psychological empowerment**: fosters a proactive approach about achieving goals. Individuals learn how to cope within the workplace environment and have more control over their lives. In addition, individuals believe they are capable of influence and by understanding workplace/system processes they are able to engage in necessary behaviors to reach their goals (Zimmerman, 1995).

Empowerment is a way to encourage employees to work beyond the usual standards, supporting a flexible approach to completing tasks and reaching goals (Pearson & Moomaw, 2005). Working beyond usual standards has multiple meanings. For example, a nurse can take a more autonomous approach to practice, educating oneself on new evidence, making a suggestion about an outdated policy, or suggesting a team meeting. While these examples may be part of usual nursing practice, and expected of all nurses, nursing staff need the support of management to follow through with certain actions. Managers need to empower nurses in order for them to have a fully autonomous practice.

Chandler (1991) shares another viewpoint of empowerment as “enabling individuals to feel effective so that they can successfully execute their jobs” (p. 66). When managers empower their nursing staff, it helps improve their confidence in carrying out tasks as they see fit. A clinic nurse may decide to follow up with a patient who was recently hospitalized. The clinic manager or provider must provide a work environment where such decision-making, and freedom, can be made by the nurse. When nurses have tight oversight from their managers, making autonomous decisions about care will be impeded, possibly leading to negative health outcomes.

Rao (2012) explains nursing empowerment as a condition where nurses have control over their practice when they successfully accomplish their goals, fulfill their responsibilities. Having control over one’s practice is empowering, nurses have the authority, or influence, to complete their tasks as they see fit, which is akin to having an autonomous practice. When nurses are empowered by their managers, they have the resources, support, and encouragement to complete their tasks. When leaders empower their staff, they are also encouraging autonomous practice.

Empowerment is foundational to interprofessional collaboration, and nursing practice as a whole, and it is associated with the following outcomes:

- Increased job satisfaction
- Increased trust within the organization
- Improved effectiveness within the nursing unit
- Positive coworker relationships (Read & Laschinger, 2015; Regan, Laschinger, & Wong, 2015)

Working in today's healthcare environment has forced leaders to improvise, creating ways to prepare themselves, and their team, to cope with workplace stressors, such as workplace bullying. Leaders can focus their efforts on strengthening empowerment, both structural and psychological, within the workplace to meet create a positive and productive environment.

Nurses as leaders at all levels, across all settings

Strong nursing leadership is required in all settings, from the bedside, to the community nurse, nurse managers, director of nursing, members of nursing organizations, nurse researchers, school nurses, etc. Nurses must exercise their leadership competencies collaboratively in all settings, such as hospitals, communities, schools, businesses, boards, the political arena, and more. All nurses must take responsibility for their professional growth by developing leadership skills and competencies in their area of specialty (IOM, 2011). Below are some examples of effective leadership from bedside to boardroom:

- Awareness of the need to advocate, mediate, collaborate
- Link actions to quality care
- Nurses' technical ability to deliver care in a safe and effective manner
- Improving work processes at the bedside/frontline
- Creating or offering new evidence for practice
- Collaborate with policy makers
- Craft policy and legislation that allows nurses to work to their fullest capacity
- Lead nursing education/curriculum changes to prepare the nursing workforce to meet the needs of a complex healthcare environment
- Serve on institutional and policy-making boards where critical decisions affecting patients are made
- Autonomous practice in community health settings

- Assertiveness, to have a strong voice in advocating for patients and their families (IOM, 2011)

Healthy Work Environments

Nurse leaders play a major role in creating and maintaining healthy work environments (HWE). HWEs foster excellence in patient care and are an essential component to reversing the current nursing shortage and providing safe, quality, compassionate nursing care. In addition, HWEs improve nurses' well-being and their perception of feeling fulfilled at work (American Association of Critical Care Nurses [AACN], 2016).

Unhealthy work environments lead to:

- Medical errors
- Ineffective delivery of care
- Conflict and stress among health care professionals (AACN, 2016)

Today's work environments demand increased attention to these negative consequences. In order to improve practice environments and nursing practice itself, nurse leaders must be positioned within their organization to have the power to inform and influence decision-making (AACN, 2016). Nurse leaders, such as nurse managers, must have the following core competencies and skills to create HWE environments:

- self-knowledge
- strategic vision
- risk-taking
- creativity
- interpersonal and communication effectiveness
- inspiration (Wong & Giallonardo, 2013)
- team builders
- agents for positive change
- role models for collaboration
- committed to service (Shirey, 2009).

AACN's (2016) Healthy Work Environment Model has developed six evidence-based standards that can improve or maintain a healthy work environment:

1. **Skilled communication**
    - Nurses must be as proficient in communication skills as they are in clinical skills
2. **True collaboration**
    - Nurses must be relentless in pursuing and fostering true collaboration
3. **Effective decision-making**
    - Nurses must be valued and committed partners in making policy, directing and evaluating clinical care, and leading organizational operations
4. **Appropriate staffing**
    - Staffing must ensure the effective match between patient needs and nurse competencies
5. **Meaningful recognition**
    - Nurses must be recognized and must recognize others for the value each brings to the work of the organization
6. **Authentic leadership**
    - Nurse leaders must fully embrace the imperative of a healthy work environment, authentically live it, and engage others in its achievement

The critical elements needed to transform and maintain HWE requires the authentic leader to perform as follows:

- share an understanding of the requirements and dynamics for providing direct patient care
- generate an enthusiasm for meeting goals (including a HWE)
- role model all six HWE standards
- nurse leaders and team members objectively evaluate the impact of the leadership processes and decision-making in relation to HWE goals

While formal leaders, such as nurse managers, are easily positioned to inform practice though collaboration with other executives and formal leaders in nursing administration, bedside or staff nurses also play a major role with incorporating all six standards into practice. Communication, collaboration, effective decision-making, and leadership skills are integrated into all nursing roles. Nurses owe it to their patients, the nursing profession, and society to advance quality care and improve the overall health of the population.

Mentoring

According to the ANA (2015c) and the IOM (2010), all nurses are leaders, and one of the expectations of being a formal or informal leader is to mentor one's peers. Mentoring is critical for advancement of nursing practice and the nursing profession as a whole, because when nurses mentor, counsel, or support their peers, the quality of nursing care is improved. Some examples of mentoring can include the following:

- Educate how to perform a new skill
- How to problem-solve a complex patient concern
- Share advice on time management
- Encourage a peer when overwhelmed
- Reassurance about abilities or skills
- Advise on career goals, share guidance/suggestions

Partnerships

Participating in community partnerships is essential for advancing the profession and transforming healthcare. The IOM (2010) discusses the importance of nurses developing partnerships with agencies or stakeholders within the community. For example, a nurse could become a member of an ethics committee at a local nursing home or create a relationship with a local food bank or soup kitchen to assist with discharge planning. Sharing knowledge from one's current role and setting with community stakeholders advances everyone's knowledge about each other's needs, available services, all leading to improving the ability to better serve patient needs.

When nurses are knowledgeable about their community, and the care and services available to their patients, they are taking important steps towards transforming healthcare. Partnerships are indispensable for reaching the overarching goal of quality healthcare for all.

Nurses as "full partners"

In order for nurses to be a full partner in transforming healthcare, all nurses must acquire leadership skills and competencies and collaborate with other healthcare professionals and organizations. Some examples of being a full partner in patient care settings includes the following activities:

- taking responsibility for identifying problems and areas of waste
- devising and implementing a plan for improvement
- tracking improvement over time
- maintain a focus on short- and long-term goals; making necessary adjustments to realize established goals (IOM, 2011)

Considering the amount of time nurses spend with patients, compared to other disciplines, nurses are in a strategic position to identify problem areas, whether it's due to a patient need or concern, or a policy, procedure, or process that impedes care. Both formal and informal leaders need to share ideas for improvement and become vested in finding solutions.

Nurses can improve workflow, improve safety of the work environment or learning new ways of team communication by taking the imitative to seek out new knowledge from the literature (such as library databases). While formal leaders, such as a nurse manager or nurse executive, may have more power to follow through with policy changes, informal leaders are integral to the process of identifying problems and offering solutions.

Nurse leaders also need to have an active voice with health policy. Healthcare reform requires nurses to take an active role with implementation of political activism efforts. Nurses can serve on advisory committees, commissions, hospital committees, and boards where policies are created or amended to advance healthcare (IOM, 2011). Participation in a committee within one's organization takes time and effort, though brings many rewards, both personally and professionally. Consider creating a goal in your professional development plan that can impact health policy. Some examples include advocating for safe staffing at hospitals or ethical treatment at end of life.

Sigma Theta Tau International ("Sigma")

The need for excellent leadership is essential in today's rapidly changing, complex healthcare environment. Sigma Theta Tau International (STTI) is a global professional nursing organization with the mission of advancing healthcare and celebrate nursing excellence in scholarship, leadership, and service. STTI advocates for strong, positive leadership throughout the nursing profession in order to advance health (Vlasich, 2017).

STTI's role is to develop leadership knowledge, skills and abilities for nurses globally. STTI believes leadership develops throughout one's career, it is a journey of lifelong learning, with mentoring as the cornerstone of one's leadership philosophy (Vlasich, 2017).

STTI (2020b) offers membership to students who are working towards a baccalaureate degree where nurses are developing leadership knowledge, skills and abilities. In order to become a member of STTI, students must meet the following criteria:

- Completed half of the nursing curriculum.
- Achieve academic excellence:
    - For universities/institutions of higher education that use a 4.0 grade point average system to measure academic achievement, baccalaureate students must have a cumulative grade point average (GPA) of at least 3.0.

- Students must rank in the top 35% of the graduating class
- Meet the expectation of academic integrity (STTI, 2020b)

STTI also provides leadership grants to assist nurses with membership fees and travel to Sigma events (STTI, 2020a).

For more additional information about membership visit the **STTI website**.

Leadership Theory and Leadership Styles

Leadership theories and styles focus on a wide variety of ways to lead others, such as an emphasis on serving others, creating relationships, having power and control over others, or working together to reach goals. This section will review the major concepts of leadership styles and some of the most common leadership theories.

Leadership styles are categorized based on human relationships or task completion (Cummings et al., 2018). The following is a brief overview of current leadership styles:

Feminine leadership style emphasizes a *power with* approach (Burns, 1978). Sindell and Shamberger (2016) explain the following feminine expressions:

- listen for the emotional context and connection
- listens to others in order to sympathize with their emotions
- consoles, supports
- shares an emotional reaction
- supportive in areas of employee progress and development

Masculine leadership style emphasizes a *power over* approach (Burns, 1978). Sindell and Shamberger (2016) explain the following masculine expressions:

- listens for content and clarity
- ignores other's emotions
- does not express one's emotions

Leadership Theories and Styles

Goh, Ang, and Della (2018) discuss the importance of examining one's professional leadership style and its impact on peers, employees, goal attainment, and outcomes. Self-reflection could motivate one to find a leadership theory or style that can bring about overall improved outcomes.

One leadership theory or style is not necessarily better than the other. Each theory or style has its strengths and weaknesses, and depending on one's perspective, goals,

work setting, task, and even gender*, some leadership styles may produce better patient outcomes or higher job satisfaction.

Table 1 below complies a brief list of the some of the most commonly used leadership theories and styles:

Table 1: Leadership Theories

Transformational leadership	Transformational leadership has a positive and direct association with the level of organization commitment and retention of staff. Leadership qualities include charisma or non-verbal influence, inspirational motivation, intellectual stimulation, and individualized consideration. These leaders are admired, trusted, and respected. Leadership qualities have a significant impact on patient outcomes due to how well leaders inspire and motivate staff. Followers of this leadership style are more involved in their organization and put more effort in their work (Al, Galdas, & Watson, 2018)
Transactional leadership	Transactional leaders use a task-focused approach, whereby managers will motivate employees using punishment and reward. These leaders have the potential to improve job satisfaction, though overall, this style is associated with reduced empowerment and poorer health and well-being of staff (Cummings et al., 2018)
Authentic leadership	Authentic leadership is a relational leadership style that inspires staff performance and organizational outcomes. These leaders promote healthy work environments. Authentic leadership results in trust in the manager, job satisfaction, structural empowerment, positive work engagement, and work group relationships (Alilyyani, Wong, & Cummings. 2018)
Servant leadership	Servant leadership focuses on benevolent service to others. The servant leader puts employees first and promotes their well-being and growth and considers the interests of customers and the community. Servant leaders are role models of considerate treatment of others and help others in their development and growth. Servant leadership is akin to how nurses provide patient care, as nurses main focus is on their patients' overall well-being and satisfaction (Neubert, Hunter, & Tolentino, 2016)
Path-goal leadership	Path-goal leadership motivates team members to accomplish designated goals by emphasizing the relationship between the leader, the follower, and the tasks. Path-goal leaders reward employees for meeting goals, leading to improved job satisfaction. This leadership defines goals, clarifies the path, removes obstacles, and provides support for task completion. Path-goal leaders understand the needs of the employee and shift their leadership style as necessary to motivate their employees to complete the task (Bickle, 2017)
Situational leadership	Situational leaders judge the response by the follower based on their ability and willingness to complete the task. The leader responds with one of four quadrants: • **Telling:** high task/low relationship (leader in command, situation with one correct response) • **Selling:** high task/high relationship (leader has most controls, assists subordinates with confidence to complete task) • **Participating:** high relationship/low task (leader and subordinate share decision-making) • **Delegating:** low task/low relationship (leader trusts subordinate's ability to take full responsibility for making decisions/completing task) (Hershey & Blanchard, 1977) Communication tools can be applied to each of the four quadrants to create an environment where communication is open, concerns and thoughts are expressed freely, and mutual understanding can become the standard within the organization. The primary consideration for a situational leader is

	communication and ensuring communication is clear and in partnership with the follower. By adjusting the leadership style to meet the followers' needs, the follower grows and becomes more capable of completing the required tasks (Wright, 2017)
Theory X	Theory X leaders assume that employees will avoid work if possible, and they are inherently lazy and dislike work. Theory X leaders closely supervise employees (micromanage) and rely heavily on threat and intimidation to stimulate productivity. These leaders provide clear expectations of the work they expect to be done, how it should be done, and how long it should take (Hattangadi, 2015)
Theory Y	Theory Y leaders assume employees will practice self-direction in achieving the goals and objectives of the organization and they are committed to those objectives. These leaders offer guidance and promote autonomy to their followers. Theory Y leaders engage their employees in decision-making processes to inspire motivation and creativity (Hattangadi, 2015)

Leadership Characteristics

Burke, Flanagan, Ditomassi, and Hickey (2018) discusses nurse retention as an essential part of patient care delivery system. Thus, all nurse leaders must concentrate on creating ways to attract and retain nurses. Leadership characteristics identified by Burke et al. (2018) reflect transformational leadership, known to enhance job satisfaction. Qualities of exemplary nurse leaders include the following:

- Passion
- Optimism
- Personal connection
- Role modeling
- Leadership mentoring
- Presence
- Availability

Burke et al. (2018) found registered nurses found the following NM behaviors positively impacted their job satisfaction:

- Empowerment and Reflective Practice: a focus on enhancing nurse autonomy
- Passion and Vision: the quest for excellence
- Visibility: promotes interpersonal connections leading to a safe and caring environment
- High Expectations and Professional Behaviors: Appreciate and value the role modeled by NMs

Leading Four Generations of Nurses

Frandsen (2014) discusses the generational divide in today's workplace, and how nurses from four generations are working together for the first time in history. Frandsen (2014) describes the characteristics of each generation:

Silent Generation or Veterans or Traditionalists (1925-1945)

- Likely the most disciplined employee, loyal
- Seek approval from their employers, a traditional work ethic
- Often have a lifetime career with one employer or one field of work
- Respect for authority

Baby Boomer (1946-1964)

- Optimistic, competitive, focus on personal accomplishment.
- Work hard, often stressed, focus on achievement, seek self-improvement,
- Complain though accept problems
- In conflict with younger generations who do not share their values
- Primary focus is on work, resulting in a higher susceptibility to burnout and stress-related illness

Generation X (1965-1980)

- Many were "latch-key" children, resulting in a sense of independence that causes resentment when peers supervise their work
- Question authority
- Expect immediate results
- Committed to their team and manager
- Loyalty resides more with their peers and supervisor than with the organization

Generation Y or Echo Boomers or Millennial (1981-2000)

- Team-oriented
- Works well in groups
- Multitasks
- Willingness to work hard
- Expects structure in the workplace
- Respects positions and titles, seeks a satisfying relationship with managers
- Seeks out continuing education, professional development

- Desire to establish a relationship with their manager may cause conflict with Gen Xers who choose a hands-off approach

In order to understand peers or followers, leaders must reflect on their own generational characteristics (André, 2018).

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 behaviors 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.

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 professionals 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, education, 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 empathize 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 Pangmanstress 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). **Feministleadership**, 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 relationships 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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Chapter 2: Delegation

Accountability

Accountability is foundational to professional nursing practice and is often referred to as the “hallmark of professionalism” (Oyetunde & Brown, 2012). Being accountable can be described in a few ways. According to the American Nurses Association (ANA, 2015), nursing accountability requires nurses to be answerable for their actions and act according to a code of ethical conduct. Such ethical conduct includes abiding by the principles of beneficence, respect for human dignity, veracity, fidelity, loyalty, and patient autonomy. See the content below on the *Code of Ethics* for the impact accountability has on nursing practice.

Leonenko and Drach-Zahavy (2016) describe how professional accountability impacts all aspects of patient care, such as activities of daily living, health promotion, patient teaching, counseling, and collaboration with the interprofessional team (provider, therapy, dietician, etc.). While some education may not be provided by the nurse, such as mobility exercises from physical therapy, it is the nurse’s responsibility to ensure all services and education are in place and monitored throughout care. Accountable nurses will focus on instilling the patient’s trust in not only oneself, but the nursing profession as a whole. Patients can earn the trust of the profession when they see team cohesiveness, collaboration, and nurses working together towards a common goal (Leonenko & Drach-Zahavy, 2016).

Accountability can be seen throughout all aspects of nursing practice, such as:

- Ensuring/providing safe, quality care
- Delegation
- Following (and questioning) policy and procedures
- Practicing within the guidelines of the Nurse Practice Act
- Maintaining confidentiality
- Questioning standard of care, provider’s orders
- Alignment of care to organizational practices, philosophy
- Competence in clinical skills
- Lifelong learning
- Patient advocacy (Battié, & Steelman, 2014)

Accountability is a broad concept that is closely related to other concepts. It will be important to understand the differences between the following concepts as they are discussed throughout this chapter:

- **Accountability**:
    - Judgment and action on the part of the nurse

    - Answerable to self and others for judgments and actions (ANA, 2015a)
- **Responsibility**:
    - Accountability or liability associated with performance of a nursing task associated with one's role
    - Portion of the responsibility can be shared with others involved in the situation (ANA, 2015a)
- **Answerability**:
    - The requirement to offer answers, rationale, and explanations (ANA, 2015a)
- **Authority:**
    - The position to make a decision and influence others to act
- **Autonomy:**
    - the authority to use professional knowledge and judgment to make decisions and take action (Skår, 2009)

Cox and Beeson (2018) describe accountability as a "… a willingness to answer for results and behavior" (p. 25). When nurses are accountable for their actions, they have made a promise to own that action, leading to learning lessons from making mistakes and successes. People don't hold others accountable, it's the individual's job to be accountable.

In today's healthcare settings, accountability in nursing practice revolves around activities associated with providing quality care, including:

- Assessments (patients or otherwise, depending on setting/role)
- Interventions (nursing care)
- Health outcomes (reduced infection rates, falls)
- Costs (containment)

Many organizations, both federal and private, have created programs to improve the quality of healthcare, including the U.S. Agency for Healthcare Research and Quality, The Joint Commission, National Patient Safety Goals, and the Institute for Healthcare Improvement. The Institute of Medicine (IOM) and Quality and Safety Education for Nurses Institute (QSEN) are two organizations focused on safety in nursing education. Scientific evidence reveals the gap in quality care and these organizations (and others) work from different vantage points inside and outside of the healthcare system to reduce the incidence of unsafe, poor quality care.

Transfer of accountability from one nurse to another is like a silent contract. For example, in an acute care setting, when a nurse receives report from the outgoing nurse, there is a transfer of accountability from one person to another. The oncoming nurse is responsible and answerable for the behaviors and outcomes of a group of

patients for the duration of the shift. Thus, anytime a nurse establishes a professional relationship with a patient (depending on role/setting), there is a binding agreement where the nurse is legally bound (see Nurse Practice Act below) to implement care according to the patient's needs and wishes.

State Boards of Nursing

As mentioned earlier, accountability within the nursing profession ensures safe, quality care. In order to protect the public and to ensure optimum care, nursing practice is regulated by state agencies. The U.S. Boards of Nursing (BON) are jurisdictional governmental agencies that have been established by each state government with the mission to protect the public's health by overseeing nursing practice (National Council of State Boards of Nursing [NCSBN], 2020a).

The NCSBN (2020a) administers and coordinates services to all state BONs. The NCSBN works with each state BON to ensure nursing accountability through a number of organizational activities, including standards for safe nursing practice, issuing licenses to practice nursing, license verification, monitoring licensees' compliance to state BON laws, and taking action against nurses who have exhibited unsafe nursing practice (NCSBN, 2020a).

Nurse Practice Act

Individual states, or jurisdictions, have a law called the nurse practice act (NPA), which is enforced by the BON in each state (NCSBN, 2020a). The NPA includes the following information:

- Qualifications for licensure
- Nursing titles that can be used
- Scope of practice (what the nurse is allowed to do)
- Actions that can or will occur if nurses do not follow the laws

The scope of practice is in place to safeguard patient care and maximize health outcomes. When nurses practice outside of their scope of practice, accountability to oneself, the patient/family, peers, the institution, and/or society are at risk. Familiarity with the NPA ensures accountability.

Access the NPA for the state you will practice in at the State's Board of Nursing Website.

Nurses should review their NPA regularly to check for updates, and most importantly, when changing jobs or taking on a formal leadership role. Laws within the NPA pertain to certain settings and roles. For a full listing of all the NPAs in every state, visit the **NCSBN website**.

Foundational Documents

Standards of Professional Practice

Accountability is an essential element of nursing practice within the Scope and Standards of Practice. Below are a few examples where accountability and responsibility for nursing practice are illustrated throughout the Standards of Professional Performance.

- **Standard 7: Ethics**
  - "Demonstrates professional **accountability and responsibility** for nursing" practice (ANA, 2015c, p. 67).
- **Standard 10: Collaboration**
  - "Clearly articulates the nurse's role and **responsibilities** within the team" (ANA, 2015c, p. 73).
- **Standard 11: Leadership**
  - "Retains accountability for delegated nursing care" (ANA, 2015c, p. 75).
- **Standard 15: Professional Practice Evaluation**
  - "Ensures that nursing practice is consistent with regulatory requirements pertaining to licensure, relevant statutes, rules, and regulations" (ANA, 2015c, p. 81).
  - "Uses organizational policies and procedures to guide professional practice" (ANA, 2015c, p. 81).
  - "Delegates in accordance with applicable legal and policy parameters" (ANA, 2015c, p. 81).

