

Part II

Basic Skills to Creatively Lead and Manage

- 3 Role Transitioning
- 4 Managing Stress
- 5 Managing Time
- 6 Critical Thinking
- 7 Communicating Effectively
- 8 Managing Conflict
- 9 Delegating
- 10 Acting Legally, Ethically, and Politically



Role Transitioning

CHAPTER OBJECTIVES

After reading this chapter, answering the leadership challenges, and participating in the leadership development exercises, you will be able to:

- Critically analyze one role transitioning situation
- List the assumptions of role theory
- Describe four paths to nursing leadership/management
- Identify ways a nurse can transition to a leadership role

Advanced nurses will be able to:

- Teach at least three nursing students about role transition
- Design a problem statement for a research study focused on role transition
- Develop a research design to answer your problem statement

Introduction

Transitioning to new roles is a frequent occurrence for nurses. This chapter focuses on role theory, paths to nursing leadership, and transitioning to a leadership role.

LEADERSHIP IN ACTION

Sarah, a new nurse manager, was promoted because of her clinical skills, but she's not sure she wants the job. She has butterflies in the pit of her stomach and a stack of notes that she's written to herself about her priorities, her goals, her vision for the unit, and more. Keeping her staff happy is at the top of her to-do list, but so far, they don't want to listen to her. Why? They used to be her colleagues and would catch a cup of coffee together on break, share pictures of their kids, and complain about the head nurse. Now Sarah's the head nurse, and she has to give them orders.

LEADERSHIP CHALLENGE What advice do you have for Sarah?**Role Theory**

Role theory may help explain what's happening to Sarah. Some of the assumptions of role theory are that people (Role theory, 2006):

- Define roles for themselves and others based on social learning and reading
- Form expectations about the roles they and others will play
- Subtly encourage others to meet those role expectations
- Act within the roles they adopt

LEADERSHIP TIP

Formal and informal information about what the leader's role should be appears in memos and reports, during training sessions and rounds, in modeling by upper-level nurse leaders, and more.

KEY TERM

Role conflict can occur when the leader's expectations differ from the group's expectations.

KEY TERM

Role transition is the process of moving from one role to another.

LEADERSHIP CHALLENGE Which role theory assumptions apply to Sarah?

Transitioning to a new role means acquiring knowledge, skills, and abilities that may differ from the ones you used in a clinical role (Nugent and colleagues, 2004; Vriesendorp & Buxbaum, 2006). This transition can be challenging.

Role conflict can occur when group members have different expectations of their leaders. Role conflict can also occur when the nurse leader has an idea about what to do that differs from rest of the group's expectations.

Role transition is the process of moving from one role to another. In the Leadership in Action vignette at the beginning of this chapter, is Sarah in role transition or role conflict?

Paths to Nursing Leadership

Why do nurses enter leadership and management positions? See **Box 3-1** for some ideas.

Because nursing care environments have become more technological and more complex, client care has become more complicated. Assuming a management role can affect your family life, relationships with employees, and self-image.

Barriers and Enablers of a Successful Transition to Nurse Manager

Nurse leaders are a vital link in stemming nursing shortages. Moving to a management position can elicit feelings of stress, confusion, and being unprepared for the job (Heller et al., 2004).

Hudson (2005) interviewed 13 nurse leaders and found they often “did” management but continued to “be” nurses. They flourished as clinical nurses but floundered as nurse managers. According to the interviewees, this schism affected attitude, job satisfaction, and performance. See **Box 3-2** for a summary of the themes Hudson found for nurse managers.

Hudson found that while the nurse managers she interviewed changed jobs, they didn’t acquire a new set of attitudes and beliefs and they reported suffering high levels of stress and tension in both their personal and professional lives. Hudson attributed such feelings to the nature of the nurses’ work, which includes tedious, nonemotional activities, such as doing payroll, making a budget, dealing with human resource issues, and going to meetings.

BOX 3-1 PATHS TO LEADERSHIP

Bondas (2006) explored why nurses want to take nursing leadership and management positions. She used a semistructured questionnaire with a strategic sample of 68 Finnish nurses who were all active in leadership positions. She applied analytic induction to generate a theory and found that the nurses took four different paths that varied according to their education, primary commitment, and situational factors: the Path of Ideals (in which the nurse leader created a caring culture and an ideal unit); the Path of Chance (chance factors

lead to a leadership position); the Career Path (which provided the nurse leader with more power); and the Temporary Path (in which the nurse accepted the position but had the option to withdraw). Bondas found that current nursing education does not equip future nurse leaders to use evidence-based practices or leadership, organizational, or economic skills. She counseled that healthcare organizations need nurse leaders who enter with a combination of the Path of Ideals and the Career Path.

BOX 3-2 THEMES IN HUDSON'S RESEARCH

Hudson (2005) found that nurse managers have or experience:

- A passion for nursing
- Beliefs about management
- Expectations of others
- Identity conflict/role ambiguity
- Self-confidence/self-efficacy
- Fulfillment

All 13 of Hudson's nurse leaders reported a lack of autonomy and power and thought they were highly "directed" and supervised in their roles—that is, they were told what to do and when and how to do it. These nurses appeared to transfer their care-taking orientation from clients to staff and reported overwhelming responsibilities in keeping the staff happy, fighting for the staff, and protecting the staff. Some participants carried a beeper 24/7 so the staff

could reach them and even missed family events to help the staff.

Participants in Hudson's study also reported a sense of isolation; they felt lost without a clear reference group with which to identify. Many talked about returning to the bedside if the management position didn't work out. Several spoke of going through "clinical withdrawal" because they missed client contact and saving lives.

Miller and Rahn (2002) found that identity commitment was strongest when "being" and "doing" corresponded to attitude and action. Hudson's findings suggest that staff nurses who aren't willing to make a change in identity and let go of attitudes about working directly with clients may have difficulty ceasing to be clinical nurses and transitioning to being a manager.

Another important finding of Hudson's study was that *none* of the participants in the study received formal management training or apprenticeships in advance or during their transition.

LEADERSHIP CHALLENGE Based on Hudson's study, what kind of training would you offer Sarah, the nurse in the Leadership in Action vignette at the beginning of this chapter?

Hudson pointed out the need for two specific levels of training for transitioning nurse managers: one focused on managerial skills and competencies (the "doing" of management), and the other focused on the nature of feeling (the "being" of management). Nurses who are transitioning to managerial positions must change their thoughts *and* feelings because both influence attitudes and behaviors (Bandura, 1997).

Outstanding clinicians do not necessarily make good nurse managers. Hudson's study showed that the selection and training of nurse managers might heighten commitment to the role. She pointed out that in other work contexts

GUIDED LEADERSHIP TIP**USING BANDURA'S SOCIAL COGNITIVE THEORY**

Social cognitive theory posits that factors such as economic conditions, socioeconomic status, and educational and familial structures do not affect human behavior directly. Instead, they affect it to the degree that they influence people's aspirations, self-efficacy beliefs, personal standards, emotional states, and other self-regulatory influences. The implications of Bandura's social cognitive theory are that, as a nurse leader, you:

- Take care to model positive behaviors, attitudes, and emotional reactions when teaching supervisees

- Provide a learning environment that allows supervisees to extract meaning from it
- Use social persuasion based on attainable success to help supervisees create and develop high self-efficacy beliefs
- Remove real or imagined social or resource constraints to encourage supervisees to perform well
- Help supervisees use self-reflection and self-evaluation to alter their thinking and behavior toward high self-efficacy
- Provide learning incentives

management is considered a discipline requiring formal preparation and ongoing training, not learned “on the job” as nurse managers may be expected to do.

The passionate nature of nursing may make the transition to the less emotional, more cognitive realm of management difficult. The profession needs to rethink how nurses are managed—and who is chosen to transition to the management role. Nurse managers and leaders must be strongly committed to the job if the nursing profession, now facing an escalating decline in numbers, can rebound to meet healthcare demands.

LEADERSHIP TIP

It's critical to receive formal management training as a way to move from being a nurse to being a manager or leader.

LEADERSHIP CHALLENGE Based on what you just read, if you could ask Sarah, the new nurse manager in the Leadership in Action vignette at the beginning of this chapter, one question, what would it be?

The Need for Formal Training and Mentorship During Transitions

Members of the Nursing Leadership Institute at Florida Atlantic University (2002) echoed Hudson's comments. They identified critical leadership competencies for nursing managers as part of their research and stated that the nurse manager role has no defined career path and is rarely a career choice for nurses.

They concluded that there is a critical need to provide new nurse managers with formal orientation and mentoring early in their career transition. They also stated that the nurse manager role must receive the same attention from academic institutions that advanced practice roles receive.

Certain variables have been associated with a positive transition to nursing leadership, including:

- Letting go of deeply held attitudes and habits and altering identity (e.g., changing daily routines, habits, and self-image) and style of interaction (Hill, 2003)
- Tuning into opinions and expectations of others (Beyer & Hannah, 2002)
- Mastering task environments and innovating with roles (Ashforth & Saks, 2000)
- Using prior knowledge and skills in the new role (Ashforth & Saks, 1995)

Butler and Hardin-Pierce (2005) presented factors that may assist with a positive transition to a nurse manager or nurse leader role, including:

- Timely provision of constructive feedback on performance (Buckenham, 1997)
- Appropriate advice and guidance (Coeling, 1995; Vance, 1992)
- Continuing staff development opportunities (Kiat, 1996)

LEADERSHIP CHALLENGE How could Sarah use these suggestions to help with her transition to becoming a leader? Give a rationale for your answer.

Box 3-3 shows a leadership model that can help emerging nurse leaders.

BOX 3-3 STAFF NURSE PERCEPTION OF NURSE LEADERS

Problem focus: Krugman and Smith (2003) developed a leadership model over 4 years to help emerging nurse leaders.

Method: Survey instruments included Kouzes and Posner's Leadership Practice Inventory, which was used to measure nurse leaders' and other staff members' perceptions of nurse leadership, and the McClosky Mueller Satisfaction Scale, which was used to measure the job satisfaction of nurse leaders and

staff. Krugman and Smith collected data pre-implementation, postimplementation, and at other points over the 4 years.

Results: Leader RNs reported significantly more favorable perceptions of the leadership's abilities than the staff did. Job satisfaction data showed nurse leaders reported higher satisfaction with scheduling, praise and recognition, control, and responsibility than staff nurses.

Nurse manager goals may also hold the key to understanding success when transitioning to a new role. Johansson, Porn, Theorell, and Gustafsson (2007) studied first-line nurse managers' goal profiles—that is, those managers' prioritization of goals. Action theory and confirmatory theory guided the study.

In a case study format, the researchers used interviews, observations, a job description, and policy documents to carry out a hermeneutic interpretation data analysis.

They found that each nurse manager had three goals. In order of priority, those goals were:

1. An accepted and well-controlled nurse goal
2. An accepted and well-controlled administrator goal
3. A leadership goal that the nurse had not accepted nor maintained control over

Both leadership and administrative goals were based on a job description, but the nurse goal was personally chosen and based on self-identity and goal fulfillment. This study contributed to a new understanding of the first-line nurse manager's identity based on goal acceptance and goal control. The researchers stated that this action-theoretic approach could be a valuable key for understanding leadership, or its lack, in clinical practice.

How Action Learning May Help with Transitions

One method that may be helpful in transitioning to a nurse manager role is **action learning**. Action learning is a method usually used to work on complex organizational problems in teams of 6–10 people, but the method can also be used with dyadic (two-person) groups. Kalliath and Kalliath (2006) reported what happened when two colleagues used the process. Taking on a new role can cause feelings of being overwhelmed and even a fear of failure. Sources of support for the transition can be a peer, colleague, mentor, or supervisor, as long as both individuals make a serious commitment to help each other in learning and retooling for the new role. Both partners learn as the process stimulates fresh ideas and deepens insights (Kalliath & Kalliath, 2006).

Action learning is both a process and a powerful program for solving real problems; participants focus on what and how they are learning, which can benefit them and the organization as a whole (Marquardt, 1999).

If you are transitioning to a managerial role, you can implement action learning by using the other person as a:

- Sounding board
- Support to generate possible solutions

KEY TERM

Action learning is both a process and a powerful program for helping with nurses' transitions to a manager status.

- Helper to plan implementation steps
- Person to provide feedback about the results of actions taken

Proponents of action learning state that the process is enriched when participants engage in questioning and reflecting (Marquardt, 1999). Some questions to raise during the transition phase include:

- Am I getting what I want from this role?
- Where am I now compared to where I want to be?
- How can I get to where I want to be and achieve?

LEADERSHIP CHALLENGE Explain in what ways Sarah could use action learning to more smoothly transition to being a leader.

Survey on Nurse Manager Preparation

The results of a survey of nurse executives and nurse managers (Denning & Associates, 2004) provides hope that nurse managers may soon be better prepared for their role. Almost all nurse executives in the study reported preparing new nurse managers with on-the-job training. More than four-fifths reported using workshops, and almost two-thirds used continuing education classes. Others used personal mentoring, but more than 6 executives in 10 reported not having enough resources. At the top of their wish list was more emphasis on leadership development and transitioning from a clinical to a supervisory role, including:

- Curriculum-based study
- In-class speakers
- Study guides
- Web-based programs

LEADERSHIP CHALLENGE How could Sarah use these survey findings to smooth out her transition?

Leadership Transition Checklist

When planning to take a leadership position, gather the following helpful items; it may ensure a smoother transition:

- Information about the organization's history, hierarchy, flowcharts, mission, policies, and procedures

- Current leader's goals and objectives for the present year
- Job descriptions for all staff, including the leader
- Status reports for current projects
- Contacts, addresses, phone numbers, and e-mail addresses
- Financial information and records, including copies of completed requisitions
- Review of failures and lessons learned
- Master calendar of meetings, programs, and events
- Organization's Web address
- Leadership development resources
- Information about mentoring opportunities or other programs to help staff and leaders develop their leadership skills
- List of delegated tasks and who is responsible for them
- List of things the current leader wished someone would have told him or her a year ago
- List of important people in the organization whom you should meet
- Tips on how to run meetings, keep records, complete budgets
- Information on where to find needed forms and files
- Minutes of meetings
- List of the unique qualities of staff members and their evaluations

Summary

This chapter provided information about role theory and paths to nursing leadership. You've explored the need for formal training and mentorship during a transition and read about how action learning may help, how nurse managers prepare, and how gathering the items in a leadership transition checklist may make things easier. Read over the key terms and complete the leadership development exercises to gain a complete understanding of role transitioning.

Key Term Review

- **Action learning** is one process to help nurses transition to a manager role.
- **Role conflict** can occur when a leader's expectations differ from the group's expectations.
- **Role transition** is the process of moving from one role to another.

Leadership Development Exercises

■ Leadership Development Exercise 3-1

List four assumptions of role theory.

■ Leadership Development Exercise 3-2

Discuss the four paths to nursing leadership/management with at least two other nursing colleagues. Come to a consensus on which path would be the best to pursue. Give a rationale for your answer.

■ Leadership Development Exercise 3-3

Discuss with at least two other colleagues ways to embrace those attitudes and beliefs that are necessary to become a nurse leader. Using Hudson's and Johansson's findings, come up with a specific plan for helping nurses transition to nurse leader roles.

■ Leadership Development Exercise 3-4

Using the action learning information in this chapter, devise a specific action learning program to help a nurse transition to a leadership role. Give a rationale for your answer.

■ Leadership Development Exercise 3-5

Search the Web, and find at least one curriculum-based study, study guide, or Web-based program to help nurses transition from a clinical to a supervisory role. Share your findings with the class.

■ Leadership Development Exercise 3-6

Using the leadership transition checklist, see how much of the information you can gather for a unit on which you practice or have practiced. Tell the class what you learned from conducting this search.

■ Leadership Development Exercise 3-7

Pretend you're a staff nurse preparing to take a leadership role.

- a. What are your concerns, and what information do you need?
- b. Search the Web for that information.
- c. Report your findings to the class.

■ Leadership Development Exercise 3-8

Organize an in-class simulation in which four to six students volunteer to simulate the situation presented in the opening Leadership in Action vignette.

- a. Bring your chairs to the center or front of the room, and form a circle.
- b. Use the leadership transition checklist if a nursing supervisor will be a part of the simulation. (In this case, the nurse leader can ask the staff to leave and discuss some of the items on the leadership transition checklist with the supervisor.)
- c. *Optional:* Add a student to play the outgoing nurse leader who comes in after the nurse leader has presented her ideas to the staff and is either supportive or competitive (the simulation group decides which).
- d. Choose a timekeeper to warn the simulation group when 5, 10, and 15 minutes are up. (A 15-minute simulation is suggested.)
- e. The student playing the new nurse leader should present his or her ideas.
- f. The students playing staff members should pay little attention to the new nurse leader until they are asked for their ideas about halfway into the simulation.
- g. The nurse in transition should raise some of the issues in the Leadership Transition Checklist with the supervisor.
- h. When time is called, the simulation players should describe their feelings and reactions and what they learned from the simulation with the class.
- i. The class members then ask questions and identify any leadership concepts they observed. They give suggestions for adding additional elements that could be played out in future simulations.

Advanced Leadership Development Exercises**■ Leadership Development Exercise 3-9**

Teach at least three advanced nursing students about role transition.

■ Leadership Development Exercise 3-10

Design a problem statement for a research study focused on role transition. Make sure it is specific, focused, and doable. Obtain feedback from at least three classmates or nurse leaders skilled in research methods.

■ Leadership Development Exercise 3-11

Develop a research design to answer your problem statement. Consult with at least three classmates or nurse leaders skilled in research methods. Revise your design, if necessary.

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Managing Stress

CHAPTER OBJECTIVES

After reading this chapter, answering the leadership challenges, and participating in the leadership development exercises, you will be able to:

- Explain the nature of stress at work
- Describe the health consequences of stressful work
- Explain how to use hardiness theory to reduce stress
- List three ways to use Bandura's self-efficacy theory to reduce stress
- Try out different stress reduction measures

Advanced nurses will be able to:

- Teach peers stress reduction measures
- Develop a problem statement for a research study related to stress
- Develop a research design to answer your problem statement

Introduction

This chapter explores stress, the source of job stress, the effect of stress on nurses and nurse leaders, two theories that may be helpful, and methods for reducing stress.

The Leadership in Action vignette that follows will be used in this chapter to explore aspects of stress.

LEADERSHIP IN ACTION

Roberta, an RN working in a medical center, had been plagued by a loss of appetite, frequent colds, restless sleep, aching muscles, lower back pain, hypertension, and exhaustion since her brother was diagnosed with multiple sclerosis. About that time, she was asked to work extra shifts. She tried to ignore her symptoms, but when she snapped at a client and her supervisor overheard it, Roberta was counseled to get help from a mental health clinical nurse specialist who consulted on her unit. Roberta didn't want to meet with this clinical specialist, but she felt the pressure from her supervisor. Roberta finally made an appointment and talked with the clinical specialist about her stress.

"Since the reorganization, it just doesn't feel safe around here," Roberta told her nurse colleague. "They're firing people and expecting the rest of us to take up the slack. I don't know how long I can keep up these 12-hour shifts. I swear, I wake up in a cold sweat, remembering someone who died on my shift or how I had to rush through pouring meds and may have made a mistake. People are calling in sick just to get a break from the pressure. They don't care that that leaves us alone to deal with everything. I'd complain to my supervisor, but then I'm caught between families, who think we're not giving their loved ones good care, and my supervisor, who tells me that my stress is all my fault. Sooner or later, someone is going to have to make changes in the way the place is run. It's just too stressful."

LEADERSHIP CHALLENGE Is Roberta's stress personal or organizational? Give a rationale for your answer.

Stress Defined

When the term *stress* was coined by Hans Selye, he used it to describe a series of responses in animals that were subjected to severe physical and emotional threats that resulted in stomach ulcers, hypertension, heart attacks, arthritis, kidney damage, and other disorders. Selye (1978) defined stress as the "non-specific response of the body to any demand for change."

Stress quickly became a popular buzzword. It is estimated that 75% to 90% of all visits to primary care physicians are for stress-related complaints. It is difficult to name an illness in which stress does not play a contributing role (Rosch, 1998b).

Rosch (1998b), Selye's protégé, who based his conclusions on some of his mentor's writings, said, "Stress, in addition to being itself, was also the cause of itself, and the result of itself." To clarify stress's relationship to itself, Selye

coined the word **stressor** to refer to the cause of stress (Rosch, 1998b).

Selye later defined stress as “the rate of wear and tear on the body,” which Rosch (1993) pointed out is also the definition of aging. As a result of these different meanings, it is difficult for scientists to define, let alone measure, stress (Rosch, 1998a).

Some experts use the term *stress* to refer to the disorder that results from repeated insults and disruption of homeostasis, such as a heart condition (Rosch, 1998a). Other authors use the term to refer to the feeling of pressure they feel; they may say, “I’m stressed out,” for example, when what they may mean is “I feel pressured.”

To add to the confusion, stress can also be mental stress. Free radicals can create stress, especially if a person has low levels of antioxidant vitamins and high levels of free radicals. Not only dietary factors but also emotional stress can affect the tenuous balance of pro-oxidative and antioxidative influences (Biesalski, Jentsch, & Kirschbaum, 1994).

Stress has also been used to describe a wide range of distressful emotions (anxiety, panic, depression) and disturbing external events or stressors (observing people die, trying to keep clients alive, working too many hours, violence in the workplace, and being responsible for life-and-death decisions, to name a few).

KEY TERM

A **stressor** is a cause of stress.

LEADERSHIP CHALLENGE Which of the many definitions of stress most closely describes Roberta’s situation? Give a rationale for your answer.

One thing that all animal and clinical research confirms is that the feeling or perception of having little control is always distressful, and that is what is perceived as **stress** (Rosch, 1998c). Whether the perception of having little control is internally or externally produced may not matter.

KEY TERM

Stress is the feeling or perception of having little control.

Can Stress Be Quantified?

Holmes and Rahe (1967) developed a **social readjustment rating scale**, popularly known as the “Holmes-Rahe scale.” It ranks and rates 43 stressful life-change events. Death of a spouse takes the top of the list at 100 points. The first work-related incident—“fired at work”—appears at 47. Other work-related stressors include a change in responsibility (29), an outstanding personal achievement (25), trouble with a boss (23), and a change in working conditions (20).

KEY TERM

The **social readjustment rating scale** ranks and rates 43 stressful life-change events.

LEADERSHIP CHALLENGE Why might work-related stress rank so far down the list of stressful life-change events? Give a rationale for your answer.

The problem with the Holmes-Rahe scale is that an outstanding personal achievement, change in responsibility, or even a change in working conditions could be a positive experience, not a stressful one.

The Nature of Stress

Because of the difficulty of defining *stress*, the term has come to mean a subjective phenomenon that differs for each person. What is distressing for one person can be pleasurable to others. For example, some nurses may perceive a code as an exhilarating challenge, and others may find it highly stressful. The code itself is not inherently stressful. It depends on how each individual perceives the event.

An unpleasant event or threat—such as having to constantly deal with an intimidating boss, coworker, or client—may be identified as stressful by some people. Others may only be aware of how they react to such situations, and this can range from anxiety and depression to palpitations, agita and stomach upset, diarrhea, sweaty palms, and dozens of other emotional and physical responses (Rosch, 1998b). No matter how stress is identified, it is clear that job stress is on the upswing (Sauter et al., 1999).

Stress and Health

Stress sets off an alarm system. The brain responds by preparing the body for action. The nervous system is aroused, and hormones are released that quicken the pulse, deepen respiration, sharpen the senses, and tense the muscles—all of which characterize a fight-or-flight response.

This response is helpful when people need to run from physical danger. And short-lived or infrequent episodes of stress pose little risk. When stress becomes long term, however, danger awaits. The body is kept in a constant state of activation, increasing the wear and tear to biological systems. Fatigue and damage are the ultimate result, and the body's ability to repair and defend itself is seriously compromised. **Box 4-1** provides information about chronic conditions and job stress.

Because it has such wide-ranging effects, job stress is of utmost importance to nurse leaders and managers.

KEY TERM

Job stress results from a mismatch between a worker's capabilities, resources, or needs and the job's requirements.

Job Stress

Job stress can be defined as the harmful physical and emotional responses that occur when a job's requirements do

BOX 4-1 WHAT THE RESEARCH SHOWS ABOUT STRESS AND HEALTH

The National Institute for Occupational Safety and Health (NIOSH) examined the effects of stress on health:

Cardiovascular disease. Numerous studies suggest that psychologically demanding jobs that provide employees with little control over the work process increase the risk of cardiovascular disease.

Musculoskeletal disorders. Research conducted by NIOSH and other organizations has shown that job stress increases the risk of back and upper-extremity musculoskeletal disorders.

Psychological disorders. Several studies suggest that depression and burnout are due in part to high job stress, although economic and lifestyle differences may also contribute.

(Sauter et al., 1999)

not match the worker's capabilities, resources, or needs. Job stress can lead to poor health and injury. Job stress is the opposite of challenge, which energizes the worker psychologically and physically and motivates learning and job mastery (Sauter et al., 1999).

There are two schools of thought about job stress. Views differ on the importance of worker characteristics versus working conditions as the primary cause of job stress (Cox & Griffiths, 1996; Sauter et al., 1999). Focusing on worker stress leads to prevention strategies based on the individual (Rosch, 1993).

According to the National Institute for Occupational Safety and Health, excessive workload demands and conflicting expectations argue for identifying working conditions as the key source of job stress and for championing job redesign as a primary prevention strategy (Sauter et al., 1999). But often a mix of individual and organizational factors combine to create job stress.

Some job conditions that can lead to stress appear in **Box 4-2**.

LEADERSHIP CHALLENGE Using **Box 4-2**, suggest at least four changes you would make if you were the nurse leader on Roberta's unit.

Stress and Nurses

Nurses work in high stress and even dangerous environments. In an online health and safety survey of 4,826 nurses (from every age group, experience level, and type of care facilities) conducted by the American Nurses Association (ANA), over 70% of respondents cited the acute and chronic effects of stress and overwork as one of their top three health and safety concerns. Yet nurses continue to

BOX 4-2 STRESSFUL JOB CONDITIONS

The design of tasks. Heavy workload, infrequent rest breaks, long work hours, and hectic and routine tasks that have little inherent meaning, do not use worker skills, and provide little sense of control can increase stress.

Example: Roberta works to the point of exhaustion, and her work allows little chance for creativity, self-initiative, or rest.

Management style. Lack of worker participation in decision making and poor communication in the organization can add to stress.

Example: Roberta cannot make a decision without consulting her supervisor, and her boss is insensitive to her need to visit her brother.

Interpersonal relationships. The social environment is nonsupportive, and coworkers and supervisors seem unconcerned with helping.

Example: Roberta's physical isolation reduces opportunities to interact with coworkers and receive help from them.

Work roles. Job expectations are conflicting and changeable. There is too much responsibility, and staff must wear too many hats.

Example: Roberta is often caught in impossible situations trying to satisfy both client family members and her supervisor.

Career concerns. Opportunities for growth, advancement, or promotion are few. Job insecurity is in the air. Change is rapid, and workers cannot prepare for what's next.

Example: Since the reorganization of the hospital, Roberta is worried about her future and what will happen next; a neighboring hospital was closed down after profits fell, and the staff was split up and sent to various hospitals throughout the city.

Environmental conditions. Some of the dangerous work conditions nurses may be exposed to include noise, air pollution, ergonomic problems, infections, and radiation.

Example: Roberta is exposed to infections, air pollution, and radiation at work.

(Sauter et al., 1999)

be pressed harder, with more than two-thirds working some type of mandatory or unplanned overtime every month. Ten percent reported working overtime eight times a month (ANA, 2001).

But stress not only affects nurses. Seventy-five percent of nurse respondents reported the quality of nursing care at their facility had declined over the past 2 years, and 56% thought that the time they had available for client care had decreased (ANA, 2001).

Four years later, a survey of 76,000 nurses conducted through ANA's National Database of Nursing Quality Indicators, found that 82% of RNs reported working overtime, with most respondents reporting that overtime had increased on their unit during the past year and 26% reporting being floated to hospital units within the past 2 weeks (ANA, 2005).

American nurses are not the only ones to suffer from job stress. The National Survey of the Work and Health of Nurses, conducted by the Canadian Institute for Health Information and Health Canada (2005) with 19,000 Canadian respondents, found that many nurses regularly worked overtime and that many had more than one job. This groundbreaking study indicated that psychosocial and interpersonal factors (including work stress, low autonomy, and lack of respect) are strongly associated with health problems among Canada's 314,900 nurses. The Canadian study found the proportion of nurses who reported a high level of work stress (as determined by the level of job strain, physical demands, and support from coworkers and supervisors) was greater than that for employed people overall.

Job strain results when the psychological demands of a job exceed the worker's discretion in deciding how to do the job. Nearly one-third (31%) of nurses in Canada were classified as having high job strain. Job strain was strongly related to fair or poor physical and mental health and to lengthy or frequent absences from work for health-related reasons. Seventeen percent of nurses who perceived high job strain reported taking 20 or more sick days in the past year, compared with 12% of nurses who reported less job strain. Nearly half (46%) of the Canadian nurses reported that their employer expected them to work overtime, and 3 in 10 did work paid overtime. Half of them regularly worked unpaid overtime, averaging 4 hours per week.

**KEY TERM**

Job strain results when the psychological demands of a job exceed the worker's discretion in deciding how to do the job.

LEADERSHIP CHALLENGE What is the relationship between job strain and taking sick days? Give a rationale for your answer.

A groundbreaking study of 10,000 nurses and 230,000 patients from 168 hospitals in Pennsylvania from 1998 to 1999 verified the dangerous and unhealthy results of nurse short-staffing and how it increases client mortality, nursing dissatisfaction, and nursing burnout (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002). See **Box 4-3** for more information.

LEADERSHIP CHALLENGE What is the relationship between staffing, patient death, and burnout? Give a rationale for your answer.

Stress and the Work Environment

While employers may believe that stressful working conditions are a necessary evil and that workers must be pressured to set aside health concerns for health

BOX 4-3 STAFFING, CLIENT MORTALITY, NURSE BURNOUT, AND JOB DISSATISFACTION

Aiken, Clarke, Sloane, Sochalski, and Silber (2002) found that each additional client assigned to a nurse resulted in:

- A 30-day mortality increase of 7%
- A failure-to-rescue rate increase of 7%
- A nursing job dissatisfaction increase of 15%
- A burnout rate increase of 23%

In fact, when nurses had eight clients instead of four, their caseload had a 31% higher chance of dying within 30 days of admission.

Other findings of the Aiken study included:

- Forty-three percent of the nurses surveyed were burned out and emotionally exhausted.
- Nurses who reported being burned out were four times as likely to report that they were leaving their jobs in the next year.

corporations to remain profitable, research findings challenge those assumptions. Studies like the ones just described show that stressful working conditions are actually associated with increased absenteeism, tardiness, and workers' intentions to quit their jobs. All these factors have a negative effect on the bottom line (Sauter et al., 1999).

LEADERSHIP CHALLENGE What motivates hospital owners or boards to continue these kinds of behaviors given the studies that are emerging? Provide a rationale for your answer. (Hint: Don't overlook the connection between the bottom line and job stress effects.)

Creating a healthy work environment for nursing practice is crucial to maintaining an adequate nursing workforce (American Association of Critical-Care Nurses, 2005). Being a nurse is associated with multiple and conflicting demands imposed by leaders, managers, and medical and administrative staff. The stressful nature of the profession often leads to burnout, disability, and high absenteeism.

The stress of healthcare environments has been linked to a shortage of registered nurses, projected to number just 400,000 by 2020 (Shirey, 2006a). In addition to the stresses of being a nurse that have already been discussed, there are other societal stresses that create even more job stress. New sources of stress are developing at what seems like supersonic speeds along with changes in society. These new sources include technostress, restructuring, and disconnectedness.

KEY TERM

Technostress results from difficulties in dealing with computer technologies or from an unusual attraction to them.

Technostress

In 1984, Craig Brod, a Silicon Valley psychiatrist, impressed with the steady increase in stress-related disorders resulting from the activities in this fast-paced and hectic community, coined the term *technostress*. He even wrote a book: *Technostress: The Human Cost of the Computer Revolution*. Technostress resulted from difficulties in dealing with computer technologies or from an unusual attraction to them.

Technostress: The Human Cost of the Computer Revolution. Technostress resulted from difficulties in dealing with computer technologies or from an unusual attraction to them.

According to Brod, technostress is related to technophobia, or a fear of new and constantly upgraded computer software and hardware devices as well as the computers themselves. Technostress can also stem from a preoccupation with computer-related activities and information overload.