Nursing's Social Policy Statement

Nursing's social policy statement describes nursing's social responsibility, accountability and contribution to healthcare (ANA, 2015b). The nursing profession is entrusted with providing quality, ethical care to society. The ANA is responsible for ensuring societies' needs are met by articulating, maintaining, and strengthening the social contracts between the nursing profession and society.

Code of Ethics

The (ANA, 2015a) *Code of Ethics* sets forth the values and obligations of the nurse. Provision 4 has a core focus on accountability and responsibility, stating, "The nurse has authority, accountability, and responsibility for nursing practice; makes decisions; and takes action consistent with the obligation to promote health and to provide optimal care" (ANA, 2015a, p. 59). The nurse's ethical obligation is to protect and be accountable to oneself, and also to the general public.

The following four interpretive statements from Provision 4 further illustrate the depth of accountability and responsibility in nursing practice:

4.1 Authority, Accountability, and Responsibility

- Accountable for one's own practice, care ordered by a provider, care coordination.

4.2 Accountability for Nursing Judgments, Decisions, and Actions

- Nurses must follow a code of ethical conduct.
- Follow the scope and standards of nursing practice.

4.3 Responsibility for Nursing Judgments, Decisions, and Action

- The nurse is always accountable for judgments, decisions, and actions, though the employer may be jointly responsible depending on the situation.
- Nurses accept or reject an assignment based on education, experience, competence, and risk for patient safety.

4.4 Assignment and Delegation of Nursing Activities or Tasks

- Assignments and delegation activities must be consistent with the Nurse Practice Act, organizational policy, and nursing standards of practice.
- Assess individual competence prior to assigning (ANA, 2015a, p. 59).

BSN Essentials

The BSN Essentials illustrate the outcomes for baccalaureate nursing education (AACN, 2008). Note that the BSN Essentials will soon be updated from the 2008 version. Accountability and responsibility are a major component of the nine essentials, see below for more information:

- **Assumptions of a Baccalaureate Generalist Nurse**
    - Assume **accountability** for one's own and delegated nursing care
- **Roles for the Baccalaureate Generalist Nurse**
    - The use of the term "professional" implies the formation of a professional identity and **accountability** for one's professional image
- **Essential II: Basic Organizational and Systems Leadership for Quality Care and Patient Safety**
    - Apply leadership concepts, skills, and decision making in the provision of high quality nursing care, healthcare team

coordination, and the oversight and **accountability** for care delivery in a variety of settings

- **Essential VI: Interprofessional Communication and Collaboration for Improving Patient Health Outcomes**
    - Individual accountability/shared accountability
- **Essential VIII: Professionalism and Professional Values**
    - Professionalism involves **accountability** for oneself and nursing practice, including continuous professional engagement and lifelong learning
- **Essential IX: Baccalaureate Generalist Nursing Practice**
    - Demonstrate clinical judgment and **accountability** for patient outcomes when delegating to and supervising other members of the healthcare team (AACN, 2008).

More information can be found in the **BSN Essentials** document.

Types of Accountability

Nurses are accountable for their actions to themselves, their peers, employer, healthcare consumers, society, and the nursing profession (ANA, 2015c).

Accountability to Self

Nurses must be accountable to themselves, otherwise they risk accountability to their peers and their patients. Nurses work very long hours, often working well past a 12-hour shift to complete care, documentation, and report to the oncoming nurse. A nurse may resent having to work a 13- or 14-hour shift, especially when compensation may not cover the extra time on the unit. Miller (2012) explains the importance of strengthening personal accountability in situations where a nurse may begin complaining or blaming others about the long hours or other issues that are beyond the nurse's control. Personal accountability begins with looking inward, rather than pointing fingers. Miller (2012) suggests asking oneself two important questions:

- What can I do?
- How can I help?

Instead of just complaining to the manager about the long shift or a different problem, nurses need to offer their assistance on how to find a resolution and offer their help with

carrying out the solution. Part of resolving problems is being part of the solution. Nurses who refuse to complain, and instead choose to find solutions, become empowered. Choosing to be positive, and part of the solution, leads to improving one's personal accountability.

As previously mentioned, working long hours in a stressful environment requires nurses to have adequate physical stamina and emotional stability. Fatigue, minor illnesses, and a stressful personal life can negatively impact professional practice. Working extra shifts in addition to a very busy life can also hamper practice. Maintaining a healthy lifestyle, including adequate sleep, diet, and exercise, and having a balanced work-personal life, is essential for one's personal accountability.

Working in an unsafe practice setting is another example where nurses need to be accountable to themselves. Some examples include working in an unfamiliar setting or having a high-acuity/high patient load assignment. Nurses need to view refusal to work in an unsafe setting as a way to protect the public, and to be personally accountable. Be sure to follow organizational policies on how to refuse and/or make a statement about working in an unsafe environment.

Accountability to Peers

Accountability to peers is also known as shared accountability. Shared accountability occurs when team members support each other, work together to ensure a safe working environment, and act as role models to demonstrate a culture of respect. If nurses need to speak up about a concern, they need to do so in a constructive, considerate way. Communication with team members should be provided consistently, in a way that does not cause embarrassment or anger. When team members consistently share feedback with each other it reinforces the desire for a supportive, cohesive team. The goal is to create an environment where suggestions for change are expected and become the norm. Establishing a culture of trust, respect, and support leads to a healthy work environment and quality safe patient care (Battié, & Steelman, 2014).

Accountability to the Employer

Nurses are accountable to their employers by following their rules and regulations and fulfilling their job duties. Since nurses must be accountable with the laws set forth in the NPA, they need to verify organization policies do not conflict with NPA regulations. Nurses risk violating regulations if they do not review the NPA regularly. Nurses are also responsible, and held accountable, for monitoring unlicensed personnel. Nurses can improve accountability to their employer by taking an active role in organization-wide committees focused on improving the delivery of care.

Accountability to the Patient

Patients have the right to safe, quality care. Nurses are held accountable to their patient by the fulfilling their obligations set for in the *Scope and Standards of Practice* and the *Code of Ethics*. As previously stated, these two foundational documents illustrate the requirement of all registered nurses to provide exemplary care to individuals in need of healthcare.

Nurses can also be accountable to their patients by educating them about the Hospital Compare website. All hospitals are now required to post health outcomes and other measures at the Hospital Compare website so patients can make choices about where to receive care. Visit the **Hospital Compare** website to view all of the outcomes. The following is a brief list of the outcomes found in the Hospital Compare website:

- Timely and effective care
- Healthcare associated infections (HAI)
- Adverse effects (i.e. mortality rates)
- Patient satisfaction/experiences

The quality measures available from the Hospital Compare website provides the healthcare system and nurses important data that helps them be more competitive with other healthcare systems, thus, further improving quality care. Nurses need to be aware their patients often enter the healthcare system with increased knowledge of healthcare in general and awareness of the organization's level of quality care. Patients may have a sense of what to expect from nurses when they begin receiving care, and nurses must be prepared to work with patients in a collaborative way. Like any other business, healthcare organizations and their employees must be accountable to their patients and their needs.

Since the healthcare system has moved towards a proactive, preventive care approach, nurses need to provide patients with the education and tools to promote health and well-being in order to prevent illness and disease. As nurses develop relationships with their patients, it will be important to understand their distinct needs and how they relate to health promotion activities. For example, determining any barriers and motivating factors will be important for nurses to include in their collaborative efforts with patients. When nurses create a plan that is patient-centered, and focused on current evidence to offer safe, quality care, nurses are taking the right steps to being accountable to their patients.

Accountability to Society

One of the characteristics of a profession is service to society. Consumers have the right to receive safe, quality care, and nurses are held accountable to meet the healthcare needs of society. To meet these needs and requirements, nurses are

obligated to stay abreast of current literature, attain continuing education, maintain skill competencies, and more. Through the NPA and the ANA's *Nursing's Social Policy Statement*, nurses are legally held accountable to provide professional nursing care that meets the required scopes and standards of practice.

Accountability to the Nursing Profession

Just as nurses are advocates for their patients, they must also be strong advocates for the nursing profession. Through participation in professional nursing organizations, nurses need to promote safe, quality nursing care, improved nursing autonomy, nurses' rights, and more. Nurses need to support professional organizations as a way to be accountable to the nursing profession (Battié, & Steelman, 2014). Nurses can demonstrate their accountability by the following activities:

- Participate in organization-sponsored conferences and activities
- Stay current with recommended practices within one's specialty
- Political advocacy
- Vote for candidates who support the profession's mission (Battié, & Steelman, 2014)

Nurses play an important role in shaping the nursing profession through formulating its own policies and laws. Nurses work collaboratively to formulate the profession's scope, standards of care, licensing, entry into practice, and more.

Provision 3 in the ANA (2015a) *Code of Ethics* states, "The nurse promotes, advocates for, and protects the rights, health, and safety of the patient" (p. 41). Interpretive statement 3.5 explains how nurses must act on questionable practice. Nurses must be alert to all instances of incompetent, unethical, illegal, or impaired practice by another member of the healthcare team, which includes issues that occur within the entire healthcare system. Nurses must take action to resolve such issues in order to protect the healthcare consumer from injustice or injury.

The *Code of Ethics* directs nurses not only to recognize questionable practice due to impairment, such as substance abuse, but nurses are also obligated with assisting each other with obtaining treatment. Weber (2017) states substance and alcohol abuse is a significant issue for the nursing profession. Chemically addicted nurses and other

healthcare workers pose a danger to themselves, patients, team members, and the organization.

Manthey (2018) discusses how nurses are at an increased risk for addiction due to working in highly stressful environments, easy access to highly addictive substances, and a “conspiracy of silence” that prevents treatment. Thomas and Siela (2011) states at least 1 in 10 nurses will develop a substance abuse disorder, similar to the general public. Resources and more information about substance abuse disorders in nurses can be found at the **NCSBN website**.

Nurses must be acutely aware of the high risk of addiction to alcohol and illegal substances for oneself. When nurses observe impaired practice or unsafe patient care from a coworker and believe wrongdoing has occurred (such as drug-diverting), nurses must be prepared to report this unethical behavior. Reporting such behaviors to authorities is known as whistleblowing. Whistleblowing is defined as “the disclosure by organisation members (former or current) of illegal, immoral or illegitimate practices under the control of their employers, to persons or organizations that may be able to effect action” (Near & Miceli, 1985, p. 4). Protecting patients from harm is one of the guiding principles of the nursing profession. Nurses owe it to themselves, and their patients to ensure be alert to impaired practice and reporting such behaviors. Additional information about whistleblowing can be found at the **ANA website**.

In order to ensure the nursing profession continues to be known as an honorable and noble profession, nurses need to support and mentor their peers throughout one’s career.

Nursing Judgment and Action

Nurses practice and act within a learned code of ethics they implicitly follow when making judgments about care. Nurses practice by the principle of fidelity (being faithful, honest), respect for dignity, work, and patient autonomy when taking action. Nurses are accountable for judgments made about care. When nurses assume accountability and responsibility for their patients, they fulfill their commitment to practice with compassion and respect for patients. The ANA (2010a) states, “The moral standard of the profession is one to which nurses must hold themselves and their peers in order to be held accountable in for their practice” (p. 46).

Nurses must either reject or accept role demands based on one’s level of education, knowledge, competence, and experience. Nurses must assess their own competencies and seek out necessary education, consultation, and collaboration. Tasks should be performed only when nurses have demonstrated sufficient competence and confidence with the skill.

When nurses are answerable for their knowledge, skills, and actions, their level of respect and nursing autonomy grows. The general public needs nurses to be competent; therefore, when nurses demonstrate their strengths by providing competent

care, they maintain the trust and respect of their patients including the healthcare system as a whole.

As described earlier, autonomy is centered around nurses making independent decisions about care based on their knowledge, judgment, and experience. Autonomy is related to accountability because nurses who make independent decisions, or any decision for that matter, are accountable for their actions. Autonomous decisions are made to ensure appropriate care, maintain high quality care, and satisfy the patient or healthcare consumer.

Shared Governance

Shared governance is an organizational model defined as "… a structure within the process of practicing professional nursing that results in favorable nurse, patient, and organizational outcomes" (Church, Baker, & Berry, 2008, p. 36). The two main assumptions of shared governance models are: 1) redistribute decision-making power from managers to staff [nurses], and 2) nurses have the interest in being part of the decision-making process (Anthony, 2004).

Golanowski, Beaudry, Kurz, Laffey, and Hook (2007) explains shared governance as a decision-making model containing four major concepts:

- **Accountability:** the foundational concept, includes authority (power to make decisions), autonomy (right to make independent decisions), and control (ability to act)
- **Equity:** measure of all team members contributions to the outcome
- **Partnership:** relationships among the team members with a focus on the outcome
- **Ownership:** invested in the organization, able to articulate personal contribution to the outcome

Shared governance can transform nurses' personal practice and benefit healthcare organizations in many ways, including:

- Empowerment of practice (Hess, 2004)
- Improved nurse satisfaction (Church et al., 2008; Golanowski et al., 2007)
- Improved patient satisfaction scores (Church et al., 2008)
- Reduced mortality and healthcare-acquired infection rates (Church et al., 2008)
- Reduced nurse turnover and vacancy rates (Church et al., 2008)
- Improved staff morale (Golanowski et al., 2007)
- Improved staff member participation (Golanowski et al., 2007)
- Personal and professional development (Golanowski et al., 2007)

Improved levels of morale, job satisfaction, and empowerment leads nurses to being happier, and more fulfilled in their daily work. Patients can sense when their caregivers (nurses and staff members) exhibit more cheerful and contented behaviors, which may translate to feelings of being cared for, and having a satisfied patient experience.

In order for a shared governance model to bring about positive outcomes, both nurses and managers need to buy into the idea that nurses need to have a voice in decisions that impact their practice, and the delivery of healthcare.

Delegation

Delegation is defined as, “The transfer of responsibility for the performance of a task from one individual to another while retaining accountability for the outcome” (ANA, 2015c, p. 86). The ANA and NCSBN (2019) created the *Joint Statement on Delegation* in order to support and guide nurses on how to use delegation safely and effectively. These organizations share the following definition and meanings about delegation:

- The process for a nurse to direct another person to perform nursing tasks and activities. The nurse retains the accountability for the delegated task (ANA & NCSBN, 2019, para 3). The two organizations further delineate:
    - NCSBN: nurse transfers authority
    - ANA: nurse transfer of responsibility

Nurses often work in chaotic healthcare environments, have a large patient load, a high acuity assignment with complex patient needs, with an added emphasis on patient satisfaction. These are just a few factors that leave nurses no choice but to delegate tasks to other members of the healthcare team. Delegation frees up nurses’ valuable time so nurses can attend to more complex patient care tasks. Delegation is an essential skill of professional nursing practice, and when done correctly, can result in safe and effective nursing care (ANA, 2019).

Delegation is an expectation and responsibility of nursing practice as identified in the ANA Standards of Professional Performance, Standard 15, Resource Utilization: “Delegates elements of care to appropriate healthcare workers in accordance with any applicable legal or policy parameters or principles” (ANA, 2015c, p. 81).

In order to delegate, nurses must consider the following:

- Nurses' legal authority to practice
- Context of their practice
- Nurse Practice Act regulations
- Professional standards
- Employer's policies and procedures on delegation (ANA, 2019)

More information about the ANA's *Principles for Delegation* and NCSBN's *Decision Tree for Delegation to Nursing Assistive Personnel* can be found in their the **Joint Statement on Delegation** document.

Creating a Culture of Accountability

It is essential to view accountability as a process of supporting others who want to be accountable for the work they accomplish. Nurses in leadership positions, whether formal (i.e. nurse manager) or informal (i.e. charge or staff nurse), should reflect on their thoughts about accountability in order to get a full understanding of one's thoughts on the topic. Reflection is an important first step because leaders set the tone for the work setting and understanding oneself better can impact thinking and actions for the future (Cox & Beeson, 2018). Some questions to consider include:

- Do you set a tone of learning from mistakes or do you focus on punishing?
- Do you focus on blaming others or fix the system?
- Are you the first or last to admit your own mistakes? (Cox & Beeson, 2018)

Providing support to individuals who make mistakes, rather than finding faults, will create an environment where accountability can grow. Enforcing a punitive consequence destroys the possibility of creating trust and a sense of partnership with a peer or follower. Accountability should be associated with support, encouragement, trust, and unquestionably, not punishment (Cox & Beeson, 2018).

Cox and Beeson (2018) explains the three major components of accountability:

- **Clear expectations**: clearly explain the expectations by answering the 4-Ws and the 1-H, such as:
    - **What** needs to be done?
    - **Why** is this important?
    - **When** does it need to be completed?
    - **Who** else will I be working with on the project?
    - **How** do I begin?
- **Follow-through**: connect with staff to offer motivation or inspiration to carry out the task or project:

    - Mentoring
    - Coaching
    - Guiding
    - Feedback
    - Encouragement
    - Support
- **Rewards or consequences**
    - Reward: A pat on the back when the task is complete. Be sincere and timely
    - Consequence: be firm and compassionate

Summary of How to Enhance Accountability

- Clear and open communication
- Skill competency
- Advanced education
- Collaboration with peers, managers
- Clear expectations
- Participate in professional organization opportunities
- Support peers, mentor new nurses, offer guidance
- Read the NPA regularly, especially when changing roles/settings
- Delegate
- Ask yourself, “What can I do? and “How can I help?”
- Maintain a healthy lifestyle; physically, emotionally, spiritually
- Choose to be positive, find a solution
- Participate in organization-wide committees
- Be compassionate, listen
- Organize a shared governance model for your unit/organization
- Compare employer’s policies/processes to NPA

Chapter 3: Communication and Collaboration Through a Leader's Eyes

Interprofessional Communication

Effective communication within the interprofessional team is one of the hallmarks to providing safe, quality care. Communication between individuals, groups, and organizations will either lead to successful interactions with high outcomes, or miscommunication, leading to poor quality, errors, unsafe care, and sentinel events (unexpected death or injury) (The Joint Commission [TJC], 2010; Weller, Boyd, & Cumin, 2014). To ensure effective interprofessional communication throughout acute care settings, TJC (n.d.) surveyors evaluate hospitals for compliance with patient-centered communication standards.

Delivery of healthcare is complex, requiring clear and timely communication between multiple disciplines. It has been well documented that miscommunication is the root cause of medication errors, poor quality, and reduced health outcomes (O'Daniel & Rosenstein, 2008; TJC, 2015).

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO, 2005) explains how a patient may interact with 50 different employees during a 4-day hospital stay. The opportunity for miscommunication is vast, compelling healthcare institutions to develop tools and training programs to improve communication throughout the entire organization (Institute of Medicine, 2010). Holmes et al. (2015) found implementation of training programs and use of standardized tools and simulation has the potential to improve patient safety.

Positive communication is a critical ingredient found throughout the culture of an effective organization. Leadership practices that will positively influence the organization's culture must be clearly defined. This plan will lead to the support that will encourage employees to identify problems early and be motivated to explore solutions and assist with implementation.

Standards of Practice

Professional nursing practice requires communication be maintained at a highly effective level. Developing a trusting relationship with patients, advocating for their needs, providing patient-centered care, and ensuring safe, quality care are vital reasons why this is indispensable.

The Scope and Standards of Practice, developed by the American Nurses Association (ANA, 2015c), serves as a template for professional nursing practice for all registered nurses. Standard 9, Communication, states, "The registered nurse communicates effectively in all areas of practice." (ANA, 2015c, p. 71). The following is a summary of the competencies of the Communication standard:

- Assesses one's own communication skills and effectiveness.
- Demonstrates cultural empathy when communicating.

- Maintains communication with interprofessional team and others to facilitate safe transitions and continuity in care delivery.
- Assesses communication ability, health literacy, resources, and preferences of healthcare consumers to inform the interprofessional team and others.
- Demonstrates continuous improvement of communication skills.
- Uses communication styles and methods that demonstrate caring, respect, deep listening, authenticity, and trust (ANA, 2015c, p. 71).

Types of Communication

Communication is an interactive process whereby one person (the sender) influences another (the receiver) with information (a message). Messages are sent verbally, non-verbally, and by the tone of voice. Effective communication occurs when both the sender and receiver have a shared understanding of the message, and both perceive the message in the same way (JCAHO, 2005).

Verbal

- Verbal communication occurs through spoken language.

Paraverbal

- During verbal communication, the qualities of an individual's voice influence transmission of the message, including:
    - Tone: indicates a feeling, such as sadness, humor, anger
    - Inflection: rise and fall of the voice
    - Rhythm
    - Flow (O'Daniel & Rosenstein, 2008)

Non-Verbal

Non-verbal communication is an interactive process that occurs continuously, with and without verbal communication. Non-verbal behavior includes posture, body movements, mimics, facial expressions, gestures (O'Daniel & Rosenstein, 2008).

Nurses can interpret their patient's body language and other non-verbal and paraverbal behaviors as part of the assessment process. Some patients may not have the ability to express themselves and body language may offer multiple inconclusive meanings. Proper follow up with additional questioning to confirm assumptions and understand new developments is prudent.

Benbenishty and Hannink (2015) states non-verbal communication has the capability to build trust by displaying an open body posture. In nursing, posture is a very important part of active listening during assessment or patient education. Consider body positions when listening to patient concerns, such as crossing arms or looking down at a patient during an interview. Positioning oneself and asking questions while looking at a laptop instead of looking directly at the patient with an open body posture will not foster open, effective, and honest communication.

Verbal communication has a smaller impact on the transmission of a message from one person to another and must be kept in perspective. Benbenishty and Hannink (2015) discuss the use of the 55/38/7 formula, used by communication psychologists, to understand the influence of each form of communication:

Verbal communication has a smaller impact on the transmission of a message from one person to another and must be kept in perspective. Communication psychologists refer to the 55/38/7 formula to understand the influence of each form of communication:

- **55%** non-verbal
- **38%** paraverbal
- **7%** verbal (Benbenishty & Hannink, 2015)

Non-Verbal Communication and Culture

The preferences and accepted norms for non-verbal behaviors listed below will vary depending on culture. Respecting patient preferences is essential for effective communication and developing trusting relationships with patients and team members. Nurses can empower patients by encouraging them to speak up if their preferences and values are overlooked or misunderstood.

- **Physical space:** Americans prefer more personal space, generally, than other cultures (*more information about physical space later in the chapter*)
- **Touching:** physical contact is associated with one's personality or communication style and can create discomfort. While touching an arm or shoulder shows support and empathy in American culture, it is best to ask patients if touching is okay.
- **Gestures:** some cultures become animated during communication, such as waving hands. Some cultures may find such gestures insulting and rude.

- **Eye contact:** in America, eye contact is understood as a sign of respect and a confident speaker. In contrast, eye contact can have negative connotations and can be insulting.
- **Silence:** some cultures are uncomfortable with silence, while others consider it as an opportunity to contemplate the message and meaning.
- **Body language:** verbal communication may be contradicted or confirmed by the use of body language. Consider the patient's impression when the nurse welcomes the patient to the unit with folded arms (Hosley & Molle, 2006; Leininger & McFarland, 2006).