Technology is all around—from computers to cell phones, pagers, iPods, BlackBerrys, electronic monitoring devices, video terminals, and more—and was supposed to make life less difficult (Leggiere, 2002). Rather than reduce the workweek, technology has increased it. Nurses are now tied to the workplace 24/7, on weekends, on holidays, and even on vacations (D'Anna, 2006). There is no rest period allowed anymore. The requirement to be constantly alert can only result in increased stress.

A part of technology enhancement in health care is the movement toward placing individual client records online (Detmer, Steen, & Dick, 1997). This can lead to additional mental stress for nurses who may be asked to add another task to their already-full day and may be especially stressful for those who are not computer savvy.

Working with computers can also lead to physical stress. Repetitive stress injuries, such as carpal tunnel syndrome, are now the most costly workplace injury. They account for one-third of the more than \$60 billion in workers' compensation payments annually (Rosch, 2000).

Restructuring

Companies, including healthcare corporations, that have eliminated jobs are more likely to see increases in disability claims ranging from back pain to gastrointestinal disorders than firms that haven't cut jobs. What is being saved in payroll costs through downsizing may be eaten up in stress-related disability costs. Simply removing people without eliminating the work they did could cost *more* in the long run.

Today's organizations test the theory that employees can work forever with no time to recover. Administrators try to convince employees that they can work and work without letting up for a second. This false urgency can result in numerous errors and in activity without purpose or awareness (Robinson, 2003).

Overworked and overstressed healthcare professionals make mistakes that can be fatal. A report from the Institute of Medicine (Kohn, Corrigan, & Donaldson, 1999) revealed that errors in hospitals cause up to 100,000 deaths a year. Nurses throughout the country report fears that they may have made mistakes because of the fast pace at which they must work (Robinson, 2003).

For nurse leaders, the dilemma is doubly challenging. On one hand, employees are experiencing greater stress (Shirey, 2006b); on the other, they have less time to attend stress management training (Shimko, Meli, Restrypo, & Oehlers, 2000).

Disconnectedness

As nurses become too busy or too tired for healthy relationships, stress increases. Nurses are working more now and enjoying it less. They may be so overloaded that they cannot maintain those close family and friend relationships that are so crucial to reducing stress. In many households, family members have their own television sets and cell phones, which cuts down on those social support opportunities that are so important to stress reduction (Charles, 2001).

Satisfaction in life comes from close relationships, a sense of belonging, positive attitudes, managing expectations, high self-esteem, work goals that are congruent with personal values, and an active leisure lifestyle (Charles, 2003). When these elements are not available because of job requirements, stress overload and burnout can occur.

KEY TERM

Burnout is a stage of exhaustion that can result from unrelieved work stress or from an erosion of the soul.

Burnout

Burnout, a term coined by Freudenberger and Richelson (1980), is a debilitating psychological condition brought about by unrelieved work stress. Signs of burnout include:

- Depleted energy and emotional exhaustion
- Lowered resistance to illness
- Increased depersonalization in interpersonal relationships
- Increased dissatisfaction and pessimism
- Increased absenteeism and work inefficiency

Burnout was further described by Maslach and Leiter (1997). They defined burnout as a disconnect between expectations about work versus the realities of what is actually experienced. Burnout is a disconnect between what nurses are and what they have to do. Burned out people can be too depleted to give of themselves in a creative and cooperative fashion (Montague, 1994). This can be a real problem for nurses whose role is to provide care.

Burnout represents an erosion in values, dignity, spirit, and will—an erosion of the human soul. Maslach and Leiter do not fault the worker, but rather the work environment.

In a presentation at the New York Academy of Medicine in November 2006, Mason and Smith reported that, 41% of US nurses are dissatisfied with their jobs, 30% to 40% have experienced burnout, and 17% aren't even working in nursing anymore. Many of these nurses have a remote, indifferent, or impersonal relationship with their clients rather than a caring one.

Burnout can be considered a crisis of caring. Nurses are caring individuals and tend to work harder at caring than some other professionals. As they become more successful at caring, they are apt to be noticed and asked to do even more for the cause.

This can put additional demands on their time and energy.

Burnout is both a physical and an emotional exhaustion during which the professional no longer has any positive feelings, sympathy, or respect for clients. Over time, unless nurses take care of themselves, they may experience burnout. Nurses are at a greater risk for burnout than people in other professions. The very fact that nurses care about other people puts them at a greater risk than if they did not care because strong emotion takes more energy and can be depleting.

According to Maslach and Leiter (1997), the six systemic sources of burnout are:

1. Work overload
2. Lack of control
3. Insufficient reward
4. Unfairness
5. Breakdown of a sense of community
6. Value conflict

Some of the negative behavioral effects of burnout include:

- Rudeness
- Sarcasm
- Criticism and insults
- Irrational anger or isolation and introversion
- Eating too much or too little
- Abusing alcohol and drugs
- Suffering physical symptoms, such as hypertension and frequent headaches
- Downhill spiral of relationships with family, friends, and colleagues
- Fading dedication and commitment to the organization

Working to exhaustion and not stopping to engage in restorative activities can lead to burnout and force the body to take its own break (D'Anna, 2006). Pain, chronic illness, and other conditions can be messages from the body to pay attention, stop, and restore.

Rest and sleep are two ways the body takes a restorative break. Sixty-three percent of American adults don't get the recommended 8.5 hours of sleep, and that includes nurses. Researchers at the National Sleep Foundation found a direct relationship between the amount of hours worked and a corresponding loss of sleep (Robinson, 2003).

Nurses who stop to rest or sleep can combat stress and burnout. Many nurses don't even stop for lunch, let alone for a break. Yet it has been known since the early 1900s that even a 5-minute rest or break increases worker output and that a 10-minute break increases it even more (D'Anna, 2006).

LEADERSHIP TIP

To reduce stress, make sure the workload is evenly distributed.

LEADERSHIP TIP

To reduce burnout, make sure you and your staff take allotted breaks.

KEY TERM

Stages of burnout include honeymoon, balancing act, chronic symptoms, crisis, and enmeshment.

KEY TERM

Psychological hardiness is the ability to survive stress and includes a commitment to self, work, family, and other important values; a sense of personal control over one's life; and the ability to see change in one's life as a challenge to master.

Box 4-4 provides an assessment tool for you to evaluate your level of burnout. Although the progression Box 4-4 presents is sobering, the model provides hope that taking action can break the cycle. It is always possible to strengthen your coping skills and return to an earlier stage. The wise course of action is to involve yourself in positive self-care to prevent anything after stage 1 from developing. Hardiness can assist with that effort.

Hardiness: A Personal Theory of Stress Protection

Dr. Suzanne Ouellette Kobasa (1984) researched the ability of humans to survive stress. She found that **psychological**

hardiness, or the ability to survive stress, is composed of three ingredients:

1. A commitment to self, work, family, and other important values
2. A sense of personal control over one's life
3. The ability to see change in one's life as a challenge to master

Kobasa tested executives, lawyers, women in gynecologist offices, supervisors, US Army officers, and college students. Her results were the same for each population: biology is not destiny.

BOX 4-4 STAGES OF BURNOUT

Stage 1: Honeymoon. This stage is marked by high job satisfaction, commitment, energy, and creativity. If positive and adaptive patterns of coping are developed, it's possible to remain in the honeymoon stage indefinitely.

Stage 2: Balancing act. A noticeable increase in job dissatisfaction, work inefficiency, avoiding making necessary decisions, losing stuff at work, general and deep muscle fatigue, sleep disturbances (because of thoughts about work), and escapist activities (eating, drinking, smoking, zoning out) is experienced.

Stage 3: Chronic symptoms. The stage 2 symptoms intensify and include chronic exhaustion, physical illness, anger, and depression.

Stage 4: Crisis. The symptoms become more critical, and the physical symptoms intensify and/or increase in number; this may include obsessing about work frustrations, allowing pessimism and self-doubt to dominate thinking, and developing an escapist mentality.

Stage 5: Enmeshment. The symptoms of burnout are so embedded in a person's life that he or she is more likely to be labeled as having a significant mental or physical illness than burnout.

(Based on Venning & Spradley, 1981)

A hardy personality is more important than a strong constitution. It is possible to come from a family with chronic illness and do better under stress if you are hardy than if you had come from a healthy family and have fewer inner resources (Kobasa, 1984).

Exercise is a good antidote to stress but may be short term. Jogging after an argument can help you that evening, but the next morning, your stress levels may rise if you reencounter the stress-provoking situation. Hardiness skills may be long-term inoculations against stressors. Two studies even found that hardiness is more powerful than optimism and religiousness in coping with stress (Maddi, 2006).

Judkins, Massey, and Huff (2006) provided evidence for the importance of hardiness. They discovered that intense job-related demands affected job performance and increased the use of sick time. They found that managers with high hardiness skills and low stress used less sick time than managers with low hardiness skills and high stress.

In another study of hardiness, Judkins, Reid, and Furlow (2006) investigated the development of a model hardiness training program to reduce stress and increase hardiness among nurse managers. Thirteen nurse managers at an urban hospital completed pretests for hardiness levels before undergoing a 2.5-day hardiness training program. Posttests were completed after the initial training, after each of 6 weekly sessions, and after 6 and 12 months. Findings suggested that the hardiness program and intermittent follow-up increased and sustained hardiness levels in nurse managers and may have had a positive effect on staff turnover rates (Judkins, Reid, & Furlow, 2006).

Three helpful techniques for increasing hardiness are:

1. Focusing on body signals that something is wrong
2. Restructuring stressful situations
3. Compensating through self-improvement (Kobasa, 1984)

Focusing

Focusing is a technique developed by Eugene Gendlin (1978) that can help you recognize signals from your body that stress is interfering with comfort. Gendlin found that executives are so used to pressure in their temples, tightened necks, or stomach knots that they have stopped noticing these signals that something is wrong.

A beginning focusing question might be “Where is tension located in my body?” Those who have learned to tune out body signals can begin with a progressive relaxation tape to help them identify the location of stress and tension.

KEY TERM

Focusing helps individuals recognize signals from their body that stress is interfering with comfort.

Reconstructing Stressful Situations

The second technique for enhancing hardiness is reconstructing stressful situations. This is accomplished by thinking about a recent episode of distress and writing about:

- Three ways it could have gone better
- Three ways it could have gone worse

This exercise will increase your ability to put the situation in perspective, which is useful for reducing stress.

Compensating through Self-Improvement

The third technique Kobasa found useful for enhancing hardiness was compensating through self-improvement. This approach works most effectively for stressors that cannot be avoided, such as an illness, an intimidating or unfair boss, or an unexpected change or loss. You can balance the feeling of lost control that results from such unexpected events by taking on a new challenge. Learning a new skill or teaching someone else can reassure you that you can still cope with life adequately.

LEADERSHIP CHALLENGE Which signs of burnout have you observed in healthcare situations? If you were the leader of that unit, what would you do to help the burned-out nurses? (Hint: How could you use hardiness theory?) Give a rationale for your answer.

In addition to hardiness theory, nurse leaders can also benefit from the use of Bandura's theory of self-efficacy.

Bandura's Theory of Self-Efficacy

KEY TERM

Bandura's **theory of self-efficacy** focuses on the belief in one's ability to perform adequately.



Bandura (1977, 1986, 1997, 2001, 2004) developed a social cognitive theory that has been widely used and accepted. Bandura (1986) wrote that individuals possess self-beliefs that can enable them to exercise control over their thoughts, feelings, and actions.

Self-efficacy, or the belief in one's ability to perform adequately, has proved to be a more consistent predictor of behavioral outcomes than others (Bandura, 2004). Learners with high self-efficacy expect more of themselves and put forth the effort to get it. They approach difficult tasks as challenges rather than as situations to avoid.

Certain environmental characteristics can cause even highly self-efficacious and well-skilled learners not to behave in concert with their beliefs and abilities if they:

- Lack the incentive
- Lack the necessary resources
- Perceive social constraints

Bandura (1977) believed that learning would be laborious and hazardous if people had to rely only on themselves. Luckily, employees have nurse managers to model appropriate behavior for them. This vicarious learning permits individuals to learn novel behaviors without going through the arduous task of trial-and-error learning.

Bandura (1977) emphasized the importance of modeling behaviors, attitudes, and emotional reactions. He believed that it was the human ability to symbolize that allowed learners to:

- Extract meaning from the environment
- Construct guides for action
- Solve problems cognitively
- Support well-thought-out courses of action
- Gain new knowledge by reflective thought
- Communicate with others at any distance in time and space
- Use self-reflection to make sense of their experiences
- Engage in self-evaluation and alter their thinking and behavior accordingly (Bandura, 1986)

LEADERSHIP CHALLENGE Based on what you know about Bandura's work, how could you, as a nurse leader, use this theory? Give a rationale for your answer.

A series of principles underlie Bandura's social cognitive theory:

- The highest level of observational learning is achieved by first organizing and rehearsing the modeled behavior symbolically and then enacting it overtly.
- Coding modeled behavior into words, labels, or images results in better retention of information than does simply observing.
- Individuals are more likely to adopt a modeled behavior if it results in outcomes they value, if others admire the role model, and if the behavior has functional value.
- Self-efficacy beliefs are paramount; motivation levels, affective states, and actions are based more on what people believe than on what is objectively true (1997).

LEADERSHIP IN ACTION

Jason, a seasoned nurse leader, had been using Bandura's social learning theory for many years. Just recently, he'd been promoted to a new nursing leadership position. He'd observed that several of the staff exhibited signs of high stress and possibly even burnout. He spent some time planning what to do and decided to call a staff meeting to discuss Bandura's theory and explain how journal writing has reduced his own job stress. Once the meeting began, he asked employees to think about their job and to write about any unsafe or unpleasant aspects of their job, whether they had too much work to do, whether they had adequate control over their duties, and whether they were able to use all their skills and talents to the fullest in their work.

LEADERSHIP CHALLENGE If you were Jason, what would you do with the information about workplace stress that he had asked employees to write about? Give a rationale for your answer.

LEADERSHIP IN ACTION

Devon, a seasoned nurse manager, planned to model the most effective way to obtain an intake interview, allow employees to practice small segments of the interview process, and provide each with a certificate of achievement once they did a full interview.

LEADERSHIP CHALLENGE Think of at least two other ways you could use self-efficacy theory to reduce job stress with employees. Give a rationale for your answer.

Individual Approaches to Job Stress

Hardiness and Bandura's theory of self-efficacy can certainly help nurses combat job-related stress. Other individual approaches to job stress include employee assistance programs and nutrition.

Employee Assistance Programs

After Roberta, the RN in this chapter's opening Leadership in Action vignette, shared her job stress concerns with the mental health clinical nurse specialist, she was directed to an employee assistance program (EAP) that provided stress

management. Stress management programs teach workers about the nature and sources of stress, the effects of stress on health, and personal skills to reduce stress, such as relaxation exercises.

EAPs also counsel employees on their work and personal problems. Stress management training can rapidly reduce stress symptoms, such as anxiety and sleep disturbances; it is also inexpensive and easy to implement.

Stress management programs have two drawbacks:

1. The beneficial effects on stress symptoms can be short lived.
2. Focusing on individual stress levels ignores important root causes of stress.

When the stress management program is administered by an EAP, a third drawback may come into play:

3. A lack of confidentiality about shared personal information can help corporations fight employee-initiated lawsuits (Rosch, 1993). For that reason, referral to off-site programs, nurse-led programs, or organizational change may be more optimal choices.

Many colleges, universities, adult education centers, and distance education providers offer stress reduction programs. Nurse leaders can develop a list of resources and suggest that staff participate in them.

Nurse leaders can also develop their own stress reduction programs for staff, ask a mental health clinical nurse specialist to design one, or hand out stress reduction information at staff meetings or shift reports.

Box 4-5 provides a relaxation/imagery exercise that nurse leaders can use and teach to supervisees.

BOX 4-5 RELAXATION/IMAGERY EXERCISE

1. Find a quiet place where you won't be disturbed.
2. Slip off your shoes, loosen tight clothing, and sit or lie down and get comfortable.
3. Close your eyes.
4. Focus on your breathing. Let your breath slowly move toward your center as you inhale and exhale. Just let it move naturally.
5. Begin to breathe in relaxing and healing energy with each inhale. See that relaxing healing energy as a color.
6. With each exhale, let go of any old thoughts, feelings, or situations that you don't need anymore. Perhaps view them as a different color. Just breathe out whatever it's time to be rid of. Inhale relaxing energy, and exhale what you're ready to let go of for a while until you feel relaxed.
7. When you're ready, scan your body, and exhale any remaining tension or ideas you don't need anymore.
8. Slowly open your eyes, feeling relaxed and refreshed. Take this relaxed and refreshed feeling with you throughout the day.

Not only is relaxation important to enhance mood and ward off exhaustion, it is more important than chewing is to the digestion of complex carbohydrates (Morse, Schacterle, Furst, Zaydenberg, & Pollack, 1989). (See the following section on nutrition for why relaxation is important.)

Another stress reduction measure includes using coping thoughts. Much of the internal dialogue people have with themselves consists of negative words and feelings. Coping thoughts counteract such negativity and provide a positive supportive voice for nurses to use. **Box 4-6** provides coping thoughts you can use yourself and teach to employees.

Nutrition

Stress is not just a mental or psychological issue; it has very real physical effects, including:

- Slowing digestion
- Releasing fats and sugars into the bloodstream

BOX 4-6 COPING THOUGHTS

Directions: Read through the list of positive thoughts that follow. Choose at least two to use to reduce your stress and enhance your coping ability. Say them often to yourself. Consider writing them down on index cards and carrying them with you or posting them on your mirror, your refrigerator, your desk, or your dashboard to remind you to be positive.

Preparatory Stage (Use these comments when preparing to enter a stressful situation)

- I can handle this.
- There's nothing to worry about.
- I'm picturing myself succeeding again and again until I believe it.
- I'll jump right in and be fine.
- It will be easier once we get started.
- Soon this will be over.

The Situation (Use these comments in the stressful situation)

- I refuse to let this situation upset me.
- Take a deep breath and relax.
- I can take this step-by-step.

- I can do this; I'm handling it now.
- I can keep my mind on the task at hand.
- It doesn't matter what others think; I will do this.
- Deep breathing really works.

Reinforcing Success (Use these comments after the stressful situation to enhance self-esteem)

- Situations don't have to overwhelm me anymore.
- I did it!
- I did well.
- I'm going to tell _____ about my success.
- By not thinking about being afraid, I wasn't afraid.
- By thinking about staying calm, I stayed calm.
- By picturing myself being successful, I was successful.

Source: Used with permission from *Wellness Practitioner, Concepts, Research, and Strategies*, by Carolyn Chambers Clark, New York: Springer Publishing Company, 1996.

- Increasing adrenaline production, which causes the body to step up its metabolism of proteins, fats, and carbohydrates to produce a quick source of energy
- Excreting amino acids, potassium, and phosphorus
- Depleting magnesium stored in muscle tissue
- Storing less calcium

The result is the body becomes deficient in many nutrients, and in chronic stress, it is unable to replace them adequately (Balch & Balch, 1997).

A diet of meat, white bread, coffee, and donuts was associated with an incidence of cancer, ischemic heart disease, and all-cause mortality in a study of 34,192 Californians (Fraser, 1999).

LEADERSHIP CHALLENGE Compare this study's findings to the third, fourth, and fifth stages of burnout described in Box 4-4.

Research shows the following connections between eating habits and health problems:

- *Meat.* Eating meat is correlated with cancer of the colon, rectum, stomach, pancreas, bladder, endometrium and ovaries, prostate, breast, and lung; heart disease; rheumatoid arthritis; type 2 diabetes; and Alzheimer's disease. These correlations indicate the presence of factors in red meat that damage biological components (Qi, van Dam, Rexrode, & Hu, 2007; Tappel, 2007).
- *White bread.* Bread that is not whole grain is correlated with breast cancer (Augustin et al., 2001), gastric cancer (De Stefani et al., 2004), prostate cancer (Walker et al., 2005), insulin resistance and type 2 diabetes (Villegas, Salim, Flynn, & Perry, 2004), and polycystic ovary syndrome (Douglas et al., 2006).
- *Coffee and caffeine.* Foods (like chocolate), drinks (like sodas, teas, coffee), and prescription drugs that contain caffeine are associated with stress. Caffeine can trigger a drop in blood sugar that results in fatigue and irritability (Rogers et al., 2005). Caffeine has been associated with increased cholesterol (Kleemola, Jousalahti, Pietinen, Vaatiainen, & Tuomilehto, 2000), systolic blood pressure, and heart rate—all of which are markers of heart inflammation (Hamer, Williams, Vuonvirta, Gibson, & Steptoe, 2006). Caffeine has also been associated with increased risk of ovarian cancer (stage 5 of burnout). The chances of such health problems may be decreased by eating at least three cruciferous vegetables a week (Goodman, Tung, McDuffie, Wilkens, & Donlon, 2003).

(Cruciferous vegetables that protect against stress include arugula, bok choy, broccoli, brussels sprouts, cabbage, cauliflower, collard greens, daikon, horseradish, kale, kohlrabi, mizuna, mustard greens, napa or Chinese cabbage, radishes, rutabaga, tatsoi, turnip greens, turnips, and watercress.

Clinically, caffeine can often be directly traced to sleeping problems and sometimes to panic attacks, including heart palpitations. Caffeine also adds to nervousness and irritability in susceptible individuals.

Caffeine is an addictive substance that can cause 49 different symptoms during withdrawal, including headache, fatigue, muscle pain and stiffness, mild nausea, decreased energy, drowsiness, depressed mood, irritability, and decreased alertness (Juliano & Griffiths, 2004). To prevent withdrawal symptoms, it is best to taper off by drinking cups of half coffee and half a cereal beverage for a few days and gradually increasing the cereal beverage until no coffee remains. Chocolate can be substituted with carob products. Tea can be substituted with herbal teas.

- *Donuts and other simple sugars.* Donuts contain a large amount of sugar, which has been associated with the suppression of the immune system (Ichimura et al., 1990; Ringsdorf, Cheraskin, & Ramsey, 1976), mineral imbalances (Fields, Ferritti, Smith, & Reiser, 1983; Kozlovsky, Moser, Reiser, & Anderson, 1986; Lemann, 1976; Sears, 2006), increased risk of diabetes (Schulze et al., 2004), and various cancers (Cornee, 1995; De Stefani et al., 2004; Michaud, 2002). Sugar can also be addictive (Colantuoni et al., 2002).

Reducing the intake of simple sugars and increasing the ingestion of the nutrients that follow can decrease stress:

- *Vitamin C.* This nutrient can reduce the levels of stress hormones in the blood and reverse other typical indicators of physical and emotional stress, such as weight loss, enlargement of the adrenal glands, and reduction in the size of the thymus gland and spleen (American Chemical Society, 1999).

Food sources of vitamin C include asparagus, beet greens, berries, broccoli, brussels sprouts, cantaloupe, citrus fruit, collard greens, dandelion greens, green peas, kale, mangos, mustard greens, onions, papayas, pineapple, radishes, spinach, sweet peppers, Swiss chard, tomatoes, turnip greens, and watercress (Balch & Balch, 1997).

- *Vitamin B.* The B-complex vitamins in combination with vitamin C are called the “stress vitamins” because they reduce stress. Vitamin B6 deficiency is especially linked to stress, probably because it is one of the building blocks for serotonin, which fights depression and stress. Without B6, even when taking into account coping style and amount of social support, individuals had significantly more psychological distress and anxiety. Research conducted at the University of Miami School of Medicine confirmed that inadequate levels of vitamin B6 were related to stress (“Researchers at UM School

of Medicine Link Vitamin B6 Deficiency to Stress,” 1995). Researchers there suggested beginning with vitamin B6 rather than antidepressant or anti-anxiety medication because the vitamin carries none of the harmful side effects associated with certain prescription drugs.

Food sources of vitamin B6 include avocado, bananas, blackstrap molasses, brewer’s yeast, broccoli, brown rice, cabbage, cantaloupe, carrots, chicken, corn, eggs, fish, peas, potatoes, soybeans, spinach, sunflower seeds, tempeh, walnuts, and wheat germ.

- *Vitamin E.* Researchers found that taking 200 mg of vitamin C and 250 IU of vitamin E can protect against the negative effects of stress (Sahin & Kucuk, 2001).

Food sources of vitamin E include brown rice, cornmeal, dark green leafy vegetables, eggs, kelp, legumes, nuts, oatmeal, organ meats, seeds, soybeans, sweet potatoes, watercress, wheat germ, and whole grains.

- *Selenium.* Diets deficient in selenium and vitamin E can lead to liver damage; a diet with sufficient selenium and vitamin E can protect against stress effects (South, Smith, Guidry, & Levander, 2006).

Food sources of selenium include Brazil nuts, broccoli, brown rice, chicken, garlic, kelp, liver, molasses, onions, salmon, seafood, tuna, vegetables, wheat germ, and whole grain breads and cereals (Balch & Balch, 1997).

- *Magnesium.* Animal and human studies have shown that magnesium deficiency increases stress-induced hypertension, stroke, myocardial infarction, rhythm disturbances, and sudden death. Conversely, the administration of magnesium protects against cardiac and blood vessel damage and damage caused by the stress-related hormones adrenaline and noradrenaline. Other stress-related conditions—such as migraines, depression, bipolar disease, panic disorder, and epilepsy—may all respond to additional magnesium (Rosch, 1997).

Food sources of magnesium include apples, apricots, avocados, bananas, black-eyed peas, blackstrap molasses, brown rice, cantaloupe, dark green leafy vegetables, figs, fish, garlic, grapefruit, lima beans, millet, nuts, peaches, seafood, sesame seeds, soybeans, tofu, watercress, and whole grains.

When it is not feasible to eat the required foods, it may be necessary to take a high-grade multivitamin and a high-grade multimineral.

LEADERSHIP CHALLENGE How would you use this nutritional information to help your staff reduce their stress?

In addition to individual strategies to reduce stress, there are organizational strategies.

Other Stress Reduction Ideas

There are many ways to reduce stress, depending on the situation and the person, including:

- *Putting job stress in perspective.* Jobs are temporary, but friends, families, and health aren't. If your employer can't or won't change, begin looking for a new job.
- *Modifying your work situation.* If you like your employer but the job is too stressful, ask about tailoring your work to your skills or making a lateral transfer.
- *Taking a break.* Walk away from a stressful situation that you feel unable to handle at the moment. Take a walk up a few flights of stairs or out in the sunshine, doing a meditation—such as counting “one, two” or saying “left, right”—as you walk. Have a cup of peppermint or chamomile tea (unless you're allergic to flowers), and let your stress melt as you sip.
- *Organizing your workspace.* Clutter and disorganization can increase a sense of loss of control.
- *Keeping track of accomplishments.* Keep a to-do list, and cross off each item as you complete it.
- *Rewarding yourself for your achievements.* Your boss may not notice, but you should. Take yourself (or a friend or two) out for a nice dinner or cook at home together, and present yourself with a certificate of achievement. Don't forget to hang it on your wall and take pictures to carry around to remind you of your accomplishment.
- *Using your support system.* Talk out your frustrations and stress with supportive others. Ask for suggestions, but carefully weigh putting them into action until you've thought them through.
- *Cultivating allies at work.* Make a pact that you'll support each other when you encounter stress.
- *Finding humor in the situation.* Share a joke or a funny story with friends or colleagues. Write a story, making your boss (or whoever is adding to your stress) the victim in a mystery plot or someone who is the target of a bully.
- *Stopping micromanaging.* No situation is perfect, and no person is, either. Change your motto from “Everything must be perfect” to “Everyone must perform at the highest level possible given the situation.”
- *Avoiding negative people and situations.* Maintain a positive attitude by relaxing, using coping skills, and making good nutritional decisions. Don't allow negativism to suck the energy and motivation out of you (Hansen, 2007).
- *Distinguishing between stress you can change and stress you can't change.* Write down stressors affecting you and separate them into those you can change

and those you can't. Focus on those you can change. Prioritize this list, and get to work (Rosch, 1998c).

- *Following a healthy lifestyle.* Eat healthy foods (hint: keep only healthy foods in your cabinets and refrigerator in case you binge), exercise daily, and use relaxation and coping strategies.
- *Finding time to be alone.* Turn off cell phones, iPods, faxes, and other forms of technology. Put a “do not disturb” sign on your door. Defend your time alone ruthlessly.
- *Keeping a stress diary.* Note when you feel stressed, and begin to notice patterns so that you can intercept stress and reduce it.
- *Cutting back on commitments.* You're only human. Talk to your boss and family about making a workable solution to overscheduling.
- *Developing a hobby.* Make sure that whatever you choose is low stress and noncompetitive.
- *Spending time outdoors.* Nature is a natural de-stresser, and 15 minutes a day of sun on your arms and face can enhance your health. If you have a yard, start a garden. If you don't, grow flowers, plants, or herbs on your terrace or even on your windowsill (Borgatti, 2000).
- *Relaxing with a hot bath.* Fifteen or 20 minutes alone in a bath can restore a feeling of calm, invigorate you, or help you unwind.
- *Writing in a journal.* Keep a journal by your bedside, and write about your best moments that day.
- *Speaking with your nurse manager.* Talk about an overwhelming assignment, and ask for a smaller assignment.
- *Speaking to the unit educator.* Ask for help with prioritizing your workload.
- *Saying no selectively.* Learn to say no appropriately. Take an assertiveness course, if necessary.
- *Being empowered by what you do.* You're a nurse who helps people; keep that in focus (Knight, 2003).
- *Tuning in to your signs of body stress.* Headache, upset stomach, and back pain all have a cause; often, it's stress. Beware of quick fixes such as aspirin, antacids, pain killers, and sleeping pills. If you have to use them, your body is telling you something, and it's important to listen.
- *Taking a break.* Set aside 3 minutes for stretching, enjoying a low-fat treat, teaching your colleagues a dance step, or telling a humorous work-related story.

Organizational Approaches to Job Stress

According to Mariano (2007), organizations have tried quick-fix solutions (higher salaries, housing, benefits, and flexible scheduling) to increase nurse retention. These actions hide the real problem and underlying causes. An organization must

nourish and care for its staff, or it will become sick—and the staff will become sick, too (Wright & Sayre-Adams, 2000).

Recent studies of so-called healthy organizations suggest that policies benefiting worker health also enhance profits. A healthy organization is defined as one whose workforce has low rates of illness, injury, and disability *and* is itself competitive in the marketplace. Research from the National Institute for Occupational Safety and Health has associated healthy, low-stress work and high levels of productivity with organizations that:

- Recognize employees for performance
- Offer opportunities for career development
- Foster an organizational culture that values the individual worker
- Makes management decisions that are consistent with organizational values (Sauter et al., 1999)
- See **Box 4-7** for information about stress prevention and job performance from an organizational viewpoint.

Judkins, Reid, and Furlow (2006) say that organizations can cultivate hardiness by instituting policies that promote:

- Collaborative practice
- Self-scheduling
- Shared governance
- Staff education on coping with stress

Let's consider the opening Leadership in Action vignette again. A new nurse manager took over as leader of Roberta's unit. The new manager not only taught the staff stress reduction measures but also brought in a consultant to recommend ways to improve working conditions.

BOX 4-7 STRESS PREVENTION AND ORGANIZATIONAL CHANGE

St. Paul Fire and Marine Insurance Company conducted several studies on the effects of stress prevention programs in hospital settings that included:

- Employee and management education on job stress
- Changes in hospital policies and procedures to reduce organizational sources of stress
- Establishing employee assistance programs

As a result of these changes:

- Medication errors declined by 50% after prevention activities were implemented in one 700-bed hospital.
- Malpractice claims declined by 70% in 22 hospitals that implemented stress prevention activities.
- In a matched group of 22 hospitals where no stress prevention activities were implemented, no reduction in claims was found.

(Sauter et al., 1999)

Such a direct approach involves identifying stressful aspects of work, including excessive workload and conflicting expectations, and designing strategies to reduce or eliminate stressors. The advantage of this approach is that it deals with the roots causes of stress. Several of the nurses who had grown comfortable with work routines and schedules fought the suggested changes; they eventually left the unit. Although not everyone reported a large reduction in job stress, most staff did.

A combination of organizational change and stress management can be the most useful approach for preventing stress at work, especially when the organization is sick. In this case, nurses must tune in to their own stress and empower themselves with personal stress management procedures, including assertiveness skills. Empowerment can help nurses be more assertive and raise their voices regarding the dangers of the practice environment (Mariano, 2007). For suggestions on changing an organization to prevent job stress, see **Box 4-8**.

LEADERSHIP CHALLENGE Brainstorm ways to incorporate the ideas for changing an organization to reduce stress. How can these principles be applied to the units you're familiar with? Give a rationale for your answer.