View the following video on eye contact and non-verbal communication:

https://youtu.be/W3CN3fd2G_E

View the video below for an animation of miscommunication:

https://youtu.be/gCfzeONu3Mo

The sender and receiver take certain roles in the transmission of the message. The sender wants to be heard and receiver needs to share acknowledgement of the message. Transmission and acknowledgement may not occur for a number of reasons, including ineffective communication skills, conflicting non-verbal behaviors, or communication barriers. Evaluating one's communication behaviors and assessing for barriers is a constant challenge. Developing a broad base of communication skills is a necessity in a complex healthcare environment where communication is at the heart of interprofessional collaboration.

How does the nurse in charge of unlicensed staff at a group home, charge nurse at a hospital, or school nurse at an elementary school adapt the type of communication needed for their setting? They must evaluate the age/education level of receiver, common communication gaps and barriers, and through experience and seeking new solutions, gaps in communication can be reduced.

Communication Styles

It is undisputed that clear and accurate communication among the interprofessional team is vital for teamwork, collaboration, and ultimately, improved outcomes. Miscommunication is often the root cause reduced patient outcomes, often due to team members having diverse, and often conflicting communication styles. In order for teams to collaborate and share knowledge in a timely way, nurses need to understand their team members' communication styles. Recognizing and understanding team members' communication styles allows nurse to adjust their communication behaviors in order to reduce or prevent conflict and misunderstanding (Plonien, 2015).

In addition to learning about the three basic communication concepts (listed below), there are additional communication styles (Controller, Supporter, Promoter, and Analyzer) discussed at the **Maximum Advantage** website.

Communication Concepts

Passive Communication

- Not expressive
- Disregards their own rights, in turn encourages others to disregard their rights
- Speaks in an apologetic way
- Hesitant to share feelings with others
- Does not respond clearly
- Unconsciously accumulates complaints, which often causes an outburst, leading to unacceptable behavior and damaged relationships, in turn, causing blame and guilt, leading again to passive behavior (Tripathy, 2018)

Aggressive Communication

- Domineering
- Ambitious
- Demands others maintain order, especially when the situation gets out of control
- Bullies and intimidates peers (Tripathy, 2018)

Assertive Communication

- Considered the best form of communication, a balance between passive and aggressive
- Positive attitude
- Good listener, respects others' opinions
- Shares views in a calm and peaceful way
- Peers establish strong relationships with these communicators
- Expresses their thoughts, feelings, and emotions openly (Tripathy, 2018)

Omura, Maguire, Levett-Jones, and Stone (2016) discuss assertiveness as a powerful tool that eliminates the power differences between individuals. When individuals assert themselves, they are acting in their own best interest (such as advocating on the patient's behalf). Being assertive helps people stand up for themselves without feeling nervous or anxious.

Professional Communication

Professional communication is defined as the interaction between healthcare professionals with the principal goal of meeting health-related outcomes (Street & Mazor, 2017). When successful communication practices become a central component of an organization it can transform healthcare delivery. Successful nurse-patient interactions require a patient-centered approach, where patient preferences and values are the center of their communication. Nurses' communication skills and strategies need to be focused on educating, supporting, and empowering patients to manage their healthcare needs (Arnold and Boggs, 2019). Effective nurse-patient communication leads to patients having a better understanding of their health conditions leading them to be more active participants in their care.

Impact of Effective Communication:

- Development of nurse-physician relationships
- Increased patient satisfaction
- Early identification of changes in health status
- Improved understanding of patient's needs, health status
- Improved patient outcomes last longer (Arnold and Boggs, 2019)

Therapeutic Communication

Effective communication occurs when nurses establish trusting, therapeutic relationships with their patients (Arnold & Boggs, 2019). When nurses communicate in a therapeutic way, they are interacting for the purpose of learning about the patient's values, preferences, culture, interests, health needs, and developmental level (Rosenberg & Gallo-Silver, 2011). Developing therapeutic relationships is akin to Standard 1 (Assessment) of the Standards of Practice, where the nurse collects relevant information about the patient's health and condition. Knowledge of valuable patient information allows the nurse to create a patient-centered plan of care.

Peplau (1960), a well-known nursing theorist, states healthcare providers must be skilled in therapeutic communication. Effective therapeutic communication is a learned skill, requiring a concerted effort to acquire knowledge on essential communication skills. Peplau (1960) states nurses need to uphold the concept called *skilled mindfulness*, which is an approach that allows the healthcare provider to consider the unique needs of the patient and at the same time having a personal awareness of one's own responses and reactions. Peplau (1960) defines the nurse's role as the "participant observer."

Communication as an Art

Similar to nursing practice, effective communication is an art and a science. The art of communication is in the expression of how a message is conveyed. The speaker's personality, sense of humor, non-judgmental approach, level of respect, calmness, and their attitude towards the dialogue will vary between individuals (Arnold & Boggs, 2019).

Reading the situation in which nurses communicate with patients, coworkers, and other healthcare professionals is also an important skill to master. The speaker needs to be intuitive to the receiver's preferences and needs, such as the amount of physical space, use of humor, or use of touch. Ensuring a positive first impression will influence the outcome of the interaction.

Communication Behaviors and Skills

The fundamental components of successful patient-centered communication include empathy, clarity, and honesty (Arnold & Boggs, 2019).

Empathy

Empathy is an essential component to building relationships with both patients and team members. Understanding each other's needs leads to better outcomes and improved work environments.

Empathy with Patients

Clinical empathy involves understanding patients' emotions and experiences regarding care. When nurses have empathy for a patient, it means they are able to communicate an understanding of the patient's experience and needs, with the intention of alleviating suffering or pain (Hojat et al., 2013).

Clinical empathy is necessary for effective patient care (Hojat, Louis, Maio, & Gonnella, 2013) and creating therapeutic caring relationships (Mercer & Reynolds, 2002). Furthermore, Egan (2013) describes empathy as a skill or way of being that are central to forming therapeutic relationships with others.

Mercer and Reynolds (2002) describe three purposes for instilling empathy in therapeutic relationships:

1. Initiating supportive, interpersonal communication in order to understand the perceptions and needs of the patient

2. Empowering the patient to learn, or cope more effectively with his or her environment
3. Reduction or resolution of the patient's problems (p. S9)

Empathy within the Interprofessional Team

Supporting teamwork and collaboration within the interprofessional team fosters safe, quality care. Caprari et al. (2018) conducted a study on ways to improve teamwork and collaboration through building empathy among the interprofessional team. The researchers found improved their experience and collaboration among each other when team members understood each other's needs, goals, and roles. When team members built personal relationships with each other, and understood their actual duties and needs, they felt more confident and trustworthy about their peers.

Active Listening

Active listening is an interactive process between two or more people. In nurse-patient interactions, nurses listen to a message, interpret the meaning, ask questions to clarify the meaning, then share feedback about the message to the patient. Nurses need demonstrate active listening through verbal and non-verbal communication, by asking open-ended questions and actively observing the patient. When the nurse is in a relaxed position, leans slightly forward, maintains eye contact, nods, and restates patient concerns, it shows interest and commitment (Arnold & Boggs, 2019).

Nurses need to offer their full attention during nurse-patient communication, without making any judgments. Ineffective body language during these interactions can impede message transmission, such as looking at the clock or watch, responding to a text message, or begin walking away from the patient.

Listening makes up 40% of the communication process (Burley-Allen, 2005) and requires the listener to be actively immersed in the dialogue. The listener must be both physically attentive and mentally focused on the spoken message while visibly displaying a relaxed, open-minded body language (Chichirez & Purcărea, 2018).

Van Servellen (2009) explains the following listener responsibilities:

- Perform active listening skills and behaviors

- Understand the message
- Interpret and ask questions about the speaker's body language
- Motivate the speaker to substantiate their message with supports, such as sharing a rationale

Henrico and Visser (2012) expressed the importance of being supportive and genuine during the communication process. An effective listener needs to be concerned about the speaker's feelings and listen in an empathetic way.

Longweni and Kroon (2018) studied the communication process between managers and their employees. The researchers found employees were more engaged and committed when their manager paid attention to their emotions during the communication process. Researchers found employees with lower levels of education perceived less effective communication and required adjustments in communication behaviors. Considering a variety of factors and abilities about the listener will increase the odds of successful communication.

Nurses communicate with interprofessional team members and a variety of other staff and employees on a daily basis. Nurses need to listen effectively and be flexible in their communication approach. The goal of effective communication is to empower all involved in the delivery of care.

Consider the following communication skills and behaviors and their impact on effective message transmission:

- **Silence:** opportunity for the patient to interpret the meaning of the message and develop a meaningful response
- **Open-ended questions:** allow for a broader exploration of the patient's situation or concerns
- **Distance reduction:** the amount of physical space varies depending on culture and the nature of the interaction. *More information on physical space in the Communication Barriers section below.*
- **Restating and Clarification:** confirms accurate understanding of the patient's message throughout the dialogue; demonstrates to the patient the nurse is listening and is interested in the dialogue
- **Focusing:** create an environment where the dialogue can be understood clearly, eliminate distractions.
- **Summarizing:** at the end of a dialogue, share a summary of the patient's messages, their needs, concerns, and requests.
- **Collaboration:** encourage patients to be an active participant in their care by communicating needs and concerns, asking questions.
- **Honesty:** honesty and trust coexist. In order to achieve a trusting relationship, honesty and truth telling are required (Bok, 1999). Without honesty, there can be no trust. Additionally, veracity (the ethical principle known as truthfulness) is the foundation for earning another's trust. Pergert and Lutzen (2012) state truth-telling in healthcare is considered a universal

communicative virtue. It is important to identify the instances where truth telling is warranted, collaboration with the patient and family at the start of care is necessary.

- **Genuineness:** be yourself, authentic in your daily practice.
- **Respect:** one of the fundamental principles of nursing practice is respect for human dignity, as stated in the ANA (2015a) Code of Ethics, Provision 1: “The nurse practices with compassion and respect for the inherent dignity, worth, and unique attributes of every person” (p. 1).

Communication Tools

Nurses and physicians have different communication styles due to a variety of factors, one being their training. Nurses are educated to share more descriptive accounts of clinical situations compared to physicians who are trained to be more concise in their communication (O’Daniel & Rosenstein, 2008). In order to reduce this communication gap, standardized communication tools have been developed.

Situation-Background-Assessment-Recommendation Tool

In 2002, a group of physicians at Kaiser Permanente developed a communication tool called Situation-Background-Assessment-Recommendation (SBAR) (Sutcliffe, Lewton, & Rosenthal, 2004). The SBAR tool is widely used in healthcare organizations to provide a framework for nurse-physicians communication. The SBAR tool is especially useful in urgent situations when immediate attention and action is critical. The Institute for Healthcare Improvement (IHI, 2020) explains SBAR as follows:

S = Situation: a concise statement of the problem

B = Background: clinical background or context of the problem

A = Assessment: patient data shared, analysis and consideration of options

R = Recommendation: action requested, recommendations shared (para. 1)

O’Daniel and Rosenstein (2008) explains the use of the SBAR tool improves critical thinking for the person (nurse) initiating the communication. When using the SBAR tool, the individual (in this case nurses) needs to assess the problem holistically, then analyze the assessment data, suggest potential underlying causes of the problem, and finally, offer solutions. Using the SBAR tool, or other communication tools, nurses learn how to problem solve in a systematic, holistic way.

View the following video on SBAR:

https://youtu.be/aR-S8UUAG6Y

TeamSTEPPS®

Healthcare facilities have instituted formal approaches using models of care to improve communication, teamwork, and facilitate a more streamlined, and safer delivery of healthcare. The Agency for Healthcare Research and Quality (AHRQ, 2019), in collaboration with the Department of Defense, has created a teamwork system called Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS®).

TeamSTEPPS® is an evidence-based approach used to improve communication, safety, and teamwork skills. The TeamSTEPPS® model involves a series of training modules and integration of healthcare principles throughout all areas of the healthcare system (AHRQ, 2019). TeamSTEPPS® improves safety and the quality of care by:

- Producing highly effective medical teams that optimize the use of information, people, and resources.
- Increasing team awareness and clarifying team roles and responsibilities.
- Resolving conflicts and improving information sharing.
- Eliminating barriers to quality and safety (AHRQ, 2019, para. 2)

Clapper et al. (2018) found improved teamwork and communication knowledge as a result of the TeamSTEPPS® training. Parker et al. (2019) completed a review of 19 studies assessing the success and influence of TeamSTEPPS® in improving communication, reducing errors, and the impact on patient satisfaction. These studies were focused on outpatient clinic settings and the results of the review found a marked improvement in communication, decrease errors, and improvement in patient satisfaction.

Implementing new communication processes requires significant research, planning, administrative support and especially, buy-in from all employees. Shaw et al. (2012) writes about the importance of having a “change champion” on each unit, a critical player who supports innovation and change. Nurses are uniquely positioned to take this role because they are positioned at the center of the interprofessional team. Nurses must take the initiative to find gaps in the healthcare delivery process and actively seek out “change” solutions.

Targeted Solutions Tool® for Hand-Off Communication

Hand-off communication has been found to be a contributing factor to adverse events (Scott et al., 2017), wrong-site surgery, delay in treatment, falls, and medication errors (CRICO Strategies, 2015). The Joint Commission for Transforming Healthcare (JCTH, 2020b) has identified inadequate hand-off communication as a sentinel event in healthcare facilities.

The JCTH (2020b) defines hand-off as “a transfer and acceptance of patient care responsibility achieved through effective communication. It is a real- time process of passing patient- specific information from one caregiver to another or from one team of

caregivers to another for the purpose of ensuring the continuity and safety of the patient's care" (para. 2). The JCTH (2020) has identified an average of 4000 hand-offs each day in a typical teaching hospital. The opportunity for inadequate communication is vast.

The Joint Commission Resources

Since TJC (2010) required hospitals to implement standardized communication procedures for patient-centered care, they developed a variety of resources, tools, and protocols to assist with improving effective interprofessional communication skills. The following resources assist hospitals with breaking down communication barriers, including cultural, language, and diversity:

- Advancing Effective Communication, Cultural Compentence, and Patient- and Family- Centered Care: A Roadmap for Hospitals
- Hospitals, Language and Culture: A Snapshot of the Nation
- Exploring Cultural and Linguistic Services in the Nation's Hospitals: A Report of Findings
- One Size Does Not Fit All: Meeting the Health Care Needs of Diverse Populations

TJC (2017) also established a hand-off communication procedure as one of the National Patient Safety Goals in 2006, then in 2010 hand-off communication became a Provision of Care standard, as follows:

The organization's process for hand-off communication provides for the opportunity for discussion between the giver and receiver of patient information. Note: Such information may include the patient's condition, care, treatment, medications, services, and any recent or anticipated changes to any of these (The Joint Commission, 2017, para. 4).

The risk for inadequate discourse and miscommunication is vast, which led the JCTH (2020a) to create the Targeted Solutions Tool® (TST) to improve hand-off communication. The TST provides a framework for improving the effectiveness of communication when a patient moves from one setting to another within the organization or to the community. The TST has the following benefits:

- Increased patient, family, and staff satisfaction
- Successful patient transfers without "bounce back" (patients returning to previous unit)
- Improved safety (JCTH, 2020a)

Benjamin, Hargrave, and Nether (2016) implemented the TST in the Emergency Department to determine the rate of defective handoffs (a TST concept) and the factors that contributed to the handoff. Prior to implementing the TST, the defective handoff rate

was 29.9% (32 defective handoffs/107 handoffs). Sixty-nine percent of the contributing factors were uncovered:

- Inaccurate/incomplete information
- Ineffective methods for handoff
- No standardized procedures for handoff
- Lack of patient knowledge of the person initiating the handoff

After implementation of the TST, the defective handoff rate dropped 58% to 12.5% (13 defective handoffs/104 handoffs). As the defective handoff rate declined, the number of adverse events declined.

In a 2015 report, it is estimated that 30 percent of all malpractice claims in U.S. hospitals and medical practices were due to communication failures, resulting in 1,744 deaths and $1.7 billion in malpractice costs over five years (CRICO Strategies, 2015).

View the following video illustrating the breakdown of communication between physicians and patients:

https://youtu.be/trJ1DUaEIuk

Nurses can bridge this communication gap by identifying and reducing communication barriers within the healthcare team.

Family-Centered Rounds

Khan et al. (2018) implemented a family-centered communication program to reduce errors and improve communication. The outcome of the study reduced harmful medical errors and improved communication processes and family experiences. To view the report and a short video on the study and its outcomes visit **the publisher's website**.

Communication Barriers

Personal Barriers

Holmes, Wieman, and Bonn (2015) conducted a comprehensive review of the research on interprofessional communication and found a number of barriers led to miscommunication, including misunderstood motives, lack of confidence, poor

organization, and structural hierarchies. In addition to reduced health outcomes, Storlie (2015) found poor communication impacted not only the patient, but also the healthcare provider and the employer:

Older adults

- chronic elevated levels of stress
- hurt feelings
- delay of care
- dissatisfaction of care

Healthcare provider

- interpersonal conflicts
- health risks
- poor morale
- absenteeism
- burnout
- staff turnover

Employer

- reduced quality of care (leading to reduced reimbursement and a poor reputation)
- reduced patient satisfaction (leading to reduced reimbursement and a poor reputation)
- lower staff retention rates leading to increased cost for new hires (Storlie, 2015)

Barriers to communication may originate from the patient or nurse perspective, the physical environment, or the structure of the team dynamics. Nurses can often identify communication barriers among the patient and entire healthcare team and assist individuals on how to reduce miscommunication.

Patient-related barriers

- Preoccupation with pain, discomfort, worry
- Feelings of being judged, insecure, or defensiveness
- Confusion, too much information, complex messages
- Lack of privacy
- Physical barrier: sensory or cognitive deficits

Nurse-related barriers

- Concerned about agenda, heavy workload

- Making assumptions about patient motivations or needs
- Cultural stereotypes
- Insecurity about ability to help patient
- Poor listening/thinking about what to say next (Arnold & Boggs, 2019)

Nurses have an ethical responsibility to prevent personal issues from impacting professional communication (Arnold & Boggs, 2019). Incorporating self-awareness and reflection into practice can assist nurses with reducing communication barriers. Nurses may consider taking a brief "planning pause" before an interaction to remind oneself on the goal of the upcoming communication, to approach the interaction without bias, and consider how non-verbal behaviors may contradict the spoken word.

Interprofessional Communication

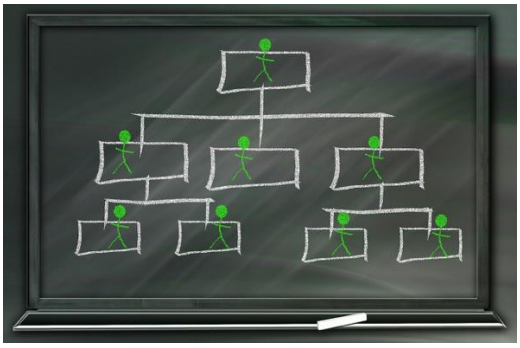
O'Daniel and Rosenstein (2008) list the following common barriers to interprofessional communication and collaboration:

- Personal values and expectations
- Personality differences
- Hierarchy
- Disruptive behavior
- Culture and ethnicity
- Generational differences
- Gender
- Historical interprofessional and intra-professional rivalries
- Differences in language and jargon
- Differences in schedules and professional routines
- Varying levels of preparation, qualifications, and status
- Differences in requirements, regulations, and norms of professional education
- Fears of diluted professional identity
- Differences in accountability, payment, and rewards
- Concerns regarding clinical responsibility
- Complexity of care
- Emphasis on rapid decision-making (para. 12)

Hierarchy

Hierarchy is defined as “the classification of a group of people according to ability or to economic, social, or professional standing” (Merriam-Webster, 2019). This definition applies to different units and professions throughout most healthcare organizations. Hierarchical relationships, such as nurse-physician, novice-to-senior nurse, or other relationships throughout the organization where levels of education, knowledge, or status vary.

Historically, nurses have held subservient roles in their everyday work with physicians. In these situations, physicians are in charge of all decision-making without nursing input leading to poorer quality of care. These hierarchical team structures, where physicians hold a senior position within the team, disempower nurses, resulting in a lack of confidence, fear of humiliation, and the feeling their knowledge and opinions are not valued. Nurses and physicians communicate differently, and while this diversity may offer valuable perspectives and a patient-centered care approach, the fast-paced, complex healthcare environment increases the occurrence of miscommunication (Foronda, MacWilliams, & McArthur, 2016).



Quality patient care is jeopardized when nurses are reluctant to communicate with physicians in order to avoid conflict and fear of repercussions (Gillespie, Chaboyer, Longbottom, and Wallis, 2010). Addressing this dangerous and unsafe communication barrier is crucial to improving communication and reaching optimum patient care outcomes.

Leadership must approach the negative consequences of a hierarchical team structure with a zero-tolerance policy. To reduce the negative aspects of hierarchy among the team, nurses need to discuss their fears and concerns with management, and together, come up with a plan for remediation. It is the nurse’s ethical responsibility to take action, to reduce the impact of hierarchical structures. By collaborating with management, nurses are taking an important step towards improving the delivery of safe, quality patient care.

The following interventions led to improved nurse-physician communication in the ICU setting:

- Daily goal sheet or form
- Bedside whiteboard

- Door communication card
- Team training
- Electronic SBAR documentation templates (Wang, Wan, Lin, Zhou, and Shang, 2017)

Effective listening and receiving unwavering support from management has also been found to reduce the negative impact of hierarchy between nurses and physicians (Lyndon, Zlatnik, & Wachter, 2011)

Interventions can be modified to apply to a variety of healthcare settings. Nurses need to assess gaps in communication at their workplace, take the initiative to find solutions and integrate them into practice. Creating unit or agency policies on the use of communication tools or interventions is a necessary step towards reducing the hierarchical structure of the team, leading to improved nurse-physician collaboration.

Implementation of the TeamSTEPPS® training program has been found to be a powerful tool in reducing hierarchy within an organization. The program provides employees with tools that empower them to voice their concerns, especially in clinical practice situations when patient safety is at risk. When employees are given opportunities to communicate in a safe way, without fear of repercussion or conflict, it minimizes the negative aspects of the hierarchical relationship (Clapper, 2018).

View the following video on nurse-physician communication:

https://youtu.be/BcC9YSTa8B8

Physical Barriers

Consider the ten major concepts of Nightingale's Environmental theory and how nurses automatically make adjustments to the patient's environment in order to aid in healing, health, improve mood, but also with communicating clearly and accurately with patients:

- Ventilation and warming
- Light and noise
- Cleanliness of the area
- Health of houses
- Bed and bedding
- Personal cleanliness
- Variety
- Offering hope and advice
- Food

- Observation (Pepetrin, 2016)

Assessing the patient's immediate environment is standard nursing practice, though it is important for the nurse to view the environment as a potential barrier to communication. Consider a patient with Chronic Obstructive Pulmonary Disease, with symptoms including shortness of breath, anxiety, restlessness, discouragement, pain, weakness, and activity intolerance. Patients with these symptoms may struggle with a number of environmental factors that could impact sending and receiving messages from others. Patients may struggle with bright or low lights; warm, still air; or a noisy environment.