Implementing a Stress Prevention Program

At a minimum, preparation for a stress prevention program should include:

- Building general awareness about the causes, costs, and control of job stress
- Securing top management's commitment and support for the program

BOX 4-8 CHANGING THE ORGANIZATION TO REDUCE JOB STRESS

- Ensure the workload is in line with worker capabilities and resources.
- Design jobs to provide meaning, stimulation, and opportunities for workers to use their skills.
- Clearly define staff roles and responsibilities.
- Give employees opportunities to participate in decisions and actions that affect their job.
- Improve communications and reduce uncertainty about career development and future employment prospects. (See Chapter 7 for suggestions on improving communications.)
- Provide opportunities for social interaction among workers.
- Establish work schedules that are compatible with demands and responsibilities outside the job.

(Sauter et al., 1999)

- Incorporating employee input and involvement in all phases of the program
- Establishing the technical capacity to conduct the program, including specialized training for staff or the use of stress consultants (Sauter et al., 1999)

Box 4-9 provides details of a study of a hardiness program that could be used to reduce staff stress.

It may not always be clear that job stress is high. Sometimes employees are fearful of losing their jobs and hide the signs of stress. A lack of obvious signs is not a good reason to dismiss concerns about job stress. The National Institute for Occupational Safety and Health (Sauter et al., 1999) suggests a problem-solving approach to prevention.

Step 1: Identify the Problem

Ways to identify job stress include:

- Holding group discussions with employees
- Designing and administering an employee survey that measures perceptions of job conditions, stress, health, and satisfaction (Box 4-8 may provide ideas; using an anonymous survey may reap more information because participants will feel more comfortable participating)
- Collecting information about absenteeism, illness, and turnover rates or performance problems to gauge the scope of job stress
- Analyzing data to identify problems and stressful job conditions

BOX 4-9 EXPLORATORY STUDY OF HARDINESS AND STRESS

Judkins, Arris, and Keener (2005) conducted an exploratory study of hardiness and stress.

Purpose: To measure the effect of a hardiness program to reduce workplace stress.

Sample: A select group of graduate nursing administration students at the University of Texas–Arlington.

Measures: Participants completed the hardiness scale and perceived stress scale at the beginning and end of their program. Six to 12 months after graduation, each student participated in a telephone survey with items related to hardiness and the core competencies of the American Association of Colleges of Nursing and the American Organization of Nurse Executives.

Treatment: Participants received 6 weekly 2-hour sessions and 2-hour sessions at 5 and 8 months. Topics covered included hardiness, stress management, power, negotiation, communication, and problem and conflict management.

Findings: Mean scores for hardiness and stress improved after taking the program, and telephone interviews revealed that graduates were engaged in hardiness behaviors. The researchers concluded that such a program could increase resiliency to workplace stresses.

Step 2: Design and Implement Interventions

Once information has been collected and analyzed, the stage is set for designing an intervention strategy. On small units, informal discussions may provide fruitful ideas for prevention. In larger organizations, a team may be asked to develop recommendations alone or in concert with outside experts.

Substeps to this step include:

- Targeting the sources of stress
- Proposing and prioritizing intervention strategies
- Communicating planned interventions to employees
- Implementing interventions

Step 3: Evaluate the Intervention

Short- and long-term time frames for evaluating interventions should be established. Evaluations should include objective measures, such as absenteeism and healthcare costs, and subjective measures, such as employee perceptions of job conditions, stress, health, and satisfaction.

LEADERSHIP IN ACTION

Roberta's new supervisor sensed an escalating level of tension and deteriorating morale among her staff. Headaches and absenteeism were on the rise. Roberta's supervisor held an all-hands meeting to explore her concerns. After reviewing a list of employee comments about their jobs, the supervisor asked one of the mental health clinical nurse specialists to conduct informal classes and hand out information about job stress causes, effects, and prevention. The supervisor also asked the clinical specialist to distribute and collect an anonymous survey about job satisfaction. Analysis of the survey data suggested that three conditions were linked to stress complaints: unrealistic deadlines, low levels of support from administration, and lack of worker involvement in decision making. The supervisor used the data to plan interventions, including greater staff participation in work scheduling and more frequent meetings between workers, managers, and administration to keep everyone updated on developing problems.

Nursing Research Needed on Job Stress and Health

McNeely (2005) evaluated studies on nurse job stress and found that even in Magnet hospitals, the focus is on healthy hospitals, not healthy nurses. Mason (2001) agreed and questions the agenda of many state-of-the-art hospitals. If they are truly places of healing, they ought to provide support groups for staff and other interventions to lessen the effects of traumatic stress. Nurses working in emergency, trauma, burn care, and psychiatry/behavioral health are especially at risk.

GUIDED LEADERSHIP TIP**JOB STRESS RESOURCE**

You can reach the National Institute for Occupation Safety and Health (NIOSH) at 1-800-35-NIOSH. This federal agency provides information and publications about a wide range of occupational hazards, including job stress. Its "Stress at Work" Web page is <http://www.cdc.gov/niosh/topics/stress>.

McNeely (2005) stated that the following research regarding nurses' job stress is needed:

- *The relationship between nurses' work, chronic job stress, and career and health trajectories* (e.g., studying stress as a risk factor for disease and disability, physiological markers of stress linked with particular working conditions and health outcomes, nurses' health in the context of work and over the course of time, how nurses adjust to their daily work or their career trajectories because of disability, why hospital nurses are younger than nurses in other settings and why so many work part-time, and the relationship between symptoms of stress exposure)
- *How or if work can be reorganized to improve the nurses' health* (e.g., determining which nursing models are healthy or unhealthy for nurses)
- *The relationship between work and a productive, safe, and affordable healthcare system* (e.g., studying whether a nurse's health explains some of the variation in quality of care, establishing the affect of work conditions on nurses' disabilities, and determining nurses' true health status)

McNeely (2005) maintains that if we asked nurses about job stress, they would tell us how to improve their job conditions and, as a result, our healthcare systems.

Summary

This chapter introduced information about quantifying job stress and the sources of workplace stress. Burnout, hardiness theory, and Bandura's theory of self-efficacy provided ideas for reducing job stress, as did nutritional changes and other individual and organizational actions.

Key Term Review

- **Burnout** is a stage of exhaustion that can result from unrelieved work stress or from an erosion of the soul.
- **Focusing** helps individuals recognize body signals of stress.
- **Job strain** is the result of psychological demands of a job exceeding the worker's discretion in deciding how to do the job.
- **Job stress** is the result of a mismatch between a worker's capabilities, resources, or needs and the job's requirements.
- **Psychological hardiness** is composed of a commitment to self, work, family, and other important values; a sense of personal control over one's life; and the ability to see change in one's life as a challenge.
- The **social readjustment rating scale** ranks and rates 43 stressful life-change events.
- **Stages of burnout** include honeymoon, balancing act, chronic symptoms, crisis, and enmeshment.
- **Stress** is the feeling or perception of having little control.
- A **stressor** is a cause of stress.
- **Technostress** is the result of difficulties dealing with computer technologies or of an unusual attraction to them.
- Bandura's **theory of self-efficacy** focuses on the belief in one's ability to perform adequately.

Leadership Development Exercises

■ Leadership Development Exercise 4-1

Demonstrate three ways to use Bandura's self-efficacy theory to help at least three colleagues reduce stress.

■ Leadership Development Exercise 4-2

Try out information in Boxes 4-5 and 4-6. Report your findings to at least two colleagues.

■ Leadership Development Exercise 4-3

Teach at least two peers stress reduction measures, and analyze the results. Share your findings with the class or with at least two other learners.

■ Leadership Development Exercise 4-4

- a. Choose at least one nutritional action to reduce job stress, and make it part of your daily regime.
- b. Provide stress reduction nutrition information to at least two other people. Evaluate the results, and share them with the class or with two other learners.

■ Leadership Development Exercise 4-5

- a. Observe a unit for signs of job stress.
- b. Write down your findings.
- c. Share them with the class or with two other learners.

■ Leadership Development Exercise 4-6

Design a job stress reduction plan for the unit you observed, and share your plan with the class or with two other learners.

■ Leadership Development Exercise 4-7

Share your job stress reduction plan with staff members or supervisors on the unit. If that's not possible, imagine a scenario of presenting your plan, identifying potential obstacles, and picturing yourself overcoming them.

Advanced Leadership Development Exercises**■ Leadership Development Exercise 4-8**

- a. Using McNeely's suggestions for research or other information in this chapter, develop a problem statement for some aspect of job stress reduction.
- b. Ask for a critique from a more advanced nurse researcher; if that's not possible, ask the class or two other colleagues for one.
- c. Revise your problem statement, if necessary, based on feedback.

■ Leadership Development Exercise 4-9

- a. Develop a research design for your problem statement on job stress reduction.
- b. Ask for a critique from a more advanced researcher, the class, or two other colleagues.
- c. Revise your plan, if necessary.

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Managing Time

CHAPTER OBJECTIVES

After reading this chapter, answering the leadership challenges, and participating in the leadership development exercises, you will be able to:

- Analyze one nurse leader's time management skills
- Assess whether you exhibit characteristics of hurry sickness and time urgency
- Identify inappropriate time management procedures and time traps
- Apply the steps of effective time management
- State two short-term and two long-term time management goals
- Develop two top-drawer and two bottom-drawer goals
- Break two long-term goals into manageable steps
- Apply approaches to overcoming procrastination
- Use at least four different ways to "make" time

Advanced nurses will be able to:

- Interview a nurse leader about time management
- Develop a time management program
- Role-play appropriate times to say no

Introduction

Although futurists predicted in 1960 that people would have more leisure time, the fact is, Americans now complain that there are not enough hours in the day to satisfy work and personal needs. Almost everything moves at a quickened pace. Eventually, this fast tempo pervades all activities and becomes a way of life. People think that they accomplish less and feel constantly hurried. Always being in a hurry and worrying whether you're accomplishing anything can be stressful.

This chapter explores hurry sickness and time management procedures and gives you a chance to develop a time management program for yourself or for a nurse leader. To begin, read about Audrey and her time management issues.

LEADERSHIP IN ACTION

Audrey, a new nurse manager, felt overwhelmed with the number of meetings, deadlines, and goals she faced. Each time someone invited her to attend a meeting or join a committee, she agreed. Her desk was soon piled high with reports, files, and books. She couldn't find anything in the piles and had no idea when her next appointment was. She considered throwing everything out the window but decided instead to consult with a mental health clinical nurse specialist with special time management skills.

LEADERSHIP CHALLENGE If you were the nurse consultant, how would you assess Audrey's time management skills? Give a rationale for your answer.

KEY TERM

Hurry sickness or **time urgency** is the struggle to achieve as much as possible in the shortest period of time.

Hurry Sickness

Hurry sickness or **time urgency** is the struggle to achieve as much as possible in the shortest period of time (Rosch, 2000a). It may be a reaction to the process of not managing time efficiently. Time urgency can manifest in different ways.

Nurse leaders who tend to fall into all the categories that follow could be classified as having a time urgency problem:

- Having an abundance of nervous energy that leads to being on edge when sitting and waiting
- Rarely taking time to eat three meals in a slow, relaxed manner
- Being urged by others to slow down
- Trying to force events into a specific and arbitrarily allotted amount of time

- Becoming excessively annoyed in slow traffic or meetings that move slowly
- Walking faster than most other people

LEADERSHIP CHALLENGE Assess your tendency for hurry sickness and time urgency. The more items from the time-urgency problem list that describe you, the more likely you have hurry sickness and time urgency.

What Is Time Management?

Time management is the ability to use time effectively. Efficient time management is neither hurrying nor procrastinating, but using tried processes to make the most of the available hours. Rather than manage time, nurse leaders should manage themselves. Time is a constant that marches on despite what gets done.

KEY TERM

Time management is the ability to use time effectively.

Characteristics of Inappropriate Time Management

When nurse leaders find themselves well behind schedule, they could have a time management problem. People who have difficulty managing time often have similar characteristics (Rosch, 1998), such as a tendency to:

- Assume that they must do everything themselves, even when portions of the work could be delegated
- Procrastinate or put things off until the last moment
- Have difficulty saying no to requests that they know they do not have enough time to accomplish
- Be late for appointments
- Have difficulty making decisions or vacillate back and forth between options
- Be irritable and frustrated
- Have an aura of hurrying
- Be easily distracted
- Not be able to set realistic goals

Brumm (2003) added the following time traps that can lead people to feel that time is slipping away without them accomplishing anything:

- Trying to accomplish too much without planning ahead
- Not setting deadlines
- Stacking their desk with papers with no apparent organization
- Too much socializing
- Not asking questions about assignments, which leads to misunderstandings

LEADERSHIP CHALLENGE Identify which of the inappropriate time management procedures and time traps apply to you.

The perception of time is relative, but you can learn to use your time more efficiently. Effective time management can not only increase productivity but also improve quality of life.

Steps in Effective Time Management

According to Rosch (2000b), the important thing you can do is to establish goals. Effective time management can help minimize deadline anxiety, avoidance anxiety, and job fatigue (Davis, McKay, & Eshelman, 2003). It consists of a series of planned and focused steps, including:

- Exploring how time is currently being spent
- Setting short-term goals
- Setting long-term goals
- Prioritizing
- Breaking goals into manageable steps

Exploring How Time Is Currently Being Spent

An easy way to explore how you spend your time is to divide the day into three segments: waking through lunch, end of lunch through dinner, and end of dinner until bedtime. Carry a small notebook, logging in the number of minutes you spend on different activities. Keep this inventory for 3 days. At the end of that time, note the total amount of time you spent in each activity. **Table 5-1** shows the amount of time that Audrey, the nurse in the Leadership in Action vignette at the beginning of this chapter, spent on different activities during 1 day.

Over the week, Audrey noticed that she spent many hours attending or organizing unnecessary meetings. She vowed to stop going to such meetings; if she had to organize one, she would keep it as brief as possible (Hill, 2002).

Audrey found herself spending too much time on the phone and promised herself to keep future conversations to a minimum and to the point. She also realized that she skipped lunch sometimes, even though she knew it was important to take meal breaks because they would keep her energy level high (Hill, 2002). When Audrey found herself taking home a report she needed to read, she wondered whether her brain might be more focused the next day, after a good night's sleep.

TABLE 5-1 TIME MANAGEMENT ASSESSMENT

Activity	Time (minutes)	Activity	Time (minutes)
Waking through Lunch		After Lunch through Dinner	
Lie in bed and plan day	20	Meeting	65
Shower	20	Daydream while staring at paperwork	20
Decide what to wear and dress	25	Meeting with assistant director	30
Cook breakfast	20	Phone call with colleague	30
Eat and read paper	30	Meeting with head nurse	40
Commute to work	30	Phone calls (which interrupted writing report)	20
Routine paperwork	30	Commute	30
Nonmandatory meeting	50	Shop	30
Mandatory report	45	Cook	40
Mandatory meeting	60	Eat and clean up kitchen	50
Lunch	40	End of Dinner until Bedtime	
		Phone calls	30
		Watch TV and procrastinate	70
		Read reports	60
		Prepare for bed and read novel	40

Setting Short-Term Goals

Based on a review of the information in Table 5-1, Audrey set the following short-term goals:

- Put out clothes for the next day before going to bed
- Get up at the alarm, and limit shower to 5 minutes
- Make breakfasts that don't require cooking, cut dinner preparation to 30 minutes, and enlist family to do food preparation and cleanup three days a week
- Take a late lunch to make the best use of the most productive work hours (9 a.m.–1 p.m.)
- Use thought stopping to limit daydreaming (see **Box 5-1** for directions)
- Stop attending nonmandatory, nonproductive meetings

LEADERSHIP CHALLENGE Set two short-term time management goals, and share them with two colleagues or the class.

BOX 5-1 THOUGHT STOPPING

Directions: Use when nagging thoughts interfere with your work. Practice for at least 3–7 days to extinguish unwanted thoughts.

- Start work.
- Interrupt unwanted thoughts with the verbal, thought, or pictured directive to stop.
- Return to work.
- If saying, thinking, or picturing the word *stop* doesn't work, use a loud noise, such as a buzzer or bell. If that's not effective, wear a rubber band around your wrist, and snap it when an unwanted thought occurs.

Setting Long-Term Goals

Audrey's next step was to set long-term goals. These goals were things she wanted to accomplish that she knew would require energy, planning, and time. She began by:

- Making a list of things she most wanted to accomplish in the near future without censoring any items
- Comparing her list to how she spent her time
- Visualizing herself being told she had 6 months to live
- Picturing how she could best spend the time

Audrey thought about going back to school for her doctorate, initiating a mentor program at work, writing a nurse management article, and teaching a continuing education course on stress management at the local community college.

LEADERSHIP CHALLENGE Set two long-term time management goals, and share them with two students or the class. Ask for feedback.