Lowering the lights, turning on a fan or air conditioning, and reducing the number of visitors can improve comfort, reduce pain or discomfort, ultimately improving the patient's ability to concentrate on nurse-patient interactions and communication more easily.

Papastavrou, Andreou, Efstathiou (2014) found the following environmental barriers negatively impacted communication for stroke patients in an acute care setting:

Provider

- physical characteristics, such as their hearing or speech attitude about caring and respect

Physical environment

- assistive devices (call bell out of reach, lack of hearing aid)
- external sounds
- poor lighting, lack of large print

Hospital procedures

- lack of staff

While this list of barriers was found to be present in a stroke unit, many of them can apply to other units or settings.

Physical Space

DeVito (2016) identifies four ranges of interpersonal space for communication in the United States:

- Intimate relationships: touch to 18 inches
- Personal: 18 inches to 4 feet
- Social: 4-12 feet
- Public: 12-25 feet (p. 152-153)

Arnold and Boggs (2019) state therapeutic communication occurs at 3-4 feet, though more physical space is needed if a patient is anxious. In contrast, less than 3 feet is often used during a painful procedure or injury. Though a patient-centered approach is needed in all situations, assessing for patient preference can prevent miscommunication.

Gender

Men and women differ in many ways in respect to both verbal and non-verbal communication behaviors. Yang et al. (2016) found men tended to stand closer to those of the same gender compared to women. This means women tend to give more space to other women compared to men. Patients and coworkers will find it awkward to tell someone to move back though having the awareness that adequate space is essential for transmission of a message from one person to the other.

Another gender barrier to communication is verbal communication. How men and women speak can be judged incorrectly. Smith (n.d.) explains the differences in how men and women communicate in Table 1:

Table 1: Gender Differences in Communication

Women	**Men**
Talk about other people	Talk about tangible things like business, sports, food and drinks
Ask questions to gain an understanding	Talk to give information rather than asking questions
More likely to talk to other women when a problem or conflict arises	Known for dealing with problems or issues internally
Focus on feelings, senses and meaning. They rely on their intuition to find answers	Focus on facts, reason and logic. They find answers by analyzing and figuring things out
Disagreement affects many aspects of their relationship and may take a long time to resolve	Can argue or disagree and then move on quickly from the conflict

Jargon

Subramaniam et al. (2017) defines jargon as the language that is focused on a specific profession or group. Jargon is commonly used during communication by medical professionals, and those who are not familiar with these terms are excluded from the conversation. Examples include “frequent flyer”, “trainwreck” and “boyfriend”. How would a patient appreciate overhearing a nurse referring to someone as a trainwreck?

The use of slang is a more casual type of jargon that is not usually used in professional settings, though can occur among nurses and other staff. One popular term is “LOL”. As with jargon, those who do not use or know these terms are again excluded from the conversation.

One negative side of slang and jargon is they can have multiple meanings. Consider “LOL”, it can mean laugh out loud, lots of love, smiling, amusement, lots of luck, lots of love. While some of these meanings can apply to the same situation, one can see how the intended message can be lost when using a word or phrase with multiple meanings.

The best approach to effective communication is to follow best practices, as follows:

- know your audience
- reduce communication barriers
- monitor non-verbal behaviors and tone of voice
- speak clearly and assertively
- use professional terminology
- listen effectively

Interprofessional Collaboration

Healthcare has faced a vast number of challenges in delivery of quality care over the past 50 years. The population is older, more diverse, medically complex with a higher prevalence of chronic disease requiring multiple specialty providers, a greater reliance on technology and innovation, and uncoordinated delivery systems. Healthcare has also shifted towards delivering care to individuals with vast healthcare disparities (Institute of Medicine [IOM], 2003a). Collaborative practice can improve the delivery of care through a concerted effort from all members of the healthcare team and leaders through the organization.

In response to these challenges, collaborative practice environments are indispensable to improving safety and patient care indicators. Collaborative practice has been found to reduce the rate of complications and errors, reduce length of stay, and lower mortality rates. Collaboration also leads to reduce conflict among staff and reduced turnover. Additionally, collaborative practice strengthens health systems, improves family health, improves infectious disease, assists with humanitarian efforts, and improved response to epidemics and noncommunicable disease (World Health Organization [WHO], 2010).

Collaboration has become an essential component to implementing health promotion and disease prevention/management (Humphreys et al., 2012; Odum & Whaley-Connell, 2012). Due to the high rates of medical errors over the past several decades, interprofessional collaboration has emerged as a pragmatic intervention step that can reduce errors and improve care (Interprofessional Education Collaborative [IPEC], 2016)

Nurses and others healthcare professionals need to work together in order to address challenges that impede progress on improving safety and quality care. The IOM (2015) states, “No single profession, working alone, can meet the complex needs of patients and communities. Nurses should continue to develop skills and competencies in leadership and innovation and collaborate with other professionals in health care delivery and health system redesign” (p. 3).

Common Concept Definitions

- **Elements of Collaboration**

“Participants from different cultures, high level of interaction, mutual authority, sharing of resources” (Green & Johnson, 2015, p. 5)

- **Interprofessional collaborative practice (IPCP)**

“When multiple health workers from different professional backgrounds work together with patients, families, and communities to deliver the highest quality of care” (Green & Johnson, 2015; WHO, 2010).

- **Interdisciplinary collaboration (IDC)**

A team of healthcare practitioners who make a joint, consensus decision about patient care facilitated by regular, face-to-face meetings (Ivey, Brown, Teske, & Silverman, 1988).

Note: The difference between IPCP and IDC is the former can be applied to multiple categories of "patients" (individual patient and/or family, groups, and communities) whereas the latter is applied exclusively to the patient and/or family.

- **Interprofessional teamwork**

"The levels of cooperation, coordination and collaboration characterizing the relationships between professions in delivering patient-centered care" (IPEC, 2016, p. 8).

- **Interprofessional team-based care**
  "Care delivered by intentionally created, usually relatively small work groups in health care who are recognized by others as well as by themselves as having a collective identity and shared responsibility for a patient or group of patients (e.g., rapid response team, palliative care team, primary care team, and operating room team)" (IPEC, 2016, p. 8).
- **Interprofessional competencies in health care**
  "Integrated enactment of knowledge, skills, values, and attitudes that define working together across the professions, with other health care workers, and with patients, along with families and communities, as appropriate to improve health outcomes in specific care contexts" (IPEC, 2016, p. 8).

The Institute of Medicine (IOM, 2011) released a landmark report called, *The Future of Nursing: Leading Change, Advancing Health.* The report addressed the critical role of nurses in the delivery of healthcare and made three core recommendations: transforming nursing education, practice, and leadership. The report states nurses must become leaders at every level of the healthcare system in order to participate in ongoing healthcare reform. Leadership is key to becoming a full partner on the healthcare team, and to advocate for policy changes that assist with improving delivery of healthcare.

Additionally, the report found nurses are the best source of information about the patient, family, and communities though are largely excluded from decision-making. Nurses are left with carrying out orders that may or may not be safe, quality patient-

centered care. In order to be part of the decision-making process, the report suggests nurses lead through engaging all members of the healthcare team through interprofessional collaboration and mutual respect. The report offers two recommendations in the area of interprofessional collaboration:

Recommendation 2

Expand Opportunities for Nurses to Lead and Diffuse Collaborative Improvement Efforts

Recommendation 7

Prepare and Enable Nurses to Lead Change to Advance Health (IOM, 2011)

The IOM (2015) has followed up on these recommendations and has concluded nursing has made progress with providing quality, patient-centered, accessible, and affordable care, though continued efforts to meet the following recommendations are ongoing:

- Removing barriers to practice and care
- Transforming education
- Collaborating and leading
- Promoting diversity
- Improving data (IOM, 2015)

Benefits of Collaborative Practice

Today's complex healthcare environment has made it difficult for patients to access care, especially those with chronic disease who need access to a variety of specialty services. Patients need assistance with following prescribed orders and follow up appointments with multiple providers. Interprofessional collaboration has improved access to care, safety, chronic disease outcomes, and use of specialty care (Lemieux-Charles & McGuire, 2006; WHO, 2010).

Interprofessional collaboration offers nurses the opportunity to lead and influence change at multiple levels of care (national, regional, local patient settings). Nurses can have a voice in political activism through professional organizations or through academic/practice partnerships (Moss, Seifert, & O'Sullivan, 2016). Collaboration offers nurses the opportunity to serve on boards of directors, government committees, or advisory boards. Through collaboration efforts, nurses can fulfill their role in a variety of ways, with the overarching goal of redesigning the healthcare delivery system.

Through interprofessional collaboration, healthcare organizations can improve safety and quality through committee membership. Nurses can participate in committees that are unit- or organization-wide. Committees are formed based on improving safety and quality by using outcome data, such as preventing hospital-acquired infections, falls, and increased patient satisfaction. Additionally, committees may focus on the health

and well-being of staff, to reduce nurse turnover and burnout. Participating in committees benefits everyone, from the patient to the entire organization.

By joining committees, nurses have the opportunity to speak up and share their knowledge and expertise with the interprofessional team, management, and other stakeholders inside and outside of the organization. Interprofessional communication gives nurses a voice, allows them to become intimately involved in the decision-making process and creating solutions. Since nurses implement many of the solutions, nurses must share their insight to ensure the solution has a patient-centered approach. Interprofessional communication is the main way nurses can advocate for and uphold patient rights.

No committees at your workplace? Create one! Locate a problem area in your workplace or unit, research solutions, and present a plan to your manager. Chairing a committee is a good way to network with other professionals and it's an important part of your professional development as a professional nurse

Littlechild and Smith (2013) cite a wide range of healthcare benefits from interprofessional collaboration, including improved efficiency, higher levels of team responsiveness, creative skill sets, and the implementation of innovative holistic services. Several additional benefits of interprofessional collaboration as follows:

- Opportunity to learn new ways of thinking
- Network with professionals from different organizations
- Gain new knowledge, wisdom from others
- Access to additional resources previously unavailable
- Potential to develop new skill sets
- Increased productivity due to shared responsibility
- Access to funding, sharing of costs (research)
- Pooling of knowledge for solving large, complex problems (as cited in Green & Johnson, 2015)

Collaboration has enabled large-scale international organizations like the WHO to achieve more than previously thought possible because of the strength and support of

individual members working collectively for a common goal (Green & Johnson, 2015). Collaborations with large groups of professionals and international organizations (such as the WHO) occur throughout all areas of healthcare education, research, and practice. All three domains are connected; research informs education, which informs clinical practice and education. The table below shares some exemplars of successful interprofessional collaboration in healthcare.

Name	Purpose	Topic	Website
The Cochrane Collaboration	‘‘Cochrane is a global independent network of health practitioners, researchers, patient advocates and others, responding to the challenge of making the vast amounts of evidence generated through research useful for informing decisions about health.’’	Evidence	www.cochrane.org
U.S. Preventive Services Task Force	‘‘. . . the U.S. Preventive Services Task Force is an independent, volunteer panel of national experts in prevention and evidence-based medicine. The Task Force works to improve the health of all Americans by making evidence-based recommendations about clinical preventive services such as screenings, counseling services, and preventive medications.’’	Public Health	www.uspreventive servicestaskforce.org
Global Alliance for Musculoskeletal Health	‘‘. . . a national and international patient, professional, scientific organisations around the world . . . focused on health policy and evidence, with a mandate to develop strategies and set the agenda, aimed at improving quality of life for individuals around the world by implementing effective prevention and treatment through its unified voice and global reach’’	Clinical Practice	https://gmusc.com

Table 1: Exemplars of Successful Interprofessional Collaboration in Healthcare

The following TEDx Talks video discusses the role of collaborative practice in healthcare:

https://youtu.be/qOV-5h0FpAo

Joy Doll, the speaker in the video above, discusses six lessons (below) she learned through developing a collaborative practice initiative for a healthcare organization. Joy found these lessons were vital to successful, productive teamwork:

1. Grit: willingness to take on challenges
2. Don’t listen to “NO”
3. “Ego-up”, engage in meaningful activities that lead towards the goal
4. Psychological safety: speak up with confidence, without consequences
5. Define your culture:
    - everyone teaches, everyone learns

- assume positive intent of others

6. know yourself through self-assessment, reflection (i.e. strengths/weaknesses)

Joy reflects on the LEGO movie where leadership and collaboration are weaved into the storyline. To watch the LEGO movie, go to **this website**.

Cost of Reduced Collaboration

The lack of interprofessional collaboration prevents nurses from working to the full extent of their training and education. In order to improve practice, and assist with improving the delivery of healthcare, all nurses must be vested in improving and reducing the barriers of interprofessional collaboration (Moss et al., 2016).

Foundational Documents of Professional Practice

Interprofessional or interdisciplinary collaboration is an indispensable part of nursing practice. The American Nurses Association (ANA, 2015c) defines collaboration as "A professional healthcare partnership grounded in a reciprocal and respectful recognition and acceptance of . . ." (p. 86) the following:

- each partner's unique expertise, power, and sphere of influence and responsibilities
- the commonality of goals
- the mutual safeguarding of the legitimate interest of each party
- the advantages of such a relationship (p. 64)

Scope and Standards of Practice

The Scope and Standards of Practice, developed by the ANA (2015c), serves as a template for professional nursing practice for all registered nurses. Standard 10, Collaboration, states, "The registered nurse collaborates with the healthcare consumer and other key stakeholders in the conduct of nursing practice" (ANA, 2015c, p. 73). The following is a summary of the competencies of the Collaboration standard:

- Identifies the areas of expertise and contribution of other professionals and key stakeholders.
- Partners with the healthcare consumer and key stakeholders to advocate for and effect change, leading to positive outcomes and quality care.
- Uses effective group dynamics and strategies to enhance team performance.
- Promotes engagement through consensus building and conflict management

- Engages in teamwork and team-building processes (ANA, 2015c, p. 73)

Nursing's Scope of Practice is dynamic and is responsive to the changing needs of individuals and society as a whole. The nursing profession relies on all healthcare professionals to be actively involved in healthcare planning and decision-making, thus collaboration is at the core of all short- and long-term goals (ANA, 2015b). Healthcare professionals are expected to collaborate in the following ways:

- Sharing knowledge, techniques, and ideas about how to deliver and evaluate quality and outcomes in healthcare
- Sharing some functions/duties with others, and having a common focus on the overarching goal
- Recognizing the expertise of others within and outside the profession, referring patients to other providers as appropriate (ANA, 2015b)

The Code of Ethics

The Code of Ethics is an expression of the values, duties, and commitments of registered nurses. Provision 8 states, "The nurse collaborates with other health professionals and the public to protect human rights, promote health diplomacy, and reduce health disparities" (ANA, 2015a, p. 129). Provision 8 includes two interpretative statements:

8.2: Collaboration for Health Human Rights, and Health Diplomacy

- Nurses are committed to advancing health, welfare, and safety to all people, to individuals and globally. Some examples include world hunger, poverty or environmental pollution, and violation of human rights. Access and availability to quality healthcare services requires interdisciplinary planning and collaboration with partners, whether locally, state-wide, nationally, or globally (ANA, 2015a, p. 203).

8.3: Obligation to Advance Health and Human Rights and Reduce Disparities

- Through collaboration with community organizations, nurses can work individually or collectively, to assist with educating the public on current or future health threats. Nurses have a responsibility to work collaboratively with community agencies to assist the public with facilitating informed choice and identify situations that may contribute to illness, injury or disease. Lastly, the nurse needs to support initiatives that address barriers to healthcare, including the needs of the culturally diverse populations (ANA, 2015a, p. 204)

Provision 2 states, "The nurse's primary commitment is to the patient, whether an individual, family, group, community or population" (ANA, 2015a, p. 25). Interpretive statement 2.3, titled Collaboration, explains shared goal making is a concerted effort of individuals and groups. The complexity of the healthcare system requires nurses to work closely with the interdisciplinary team for safe, quality delivery of care.

Provision of safe, quality care at the community, national, and international levels can be accomplished through creation of community partnerships, political activism and substantial collaboration with all stakeholders. It is the nurse's ethical responsibility to consider collaboration in all aspects of nursing practice. Safe, quality care cannot be performed by one person, but together, with others, goals can be achieved. It is through communication and collaboration that nurses are able to provide the best possible care to their patients.

Nursing's Social Policy Statement

Nursing's social policy statement describes the value of the nursing profession within society, defines the concept of nursing, reviews the standards of practice, and regulation of nursing practice. The nursing practice is inherently connected to society, thus requiring a social contract between society and the profession (ANA, 2015b).

Collaborative efforts with other healthcare professionals are rooted in establishing effective trusting relationships, leading to partnerships where individuals begin to value each other's differences, similarities, experience, and knowledge.

BSN Essentials

Transforming practice to collaborative care environments required transformation of nursing education, as stated in the IOM (2011) report. The BSN Essentials contains nine curricular elements, called Essentials, which provide a framework for baccalaureate nursing education (American Association of Colleges of Nursing [AACN], 2008). Essential VI: Interprofessional Communication and Collaboration for Improving Patient Health Outcomes apples to interprofessional collaboration, as follows:

Communication and collaboration among healthcare professionals are critical to delivering high quality and safe patient care (AACN, 2008, p.3). Collaboration is based on the complementary interaction of the team member's roles. Understanding roles and perspectives are vital to collaboration. The following is a summary of the competencies of a BSN prepared nurse:

- Contribute the nursing perspective to optimize outcomes
- Develop and demonstrate team building and collaborative strategies
- Incorporate effective communication skills to improve team effectiveness
- Consider team member roles, responsibilities, and perspectives during decision-making (AACN, 2008)

Interprofessional Collaborative Practice Organizations

Interprofessional Education Collaborative

The IPEC (2016) was created in 2009 to develop core competencies for interprofessional collaborative practice. The original IPEC report was developed 2011, since revised in 2016, was developed through the initiative of six healthcare disciplines with the intent of defining core interprofessional competencies for their professions. The professions included dentistry, nursing, medicine, osteopathic medicine, pharmacy, and public health. After the release of the first IEC report, support from additional health professions and educational organizations ensued. The four core competencies for interprofessional collaborative practice are as follows:

Competency 1: Values/Ethics for Interprofessional Practice

- Work with individuals of other professions to maintain a climate of mutual respect and shared values.

Competency 2: Roles/Responsibilities

- Use the knowledge of one's own role and those of other professions to appropriately assess and address the health care needs of patients and to promote and advance the health of populations.

Competency 3: Interprofessional Communication

- Communicate with patients, families, communities, and professionals in health and other fields in a responsive and responsible manner that supports a team approach to the promotion and maintenance of health and the prevention and treatment of disease.

Competency 4: Teams and Teamwork

- Apply relationship-building values and the principles of team dynamics to perform effectively in different team roles to plan, deliver, and evaluate patient/population- centered care and population health programs and policies that are safe, timely, efficient, effective, and equitable (IPEC, 2016, p. 10)

While standardized forms of communications improve communication, integrating the constructs of teamwork, collaboration, and the awareness of each team member's roles is crucial to the success of interprofessional communication (IPEC, 2016).

Interprofessional Professionalism Collaborative

The Interprofessional Professionalism Collaborative (IPC, n.d.) was created to develop tools used by healthcare education organizations to assist with developing interprofessional professionalism behaviors within academic curriculum. In addition,

researchers us the tools developed by the IPC to advance interprofessional professionalism, a required element of interprofessional collaborative practice. The definition of interprofessional professionalism is as follows:

Consistent demonstration of core values evidenced by professionals working together, aspiring to and wisely applying principles of, altruism and caring, excellence, ethics, respect, communication, accountability to achieve optimal health and wellness in individuals and communities (Frost et al., 2019; Stern, 2006, p. 15).

The IPC (n.d.) has identified six core interprofessional behaviors:

1. **Communication**
    - Impart or interchange of thoughts, opinions or information by speech, writing, or signs; “the means through which professional behavior is enacted.” (Stern 2006)
2. **Respect**
    - “Demonstrate regard for another person with esteem, deference and dignity . . . personal commitment to honor other peoples’ choices and rights regarding themselves . . . includes a sensitivity and responsiveness to a person’s culture, gender, age and disabilities . . . the essence of humanism . . . signals the recognition of the worth of the individual human being and his or her belief and value system.” (Stern, 2006)
3. **Altruism and Caring**
    - Overt behavior that reflects concern, empathy, and consideration for the needs, values, welfare, and well-being of others and assumes the responsibility of placing the needs of the patients or client ahead of the professional interest (IPC, n.d., para. 4).
4. **Excellence**
    - Adherence to, exceeds, or adapts best practices to provide the highest quality care (IPC, n.d., para. 5).
5. **Ethics**
    - Consideration of a social, religious, or civil code of behavior in the moral fitness of a decision of course of action, especially those of a particular group, profession, or individual, as these apply to every day delivery of care (IPC, n.d., para.6).
6. **Accountability**
    - Accept the responsibility for the diverse roles, obligations, and actions, including self-regulations and other behaviors that positively influence patient and client outcomes, the profession, and the health needs of society (IPC, n.d., para. 7).

Nurses are engaged and motivated to provide the best possible care for their patients. Nurses use their knowledge and expertise to design patient-centered goals. In order to realize these goals, nurses must be leaders throughout the healthcare system, and engage others to participate and be vested in full collaboration with the patient's best interest in mind. Sherman (2015) states the following behaviors helps nurses influence others to foster interprofessional collaboration:

- **Establish your voice:** effective communication and listening skills, address concerns, be perceived as trustworthy
- **Expand networks:** develop relationships with others to form a joint vision
- **Shared accountability:** leads to a sense of community, joint decision-making
- **Empower others:** encourage others to speak up and act

WHO: Interprofessional Education & Collaborative Practice

WHO (2010) has created strategies to improve interprofessional education and collaborative practice to improve health outcomes globally. To make this initiative achievable, WHO has outlined a series of action items policymakers can use to improve their local healthcare systems.

WHO (2010) explains that the overall well-being of a country is centered on maternal and child health. Each day, 1500 women die from complications during pregnancy or childbirth worldwide. Healthcare workers who work together to identify the key strengths of each team member and use those strengths to improve the care of complex health issues, can improve these alarmingly high death rates. Maternal and child health is just one of many complex health problems within society that can be improved through collaborative work environments.

Acute care hospitals conduct morning meetings or interprofessional rounds to discuss care practices, plans, discharge. Nurses are uniquely positioned at the center of the interprofessional team to monitor information exchange between nursing, medicine, dietary, social work, unlicensed staff, and others. Team collaboration will be most effective when trained team members are fully vested in the organization and are experienced in working as a cohesive team

Developing core competencies is an expectation of all nurses. Seeking out professional development opportunities is an obligation as stated in the Code of Ethics. Provision 5,

interpretative statement 5.2 states, the nurse has the responsibility for professional growth and maintenance of competence (ANA, 2010a, p. 159).