Prioritizing

Once Audrey had her lists, she separated her goals for the next day into those activities that had to be done that day and the items that could wait a day by using the top-drawer/bottom-drawer system for prioritizing.

KEY TERM

Top-drawer items must be accomplished today.

Top-drawer items were the items that she absolutely had to accomplish, such as those items that:

- Were due that day
- Would otherwise cause clients or their families distress
- Were needed by staff so they could do their job
- Presented a risk or hazard
- Were needed by her supervisor

LEADERSHIP CHALLENGE List two top-drawer items, and share them with two colleagues or the class. Ask for feedback.

Bottom-drawer items were items that could wait for a day or more before being completed:

- Items without a personal or work-related time frame
- Items that if left until later would not affect care on the unit

KEY TERM

Bottom-drawer items can be accomplished at a later date.

LEADERSHIP CHALLENGE List two bottom-drawer items, and share them with two students or the class. Ask for feedback.

Audrey then chose her bottom-drawer goals, categorizing them as lifetime goals, 1-year goals, and 1-month goals:

- Take an introductory nursing management course at the doctoral level (1-year goal)
- Write an article for the *Journal of Nursing Administration* (lifetime goal to contribute to the profession)
- Have dinner with husband and friends once a week (1-month goal to reduce stress)
- Start a mentor program at work (1-year goal)
- Complete report at work (1-month goal)

Breaking Goals into Manageable Steps

When Audrey took a look at her five goals, she felt overwhelmed. She decided to break each one down into manageable steps.

The steps for taking an introductory management course at the doctoral level included:

- Calling the university and finding out how to apply
- Filling out the application materials and mailing them in
- Finding out about any exams or courses that were needed to meet application criteria
- Making the appointment to take any necessary exams
- Finding out where any necessary courses could be taken
- Taking the exams
- Taking the courses

LEADERSHIP CHALLENGE List one long-term goal, and break the goal into manageable steps. Share your steps with at least two classmates, and ask for a critique.

GUIDED LEADERSHIP TIP

RULES FOR MAKING TIME

- *Learn to say no.* Remind yourself that this is your life and your time to spend as best befits you. You should spend time on bottom-drawer items only when your boss asks you to. Be prepared to say, "I don't have the time." If necessary, take an assertiveness training course to help you.
- *Build time into your schedule for unforeseen events and interruptions.* Such occurrences will otherwise wreck havoc in your schedule.
- *Set aside several time periods during the day for structured relaxation.* Being relaxed will allow more efficient use of available time.
- *Keep a list of short 5-minute tasks.* You can do these anytime you are waiting or are between other tasks.
- *Learn to do two things at once.* Plan dinner while driving home, or organize an important letter or list while waiting in line at the grocery store.
- *Delegate bottom-drawer tasks to family or assistants.* You don't have to do everything yourself.
- *Get up 15 to 30 minutes earlier every day.* This extra time quickly adds up to hours of gained time.
- *Allow no more than 1 hour of television watching daily.* Use time in front of the TV as a reward for working on a top-drawer item.

Other Key Time Management Approaches

Audrey just stared at the list of steps. Even though they seemed manageable, she could not get herself to take action. She remembered a tip she read in an online article and developed a daily to-do list. She included the first step in her school goal in that list.

This approach helped Audrey with some of her goals, but she still had difficulties taking action until she discovered the rules for making time (Davis, McKay, & Eshelman, 2003), which appear in the leadership tip.

LEADERSHIP CHALLENGE Choose at least three ways from "Rules for Making Time," and plan how to add them into your daily regime. Share your plan with at least two other students, and ask for their critique.

Fighting Procrastination: The Great Time Robber

KEY TERM

Procrastination is the inability or lack of incentive to make a decision or take action.

Even with the tools Audrey developed, she still occasionally **procrastinated** and found it difficult to make a decision or take action. There are specific steps to take to overcome procrastination:

- *List the pros and cons of taking action.* Compare the unpleasantness of making a decision versus the unpleasantness that can accrue from putting it off. Analyze the costs and risks of delay.
- *Examine the payoffs of procrastination.* Possible payoffs include being protected against possible failure, having others rush in to take responsibility and help, and gaining attention.
- *Bolster your procrastination efforts.* Exaggerate and intensify whatever you are doing to put off the decision to act. Keep it up until you are bored and making the decision seems more attractive than whatever you are doing to procrastinate.
- *Take responsibility for delaying tactics.* Write down how long each delay took.
- *When you get stuck making unimportant decisions, resort to a predetermined action.* When you get lost in the car, for example, always choose south or east over north or west; or always take a left-hand turn over a right-hand turn. For other decisions, choose the closer option instead of the one farther away. Or when in doubt, take the option whose first letter is closest to the beginning of the alphabet.
- *Take small steps toward the decision to act.* Take out the materials for a report you need to write, and place them by you as a lead-in to taking action.
- *Avoid beginning a new task until you've completed a predecided segment of the current one.* Fully experience the reward of finishing something before moving on. This is one of the great payoffs of decision making. (Davis, McKay, & Eshelman, 2003)

Summary

This chapter presented information on managing time, including hurry sickness, the definition of time management, characteristics of inappropriate time management, and steps in effective time management.

Key Term Review

- **Bottom-drawer items** can be completed later.
- **Hurry sickness** or **time urgency** is the struggle to achieve as much as possible in the shortest period of time.
- **Procrastination** is the inability or lack of incentive to make a decision or take action.
- **Time management** is the ability to use time effectively.
- **Top-drawer items** must be accomplished today.

Leadership Development Exercises

■ Leadership Development Exercise 5-1

With at least two other colleagues, discuss ways to better manage time. Use the information in this chapter to assist you.

■ Leadership Development Exercise 5-2

Keep a monthly or weekly planner or a daily to-do list. Review it weekly with a trusted peer, and ask for feedback.

■ Leadership Development Exercise 5-3

Set goals to accomplish your assignments. Evaluate how well you accomplish goals. Ask for feedback and suggestions for meeting your goals from a trusted peer.

■ Leadership Development Exercise 5-4

Plan a hypothetical or real “day in the life” to make sure you accomplish the most difficult tasks first while you’re the most energetic.

■ Leadership Development Exercise 5-5

Set up a “tickler file” to prompt you about important class assignments. Go over your file and the results with a trusted peer.

Optional: Report back your findings to the class or group.

■ Leadership Development Exercise 5-6

Pair off with a partner, and interview each other about how you manage time. Brainstorm new ways to handle your time better.

More advanced option: Interview a nurse leader about how he or she manages time. Consider writing up your interview and making it the basis of a publishable paper.

■ Leadership Development Exercise 5-7

Pair off and role-play a situation in which a nurse leader must say no to an invitation to join a committee or attend a meeting.

- a. Flip a coin or draw a role from a hat to determine which partner will play the nurse leader first.
- b. Role-play the situation.
- c. Ask for feedback on whether the nurse leader sounded firm.
- d. Keep role-playing the situation until the person playing the nurse leader sounds convincing.
- e. Switch roles.

■ Leadership Development Exercise 5-8

Develop a time management program for either a hypothetical nurse leader or yourself, if you are a nurse leader.

More Advanced Leadership Development**■ Leadership Development Exercise 5-9**

Collaborate with a nurse leader to help set up a time management program for that person using concepts you learned in this chapter.

■ Leadership Development Exercise 5-10

Develop a research problem statement related to time management. Obtain at least three critiques from savvy nurse researchers and revise your statement as needed.

■ Leadership Development Exercise 5-11

Develop a research design that matches your problem statement. Obtain at least three critiques from more experienced nurse researchers and revise your design as needed.

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Critical Thinking

CHAPTER OBJECTIVES

After reading this chapter, answering the leadership challenges, and participating in the leadership development exercises, you will be able to:

- Explain what critical-thinking skills are
- Describe the relationship between critical-thinking skills, problem solving, and decision making
- Discuss the research on evaluating critical-thinking skills
- Choose appropriate action for two critical-thinking situations
- Identify the steps in the problem-solving process
- Develop three high-level critical-thinking questions
- Identify problem-solving assumptions
- Construct a design or system model
- Construct a structural or recipe model

Advanced nurses will be able to:

- Chart a group's decision-making process
- Use the Six Hats technique to enhance group decisions
- Use algorithmic methods to solve a problem

Introduction

As a nurse leader, you will use critical-thinking skills every day to assess, diagnose, plan, intervene, and evaluate. Merely acquiring information or possessing a particular skill set is not enough to qualify as critical thinking. This chapter focuses on what critical thinking is, how it's measured, and what you can do to enhance critical thinking in yourself and others. Ms. Jeffries provides an example of how critical thinking is important in nursing.

LEADERSHIP IN ACTION

Ms. Jeffries, a nurse manager, has been evaluating her staff. She has noticed that some nurses use poor judgment and/or biased thinking when providing nursing care, especially when determining what treatments to provide or which actions to take. Several of the nursing staff seemed to go on intuition alone when making decisions; some are obviously new to nursing and have been asking for advice on what to do next.

LEADERSHIP CHALLENGE What critical-thinking situations deserve a nurse manager's immediate attention?

KEY TERM

Critical thinking is the process of actively conceptualizing, applying, analyzing, synthesizing, and/or evaluating information to guide action.



Nurses and Critical Thinking

Critical thinking is the process of actively conceptualizing, applying, analyzing, synthesizing, and/or evaluating information to guide action.

Why is critical thinking so important in nursing? Nurses must not rely on biased, distorted, partial, uninformed, or prejudicial thinking in their approach. In addition, noncritical thinking is costly and affects quality of life. When action is taken without using appropriate guiding information, mistakes are easily made, helpful measures are overlooked, and client wellness is at risk.

Scriven and Paul (2004) propose that a critical thinker:

- Raises vital questions and problems in a clear and precise manner
- Gathers relevant information and comes to well-reasoned conclusions and solutions by testing them against relevant criteria and standards
- Assesses assumptions, implications, and practical consequences
- Communicates effectively with others to figure out solutions to complex problems

Measures of Critical Thinking

Two instruments for measuring critical-thinking skills are available. They were selected by the task force at one northeastern university because of their wide acceptance and use as sound psychometric measures (Walsh & Seldomridge, 2006). They focus on the ability to infer, recognize assumptions, deduce, interpret, and evaluate arguments; as a result, they allow for comparison across settings. Both are relatively inexpensive, can be scored by hand, and take less than an hour to administer.

The first instrument is the Watson-Glaser Critical Thinking Appraisal Form S (Watson & Glaser, 1994.) This instrument was selected for its ability to evaluate critical-thinking dispositions, such as open-mindedness, truth seeking, systematicness, confidence, analyticity, inquisitiveness, and maturity. The other instrument is the California Critical Thinking Dispositions Inventory (Facione, 1992).

Several researchers have used one instrument or the other in their work. Walsh and Seldomridge (2006) found only modest critical-thinking gains in their population of learners as those learners progressed through years of nursing studies. This led the authors to question their definition of critical thinking (“knowing what to believe or do”) and the usefulness of standardized measuring instruments.

Because their research findings were inconsistent, Walsh and Seldomridge (2006) concluded that it is time to rethink the usefulness of standardized measurements.

Insights about Critical Thinking

The research on critical thinking may provide some answers for nurse leaders who want to help their staff develop and use critical-thinking skills.

Oral questioning shows promise as a way to teach learners critical thinking, but it's only effective if higher-level questions that use verbs such as *compare*, *contrast*, *analyze*, and *evaluate* are posed (Sellappah, Hussey, Blackmore, & McMurray, 1998). **Logic client concept maps and models** use a visual format (such as boxes and arrows to show the relation between resources, inputs, activities, outputs, and outcomes or goals) to develop an account of an illness or health issue, using inductive and deductive thinking to examine alternative actions that nurses should take. A qualitative analysis of learner reactions to logic models provided evidence that learners found them helpful in making decisions about client care, predicting outcomes of their interventions, and thinking critically (Ellermann, Kataoka-Yahiro, & Wong, 2006).

Many methods can promote learners' critical thinking, including:

KEY TERM

Logic client concept maps and models use a visual format to develop an account of illness or health issue.

- Written or simulated case studies (Baumberger-Henry, 2005; Ellermann, Kataoka-Yahiro, & Wong, 2006; Reising, 2004; Tomey, 2003)
- Concept mapping (Akinsanya & Williams, 2004; Luckowski, 2003; Staib, 2003)
- Journal reading (Ibarreta & McLeod, 2004; Wagner & Ash, 1998)
- Role-play and simulations (Cote-Arsenault, 2004; Jeffries, 2005; Phillips, 2005)

Stages of Critical Thinking in Nursing Practice

Benner (1984) studied stages of clinical competence in nurses. She found that nurses moved from being a novice or beginner to being an expert. The five stages she identified are:

Stage 1: Novice. These are nurses who have no experience and use rules to help them perform. Critical thinking at this stage is minimal. Beginners at this stage follow the motto “Just tell me what I need to do, and I’ll do it.”

Stage 2: Advanced beginner. As nurses gather experience, they formulate principles to guide their actions.

Stage 3: Competent. Nurses at this stage need conscious, deliberate planning and analysis to achieve efficiency and organization.

Stage 4: Proficient. Proficient nurses can perceive a situation as a whole and its meaning in terms of long-term goals.

Stage 5: Expert. At this stage, nurses no longer need analytic principles or rules; they now have an intuitive grasp of each situation and zero in on the problem without wasting time on considering alternative diagnoses and solutions.

LEADERSHIP CHALLENGE Using Benner’s stages of nursing, which stages of clinical competence are exemplified by Ms. Jeffries at the beginning of this chapter? Give a rationale for your answer.

KEY TERM

Problem solving provides a format for critical thinking.

Problem Solving and Critical Thinking

Critical thinking requires a format. **Problem solving** can provide that format. In nursing, problem solving occurs in the contexts of client care, team leadership, client advocacy, and case management. **Box 6-1** provides a problem-solving format that you can use to enhance critical thinking.

BOX 6-1 PROBLEM-SOLVING FORMAT**1. Definition of the problem**

- a. What is the nature of the problem?

Questions to elicit answers include:

"Tell me what the problem is."

"What is the problem as you see it?"

"Correct me if I'm wrong, but

what I hear you saying is

_____."

- b. How severe is the problem?

"What effect is the problem having on you?"

"How is the problem making it difficult for you to do your work?"

"How often does this problem occur?"

"Let me see if I have understood what you

said. You told me _____

_____. Is that

correct?"

- c. When does the problem occur?

"How long has this problem been going on?"

"When does the problem usually come up?"

"What else is going on when the problem comes up?"

2. Determinants of the problem

"What makes the problem worse?"

"What else is going on when the problem occurs?"

"What improves the problem?"

"What have you tried to do that reduces the problem?"

"What do you think is causing the problem?"

"What evidence or facts do you have to support the problem?"

"What brings the problem on?"

"What sorts of things are going on when the problem surfaces?"

"What do your colleagues do to help when the problem occurs?"

"What do your colleagues do to improve the problem?"

"What do your colleagues do to worsen the problem?"

"What feelings are you having about the effects of the problem?"

"How is this problem affecting your motivation?"

"In what ways does this problem create stress for you?"

"On one hand, I hear you saying

_____. On the other hand, I

hear you saying _____.

I wonder how these two things go together."

3. Possible solutions

"What do you think should be done to improve the situation?"

"Looking back, how could you have reacted differently to the problem?"

"What is the best way to decide what to do?"

"What would be a good backup decision?"

"What could you or I do to improve the chances of being successful?"

"What can I do to help with the problem?"

"What other information do you need to help solve the problem?"

"What support do you need to help solve this problem?"

"Let's consider how we might find out more about the problem together."

"We've covered a lot of ground. Is there anything I've said that was confusing or troubling?"

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KEY TERM

Creative problem solving involves identifying assumptions, using multiple techniques to approach a problem (including visualization, modeling, and using metaphors), and asking for criticism and suggestions.

Creative Problem Solving

Creative problem solving involves identifying assumptions, using multiple techniques to approach a problem (including visualization, modeling, and using metaphors), and asking for criticism and suggestions (Harris, 2002).