Barriers and Promoters to Collaboration

Collaboration among healthcare professionals requires leadership and planning, common goals, and a "teamwork" atmosphere. The literature discussed below reviews an assortment of promoters (actions that enhance collaboration and teamwork) and barriers that impact the success of collaboration. The main take aways include a commitment to work together for a common goal, use of effective communication and collaboration skills, and the initiative to identify and resolve team conflicts.

Choi and Pak (2007) conducted a literature review to determine the promotors, barriers, and approaches to enhance interdisciplinary teamwork. The researchers discovered eight major concepts of teamwork and formulated them within the acronym "TEAMWORK."

See Table 2 for the promoters, barriers, and approaches for each concept are aligned to the acronym, including the "14 C's" for teamwork approaches.

Table 2: Promotors, Barriers, and Approaches for Interdisciplinary Teamwork

Strategy	Promoting Behaviors	Barriers	The 14 C's of Teamwork
T	Team		
	• good selection of team members • good team leaders • maturity and flexibility of team members	• poor selection of the disciplines and team members • poor process of team functioning	• Coordination of efforts • Conflict management
E	Enthusiasm		
	• personal commitment of team members	• lack of proper measures to evaluate success of interdisciplinary work • lack of guidelines for multiple authorship in research publications	• Commitment
A	Accessibility		
	• physical proximity of team members • Internet and email as a sup- porting platform	• language problems	• Cohesiveness • Collaboration
M	Motivation		
	• incentives	• insufficient time for the project	• Contribution

			• insufficient funding for the project	
W	Workplace			
		• institutional support and changes in the workplace	• institutional constraints	• Corporate support
O	Objectives			
		• a common goal and shared vision	• discipline conflicts	• Confronts problems directly
R	Role			
		• clarity and rotation of roles	• team conflicts	• Cooperation • Consensus decision-making • Consistency
K	Kinship			
		• communication among team members • constructive comments among team members	• lack of communication between disciplines • unequal power among disciplines	• Communication • Caring • Chemistry (personality, "good fit")

(Choi and Pak, 2007)

Similar to some of the above points, WHO (2010) has identified the following mechanisms that impact collaborative practice, including:

- Management support: need to identify and support change champions
- Initiative to change the culture of an organization, and oneself
- Individual's attitude towards collaboration

Hierarchical Team Structure

Lancaster, Kolakowsky-Hayner, Kovacich, and Greer-Williams (2015) found a lack of collaboration among physicians, nurses, and unlicensed personnel (UAP) due to hierarchical team structures. While some physicians acknowledged nurses' knowledge and expertise, the study revealed hierarchical, subservient relationships. Nurses and UAPs did not have meaningful discussions about patient needs or care, and physicians viewed themselves as the main decision-maker.

The hierarchical structure of healthcare teams must be addressed in order to improve collaboration and communication among the team members. If unresolved, hierarchy will lead to tension, misunderstandings, and conflicts, burdening the healthcare system with consistent poor outcomes and fragmentation of care.

See more information about hierarchy in the previous section on Communication

Nursing leadership has a responsibility to create environments where collaboration can transpire on a daily basis, with full, open participation from all members of the interprofessional team. Awareness of the barriers to collaboration, such as unequal power among disciplines (hierarchy), language conflicts, or lack of a “good fit” among team members gives rise to educational opportunities for the organization and/or nursing units. Nurses at all levels of care in the organization are responsible for addressing their personal educational gaps, and encourage the team to seek out competency training.

Awareness of team members’ roles assists with having accurate expectations of each other. Since nurses spend the greatest amount of time with patients, they are uniquely positioned to share an abundant amount of important information about the patient, thus, an assertive, effective communication style is warranted during collaborative meetings. Eliminating the hierarchy barriers is key to ensuring nurses have the confidence to speak up without fear of being reprimanded by physicians. advocating for patient needs, ensuring safe, quality care is provided requires an environment where information is shared freely and everyone’s voice is heard.

Tools and Frameworks to Improve Interprofessional Collaboration

Morgan, Pullon, and McKinlay (2015) conducted a review of the literature examining the elements of interprofessional collaboration in primary care settings. The overarching element to achieving and sustaining effective interprofessional collaboration was the opportunity to share frequent, informal communication among team members. Continuous sharing of information led to an interprofessional collaborative practice, where knowledge is shared and created among the team members, leading to development of shared goals and joint decision-making. Two key facilitators to interprofessional collaboration are the availability of a joint meeting time to communicate and having adequate physical space.

See the previous chapter on Communication for information on TeamSTEPPS®, an evidence-based tool designed to improve patient safety and quality though improved communication and collaboration.

In Week 4, Leadership in Nursing, discussion about the Healthy Work Environment Model (HWEM), created by the American Association of Critical Care Nurses (AACN, 2016), incorporates *True Collaboration* as one of the six core standards. The *True Collaboration* standard states nurses must be relentless in pursuing collaboration.

Successful collaboration is highly valued and a necessity in today’s healthcare environment. Experts suggest the daunting process of building a culture of collaboration within an organization is well worth the effort and an indispensable part of success (Adler, Heckscher, & Prusak, 2011).

Chapter 4: Leadership in Quality Management and Safety

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 centered 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).

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).

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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Chapter 5: Organizational Culture

Organizational Culture

Essential Questions:

1. What are identifiable elements of culture in an organization?
2. What are different types of organizational cultures that an employee might encounter?
3. How is organizational culture created?
4. How is organizational culture maintained?

What Is Organizational Culture?

Organizational culture refers to a system of shared assumptions, values, and beliefs that show people what is appropriate and inappropriate behavior (Chatman & Eunyoung, 2003; Kerr & Slocum, 2005). These values have a strong influence on employee behavior as well as organizational performance. In fact, the term organizational culture was made popular in the 1980s when Peters and Waterman's best-selling book *In Search of Excellence* made the argument that company success could be attributed to an organizational culture that was decisive, customer-oriented, empowering, and people-oriented. Since then, organizational culture has become the subject of numerous research studies, books, and articles. Organizational culture is still a relatively new concept. In contrast to a topic such as leadership, which has a history spanning several centuries, organizational culture is a young but fast-growing area within management.

Culture is largely invisible to individuals just as the sea is invisible to the fish swimming in it. Even though it affects all employee behaviors, thinking, and behavioral patterns, individuals tend to become more aware of their organization's culture when they have the opportunity to compare it to other organizations. It is related to the second of the three facets that compose the function of organizing. The organizing function involves creating and implementing organizational design decisions. The culture of the organization is closely linked to organizational design. For instance, a culture that empowers employees to make decisions could prove extremely resistant to a centralized organizational design, hampering the manager's ability to enact such a design. However, a culture that supports the organizational structure (and vice versa) can be very powerful.

Why Does Organizational Culture Matter?

An organization's culture may be one of its strongest assets or its biggest liability. In fact, it has been argued that organizations that have a rare and hard-to-imitate culture enjoy a competitive advantage (Barney, 1986). In a survey conducted by the management consulting firm Bain & Company in 2007, worldwide business leaders identified corporate culture to be as important as corporate strategy for business success.[1] This comes as no surprise to leaders of successful businesses, who are quick to attribute their company's success to their organization's culture.

Culture, or shared values within the organization, may be related to increased performance. Researchers found a relationship between organizational cultures and company performance, with respect to success indicators such as revenues, sales volume, market share, and stock prices (Kotter & Heskett, 1992; Marcoulides & heck, 1993). At the same time, it is important to have a culture that fits with the demands of the company's environment. To the extent that shared values are proper for the company in question, company performance may benefit from culture (Arogyaswamy & Byles, 1987). For example, if a company is in the high-tech industry, having a culture that encourages innovativeness and adaptability will support its performance. However, if a company in the same industry has a culture characterized by stability, a high respect for tradition, and a strong preference for upholding rules and procedures, the company may suffer because of its culture. In other words, just as having the "right" culture may be a competitive advantage for an organization, having the "wrong" culture may lead to performance difficulties, may be responsible for organizational failure, and may act as a barrier preventing the company from changing and taking risks.

In addition to having implications for organizational performance, *organizational culture is an effective control mechanism dictating employee behavior*. Culture is a more powerful way of controlling and managing employee behaviors than organizational rules and regulations. For example, when a company is trying to improve the quality of its customer service, rules may not be helpful, particularly when the problems customers present are unique. Instead, creating a culture of customer service may achieve better results by encouraging employees to think like customers, knowing that the company priorities in this case are clear: Keeping the customer happy is preferable to other concerns, such as saving the cost of a refund. Therefore, the ability to understand and influence organizational culture is an important item for managers to have in their tool kit when they

are carrying out their controlling P-O-L-C function as well as their organizing function.

Levels of Organizational Culture

Three Levels of Organizational Culture

Adapted from Schein, E. H. (1992). Organizational Culture and Leadership. San Francisco: Jossey-Bass

Organizational culture consists of some aspects that are relatively more visible, as well as aspects that may lie below one's conscious awareness. Organizational culture can be thought of as consisting of three interrelated levels (Schein, 1992).

At the deepest level, below our awareness, lie basic **assumptions** (Figure 1). These assumptions are taken for granted and reflect beliefs about human nature and reality. At the second level, **values** exist. Values are shared principles, standards, and goals. Finally, at the surface, we have **artifacts**, or visible, tangible aspects of organizational culture. For example, in an organization, a basic assumption employees and managers share might be that happy employees benefit their organizations. This might be translated into values such as egalitarianism, high-quality relationships, and having fun. The artifacts reflecting such values might be an executive "open door" policy, an office layout that includes open spaces and gathering areas equipped with pool tables, and frequent company picnics.

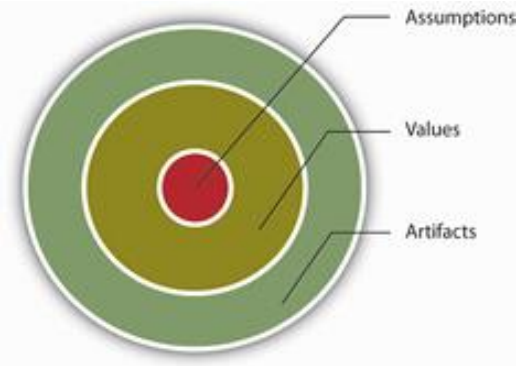

Figure 1: Adapted from Schein, E. H. (1992). Organizational Culture and Leadership. San Francisco: Jossey-Bass.

Understanding the organization's culture may start from observing its artifacts: its physical environment, employee interactions, company policies, reward systems, and other observable characteristics. When you are interviewing for a position, observing the physical environment, how people dress, where they relax, and how they talk to others is definitely a good start to understanding the company's culture. However, simply looking at these tangible aspects is unlikely to give a full picture of the organization, since an important chunk of what makes up culture exists below one's degree of awareness. The values and, deeper, the assumptions that shape the organization's culture can be uncovered by observing how employees interact and the choices they make, as well as by inquiring about their beliefs and perceptions regarding what is right and appropriate behavior.

Key Takeaway

Organizational culture is a system of shared assumptions, values, and beliefs that helps individuals understand which behaviors are and are not appropriate within an organization. Cultures can be a source of competitive advantage for organizations. Strong organizational cultures can be an organizing as well as a controlling mechanism for organizations. And finally, organizational culture consists of three levels: assumptions that are below the surface, values, and artifacts.

Source: Why culture can mean life or death for your organization. (September, 2007). HR Focus, 84, 9.

Measuring Organizational Culture

Dimensions of Culture

Which values characterize an organization's culture? Even though culture may not be immediately observable, identifying a set of values that might be used to describe an organization's culture helps us identify, measure, and manage culture more effectively. For this purpose, several researchers have proposed various culture typologies. One typology that has received a lot of research attention is the Organizational Culture Profile (OCP) where culture is represented by seven distinct values (Chatman & Jehn, 1991; O'Reilly, et. al., 1991) (Figure 2).

Figure 2: Dimensions of Organizational Culture Profile (OCP). Adapted from information in O'Reilly, C. A., III, Chatman, J. A., & Caldwell, D. F. (1991). People and organizational culture: A profile comparison approach to assessing person-organization fit. Academy of Management Journal, 34, 487–516.

Innovative Cultures

According to the OCP framework, companies that have **innovative cultures** are flexible, adaptable, and experiment with new ideas. These companies are characterized by a flat hierarchy and titles and other status distinctions tend to be downplayed. For example, W. L. Gore & Associates is a company with innovative products such as GORE-TEX® (the breathable fabric that is windproof and waterproof), Glade dental floss, and Elixir guitar strings, earning the company the distinction as the most innovative company in the United States by *Fast Company* magazine in 2004. W. L. Gore consistently manages to innovate and capture the majority of market share in a wide variety of industries, in large part because of its unique culture. In this company, employees do not have bosses in the traditional sense, and risk taking is encouraged by celebrating failures as well as successes (Deutschman, 2004). Companies such as W. L. Gore, Genentech, and Google also encourage their employees to take risks by allowing engineers to devote 20% of their time to projects of their own choosing.

Aggressive Cultures

Companies with **aggressive cultures** value competitiveness and outperforming competitors; by emphasizing this, they often fall short in corporate social responsibility. For example, Microsoft is often identified as a company with an aggressive culture. The company has faced a number of antitrust lawsuits and disputes with competitors over the years. In aggressive companies, people may use language such as “we will kill our competition.” In the past, Microsoft executives made statements such as “we are going to cut off Netscape’s air supply…Everything they are selling, we are going to give away,” and its aggressive culture is cited as a reason for getting into new legal troubles before old ones are resolved (Greene, et. al., 2004; Schlender, 1998) (Figure 3).

Figure 3: Microsoft, the company that Bill Gates co-founded, has been described as having an aggressive culture. IsaacMao – Bill Gates world’s most “spammed” person – CC BY 2.0

Outcome-Oriented Cultures

The OCP framework describes **outcome-oriented cultures** as those that emphasize achievement, results, and action as important values. A good example of an outcome-oriented culture may be the electronics retailer Best Buy. Having a culture emphasizing sales performance, Best Buy tallies revenues and other relevant figures daily by department. Employees are trained and mentored to sell company products effectively, and they learn how much money their department made every day (Copeland, 2004). In 2005, the company implemented a Results Oriented Work Environment (ROWE) program that allows employees to work anywhere and anytime; they are evaluated based on results and fulfillment of clearly outlined objectives (Thompson, 2005). Outcome-oriented cultures hold employees as well as

managers accountable for success and use systems that reward employee and group output. In these companies, it is more common to see rewards tied to performance indicators as opposed to seniority or loyalty. Research indicates that organizations that have a performance-oriented culture tend to outperform companies that are lacking such a culture (Nohria, et. al., 2003). At the same time, when performance pressures lead to a culture where unethical behaviors become the norm, individuals see their peers as rivals, and short-term results are rewarded, the resulting unhealthy work environment serves as a liability (Probst & Raisch, 2005).

Stable Cultures

Stable cultures are predictable, rule-oriented, and bureaucratic. When the environment is stable and certain, these cultures may help the organization to be effective by providing stable and constant levels of output (Westrum, 2004). These cultures prevent quick action and, as a result, may be a misfit to a changing and dynamic environment. Public sector institutions may be viewed as stable cultures. In the private sector, Kraft Foods is an example of a company with centralized decision making and rule orientation that suffered as a result of the culture-environment mismatch (Thompson, 2006). Its bureaucratic culture is blamed for killing good ideas in early stages and preventing the company from innovating. When the company started a change program to increase the agility of its culture, one of its first actions was to fight bureaucracy with more bureaucracy: The new position of vice president of “business process simplification” was created but was later eliminated (Boyle, 2004; Thompson, 2005; Thompson, 2006).

People-Oriented Cultures

People-oriented cultures value fairness, supportiveness, and respecting individual rights. In these organizations, there is a greater emphasis on and expectation of treating people with respect and dignity (Erdogan, et. al., 2006). One study of new employees in accounting companies found that employees, on average, stayed 14 months longer in companies with people-oriented cultures (Sheridan, 1992). Starbucks is an example of a people-oriented culture. The company pays employees above minimum wage, offers health care and tuition reimbursement benefits to its part-time as well as full-time employees, and has creative perks such as weekly free coffee for all

associates. As a result of these policies, the company benefits from a turnover rate lower than the industry average (Weber, 2005).

Team-Oriented Cultures

Companies with a**team-oriented culture** are collaborative and emphasize cooperation among employees. For example, Southwest Airlines facilitates a team-oriented culture by cross-training its employees so that they are capable of helping one another when needed. The company also emphasizes training intact work teams (Bolino & Turnley, 2003). In Southwest's selection process, applicants who are not viewed as team players are not hired as employees (Miles & Mangold, 2005) (Figure 4). In team-oriented organizations, members tend to have more positive relationships with their coworkers and particularly with their managers (Erdogan, et. al., 2006).

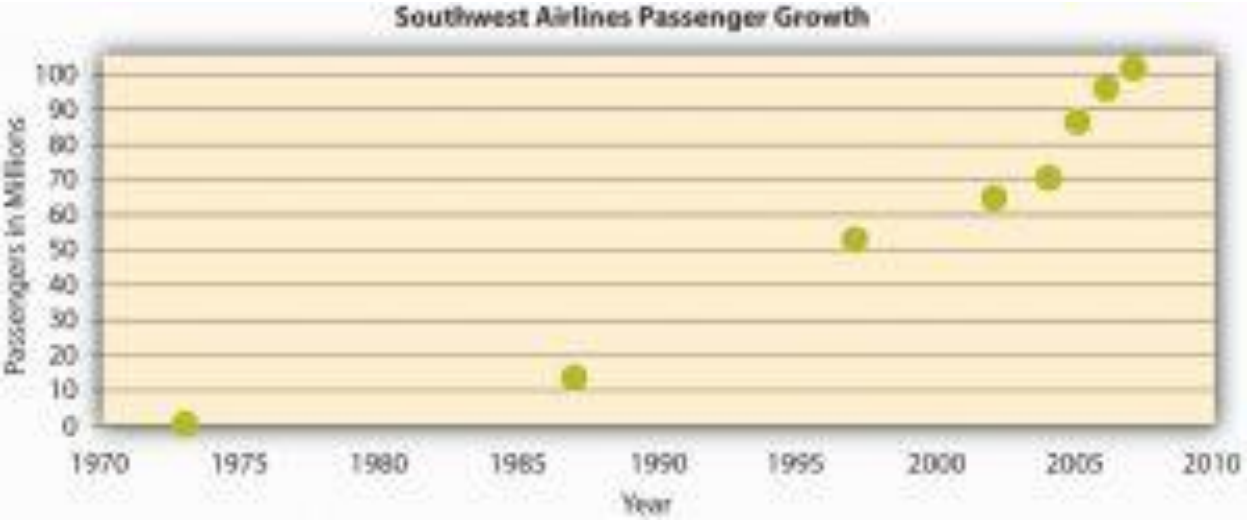

Figure 4: The growth in the number of passengers flying with Southwest Airlines from 1973 until 2007 when Southwest surpassed American Airlines as the most flown U.S. airline. While price has played a role in this, their emphasis on service has been a key piece of their culture and competitive advantage. Adapted from http://upload.wikimedia.org/wikipedia/commons/6/69/Southwest-airlines-passengers.jpg

Detail-Oriented Cultures

Remember that, in the end, culture is really about people.

Organizations with a **detail-oriented culture** are characterized in the OCP framework as emphasizing precision and paying attention to details. Such a culture gives a competitive advantage to companies in the hospitality industry

by helping them differentiate themselves from others. For example, Four Seasons and Ritz Carlton are among hotels who keep records of all customer requests such as which newspaper the guest prefers or what type of pillow the customer uses. This information is put into a computer system and used to provide better service to returning customers. Any requests hotel employees receive, as well as overhear, might be entered into the database to serve customers better (Figure 5).

Figure 5: Chris Jones – Culture in the UK – CC BY-NC 2.0.

Strength of Culture

A **strong culture** is one that is shared by organizational members (Figure 6)(Arogyaswamy & Byles, 1987; Chatman & Eunyoung, 2003) — that is, a culture in which most employees in the organization show consensus regarding the values of the company. The stronger a company's culture, the more likely it is to affect the way employees think and behave. For example, cultural values emphasizing customer service will lead to higher-quality customer service if there is widespread agreement among employees on the importance of customer-service-related values (Schneider, et. al., 2002).

Figure 6: Walt Disney created a strong culture at his company that has evolved since its founding in 1923.

It is important to realize that a strong culture may act as an asset or a liability for the organization, depending on the types of values that are shared. For example, imagine a company with a culture that is strongly outcome-oriented. If this value system matches the organizational environment, the company may perform well and outperform its competitors. This is an asset as long as members are behaving ethically. However, a strong outcome-oriented culture coupled with unethical behaviors and an obsession with quantitative performance indicators may be detrimental to an organization's effectiveness. Enron is an extreme example of this dysfunctional type of strong culture.

One limitation of a strong culture is the difficulty of changing it. In an organization where certain values are widely shared, if the organization decides to adopt a different set of values, unlearning the old values and learning the new ones will be a challenge because employees will need to adopt new ways of thinking, behaving, and responding to critical events. For example, Home Depot had a decentralized, autonomous culture where many business decisions were made using "gut feeling" while ignoring the available data. When Robert Nardelli became CEO of the company in 2000, he decided to change its culture starting with centralizing many of the decisions that were previously left to individual stores. This initiative met with substantial resistance, and many high-level employees left during Nardelli's first year. Despite getting financial results such as doubling the sales of the company, many of the changes he made were criticized. He left the company in January 2007 (Charan, 2006; Herman & Wernle, 2007).

A strong culture may also be a liability during a merger. During mergers and acquisitions, companies inevitably experience a clash of cultures, as well as a clash of structures and operating systems. Culture clash becomes more

problematic if both parties have unique and strong cultures. For example, during the merger of Daimler-Benz with Chrysler to create DaimlerChrysler, the differing strong cultures of each company acted as a barrier to effective integration. Daimler had a strong engineering culture that was more hierarchical and emphasized routinely working long hours. Daimler employees were used to being part of an elite organization, evidenced by flying first class on all business trips. However, Chrysler had a sales culture where employees and managers were used to autonomy, working shorter hours, and adhering to budget limits that meant only the elite flew first class. The different ways of thinking and behaving in these two companies introduced a number of unanticipated problems during the integration process (Badrtalei & Bates, 2007; Bower, 2001).

Do Organizations Have a Single Culture?

So far, we have assumed that a company has a single culture that is shared throughout the organization. In reality there might be multiple cultures within the organization. For example, people working on the sales floor may experience a different culture from that experienced by people working in the warehouse. Cultures that emerge within different departments, branches, or geographic locations are called **subcultures**. Subcultures may arise from the personal characteristics of employees and managers, as well as the different conditions under which work is performed. In addition to understanding the broader organization's values, managers will need to make an effort to understand subculture values to see their effect on workforce behavior and attitudes.

Sometimes, a subculture may take the form of a **counterculture.** Defined as shared values and beliefs that are in direct opposition to the values of the broader organizational culture (Kerr, et. al., 2005), countercultures are often shaped around a charismatic leader. For example, within a largely bureaucratic organization, an enclave of innovativeness and risk taking may emerge within a single department. A counterculture may be tolerated by the organization as long as it is bringing in results and contributing positively to the effectiveness of the organization. However, its existence may be perceived as a threat to the broader organizational culture. In some cases, this may lead to actions that would take away the autonomy of the managers and eliminate the counterculture.