Identifying Assumptions

A frequently overlooked step in problem solving is identifying assumptions that you make. An unidentified assumption can prevent you from developing a solution. Assumptions may be hidden or unidentified and still affect the problem-solving process. Some areas where assumptions may lie hidden include:

- *Time.* What assumptions are being made about how long the solution will take?
- *Money.* What assumptions are being made about the availability of money?
- *Cooperation.* What assumptions are being made about who will support the solution?
- *Law.* Can a law be changed or reinterpreted to permit the solution?
- *Energy.* What assumptions are being made about the amount of energy necessary to find a solution? Is it better to expend more energy now than later?
- *Information.* What assumptions are being made about the available information, and has it been triple-checked for accuracy?
- *Cultural binds.* How are attitudes about the culture interfering with thinking and limiting solutions? (Harris, 2002)

LEADERSHIP IN ACTION

Anna leads a nursing unit where clients and visitors complain that noise interferes with their sleep. Her problem is this: how can we reduce noise on this unit? Phrased this way, Anna realized certain solutions would be more likely, such as putting silencers or mufflers on the PA system and noisy monitors, soundproofing some rooms or hallways, installing sound-absorbing panels, and so forth. None of these seemed plausible, so Anna decided to check her assumptions and found that she was assuming that the unit really was noisy and that noise was interfering with sleep. From there, she decided to obtain information about the number of hours clients were sleeping on the unit to find out just how much of a problem noise was.

Techniques for Approaching a Problem

There are a number of techniques to approaching a problem, including examining the problem carefully, formulating the problem statement carefully,

breaking the problem into small parts, choosing a different entry point, visualizing the problem, using models, trying metaphors, and using searching techniques. Explore a wide range of ideas and solutions to find the best fit for you and your problem (Harris, 2002).

Examine the Problem Carefully

You should examine the problem carefully before looking for a solution. Part of examining the problem is recognizing that something can always be done to solve it and that a problem is not a punishment. Denying a problem only perpetuates it.

Make sure that the problem you think exists does exist. Once a problem has been identified, use the opportunity to demonstrate the power of leadership and to increase happiness in the workplace. Before jumping into action, take enough time to examine and explore the problem thoroughly. Understanding the problem often solves it (Harris, 2002).

Formulate the Problem Statement Carefully

You should formulate problem statements carefully and with the knowledge that the questions you ask will determine the range of choices and the answers that you will receive. Make sure that you are not approaching a problem with a preconceived solution and that you are focusing on the problem itself, not just on the symptoms of a problem or on a problem that someone else thinks exists (Harris, 2002).

Break the Problem into Small Parts

Problems can be solved more easily when they are broken into smaller parts or goals. Each subproblem or subgoal can then be solved.

Choose a Different Entry Point

Most people attack problems in a linear way at the front end, as Anna did, but you can start at the solution and work backward. This is especially useful when the goal is clear but the present situation is ambiguous (Harris, 2002).

LEADERSHIP IN ACTION

Todd hadn't been able to improve relationships with his supervisees by asking them what was wrong or by trying to figure out what was going wrong between them. As soon as he gave up trying to understand the problem and envisioned how he wanted the relationships to change, he worked backward to find the problem that had been hampering him. He wrote himself a note to remember that whenever the goal is clearer than the problem, he should start at the solution and work backward.

Entry points could just as well be in the middle. For example:

LEADERSHIP IN ACTION

Rebecca was in charge of planning a new nursing center. The task was overwhelming, and the deadline for ideas seemed so close. She decided to attack the middle of the problem, pretending as if the funding and planning had already been done, and to begin with the construction and design phase. From there, she moved in both directions, working backward toward planning where the unit would attach to the current building and how to get funding, and forward toward arranging for clients to move into the center. Split that way, she felt less pressured, and the project moved along to completion.

LEADERSHIP CHALLENGE What kind of note should Rebecca make to herself about when to start a solution in the middle instead of at the beginning? Give a rationale for your answer.

Visualize the Problem

Before attempting a solution or taking action, it may be helpful to practice or picture the solution mentally. Once you can visualize the problem and its solution, it will be easier to solve. Imaging being someone else who is involved in either the solution or the problem may also be helpful (Harris, 2002).

LEADERSHIP IN ACTION

Cara was having difficulty with one staff nurse who argued with her about everything. When Cara imagined herself as the staff nurse, she began to get some insight into what made the staff nurse act that way, what might improve their relationship, and what the nuances of the staff nurse's personality were.

Another way is to use visualization to imagine being an expert or mentor who can solve the problem with special knowledge.

KEY TERM

A **model** is a simplified, concrete, visual, or symbolic representation of reality.

Use Models

A **model** is a representation or pattern of an idea or problem. Models can make an idea more concrete, especially when they use a picture or symbol. A drawing can simplify and show a

relationship or connection more quickly than words alone.

Models serve several purposes, including to:

- *Make an idea concrete.* A picture, drawing, symbol, map, box, or circle can show relationships, connections, hierarchy, and more in a dramatic way that

enhances understanding by converting an idea into something that stimulates the senses.

- *Reveal relationships between ideas.* Models can have profound effects on perception and conceptualization. They can help viewers think about the relationships between parts and the associated possibilities. Multiple models allow viewers to think about the same concept in different ways without the controlling influences that a single model might present.
- *Simplify the complex.* All models make complex concepts manageable or understandable. When using models, it is important not to eliminate important aspects of a prime concept. (Harris, 2002)

Several types of models exist. **Conceptual models** concretize an idea and aid memory. **Structural models** concretize physical structures, such as nursing centers or nursing units.

A model is created before all large construction projects. Models can be visual (a door, a machine, a bathroom); physical (a blueprint for a nursing unit); or mathematical (a decision matrix can help a nurse leader decide whom among many applicants to hire).

There are many paradigms to use when creating models:

- *System model.* A **system model** is a collection of interacting elements that work together to accomplish a specific goal.
 - Example: Improving relationships on a clinical unit
 - Input: Words, actions
 - Processing: Reactions
 - Output: Mutual support/dissatisfaction
 - Feedback: Communication through words and actions
 - Control: Processing is changed to positive reactions, actions, and output
- *Design model.* A **design model** is used to plan an overall pattern.
- *Construction model.* A **construction model** emphasizes the parts in a sequential manner. It can be used for a year-end report, for ordering information, or for building a clinical unit.
- *Recipe model.* The **recipe model** emphasizes proportions and ingredients. Spice or flavor can be added to a recipe. Toolkits can be used, along with formulas for success. (Harris, 2002)

KEY TERM

Conceptual models concretize an idea and aid memory.

KEY TERM

Structural models concretize physical structures.

KEY TERM

A **system model** is a collection of interacting elements that work together to accomplish a specific goal.

KEY TERM

A **design model** can be used to plan an overall pattern.

KEY TERM

A **construction model** emphasizes the parts in a sequential manner.

KEY TERM

A **recipe model** emphasizes proportions and ingredients.

Try Metaphors to Solve Problems

When using a model to solve problems, it is often helpful to incorporate metaphors. For example, ask yourself:

- How is this problem or its solution like a garden? Clue: Consider words like *vegetative*, *growing*, *expansive*, and *infested*.
- How is this problem or its solution like a machine? Clue: Consider concepts like energy input, the driving force, work output, and how the parts work together.
- How is this problem or its solution like a symphony? Clue: Consider factors like the conductor, soloists, the type of music, harmony, and the orchestration of various parts.
- How is this problem or its solution like the human body? Clue: Consider the functions of hands, feet, mouth, eyes, and ears.
- How is the problem or its solution like a vehicle? Clue: Consider the kind of vehicle, what powers it, its passengers, where it's going, and what propels it.

Use Searching Approaches

Searching techniques can help with problem solving and decision making. Some common searching techniques are:

KEY TERM

A systematic **trial-and-error method** includes searching for a solution with a plan in mind and keeping a record of attempts and failures.

KEY TERM

Algorithmic methods use computer programs and math formulas such as the maze and split-half method.

KEY TERM

A **public solution** helps workers take responsibility for others' problems and fosters problem-solving and decision-making skills by posting the problem and asking for suggestions.

- **Trial-and-error method.** Make this method more efficient by keeping a record of attempts and failures so that ineffective solutions are discarded and not retried.
- **Algorithmic methods.** Algorithms use computer programs and math formulas. A maze algorithm follows a maze or intricate passageway. The split-half method involves going to the halfway point and seeing whether the problem appears there (e.g., somewhere in the process of feeding clients, they aren't being fed; where is the problem occurring?). This method can be used with many leadership situations, including bathing clients, completing intake interviews, and transmitting data from staff to the nurse leader (and vice versa).
- **Public solution.** Post the problem on a bulletin board, in a newsletter, in an e-mail, or in a memo. This can work well with employee absenteeism or dissatisfaction, budgets, and reward systems. This kind of approach develops interest and discussion about the problem, helps workers take responsibility for others' problems, and fosters problem-

solving and decision-making skills in all members of the work group. Be aware that people will work to implement their own ideas and solutions more energetically than they will work to implement yours (Harris, 2002).

Asking for Criticism and Suggestions

It is always wise to accept criticism and suggestions when problem solving. Nurse leaders must be careful not to get so involved in an idea that they are unwilling to alter it once they discover a better way of viewing the problem or the solution. Other people—even those not knowledgeable on the subject—including children who are especially open to giving honest feedback—can provide valuable insights. Suggested ways to frame a request for feedback include:

- I'm asking you to help me improve on my idea to _____. Can you give me some feedback on it?
- I'm working on the problem of _____. Do you have any ideas about a solution? Take a look at what I've come up with so far, and tell me your reactions. Can you think of anything I'm missing? Is there anything wrong with this? Is there anything you can improve on?

Group Decision Making

Group decision making is a key component to the functioning of an organization. Whenever a decision could impact employees, it is helpful to involve them in making that decision (Burke, 1994; Sandifer, 2005; Winch, 1995).

Learning about Group Decision Making

Decision making and problem solving are often the same process in groups. The best way to learn about the decision-making process is to sit in on a task group that is going to make a decision or to lead a group and help its members come to a decision. If you're leading a group, your role may include:

- *Initiating.* Keep the group moving by suggesting an action step ("Let's poll the group"); pointing out a goal ("As I remember, our goal is to make this decision today"); proposing a procedure ("Let's role-play to see whether that helps us"); or identifying potential obstacles ("I'm wondering whether pushing too hard to come to consensus has become an obstacle for us").
- *Regulating.* Summarize what's happened so far ("So far, we've listed some alternative solutions"); point out time limits ("We have 10 minutes left today"); and restate the agreed-upon goals ("We agreed to set priorities in the next 15 minutes").
- *Informing.* Bring information or opinions to the group ("I brought these summaries of possible solutions based on what we discussed last time").
- *Supporting.* Create an emotional climate that makes it easy for group members to get along, stay calm, and voice their feelings ("Let's try a relaxation exercise to keep us calm" and "It's OK to share your feelings").

- *Evaluating.* Help the group evaluate its decisions by noting a group process that either helps or hinders decision making and by testing for a consensus (“I’m wondering if polling the group so soon has prevented us from considering alternatives” and “Are we ready to test for a consensus?”). (Clark, 2003)

Using the Six Hats Method

KEY TERM

Lateral thinking uses a set of systematic techniques, not just one, to change concepts and perceptions and to generate new ones.

Six Hats is a structured process for introducing lateral thinking into problem solving, especially group problem solving. **Lateral thinking** is a set of systematic techniques used to change concepts and perceptions and to generate new ones. Lateral thinking allows the user to explore multiple possibilities and approaches instead of pursuing only one.

Each hat in the Six Hats method represents a different perspective or way of thinking. Participants can put on or take off these metaphorical hats to indicate the kind of thinking they are using. Sometimes, groups are asked to put on the different hats in a particular sequence to facilitate the problem-solving process. According to de Bono (1995), the hats are:

- *The white hat.* When group members put on the white hat, they ignore arguments and proposals. They examine facts, figures, and information and identify needed information and how it can be obtained.
- *The red hat.* This hat means that it is time to focus on feelings, hunches, and intuition. The red hat gives the wearer permission to share his or her feelings without explaining them, justifying them, or apologizing for them.
- *The black hat.* This is the hat of caution and critical judgment, and it is the one most often used, even though it can kill creative ideas with its negativity and it makes references to rules, policies, and procedures, which can make progress impossible.
- *The yellow hat.* This hat signifies optimism and a positive view of the situation. When wearing the yellow hat, a person observes how something can be accomplished and the benefit of a particular solution.
- *The green hat.* Creative thinking, new ideas, and additional alternatives are associated with the green hat. When a group wears the green hat, creative effort is encouraged, and people have permission to ask, “Could we do this in a different way, or could there be another explanation?”
- *The blue hat.* The last hat helps set the agenda for thinking, suggests the next step for thinking, and asks for conclusions, decisions, and summaries.

The Six Hats technique is a cooperative technique to get a group back on track when participants get bogged down in arguments or take positions and defend them to death. The Six Hats method challenges participants to see all sides of a problem or decision (de Bono, 1995).

Dilemmas Related to Enhancing Critical Thinking

Because critical thinking has not been adequately defined to date, it may be wise for nurse leaders to decide which kinds of critical thinking to promote and then define and operationalize them for various learner levels.

For example:

- **Problem solving** allows the transfer of theory into practice
- **Decision making** anticipates potential problems
- **Diagnostic reasoning** helps settle on a client's condition by ruling out improbable conclusions or diagnoses (Walsh & Seldomridge, 2006)

LEADERSHIP CHALLENGE Decide on one kind of critical thinking, and suggest ways to operationalize a program for that aspect.

KEY TERM

Problem solving provides a format for critical thinking.

KEY TERM

Decision making anticipates potential problems.

KEY TERM

Diagnostic reasoning helps settle on a client's condition by ruling out improbable conclusions.

Summary

This chapter presented information on critical thinking, including measures of critical thinking, insights gained about critical thinking, stages of critical thinking in nursing practice, problem solving in critical thinking, creative problem solving, group decision making, and suggested ways to operationalize a critical thinking skills program.

Key Term Review

- **Algorithmic methods** use computer programs and math formulas such as the maze and split-half method.
- **Conceptual models** concretize an idea and aid memory.
- **Construction models** emphasize the parts in a sequential manner and can be used for a year-end report, for ordering information, or for building a clinical unit.
- **Creative problem solving** involves identifying assumptions, using multiple techniques to approach a problem (including visualization, modeling, and using metaphors), and asking for criticism and suggestions.
- **Critical thinking** is the process of actively conceptualizing, applying, analyzing, synthesizing, and/or evaluating information to guide action.
- **Decision making** anticipates potential problems.
- **Design models** are used to plan an overall pattern; if harmony is the goal, all the components of achieving a harmonious whole are presented.
- **Diagnostic reasoning** helps settle on a client's condition by ruling out improbable conclusions.
- **Lateral thinking** uses a set of systematic techniques, not just one technique, to change concepts and perceptions and to generate new ones.
- **Logic client concept maps and models** use a visual format to develop an account of illness or health issue.
- A **model** is a simplified, concrete, visual, or symbolic representation of reality.
- **Problem solving** provides a format for critical thinking.
- A **public solution** helps workers take responsibility for others' problems and fosters problem-solving and decision-making skills by posting the problem and asking for suggestions.
- **Recipe models** emphasize proportions and ingredients; spice or flavor can be added to give a recipe a twist; toolkits can be used, along with formulas for success.
- **Structural models** concretize physical structures.
- **System models** portray a collection of interacting elements that work together to accomplish a specific goal.
- A **systematic trial-and-error method** includes searching for a solution with a plan in mind and keeping a record of attempts and failures.

Leadership Development Exercises

■ Leadership Development Exercise 6-1

Develop three high-level critical-thinking questions, using verbs such as *compare*, *contrast*, *analyze*, and/or *evaluate*. Share them with at least three colleagues, and obtain feedback.

■ Leadership Development Exercise 6-2

Pick a problem that needs to be solved. Identify any assumptions that could prevent a solution. (See the “Identifying Assumptions” section in this chapter for ideas, p. 118.)

■ Leadership Development Exercise 6-3

Construct a design or system model.

■ Leadership Development Exercise 6-4

Construct a structural or recipe model.

Advanced Leadership Development Exercises**■ Leadership Development Exercise 6-5**

Sit in on a task group (or join with your classmates who agree to portray a task group), and use the decision steps that follow to chart the group’s process to making a decision.

Steps in the Decision**Examples**

- a. Stating the problem/decision
- b. Clarifying and elaborating
- c. Developing alternative solutions
- d. Keeping the discussion relevant
- e. Testing the group’s commitment to the emerging decision
- f. Summarizing
- g. Agreeing to the decision
- h. Testing the consequences of solutions

■ Leadership Development Exercise 6-6

Use the Six Hats method to enhance group decision making. Choose a common nursing leadership situation from the following list or develop your own and use the Six Hats method to solve the problem or keep the group from getting bogged down in argument.