Key Takeaway

Culture can be understood in terms of seven different culture dimensions, depending on what is most emphasized within the organization. For example, innovative cultures are flexible, adaptable, and experiment with new ideas, while stable cultures are predictable, rule-oriented, and bureaucratic. Strong cultures can be an asset or liability for an organization but can be challenging to change. Multiple cultures may coexist in a single organization in the form of subcultures and countercultures.

Creating and Maintaining Organizational Culture

How are cultures created? Where do cultures come from? Understanding this question is important in understanding how they can be changed. An organization's culture is shaped as the organization faces external and internal challenges and learns how to deal with them (Figure 7). When the organization's way of doing business provides a successful adaptation to environmental challenges and ensures success, those values are retained. These values and ways of doing business are taught to new members as *the*way to do business (Schein, 1992). The factors that are most important in the creation of an organization's culture include founders' values, preferences, and industry demands.

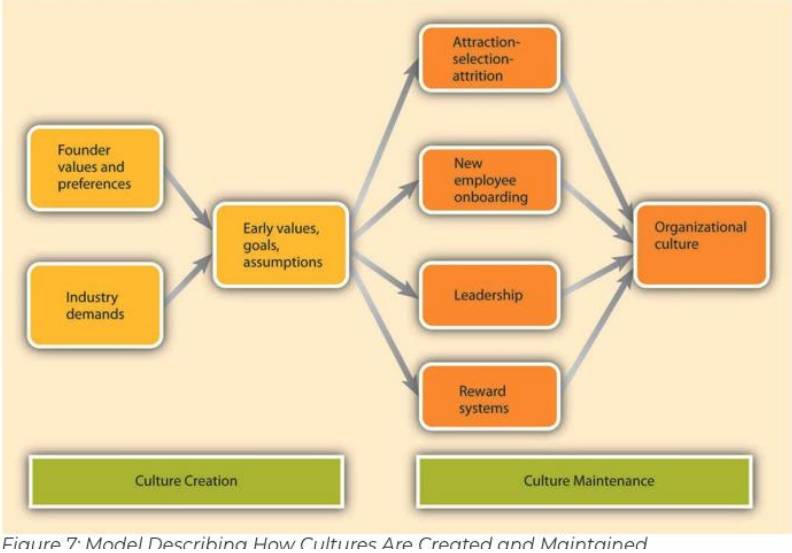

Figure 7: Model Describing How Cultures Are Created and Maintained.

Founder Values

A company's culture, particularly during its early years, is inevitably tied to the personality, background, and values of its founder or founders, as well as their vision for the future of the organization. When entrepreneurs establish their own businesses, the way they want to do business determines the organization's rules, the structure set up in the company, and the people they hire to work with them. For example, some of the existing corporate values of the ice cream company Ben & Jerry's Homemade Holdings Inc. can easily be traced to the personalities of its founders Ben Cohen and Jerry Greenfield (Figure 8). In 1978, the two high school friends opened up their first ice-cream shop in a renovated gas station in Burlington, Vermont. Their strong social convictions led them to buy only from the local farmers and devote a certain percentage of their profits to charities. The core values they instilled in their business can still be observed in the current company's devotion to social activism and sustainability, its continuous contributions to charities, use of environmentally friendly materials, and dedication to creating jobs in low-income areas. Even though Unilever acquired the company in 2000, the social activism component remains unchanged and Unilever has expressed its commitment to maintaining it (Kiger, 2005; Rubis, et. al., 2005; Smalley, 2007).

Figure 8: Ben & Jerry's has locations around the world, including this store in Singapore.

Founder values become part of the corporate culture to the degree to which they help the company be successful. For example, the social activism of Ben and Jerry's was instilled in the company because the founders strongly believed in these issues. However, these values probably would not be surviving 3 decades later if they had not helped the company in its initial stages. In the case of Ben and Jerry's, these values helped distinguish their brand from larger corporate brands and attracted a loyal customer base.

Thus, by providing a competitive advantage, these values were retained as part of the corporate culture and were taught to new members as the right way to do business.

Industry Demands

While founders undoubtedly exert a powerful influence over corporate cultures, the industry characteristics also play a role. Companies within the same industry can sometimes have widely differing cultures. At the same time, the industry characteristics and demands act as a force to create similarities among organizational cultures. For example, despite some differences, many companies in the insurance and banking industries are stable and rule-oriented, many companies in the high-tech industry have innovative cultures, and those in nonprofit industry may be people-oriented. If the industry is one with a large number of regulatory requirements — for example, banking, health care, and high-reliability (such as nuclear power plant) industries — then we might expect the presence of a large number of rules and regulations, a bureaucratic company structure, and a stable culture. The industry influence over culture is also important to know because this shows that it may not be possible to imitate the culture of a company in a different industry, even though it may seem admirable to outsiders.

How Are Cultures Maintained?

As a company matures, its cultural values are refined and strengthened. The early values of a company's culture exert influence over its future values. It is possible to think of organizational culture as an organism that protects itself from external forces. Organizational culture determines what types of people are hired by an organization and what types of people are left out. Moreover, once new employees are hired, the company assimilates new employees and teaches them the way things are done in the organization. We call these processes *attraction-selection-attrition* and *onboarding processes*. We will also examine the role of *leaders* and *reward systems* in shaping and maintaining an organization's culture.

Attraction-Selection-Attrition

Organizational culture is maintained through a process known as attraction-selection-attrition (ASA). First, employees are *attracted* to organizations where they will fit in. Someone who has a competitive nature may feel comfortable in and may prefer to work in a company where interpersonal competition is the norm. Others may prefer to work in a team-oriented workplace. Research shows that employees with different personality traits find different cultures attractive. For example, out of the Big Five personality traits, employees who demonstrate neurotic personalities were less likely to be attracted to innovative cultures, whereas those who had openness to experience were more likely to be attracted to innovative cultures (Judge & Cable, 1997).

Of course, this process is imperfect, and value similarity is only one reason a candidate might be attracted to a company. There may be other, more powerful attractions such as good benefits. At this point in the process, the second component of the ASA framework prevents them from getting in: *selection*. Just as candidates are looking for places where they will fit in, companies are also looking for people who will fit into their current corporate culture. Many companies are hiring people for fit with their culture, as opposed to fit with a certain job. For example, Southwest Airlines prides itself for hiring employees based on personality and attitude rather than specific job-related skills, which they learn after they are hired. Companies use different techniques to weed out candidates who do not fit with corporate values. For example, Google relies on multiple interviews with future peers. By introducing the candidate to several future coworkers and learning what these coworkers think of the candidate, it becomes easier to assess the level of fit.

Even after a company selects people for person-organization fit, there may be new employees who do not fit in. Some candidates may be skillful in impressing recruiters and signal high levels of culture fit even though they do not necessarily share the company's values. In any event, the organization is eventually going to eliminate candidates eventually who do not fit in through *attrition*. Attrition refers to the natural process where the candidates who do not fit in will leave the company. Research indicates that person-organization misfit is one of the important reasons for employee turnover (Kristof-Brown, et. al., 2005; O'Reilly, et. al., 1991).

Because of the ASA process, the company attracts, selects, and retains people who share its core values, whereas those people who are different in core values will be excluded from the organization either during the hiring

process or later on through naturally occurring turnover. Thus, organizational culture will act as a self-defending organism where intrusive elements are kept out. Supporting the existence of such self-protective mechanisms, research shows that organizations demonstrate a certain level of homogeneity regarding personalities and values of organizational members (Giberson, et. al., 2005).

New Employee Onboarding

Another way in which an organization's values, norms, and behavioral patterns are transmitted to employees is through **onboarding** (also referred to as the *organizational socialization process*). Onboarding refers to the process through which new employees learn the attitudes, knowledge, skills, and behaviors required to function effectively within an organization. If an organization can successfully socialize new employees into becoming organizational insiders, new employees will feel accepted by their peers and confident regarding their ability to perform; they will also understand and share the assumptions, norms, and values that are part of the organization's culture. This understanding and confidence in turn translate into more effective new employees who perform better and have higher job satisfaction, stronger organizational commitment, and longer tenure within the company (Bauer, et. al., 2007). Organizations engage in different activities to facilitate onboarding, such as implementing orientation programs or matching new employees with mentors.

What Can Employees Do During Onboarding?

New employees who are proactive, seek feedback, and build strong relationships tend to be more successful than those who do not (Bauer & Green, 1998; Kammeyer-Mueller & Wanberg, 2003; Wanberg & Kammeyer-Mueller, 2000). For example, *feedback seeking* helps new employees. Especially on a first job, a new employee can make mistakes or gaffes and may find it hard to understand and interpret the ambiguous reactions of coworkers. By actively seeking feedback, new employees may find out sooner rather than later any behaviors that need to be changed and gain a better understanding of whether their behavior fits with the company culture and expectations.

Relationship building or *networking* (a facet of the organizing function) is another important behavior new employees may demonstrate. Particularly when a company does not have a systematic approach to onboarding, it becomes more important for new employees to facilitate their own onboarding by actively building relationships. According to one estimate, 35% of managers who start a new job fail in the new job and either voluntarily leave or are fired within one and a half years. Of these, over 60% report not being able to form effective relationships with colleagues as the primary reason for this failure (Fisher, 2005).

What Can Organizations Do During Onboarding?

Many organizations, including Microsoft, Kellogg Company, and Bank of America take a more structured and systematic approach to new employee onboarding, while others follow a "sink or swim" approach where new employees struggle to figure out what is expected of them and what the norms are.

A **formal orientation program** indoctrinates new employees to the company culture, as well as introducing them to their new jobs and colleagues. An orientation program has a role in making new employees feel welcome in addition to imparting information that may help them be successful in their new jobs. Many large organizations have formal orientation programs consisting of lectures, videotapes, and written material, while some may follow more informal approaches. According to one estimate, most orientations last anywhere from one to five days, and some companies are currently switching to a computer-based orientation. Ritz Carlton, the company ranked number 1 in *Training* magazine's 2007 top 125 list, uses a very systematic approach to employee orientation and views orientation as the key to retention. In the 2-day classroom orientation, employees spend time with management, dine in the hotel's finest restaurant, and witness the attention to customer service detail firsthand. During these two days, they are introduced to the company's intensive service standards, team orientation, and its own language. Later, on their 21st day they are tested on the company's service standards and are certified (Durett, 2006; Elswick, 2000). Research shows that formal orientation programs are helpful in teaching employees about the goals and history of the company, as well as communicating the power structure. Moreover, these programs may also help with a new employee's integration to the team. However, these benefits may not be realized to the same extent in computer-based orientations. In fact, compared to those taking part in a regular, face-to-

face orientation, those undergoing a computer-based orientation were shown to have lower understanding of their job and the company, indicating that different formats of orientations may not substitute for each other (Klein & Weaver, 2000; Moscato, 2005; Wesson & Gogus, 2005).

What Can Organizational Insiders Do During Onboarding?

One of the most important ways in which organizations can help new employees adjust to a company and a new job is through *organizational insiders* — namely, supervisors, coworkers, and mentors. Leaders have a key influence over onboarding and the information and support they provide determine how quickly employees learn about the company politics and culture, while coworker influence determines the degree to which employees adjust to their teams. **Mentors** can be crucial to helping new employees adjust by teaching them the ropes of their jobs and how the company really operates. A mentor is a trusted person who provides an employee with advice and support regarding career-related matters. Although a mentor can be any employee or manager who has insights that are valuable to the new employee, mentors tend to be relatively more experienced than their protégés. Mentoring can occur naturally between two interested individuals or organizations can facilitate this process by having formal mentoring programs. These programs may successfully bring together mentors and protégés who would not come together otherwise. Research indicates that the existence of these programs does not guarantee their success, and there are certain program characteristics that may make these programs more effective. For example, when mentors and protégés feel that they had input in the mentor-protégé matching process, they tend to be more satisfied with the arrangement. Moreover, when mentors receive training beforehand, the outcomes of the program tend to be more positive (Allen, et. al., 2006). Because mentors may help new employees interpret and understand the company's culture, organizations may benefit from selecting mentors who personify the company's values. Thus, organizations may need to design these programs carefully to increase their chance of success.

Leadership

Leaders are instrumental in creating and changing an organization's culture. There is a direct correspondence between the leader's style and an organization's culture. For example, when leaders motivate employees through inspiration, corporate culture tends to be more supportive and people-oriented. When leaders motivate by making rewards contingent on performance, the corporate culture tended to be more performance-oriented and competitive (Sarros, et. al., 2002). In these and many other ways, what leaders do directly influences the cultures of their organizations. This is a key point for managers to consider as they carry out their leading P-O-L-C function.

Part of the leader's influence over culture is through role modeling. Many studies have suggested that leader behavior, the consistency between organizational policy and leader actions, and leader role modeling determine the degree to which the organization's culture emphasizes ethics (Driscoll & McKee, 2007). The leader's own behaviors will signal to individuals what is acceptable behavior and what is unacceptable. In an organization in which high-level managers make the effort to involve others in decision making and seek opinions of others, a team-oriented culture is more likely to evolve. By acting as role models, leaders send signals to the organization about the norms and values that are expected to guide the actions of its members.

Leaders also shape culture by their reactions to the actions of others around them. For example, do they praise a job well done or do they praise a favored employee regardless of what was accomplished? How do they react when someone admits to making an honest mistake? What are their priorities? In meetings, what types of questions do they ask? Do they want to know what caused accidents so that they can be prevented, or do they seem more concerned about how much money was lost because of an accident? Do they seem outraged when an employee is disrespectful to a coworker, or does their reaction depend on whether they like the harasser? Through their day-to-day actions, leaders shape and maintain an organization's culture.

Reward Systems

Finally, the company culture is shaped by the type of reward systems used in the organization and the kinds of behaviors and outcomes it chooses to reward and punish. One relevant element of the reward system is *whether the organization rewards behaviors or results*. Some companies have reward systems that emphasize intangible elements of performance as well as more

easily observable metrics. In these companies, supervisors and peers may evaluate an employee's performance by assessing the person's behaviors as well as the results. In such companies, we may expect a culture that is relatively people- or team-oriented, and employees act as part of a family (Kerr & Slocum, 2005). However, in companies in which goal achievement is the sole criterion for reward, there is a focus on measuring only the results without much regard to the process. In these companies, we might observe outcome-oriented and competitive cultures. *Whether the organization rewards performance or seniority* would also make a difference in culture. When promotions are based on seniority, it would be difficult to establish a culture of outcome orientation. Finally, *the types of behaviors that are rewarded or ignored* set the tone for the culture. Which behaviors are rewarded, which ones are punished, and which are ignored will determine how a company's culture evolves. A reward system is one tool managers can wield when undertaking the controlling function.

Signs of Organizational Culture

How do you find out about a company's culture? We emphasized earlier that culture influences the way members of the organization think, behave, and interact with one another. Thus, one way of finding out about a company's culture is by observing employees or interviewing them. At the same time, culture manifests itself in some visible aspects of the organization's environment. In this section, we discuss five ways in which culture shows itself to observers and employees.

Visual Elements of Culture

Mission Statement

A **mission statement** is a statement of purpose, describing who the company is and what it does (Figure 9). It serves an important function for organizations as part of the first facet of the planning P-O-L-C function. But, while many companies have mission statements, they do not always reflect the company's values and its purpose. An effective mission statement is well known by employees, is transmitted to all employees starting from their first day at work, and influences employee behavior.

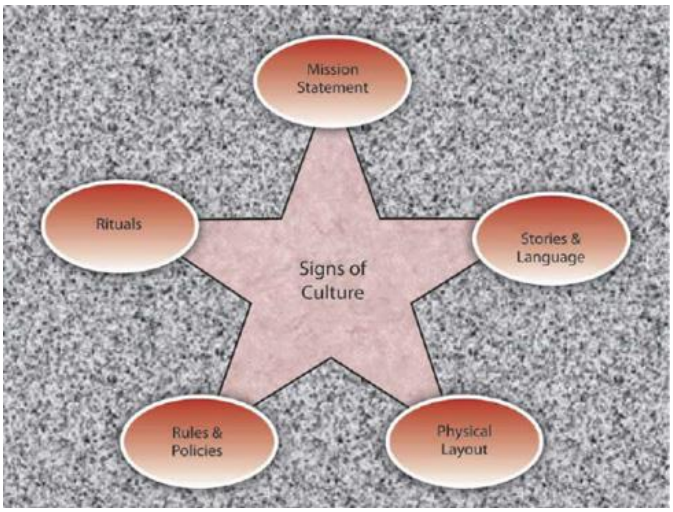

Figure 9

Some mission statements reflect who the company wants to be as opposed to who they actually are. If the mission statement does not affect employee behavior on a day-to-day basis, it has little usefulness as a tool for understanding the company's culture. Enron provided an often-cited example of a disconnect between a company's mission statement and how the company actually operated. Their missions and values statement started with "As a partner in the communities in which we operate, Enron believes it has a responsibility to conduct itself according to certain basic principles." Their values statement included such ironic declarations as "We do not tolerate abusive or disrespectful treatment. Ruthlessness, callousness and arrogance don't belong here (Kunen, 2002)."

A mission statement that is taken seriously and widely communicated may provide insights into the corporate culture. For example, the Mayo Clinic's mission statement is "The needs of the patient come first." This mission statement evolved from the founders who are quoted as saying, "The best interest of the patient is the only interest to be considered." Mayo Clinics have a corporate culture that puts patients first. For example, no incentives are given to physicians based on the number of patients they see. Because doctors are salaried, they have no interest in retaining a patient for themselves, and they refer the patient to other doctors when needed (Jarnagin & Slocum, 2007). Wal-Mart may be another example of a company that lives its mission statement and therefore its mission statement may give hints about its culture: "Saving people money so they can live better (Wal-Mart, 2008)."

Rituals

Rituals refer to repetitive activities within an organization that have symbolic meaning (Anand, 2005). Usually rituals have their roots in the history of a company's culture. They create camaraderie and a sense of belonging among employees. They also serve to teach employees corporate values and create identification with the organization. For example, at the cosmetics firm Mary Kay Inc., employees attend ceremonies recognizing their top salespeople with an award of a new car — traditionally a pink Cadillac (Figure 10). These ceremonies are conducted in large auditoriums where participants wear elaborate evening gowns and sing company songs that create emotional excitement. During this ritual, employees feel a connection to the company culture and its values such as self-determination, willpower, and enthusiasm (Jarnagin & Slocum, 2007). Another example of rituals is the Saturday morning meetings of Wal-Mart. This ritual was first created by the company founder Sam Walton, who used these meetings to discuss which products and practices were doing well and which required adjustment. He was able to use this information to make changes in Wal-Mart's stores before the start of the week, which gave him a competitive advantage over rival stores who would make their adjustments based on weekly sales figures during the middle of the following week. Today, hundreds of Wal-Mart associates attend the Saturday morning meetings in the Bentonville, Arkansas, headquarters. The meetings, which run from 7:00 a.m. to 9:30 a.m., start and end with the Wal-Mart cheer; the agenda includes a discussion of weekly sales figures and merchandising tactics. As a ritual, the meetings help maintain a small-company atmosphere, ensure employee involvement and accountability, communicate a performance orientation, and demonstrate taking quick action (Schlender, 2005).

Figure 10: Tradition is important at Mary Kay Cosmetics. Pink Cadillacs are given to top performers at large annual events. Phillip Pessar – Pink 1963 Cadillac – CC BY 2.0.

Rules and Policies

Another way in which an observer may find out about a company's culture is to examine its rules and policies. Companies create rules to determine acceptable and unacceptable behavior and, thus, the rules that exist in a company will signal the type of values it has. Policies about issues such as decision making, human resources, and employee privacy reveal what the company values and emphasizes. For example, a company that has a policy such as "all pricing decisions of merchandise will be made at corporate headquarters" is likely to have a centralized culture that is hierarchical, as opposed to decentralized and empowering. The presence or absence of policies on sensitive issues such as English-only rules, bullying and unfair treatment of others, workplace surveillance, open-door policies, sexual harassment, workplace romances, and corporate social responsibility all provide pieces of the puzzle that make up a company's culture. This highlights how interrelated the P-O-L-C functions are in practice. Through rules and policies, the controlling function affects the organization's culture, a facet of organizing.

Impact of HR Practices on Organizational Culture

Below are scenarios of critical decisions you may need to make as a manager one day. Read each question and select one response from each pair of statements. Then, think about the effect your choice would have on the company's culture (your organizing function) as well as on your controlling function.

1. Your company needs to lay off 10 people. Would you
    - lay off the newest 10 people?
    - lay off the 10 people who have the lowest performance evaluations?
2. You're asked to establish a dress code. Would you
    - ask employees to use their best judgment?
    - create a detailed dress code highlighting what is proper and improper?
3. You need to monitor employees during work hours. Would you
    - not monitor them because they are professionals and you trust them?
    - install a program monitoring their Web usage to ensure that they are spending work hours actually doing work?

4. You're preparing performance appraisals. Would you
    - evaluate people on the basis of their behaviors?
    - evaluate people on the basis of the results (numerical sales figures, etc.)?
5. Who will be promoted? Would you promote individuals based on
    - seniority?
    - objective performance?

Physical Layout

A company's building, layout of employee offices, and other workspaces communicate important messages about a company's culture. For example, visitors walking into the Nike campus in Beaverton, Oregon, can witness firsthand some of the distinguishing characteristics of the company's culture. The campus is set on 74 acres and boasts an artificial lake, walking trails, soccer fields, and cutting-edge fitness centers. The campus functions as a symbol of Nike's values such as energy, physical fitness, an emphasis on quality, and a competitive orientation. In addition, at fitness centers on the Nike headquarters, only those using Nike shoes and apparel are allowed in. This sends a strong signal that loyalty is expected. The company's devotion to athletes and their winning spirit are manifested in campus buildings named after famous athletes, photos of athletes hanging on the walls, and their statues dotting the campus (Capowski, 1993; Collins & Porras, 1996 Labich & Carvell, 1995; Mitchell, 2002).

The layout of the office space also is a strong indicator of a company's culture. A company that has an open layout where high-level managers interact with employees may have a culture of team orientation and egalitarianism, whereas a company where most high-level managers have their own floor may indicate a higher level of hierarchy. Microsoft employees tend to have offices with walls and a door because the culture emphasizes solitude, concentration, and privacy. In contrast, Intel is famous for its standard cubicles, which reflect its egalitarian culture. The same value can also be observed in its avoidance of private and reserved parking spots (Clark, 2007). The degree to which playfulness, humor, and fun are part of a company's culture may be indicated in the office environment. For example, Jive Software boasts a colorful, modern, and comfortable office design. Their break room is equipped with a keg of beer, free snacks and sodas, an Xbox 360, and Nintendo Wii. A casual observation of their work environment sends

the message that employees who work there see their work as fun (Jive Software, 2008).

Stories and Language

Perhaps the most colorful and effective way in which organizations communicate their culture to new employees and organizational members is through the skillful use of stories. A story can highlight a critical event an organization faced and the organization's response to it, or a heroic effort of a single employee illustrating the company's values. The stories usually engage employee emotions and generate employee identification with the company or the heroes of the tale. A compelling story may be a key mechanism through which managers motivate employees by giving their behavior direction and by energizing them toward a certain goal (Beslin, 2007). Moreover, stories shared with new employees communicate the company's history, its values and priorities, and create a bond between the new employee and the organization. For example, you may already be familiar with the story of how a scientist at 3M invented Post-it notes. Arthur Fry, a 3M scientist, was using slips of paper to mark the pages of hymns in his church choir, but they kept falling off. He remembered a superweak adhesive that had been invented in 3M's labs, and he coated the markers with this adhesive. Thus, the Post-it notes were born. However, marketing surveys for the interest in such a product were weak and the distributors were not convinced that it had a market. Instead of giving up, Fry distributed samples of the small yellow sticky notes to secretaries throughout his company. Once they tried them, people loved them and asked for more. Word spread and this led to the ultimate success of the product. As you can see, this story does a great job of describing the core values of a 3M employee: Being innovative by finding unexpected uses for objects, persevering, and being proactive in the face of negative feedback (Higgins & McAllester, 2002).

Language is another way to identify an organization's culture. Companies often have their own acronyms and buzzwords that are clear to them and help set apart organizational insiders from outsiders. In business, this code is known as jargon. Jargon is the language of specialized terms used by a group or profession. Every profession, trade, and organization has its own specialized terms.

Key Takeaway

Organizational cultures are created by a variety of factors, including founders' values and preferences, industry demands, and early values, goals, and assumptions. Culture is maintained through attraction-selection-attrition, new employee onboarding, leadership, and organizational reward systems. Signs of a company's culture include the organization's mission statement, stories, physical layout, rules and policies, and rituals.

Exercises

1. Do you think it is a good idea for companies to emphasize person-organization fit when hiring new employees? What advantages and disadvantages do you see when hiring people who fit with company values?
2. What is the influence of company founders on company culture? Give examples based on your personal knowledge.
3. What are the methods companies use to aid with employee onboarding? What is the importance of onboarding for organizations?
4. What type of a company do you feel you would fit in? What type of a culture would be a misfit for you? In your past work experience, were there any moments when you felt that you did not fit in? Why?
5. What is the role of physical layout as an indicator of company culture? What type of a physical layout would you expect from a company that is people-oriented? Team-oriented? Stable?

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Chapter 6: Professional Organizations

Professional Organizations

Professional organizations were created as a platform for nurses to advocate for the profession, support nurses' rights, and ensure quality healthcare for consumers (Echevarria, 2018). Members of professional organizations can advocate locally, state-wide, nationally, and globally to support issues that impact the nursing profession and healthcare as a whole.

Nurses can choose from hundreds of professional organizations to advocate for the profession and attain a wide variety of membership benefits. For a list of national, state, and international professional organizations, **visit this website**.

Benefits of Membership

Membership within professional organizations offers nurses infinite opportunities to make a significant impact with advancing the profession, professional growth, and the healthcare system. Echevarria (2018) shares some additional ways to get involved:

- Advocate for healthcare consumers' rights, health, and safety
- Influence healthcare delivery by participating in, promoting, and using evidence-based knowledge and research findings to guide practice and decision-making
- Promote the ethical principles of research
- Identify barriers and opportunities to improve healthcare safety, equitability, and efficiency
- Critically review policies, procedures, and guidelines to improve quality
- Influence organizational policies and procedures to guide practice and promote interprofessional, evidence-based practices
- Advocate for resources that promote and support nursing practice

In addition to serving the profession and improving the healthcare system, membership offers nurses a multitude of professional benefits. Some benefits also include:

- Continuing education
- Specialty certification
- Best practices for nursing care
- Promote the rights of nurses
- Synchronous and asynchronous webinars
- Face-to-face seminars
- Journal access

- Career resources, job boards
- Conference engagements and opportunities (Echevarria, 2018)
- Discount on conference and certification registration fees
- Personal benefits, such as discounts on car rental, life insurance, professional liability insurance, and more

Nursing Scope and Standards of Practice

Nurses who take advantage of the activities offered by professional organizations meet the competencies for Standard 12, Education, in the ANA (2015c) Nursing Scope and Standards of Practice. For example, attending conferences offer nurses an opportunity to share their research and knowledge through podium and poster presentations. Participation in professional development opportunities, such as listening to a webinar or reading a nursing journal meets the following competencies for Standard 12:

- Shares educational findings, experiences, and ideas with peers.
- Demonstrates a commitment to lifelong learning through self-reflection and inquiry for learning and personal growth.
- Maintains a professional portfolio that provides evidence of individual competence and lifelong learning (ANA, 2015c, p. 76)

The following six values of membership in professional organizations aligns with the American Nurses Association (ANA, 2015c) *Nursing Scope and Standards of Practice*:

- Advocacy
- Professional development
- Service to the profession
- Career growth
- Mentoring*
- Networking*

Code of Ethics

Provision 9 of the ANA (2015a) *Code of Ethics* includes a requirement about advocacy efforts. Advocacy is fundamental to nursing practice, and through membership and participation in professional organizations, nurses can fulfill the following provision: “The profession of nursing, collectively through its professional organizations, must articulate nursing values, maintain the integrity of the profession, and integrate principles of social justice into nursing and health policy” (ANA, 2015a, p. 151).

How to Get Involved

Most state nursing organizations sponsor an annual Lobby Day. Thousands of nurses gather each year to organize their efforts and meet with legislators to share their position on the current bills in the house or senate. Information can be found on your state nursing organization's webpage.

The ANA also has an annual Lobby Day Lobby Day in Washington D.C. Hundreds of nurses gather at Capitol Hill to meet with federal lawmakers to discuss major health issues, such as workplace violence, Title VIII Nursing Workforce Reauthorization Act of 2019, Home Health Care Planning Improvement Act of 2019 and more (Capitol Beat, 2019). For information about Lobby Day, visit **ANA's website**.

Participating in professional organization activities gives nurses an opportunity to give back to the profession. Echevarria (2018) shares a number of volunteer options for nurses:

- Participate on committees and task forces
- Hold a board position (see NOBC narrative below)
- Assist with organization-sponsored conferences and community events
- Work on regional and national projects:
    - Item-writing
    - Review certification exams
    - Work on legislative issues
    - Serve as a regional director
    - Work on an education committee

The Nurses on Boards Coalition (NOBC, 2019) represents national nursing (and other) organizations to build healthier communities through nurses' presence on corporate, health-related, and other boards, panels, and commissions. The NOBC was created in 2014 in response to the Institute of Medicine (2010) report, *The Future of Nursing: Leading Change, Advancing Health*. The report recommended increasing the number of nurse leaders in pivotal decision-making roles on boards and commissions that work to improve the health of the U.S. population.

The goal of the NOBC (2019) is to fill at least 10,000 board seats with nurses by 2020. In addition, NOBC seeks to raise awareness about the benefits of having a nurse's perspective in decision-making on issues related to improving health and creating a

more efficient and effective healthcare system at local, state, and national levels. For more information about NOBC, **visit their website**.

Summary

As stated earlier, benefits to joining a professional organization give nurses the opportunity to meet required competencies of a professional registered nurse. Nurses have an opportunity to advocate for themselves the nursing profession (such as the Safe Staffing bill) and serve society by using their knowledge and competencies to improve the health of their communities.

Professional growth and career opportunities are endless. Membership offers many networking opportunities with other healthcare professionals at conferences, involvement in Lobby Days, community events, serving on a board of trustees, and more. Mentoring is a rewarding experience for both the mentor and mentee. By helping nurses gain competencies and confidence, the healthcare system is strengthened, patients receive quality care, which in turn leads to improved patient care experiences and satisfaction rates.

Through organization membership, nurses can fulfill lifelong learning requirements to meet a variety of needs and requirements, such as license and certification renewal and incorporate evidence into practice. Depending on career goals and professional development needs, nurses should evaluate and compare member benefits from different organizations. If a career goal is to obtain specialty certification, it would be prudent to choose an organization that offers reduced fees for a review course. If the goal is to obtain access to evidence-based practice resources for a specialty setting, find a specialty organization that offers these resources.

Some membership dues can be costly, though some offer a student discount. Nurses who are unable to join an organization can still benefit from visiting professional organization websites. Many organizations offer resources without membership. To choose the right organization, Echevarria (2018) suggests nurses ask themselves if the organization:

- meets professional growth needs
- aligns with current role/specialty
- meets personal/professional advocacy efforts

Professional organization membership benefits everyone: patients, nurses, the nursing profession, and the entire healthcare delivery system as a whole.

Chapter 7: Evaluating Employees

Managing Human Resources

Performance Appraisal

Employees generally want their managers to tell them three things: what they should be doing, how well they're doing it, and how they can improve their performance. Good managers address these issues on an ongoing basis. On a semiannual or annual basis, they also conduct formal performance appraisals to discuss and evaluate employees' work performance.

The Basic Three-Step Process

Appraisal systems vary both by organization and by the level of the employee being evaluated, but as you can see in Figure 12.8, it's generally a three-step process:

1. Before managers can measure performance, they must set goals and performance expectations and specify the criteria (such as quality of work, quantity of work, dependability, initiative) that they'll use to measure performance.
2. At the end of a specified time period, managers complete written evaluations that rate employee performance according to the predetermined criteria.
3. Managers then meet with each employee to discuss the evaluation. Jointly, they suggest ways in which the employee can improve performance, which might include further training and development.

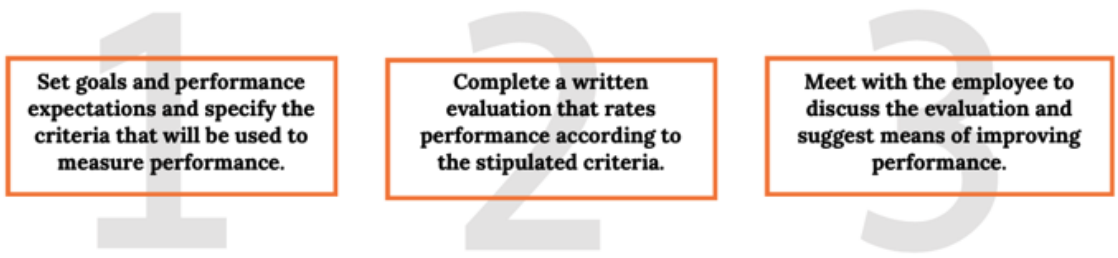

Figure 12.8: Performance Appraisal Process

It sounds fairly simple, but why do so many managers report that, except for firing people, giving performance appraisals is their least favorite task?[161] To get some

perspective on this question, we'll look at performance appraisals from both sides, explaining the benefits and identifying potential problems with some of the most common practices.

Among other benefits, formal appraisals provide the following:

- An opportunity for managers and employees to discuss an employee's performance and to set future goals and performance expectations.
- A chance to identify and discuss appropriate training and career-development opportunities for an employee.
- Formal documentation of the evaluation that can be used for salary, promotion, demotion, or dismissal purposes.[62]

As for disadvantages, most stem from the fact that appraisals are often used to determine salaries for the upcoming year. Consequently, meetings to discuss performance tend to take on an entirely different dimension: the manager may appear judgmental (rather than supportive), and the employee may get defensive. This adversarial atmosphere can make many managers not only uncomfortable with the task but also less likely to give honest feedback. (They may give higher marks in order to avoid delving into critical evaluations.) HR professionals disagree about whether performance appraisals should be linked to pay increases. Some experts argue that the connection eliminates the manager's opportunity to use the appraisal to improve an employee's performance. Others maintain that it increases employee satisfaction with the process and distributes raises on the basis of effort and results.[63]

360-Degree and Upward Feedback

Instead of being evaluated by one person, how would you like to be evaluated by several people—not only those above you in the organization but those below and beside you? The approach is called 360-degree feedback, and the purpose is to ensure that employees (mostly managers) get feedback from all directions—from supervisors, reporting subordinates, coworkers, and even customers. If it's conducted correctly, this technique furnishes managers with a range of insights into their performance in a number of roles.

Some experts, however, regard the 360-degree approach as too cumbersome. An alternative technique, called upward feedback, requires only the manager's subordinates to provide feedback. Computer maker Dell uses this approach as part of its manager-development plan. Every year, 40,000 Dell employees complete a survey in which they rate their supervisors on a number of dimensions, such as practicing

ethical business principles and providing support in balancing work and personal life. Dell uses survey results for development purposes only, not as direct input into decisions on pay increases or promotions.[64]

Retaining Valuable Employees

When a valued employee quits, the loss to the employer can be serious. Not only will the firm incur substantial costs to recruit and train a replacement, but it also may suffer temporary declines in productivity and lower morale among remaining employees who have to take on heavier workloads. Given the negative impact of turnover—the permanent separation of an employee from a company—most organizations do whatever they can to retain qualified employees. Compensation plays a key role in this effort: companies that don't offer competitive compensation packages tend to lose employees. Other factors also come into play, such as training and development, as well as helping employees achieve a satisfying work/non-work balance. In the following sections, we'll look at a few other strategies for reducing turnover and increasing productivity.[65]

Creating a Positive Work Environment

Employees who are happy at work are more productive, provide better customer service, and are more likely to stay with the company. A study conducted by Sears, for instance, found a positive relationship between customer satisfaction and employee attitudes on ten different issues: a 5 percent improvement in employee attitudes results in a 1.3 percent increase in customer satisfaction and a 0.5 percent increase in revenue.[66]

Employee-Friendly Workplace

What sort of things improve employee attitudes? The 12,000 employees of software maker SAS Institute fall into the category of "happy workers." They choose the furniture and equipment in their offices, eat subsidized meals at one of three on-site restaurants, and enjoy other amenities like a 77,000 square-foot fitness center. They also have job security: no one's ever been laid off because of an economic downturn. The employee-friendly work environment helps SAS employees focus on their jobs and contribute to the attainment of company goals.[67] Not surprisingly, it also results in very low 3 percent turnover.

Recognizing Employee Contributions

Thanking people for work done well is a powerful motivator. People who feel appreciated are more likely to stay with a company than those who don't.[68] While a personal thank-you is always helpful, many companies also have formal programs for identifying and rewarding good performers. The Container Store rewards employee accomplishments in a variety of ways. For example, employees with 20 years of service are given a "dream trip"—one employee went on a seven day Hawaiian cruise.[69] The company is known for its supportive environment and in 2016 celebrated its seventeenth year on *Fortune*'s 100 Best Companies to Work For®.[70]

Involving Employees in Decision Making

Companies have found that involving employees in decisions saves money, makes workers feel better about their jobs, and reduces turnover. Some have found that it pays to take their advice. When General Motors asked workers for ideas on improving manufacturing operations, management was deluged with more than 44,000 suggestions during one quarter. Implementing a few of them cut production time on certain vehicles by 15 percent and resulted in sizable savings.[71]

Similarly, in 2001, Edward Jones, a personal investment company, faced a difficult situation during the stock-market downturn. Costs had to be cut, and laying off employees was one option. Instead, however, the company turned to its workforce for solutions. As a group, employees identified cost savings of more than $38 million. At the same time, the company convinced experienced employees to stay with it by assuring them that they'd have a role in managing it.[72]

Why People Quit

As important as such initiatives can be, one bad boss can spoil everything. The way a person is treated by his or her boss may be the primary factor in determining whether an employee stays or goes. People who have quit their jobs cite the following behavior by superiors:

- Making unreasonable work demands
- Refusing to value their opinions
- Failing to be clear about what's expected of subordinates
- Showing favoritism in compensation, rewards, or promotions[73]

Holding managers accountable for excessive turnover can help alleviate the "bad-boss" problem, at least in the long run. In any case, whenever an employee quits, it's a good idea for someone—other than the individual's immediate supervisor—to conduct an exit interview to find out why. Knowing why people are quitting gives an organization the opportunity to correct problems that are causing high turnover rates.

Involuntary Termination

Some companies employ a process called **Forced Ranking** to manage out their under-performers. In this approach, only a certain percentage of employees can receive a particular performance evaluation score, which forces some employees to the bottom of the distribution—sort of the opposite of a curved exam score. The employee pool in question is typically made up of those who do similar kinds of work. Ideally after being given some amount of time to improve, those who remain at the bottom of the performance distribution are then separated from the company. As you can imagine, this practice has caused a fair amount of controversy!

Before we leave this section, we should say a word or two about termination—getting fired. Though turnover—voluntary separations—can create problems for employers, they're not nearly as devastating as the effects of involuntary termination on employees. Losing your job is what psychologists call a "significant life change," and it's high on the list of "stressful life events" regardless of the circumstances. Sometimes, employers lay off workers because revenues are down and they must resort to downsizing—to cutting costs by eliminating jobs. Sometimes a particular job is being phased out, and sometimes an employee has simply failed to meet performance requirements.

Employment at Will

Is it possible for you to get fired even if you're doing a good job and there's no economic justification for your being laid off? In some cases, yes—especially if you're not working under a contract. Without a formal contract, you're considered to be employed at will, which means that both you and your employer have the right to terminate the employment relationship at any time. You can quit whenever you want, but your employer can also fire you whenever they want.

Fortunately for employees, over the past several decades, the courts have made several decisions that created exceptions to the employment-at-will doctrine.[74] Since managers generally prefer to avoid the expense of fighting wrongful discharge claims

in court, many no longer fire employees at will. A good practice in managing terminations is to maintain written documentation so that employers can demonstrate just cause when terminating an employee. If it's a case of poor performance, the employee would be warned in advance that his or her current level of performance could result in termination and then be permitted an opportunity to improve performance. When termination is necessary, communication should be handled in a private conversation, with the manager explaining precisely why the action is being taken.

Chapter 8: Personal Finance

Note: Although understanding the basics of personal finance is not specifically covered in this course, this information is provided as part of the transition to practice content.

Personal Finances

Learning Objectives

- Develop strategies to avoid being burdened with debt.
- Explain how to manage monthly income and expenses.
- Define personal finances and financial planning.
- Explain the financial planning life cycle.
- Discuss the advantages of a college education in meeting short- and long-term financial goals.
- Explain compound interest and the time value of money.
- Discuss the value of getting an early start on your plans for saving.

The World of Personal Credit

Do you sometimes wonder where your money goes? Do you worry about how you'll pay off your student loans? Would you like to buy a new car or even a home someday and you're not sure where you'll get the money? If these questions seem familiar to you, you could benefit from help in managing your personal finances, which this chapter will seek to provide.

Figure 18.1: Credit Cards

Let's say that you're 28 and single. You have a good education and a good job—you're pulling down $60,000 working with a local accounting firm. You have $6,000 in a retirement savings account, and you carry three credit cards. You plan to buy a condo in two or three years, and you want to take your dream trip to the world's

hottest surfing spots within five years. Your only big worry is the fact that you're $70,000 in debt, due to student loans, your car loan, and credit card debt. In fact, even though you've been gainfully employed for a total of six years now, you haven't been able to make a dent in that $70,000. You can afford the necessities of life and then some, but you've occasionally wondered if you're ever going to have enough income to put something toward that debt.[1]

Now let's suppose that while browsing through a magazine in the doctor's office, you run across a short personal-finances self-help quiz. There are six questions:

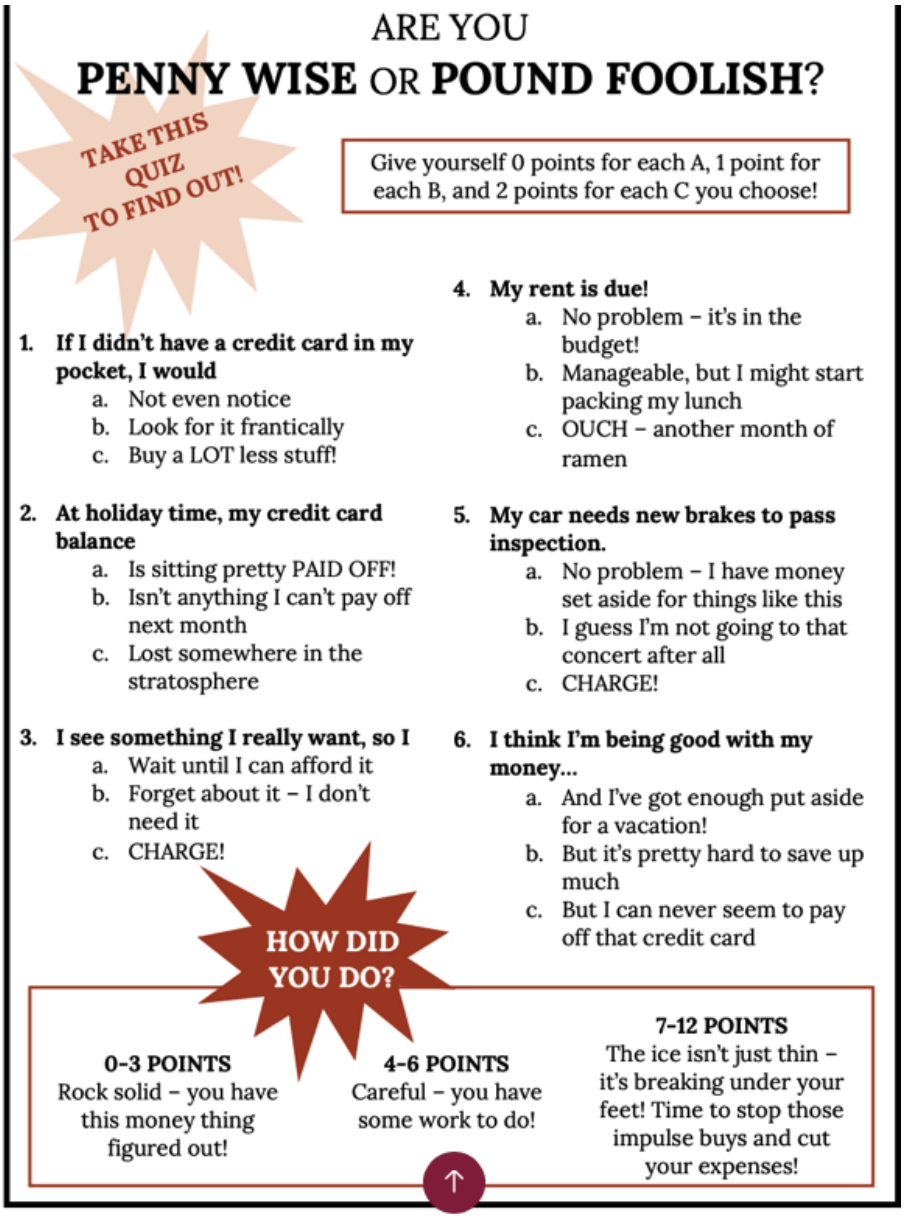

Figure 18.2: Financial Quiz

You took the quiz and answered with a B or C to a few questions, and are thereby informed that you're probably jeopardizing your entire financial future.

Personal-finances experts tend to utilize the types of questions on the quiz: if you answered B or C to any of the first three questions, you have a problem with splurging; if any questions from four through six got a B or C, your monthly bills are too high for your income.

Building a Good Credit Rating

So, you have a financial problem. According to the quick test you took, you splurge and your bills are too high for your income. If you get in over your head and can't make your loan or rent payments on time, you risk hurting your **credit rating**—your ability to borrow in the future.

How do potential lenders decide whether you're a good or bad credit risk? If you're a poor credit risk, how does this affect your ability to borrow, or the rate of interest you have to pay? Whenever you use **credit**, those from whom you borrow (retailers, credit card companies, banks) provide information on your debt and payment habits to three national **credit bureaus**: Equifax, Experian, and TransUnion. The credit bureaus use the information to compile a numerical credit score, called a **FICO score**; it ranges from 300–850, with the majority of people falling in the 600–700 range. In compiling the score, the credit bureaus consider five criteria: **payment history**—paying your bills on time (the most important), **total amount owed**, **length of your credit history**, **amount of new credit you have**, and **types of credit you use**. The credit bureaus share their score and other information about your credit history with their subscribers.[2]

Figure 18.3: FICO Credit Score Range

So what does this do for you? It depends. If you pay your bills on time and don't borrow too heavily, you'd likely have a high FICO score and lenders would like you, probably giving you reasonable interest rates on the loans you requested. But if your FICO score is low, lenders won't likely lend you money (or would lend it to you at high interest rates). A low FICO score can even affect your chances of renting an apartment or landing a particular job. So it's very important that you do everything possible to earn and maintain a high credit score.

As a young person, though, how do you build a credit history that will give you a high FICO score? Based on feedback from several financial experts, Emily Starbuck Gerson and Jeremy Simon of CreditCards.com compiled the list in Figure 18.4 of ways students can build good credit.[3]

Figure 18.4: How to Build Good Credit as a Student

If you meet the qualifications to obtain your own credit card, look for a card with a low interest rate and no annual fee.

Secured vs. Unsecured Credit

On some types of loans, the lender (likely a bank) will require the borrower to offer collateral in order to be approved for the loan. Anyone who has taken out a car loan or bought a house using a mortgage loan has likely pledged the car or the home as a way to ensure the bank that they will be repaid—if the borrower fails to repay, the bank can repossess the car or foreclose on the house, taking ownership of it temporarily and reselling it in order to recover the amount of the loan. In these cases, the car or the house serve as collateral—security pledged to the lender in order to make it more likely that the amount of the loan will be repaid. Loans that involve this type of security are referred to as secured loans or secured credit.

Not all types of loans involve collateral. For example, many families take out student loans when their children go off to college. Credit cards are a form of loan as well. Neither case involves collateral; the lender makes the loans based, at least in part, on the credit worthiness of the borrower. When no collateral is involved, the loans are called *unsecured.* Since the bank takes more risk in lending when no collateral can be pledged, unsecured loans will often require higher interest rates in order for it to be worth the bank taking the risk in making this type of loan.

A Few More Words about Debt

What should you do to turn things around—to start getting out of debt? According to many experts, you need to take two steps:

1. Cut up your credit cards and start living on a cash-only basis.
2. Do whatever you can to bring down your monthly bills.

Although credit cards can be an important way to build a credit rating, many people simply lack the financial discipline to handle them well. If you see yourself in that statement, then moving to a pay-as-you go basis, i.e., cash or debit card only, may be for you. Be honest with yourself; if you can’t handle credit, then don’t use it.

Bringing Down Those Monthly Bills

So what can you can to bring down your monthly bills? If you want to take a gradual approach, one financial planner suggests that you perform the following "exercises" for one week:[4]

- Keep a written record of everything you spend and total it at week's end.
- Keep all your ATM receipts and count up the fees.
- Take $100 out of the bank and don't spend a penny more.
- Avoid gourmet coffee shops.

You'll probably be surprised at how much of your money can quickly become somebody else's money. If, for example, you spend $3 every day for one cup of coffee at a coffee shop, you're laying out nearly $1,100 a year just for coffee. If you use your ATM card at a bank other than your own, you'll probably be charged a fee that can be as high as $3. The average person pays more than $60 a year in ATM fees. If you withdraw cash from an ATM twice a week, you could be racking up $300 in annual fees.[5] Another idea—eat out as a reward, not as a rule. A sandwich or leftovers from home can be just as tasty and can save you $6 to $10 a day, even more than our number for coffee! In 2013, the website *DailyWorth* asked three women to try to cut their spending in half. After tracking her spending, one participant discovered that she had spent $175 eating out in just one week; do that for a year and you'd spend over $9,000![6] If you think your cable bill is too high, consider alternatives like *PlaystationVue* or *Sling*. Changing channels is a bit different, but the savings can be substantial.

Figure 18.5: These Can Really Add Up Quickly!

You may or may not be among the American consumers who buy 35 million cans of Bud Light each day, or 150,000 pounds of Starbucks coffee, or 2.4 million Burger King hamburgers. Yours may not be one of the 70 percent of US households with an unopened consumer-electronics product lying around.[7] Bottom line: If at age 28 you have a good education and a good job, a $60,000 income, and a $70,000 debt (by no means an implausible scenario) there's a very good reason why you should think hard about controlling your debt. Your level of indebtedness will be a key factor in your ability—or inability—to reach your long-term financial goals, such as home ownership, a dream trip, and, perhaps most importantly, a reasonably comfortable retirement.

Financial Planning

Before we go any further, we need to nail down a couple of key concepts. First, just what, exactly, do we mean by personal finances? Finance itself concerns the flow of money from one place to another, and your personal finances concern your money and what you plan to do with it as it flows in and out of your possession. Essentially, then, personal finance is the application of financial principles to the monetary decisions that you make either for your individual benefit or for that of your family.

Second, as we suggested earlier, monetary decisions work out much more beneficially when they're planned rather than improvised. Thus our emphasis on financial planning—the ongoing process of managing your personal finances in order to meet goals that you've set for yourself or your family.

Financial planning requires you to address several questions, some of them relatively simple:

- What's my annual income?
- How much debt do I have, and what are my monthly payments on that debt?

Others will require some investigation and calculation:

- What's the value of my assets?
- How can I best budget my annual income?

Still others will require some forethought and forecasting:

- How much wealth can I expect to accumulate during my working lifetime?
- How much money will I need when I retire?

The Financial Planning Life Cycle

Another question that you might ask yourself—and certainly would do if you worked with a professional in financial planning—is, "How will my financial plans change over the course of my life?" Figure 18.6 illustrates the financial life cycle of a typical individual—one whose financial outlook and likely outcomes are probably a lot like yours.[8] As you can see, our diagram divides this individual's life into three stages, each of which is characterized by different life events (such as beginning a family, buying a home, planning an estate, retiring).

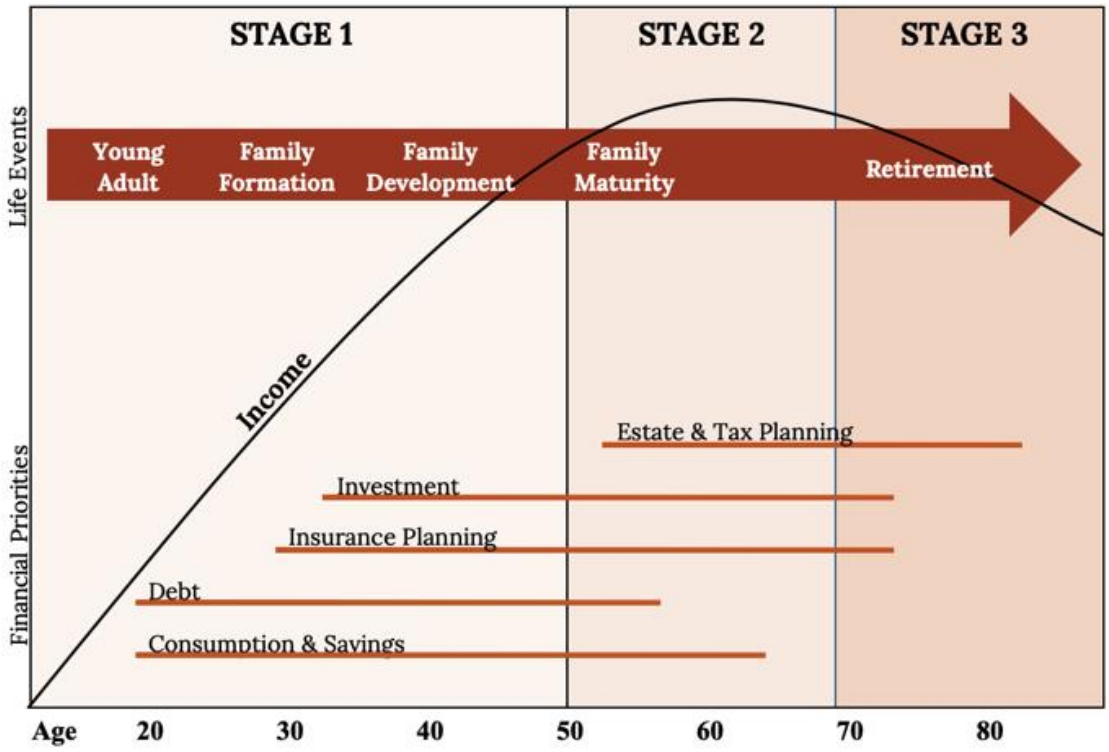

Figure 18.6: The Financial Life Cycle

At each stage, there are recommended changes in the focus of the individual's financial planning:

- Stage 1 focuses on building wealth.
- Stage 2 shifts the focus to the process of preserving and increasing wealth that one has accumulated and continues to accumulate.
- In Stage 3, the focus turns to the process of living on (and, if possible, continuing to grow) one's saved wealth after retirement.

At each stage, of course, complications can set in—changes in such conditions as marital or employment status or in the overall economic outlook, for example. Finally, as you can also see, your financial needs will probably peak somewhere in stage 2, at approximately age 55, or 10 years before typical retirement age.

Choosing a Career

Until you're on your own and working, you're probably living on your parents' wealth right now. In our hypothetical life cycle, financial planning begins in the individual's early 20s. If that seems like rushing things, consider a basic fact of life: this is the age at which you'll be choosing your career—not only the sort of work you want to do during your prime income-generating years, but also the kind of lifestyle you want to live. What about college? Most readers of this book, of course, have decided to go to college. If you haven't yet decided, you need to know that college is an extremely good investment of both money and time.

Figure 18.7 summarizes the findings of a study conducted by the US Census Bureau.[9] A quick review shows that people who graduate from high school can expect to enjoy average annual earnings about 28 percent higher than those of people who don't, and those who go on to finish college can expect to generate 76 percent more annual income than high school graduates who didn't attend college. Over the course of the financial life cycle, families headed by those college graduates will earn about $1.6 million more[10] than families headed by high school graduates. (With better access to health care—and, studies show, with better dietary and health practices—college graduates will also live longer. And so will their children.)[11]

Figure 18.7: Average Earnings by Education Level

Education	Average income	Percentage increase over previous level
High school dropout	$30,612	–
High school diploma	$41,829	37%

Figure 18.7: Average Earnings by Education Level

Education	Average income	Percentage increase over previous level
Associate's degree	$49,966	20%
Bachelor's degree	$73,880	48%
Master's degree	$87,570	19%
Doctorate degree	$125,331	43%
Professional degree	$150,215	20%

What about the student-loan debt that so many people accumulate? For every $1 that you spend on your college education, you can expect to earn about $35 during the course of your financial life cycle.[12] At that rate of return, you should be able to pay off your student loans (unless, of course, you fail to practice reasonable financial planning).

Naturally, there are exceptions to these average outcomes. You'll find some college graduates stocking shelves at 7-Eleven, and you'll find college dropouts running multibillion-dollar enterprises. Microsoft cofounder Bill Gates dropped out of college after two years, as did his founding partner, Paul Allen. Though exceptions to rules (and average outcomes) certainly can be found, they fall far short of disproving them: in entrepreneurship as in most other walks of adult life, the better your education, the more promising your financial future. One expert in the field puts the case for the average person bluntly: educational credentials "are about being employable, becoming a legitimate candidate for a job with a future. They are about climbing out of the dead-end job market."[13]

Time Is Money

The fact that you have to choose a career at an early stage in your financial life cycle isn't the only reason that you need to start early on your financial planning. Let's assume, for instance, that it's your eighteenth birthday and that on this day you take possession of $10,000 that your grandparents put in trust for you. You could, of course, spend it; in particular, it would probably cover the cost of flight training for a private pilot's license—something you've always wanted but were convinced that you couldn't afford right away. Your grandfather, of course, suggests that you put it into some kind of savings account. If you just wait until you finish college, he says, and if you can find a savings plan that pays 5 percent interest, you'll have the $10,000 plus about another $2,000 for something else or to invest.

The total amount you'll have—$12,000—piques your interest. If that $10,000 could turn itself into $12,000 after sitting around for four years, what would it be worth if you actually held on to it until you did retire—say, at age 65? A quick trip to the Internet to find a compound-interest calculator informs you that, 47 years later, your $10,000 will have grown to $104,345 (assuming a 5 percent interest rate). That's not really enough for retirement on, but it would be a good start. On the other hand, what if that four years in college had paid off the way you planned, so that once you get a good job you're able to add, say, another $10,000 to your retirement savings account every year until age 65? At that rate, you'll have amassed a nice little nest egg of slightly more than $1.6 million.

Compound Interest

In your efforts to appreciate the potential of your $10,000 to multiply itself, you have acquainted yourself with two of the most important concepts in finance. As we've already indicated, one is the principle of compound interest, which refers to the effect of earning interest on your interest.

Let's say, for example, that you take your grandfather's advice and invest your $10,000 (your principal) in a savings account at an annual interest rate of 5 percent. Over the course of the first year, your investment will earn $500 in interest and grow to $10,500. If you now reinvest the entire $10,500 at the same 5 percent annual rate, you'll earn another $525 in interest, giving you a total investment at the end of year 2 of $11,025. And so forth. And that's how you can end up with $81,496.67 at age 65.

Time Value of Money

You've also encountered the principle of the time value of money—the principle whereby a dollar received in the present is worth more than a dollar received in the future. If there's one thing that we've stressed throughout this chapter so far, it's the fact that most people prefer to consume now rather than in the future. If you borrow money from me, it's because you can't otherwise buy something that you want at the present time. If I lend it to you, I must forego my opportunity to purchase something I want at the present time. I will do so only if I can get some compensation for making that sacrifice, and that's why I'm going to charge you interest. And you're going to pay the interest because you need the money to buy what you want to buy now. How much interest should we agree on? In theory, it could be just enough to cover the cost of my lost opportunity, but there are, of course, other factors. Inflation, for example, will have eroded the value of my money by the time I get it back from you. In addition, while I would be taking no risk in loaning money to the US government, I am taking a risk in lending it to you. Our agreed-on rate will reflect such factors.[14]

Finally, the time value of money principle also states that a dollar received today starts earning interest sooner than one received tomorrow. Let's say, for example, that you receive $2,000 in cash gifts when you graduate from college. At age 23, with your college degree in hand, you get a decent job and don't have an immediate need for that $2,000. So you put it into an account that pays 10 percent compounded and you add another $2,000 ($167 per month) to your account every year for the next 11 years.[15] The blue line in Figure 18.8 graphs how much your account will earn each year and how much money you'll have at certain ages between 24 and 67.

As you can see, you'd have nearly $52,000 at age 36 and a little more than $196,000 at age 50; at age 67 you'd be just a bit short of $1 million. The yellow line in the graph shows what you'd have if you hadn't started saving $2,000 a year until you were age 36. As you can also see, you'd have a respectable sum at age 67, but less than half of what you would have accumulated by starting at age 23. More important, even to accumulate that much, you'd have to add $2,000 per year for a total of 32 years, not just 12.

Here's another way of looking at the same principle. Suppose that you're 20 years old, don't have $2,000, and don't want to attend college full-time. You are, however, a hard worker and a conscientious saver, and one of your financial goals is to accumulate a $1 million retirement nest egg. As a matter of fact, if you can put $33 a month into an account that pays 12 percent interest compounded,[16] you can have

your $1 million by age 67. That is, if you start at age 20. As you can see from Figure 18.9, if you wait until you're 21 to start saving, you'll need $37 a month. If you wait until you're 30, you'll have to save $109 a month, and if you procrastinate until you're 40, the ante goes up to $366 a month.[17] Unfortunately in today's low interest rate environment, finding 10–12 percent return is not likely. Nevertheless, these figures illustrate the significant benefit of saving early.

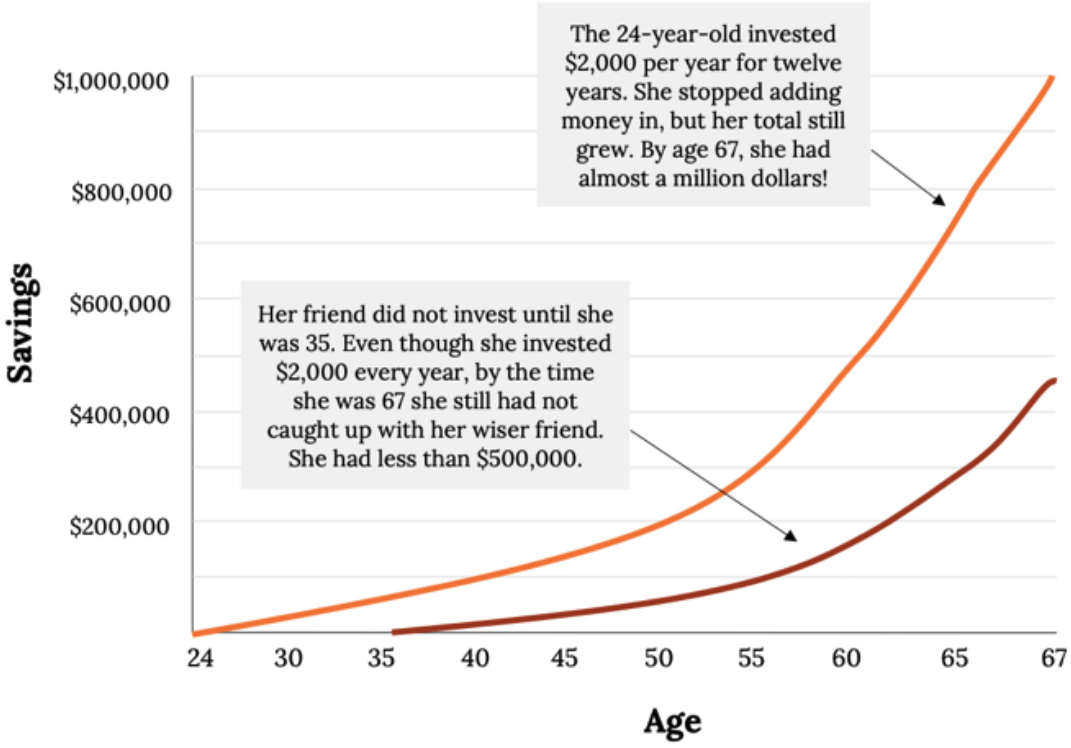

Figure 18.8: The Power of Compound Interest

How to save a million dollars by age 67	
Make your first payment at age:	**And this is what you'll have to save each month:**
20	$33
21	$42
23	$47
24	$53
25	$60
26	$67
27	$76
28	$85
30	$109
35	$199
40	$366
50	$1,319
60	$6,253

Figure 18.9: What Does It Take to Save a Million Dollars?

The reason should be fairly obvious: a dollar saved today not only starts earning interest sooner than one saved tomorrow (or 10 years from now) but also can ultimately earn a lot more money in the long run. Starting early means in your 20s—early in stage 1 of your financial life cycle. As one well-known financial advisor puts it, "If you're in your 20s and you haven't yet learned how to delay gratification, your life is likely to be a constant financial struggle."[18]

Suppose you want to save or invest—do you know how or where to do so? You probably know that your branch bank can open a savings account for you, but interest rates on such accounts can be pretty unattractive. Investing in individual stocks or bonds can be risky, and usually require a level of funds available that most students don't have. In those cases, mutual funds can be quite interesting. A mutual fund is a professionally managed investment program in which shareholders buy into a group of diversified holdings, such as stocks and bonds. Companies like Vanguard and Fidelity offer a range of investment options including indexed funds, which track with well-known indices such as the Standard & Poors 500, a.k.a. the S&P 500. Minimum investment levels in such funds can actually be within the reach of many students, and

the funds accept electronic transfers to make investing more convenient. One key to keep in mind when investing is **diversification**—a fancy way of saying not to put all your eggs in one basket. We'll leave a more detailed discussion of investment vehicles to your more advanced courses.

Chapter Video

If you ask graduates who came before you what they wish they had known when they were first out of school, many would probably say, "how to handle my personal finances." While these two videos and this chapter won't make you financially literate, hopefully they will whet your appetite to learn more.

https://youtu.be/ToyLXa0ULaM

https://youtu.be/pysohj7GsBI

Key Takeaways

- Credit worthiness is measured by the **FICO score**—or **credit rating**—which can range from 300–850. The average ranges from 680–719.
- To maintain a satisfactory score, pay your bills on time, borrow only when necessary, and pay in full whenever you do borrow.
- Eighty-one percent of financial planners recommend eating out less as a way to reduce your expenses.
- **Personal finance** is the application of financial principles to the monetary decisions that you make.
- **Financial planning** is the ongoing process of managing your personal finances in order to meet your goals, which vary by stage of life.
- **Time value of money** is the principle that a dollar received in the present is worth more than a dollar received in the future due to its potential to earn interest.
- **Compound interest** refers to the effect of earning interest on your interest. It is a powerful way to accumulate wealth.

Image Credits: Chapter 18

Figure 18.1: Avery Evans (2020). “White and Blue Magnetic Card Photo.” Unsplash. Public Domain. Retrieved from: https://unsplash.com/photos/RJQE64NmC_o

Figure 18.2: Utilizes several sentences from: http://www.saylor.org/site/textbooks/Exploring Business.docx. CC BY 4.0.

Figure 18.4: Information for graphic: Emily Starbuck Gerson and Jeremy M. Simon (2016). “10 Ways Students Can Build Good Credit.” CreditCards.com. Retrieved from: https://www.creditcards.com/credit-card-news/help/10-ways-students-get-good-credit-6000/

Figure 18.5: Poolie (2008). “Chillin’ at Starbucks.” Flickr. CC BY-SA 2.0. Retrieved from: https://web.archive.org/web/20190130221114/https://www.flickr.com/photos/poolie/2611738444

Figure 18.6: Figure adapted from: Timothy J. Gallager and Joseph D. Andrews Jr. (2003). *Financial Management: Principles and Practice*, 3rd ed. Upper Saddle River, NJ: Prentice Hall. pp. 34, 196.

Figure 18.7: U.S. Census Bureau (2015). “PINC-03. Educational Attainment-People 25 Years Old and Over, by Total Money Earnings, Work Experience, Age, Race, Hispanic Origin, and Sex.” Table Data Retrieved from: http://www.census.gov/data/tables/time-series/demo/income-poverty/cps-pinc/pinc-03.html

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