- Staffing
- Role transition
- Conflict management

■ Leadership Development Exercise 6-7

Teach critical thinking techniques to a group of nursing students or staff members.

■ Leadership Development Exercise 6-8

Develop a research problem statement for some aspect of critical thinking. Obtain critiques from at least two nurses with advanced research skills.

■ Leadership Development Exercise 6-9

Develop a research design to test our problem statement. Obtain feedback from at least two nurses with advanced research skills.

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Communicating Effectively

CHAPTER OBJECTIVES

After reading this chapter, answering the leadership challenges, and participating in the leadership development exercises, you will be able to:

- List ingredients of effective interpersonal communication
- Identify ways to use emotional intelligence to communicate with others
- Discuss three ways to enhance support during nurses' intershift reports
- Describe strategies that are effective for communicating with various generations in the workforce
- Identify ways to enhance collaborative communication with physicians
- Describe group communication methods

Advanced nurses will be able to:

- Develop a problem statement to study aspects of leader communication
- Teach communication skills to novice leaders
- Complete a small research project related to leader communication

Introduction

Clear communication is crucial to being an effective nurse leader. Both verbal and nonverbal aspects of communication are important. This chapter explores theories that can help you communicate effectively with individuals and groups, including social cognitive theory, language expectancy theory, contagion theory, and cognitive dissonance theory. Interventions that show promise include emotional intelligence, assertiveness, and positive feedback. But first read about Hilda T.'s communication dilemma.

LEADERSHIP IN ACTION

Hilda T., a nurse leader, wanted to open up communication on her unit. Physicians were grumpy and disrespectful to nurses, who, in turn, were indirectly hostile (passive-aggressive). When Hilda observed nursing shift reports, she noted little supportive communication from the head nurse to staff nurses. When she thought about the staff, she realized that they spanned at least four generations of workers. Hilda also noticed that staff from different cultural or ethnic groups sometimes didn't get along. When she asked staff members what she could do to help, she got little information.

LEADERSHIP CHALLENGE What would you suggest Hilda do to improve communication on her unit?

KEY TERM

An **effective communication** is easily understood and accepted.

The Importance of Communication

Humans are social creatures. We require information and feedback to feel good about ourselves. **Effective communication** is a message that is easily understood and accepted.

Communication has been cited as a critical skill for all aspects of nursing (Hays, 2002). Without clear and effective communication, employees feel isolated and dissatisfied. Effective interpersonal relationships are part of being a competent nurse leader (Nurse Leadership Institute, 2002).

KEY TERM

Human communication is **multimodal**, which means that more than one piece of information is interpreted to convey meaning, and includes verbal and nonverbal aspects.

Types of Human Communication

Human communication is **multimodal**, which means that more than one piece of information is interpreted to convey meaning (Baber & Mellor, 2001). Verbal communication is only one aspect of total communication. Nonverbal commu-

nication provides the major message. Often, people react to unspoken **elements of communication** more than they do to words, so it is important for you to know just what you are conveying.

Misunderstandings can often be clarified when the people involved observe and comment on nonverbal communication (Blatner, 2002).

Blatner (2002) developed one system of classification that includes 13 categories of nonverbal communication:

1. *Personal space* includes the comfortable or uncomfortable distance between people. People from parts of Latin America or the Middle East may prefer standing closer to each other than persons of northern European descent. Different distances are appropriate for coworkers, friends, people dining at a restaurant, and people in intimate relationships.
2. *Eye contact* includes glancing, gazing, staring, or not looking at another person. Limiting eye contact can lessen the discomfort of close personal space in elevators and other tight spaces. Modern management and business culture values a fair degree of eye contact; looking away may be interpreted as avoidance or deviance, but some cultures raise their children to minimize eye contact with authority figures for fear of appearing uppity or arrogant. Others may misinterpret this respectful looking away as passive aggressiveness.
3. *Position* includes sitting, standing behind, facing, being in front of, or standing opposite.
4. *Posture* includes slouching, stiffening, slumping, twisting, cringing, towering, crouching, angling, tilting the pelvis down and forward (swagger), or tilting the buttocks to the rear (mincing steps).
5. *Paralanguage* includes vocal inflection, such as rising, falling, rapid, slow, measured, changing, choppy, loud, soft, breathy, nasal, operatic, growling, wheedling, whining, high, medium, low, meaningful pauses, disorganized pauses, shy pauses, or hesitant pauses.
6. *Facial expression* includes using the face to express being pensive, amused, sad, barely tolerant, cautious, angry, pouting, anxious, sexually attracted, startled, confused, sleepy, or intoxicated.
7. *Gesture* includes clenching a fist, shaking a finger, pointing, biting fingernails, tugging at hair, squirming, rubbing chin, smoothing hair, folding arms, raising eyebrows, pursing lips, narrowing eyes, scratching head, looking away, hands on hips, hands behind head, rubbing nose, rocking, sticking out tongue, tugging earlobe, and waving.
8. *Touch* includes gentle, firm, hurrying, coercive, overly friendly, and respectful touches, as well as gripping a hand in a permission-giving way,

KEY TERM

Elements of communication include words, gestures, movement, posture, eye contact/gaze, adornment and other artifacts, rate of speech, pauses, facial expression, silences, touch, sound effects, intonation, and proxemics or use of space.

holding onto the arm or upper back, pushing, tugging, patting, rubbing, and grabbing.

9. *Locomotion* includes styles of moving, such as strolling, shuffling, hurrying, running, jogging, springing, tiptoeing, marching, crawling, tottering, walking, and swinging.
10. *Pacing* refers to how action is taken—for example, jerky, pressured, gradual, graceful, nervous, tense, easy, fatigued, deliberate, clumsy, shaky, or deliberate.
11. *Latency of response* refers to the time it takes to react to questions or interact in conversations.
12. *Context* refers to the amount and source of light, color of lighting, props, size of the room, colors of the walls and furniture, seating arrangement, number of people present, sounds, smells, temperature of the room, and people's proximity to each other.
13. *Physiological response* refers to signs of emotion—for example, flaring nostrils, trembling chin, sweating, cold or clammy skin, flushing, moisture in eyes, blushing, swallowing, blinking, breathing heavily, and blanching.

LEADERSHIP CHALLENGE How could Hilda use Blatner's categories to help examine communication on her unit?

Communication Theories

There are many communication theories. Some of these theories that are more relevant to nursing are discussed here, including social cognitive, language expectancy, contagion, and cognitive dissonance.

KEY TERM

Social cognitive theory posits that if people are to perform a behavior, it is important to communicate what the behavior is and how to achieve it, to support the behavior, to model or observe the behavior, and to build confidence that the behavior will appear.



Social Cognitive Theory

Social cognitive theory is relevant to health communication because it deals with the cognitive, emotional, and behavioral aspects of change. This theory, developed by Bandura (2001), explains how people acquire and maintain a certain behavioral pattern, which includes communication with others.

Concepts of social cognitive theory, including the following, can be applied to nursing leadership:

- *Behavioral capability*. If a person is to perform a behavior, it is important to communicate what the behavior is and how to achieve it. If nurse leaders expect staff to perform professionally, they must communicate the necessary behaviors clearly and explain how those behaviors can be achieved.

- *Expectations.* By anticipating and modeling positive outcomes of a behavior, success is more likely. Nurse leaders should suggest to staff that they will have a positive outcome, and then nurse leaders should model the behavior.
- *Observational learning.* Behavioral acquisition occurs by watching people's actions and observing the reinforcements they receive for performing the behavior. Nurse leaders can ask staff members to observe skilled staff members who perform the required task and then are rewarded with verbal praise or by some other mechanism.
- *Self-efficacy.* The more confidence people have in performing a particular behavior, the more successful they will be. Nurse leaders enhance staff self-confidence by rewarding and praising their successes.
- *Expectancies.* The greater value a person places on a given outcome, the more likely that outcome will occur. When nurse leaders verbalize the value of a given behavior, it encourages staff to produce the behavior.

LEADERSHIP CHALLENGE How could Hilda use social cognitive theory with her staff?

Language Expectancy Theory

Language expectancy theory is a formalized model about message strategies and attitude and behavior change. The theory, developed by Burgoon and Burgoon (2001), holds that language is a rule-governed system and that people develop expectations about the message strategies that others employ in their attempts to persuade. These expectations are a function of cultural and social norms and preferences.

Buller et al. (2000) tested this theory by carefully adjusting features of a message about safety. The researchers knew that people do not always comply with prevention advice, and they predicted that messages with high language intensity and a deductive argument style would improve compliance with prevention recommendations. They presented newsletters, brochures, and tip cards that varied in language intensity and style of logic. These researches found that by carefully adjusting messages, they received a more favorable response—especially when advice was aimed at expectations about reducing personal risk. They found that people who received messages with high-intensity language were more apt to comply with safety recommendations.

KEY TERM

Language expectancy theory holds that language is a rule-governed system and that people develop expectations about message strategies that others employ in their attempts to persuade. It explains how speakers vary language intensity to make their messages more persuasive.

LEADERSHIP CHALLENGE How could Hilda use language expectancy theory with her staff?

KEY TERM

Contagion theories explain how networks of people spread “infectious” attitudes and behavior.

KEY TERM

Contagion by cohesion refers to the influence of those with a tendency toward direct communication on those with a tendency toward indirect communication.

KEY TERM

Contagion by structural equivalence refers to the mutual influence of those who have similar communication patterns.

KEY TERM

Cognitive dissonance theory holds that when individuals are presented with information that is inconsistent with their beliefs, they will strive to reach balance.

Contagion Theories

Contagion theories seek to explain how networks of people spread “infectious” attitudes and behavior. **Contagion by cohesion** refers to the influence of those with a tendency toward direct communication on those with a tendency toward indirect communication. **Contagion by structural equivalence** refers to the mutual influence of those who have similar communication patterns (Contractor & Eisenberg, 1990).

Rice and Aydin (1991) tested contagion theory and found that hospital employees who communicated with one another or who had supervisory-subordinate relationships were more apt to share similar attitudes about recently introduced information technology (contagion by cohesion). Burkhardt (1994) examined individual attitudes about a recently implemented distributed data-processing computer network and found that they were significantly influenced by the attitudes and use of others in their communication network (contagion by structural equivalence).

Cognitive Dissonance Theory

In 1957 Leon Festinger synthesized a set of studies and distilled his **cognitive dissonance theory**, which examined the social influences of communication. *Cognitive* means the theory has to do with thinking, and *dissonance* indicates an inconsistency or conflict. Cognitive dissonance is the uncomfortable feeling that results when someone holds two or more

incompatible beliefs at the same time. The theory views individuals as purposeful decision makers who strive to balance their beliefs. When presented with decisions or information that creates dissonance, they try to regain equilibrium, especially if the dissonance affects their self-esteem. Dissonance can be reduced by altering behavior or seeking information that is consonant with behavior. This theory is especially relevant when you make a decision or solve a problem. By presenting new or challenging information, you can create dissonance and, thus, an effort to regain equilibrium, solve problems, or make decisions.

LEADERSHIP CHALLENGE How can Hilda use cognitive dissonance theory with her staff?

GUIDED LEADERSHIP TIP

WAYS TO FIND OUT WHAT STAFF THINK

Finding out what staff think may not be easy. They may fear being fired or labeled as “trouble-makers” if they share information. If you want to obtain information, you may have to ask for feedback numerous times in groups and in one-to-one meetings.

It is important to inform staff why information is needed (e.g., “I need to be tapped into what is going on here to do my job well”). Once staff begin to share information, it's important to listen and interrupt only to clarify. Employees' suggestions should always be met with encouraging words (e.g., “That's helpful,” “That's important to know,” or “I understand”). Avoid using comments such as “That's interesting,” which can be interpreted as though you don't really care or understand their suggestion.

Whistle-blowers who uncover the source of problems should be promptly rewarded. The reward can be made publicly (if that is appropriate) or with a personal handwritten note of thanks (Tanouye, 1990).

Providing staff with a survey and asking for feedback on unit problems can also work if answers are anonymous. Being visibly present on the unit and talking to staff can also elicit useful information. When staff bring up a problem, ask that they discuss the worst-case scenarios, potential pitfalls, and alternative actions. This will help them learn problem-solving skills, help them own the problem, and help them grow (Tanouye, 1990).

Effective One-on-One Communication

The Nursing Leadership Institute (2002) identified the following competencies for interpersonal effectiveness:

- Listens attentively to others' ideas and concerns
- Invites contact and is approachable
- Treats employees with respect
- Develops collaborative relationships within the organization
- Builds and sustains positive relations in the organization
- Shares information readily with staff
- Recognizes and uses the staff's ideas
- Articulates ideas effectively both verbally and in writing
- Succinctly communicates viewpoints
- Involves staff in building consensus on issues
- Models health communication and promotes cooperative behaviors

Effective nurse leaders use persuasive communication. They impart inspiration and vision to others in an exciting and motivating way (Stordahl, 1995).

LEADERSHIP CHALLENGE How could Hilda begin to share her vision with staff in an exciting and motivating way?

Emotional Intelligence

Rager (1998) underscored the importance of setting a positive tone in the work setting. Developing a high degree of emotional intelligence may be the most important ingredient in effective leadership, more important than having an MBA, an advanced nursing degree, or even vast leadership experience. Managing emotions and relating to others in a positive way can have the most influential results (Weisinger, 1998). **Box 7-1** lists characteristics of leaders with high emotional intelligence.

Weisinger (1998) offers advice for leaders and staff members about using and developing their emotional intelligence:

- Listen to and thank others for positive criticism: it is a vote of confidence that can lead to success. “Thank you for your critique. I’m going to think hard about what you said.”
- Carry around an image of an inspiring person, and use it to picture how to handle a particular situation.
- Trust your feelings and behavior.
- Use constructive inner dialogue as a guideline. “I can handle this. I’m already handling it.”
- Learn to manage fear and anger by saying or thinking positive coping messages, such as “I can stay calm so I can listen and help this person” and “I refuse to let this person upset me.”

BOX 7-1 QUALITIES OF LEADERS WITH DEVELOPED EMOTIONAL INTELLIGENCE

Emotional intelligence includes the ability to:

- Perceive and identify emotions in others’ faces, tone of voice, and body language and the ability to name one’s own feelings, discuss emotions, and communicate clearly and directly
- Analyze, reason, solve problems, make decisions, and guide what is important to think about
- Understand how emotions, thoughts, and behavior affect each other and how feelings can lead to behavior
- Take responsibility for one’s own emotions and happiness, to turn negative emotions into positive learning and growing opportunities, and to help others identify and benefit from their emotions

Source: Adapted from Steve Hein. (2005). *Emotional intelligence*. Retrieved April 15, 2007, from <http://eqi.org>

- Appreciate differing viewpoints by telling others, “I appreciate your viewpoint; let’s see if we can come to a consensus on this.”
- Avoid mind reading; check out intuitions or conclusions by asking for verification. “I heard you say _____; is this what you meant?”
- Keep things in perspective; don’t overplay the significance of one bad encounter.
- Remember that emotions are contagious, so use positive messages. “We were in a difficult situation; we got through it, and I’m positive we can learn from it.”
- Tune in to the emotional context within which words occur, and read between the lines. Always phrase findings as hunches, not verified facts. “I’m wondering whether you’re feeling angry about the changes. Are you?”
- Remember past emotional experiences, and use them to be empathic with others.
- Invite disagreement; it will lead to learning on both sides. Make comments like “Let’s hear some opposing viewpoints; we need to get everyone’s ideas.”

Bobulski (2002) added the following suggestion:

- Focus on the circumstances and how they can change, not on the negative characteristics of the person or situation; this will take the heat and emotion of the situation and transform it into a learning opportunity. “Let’s look at the situation and what we can learn from it.”

LEADERSHIP CHALLENGE Apply Weisinger’s and Bobulski’s principles to the situation that follows. Choose a response, and give a rationale for your choice.

Situation: A team member has handled a client situation poorly. Your supervisor has said that such behavior is bad for the hospital and that it is up to the nurse leader to handle the situation.

Response 1: “What you did was irresponsible and cannot be tolerated. I will be writing up an incident report about the matter.”

Response 2: “Good afternoon. May I speak to you alone, Mr. Justin? (Move the conversation to a private area.) “I noticed you spoke with Mrs. Emerson this morning and it didn’t turn out well. Let’s take a look at what happened and see if we can come up with an alternate way to deal with the situation.”

Assertive Communication

Assertive talk—such as communicating clearly with staff, allowing them to be autonomous, and supporting group cohesion—can increase job satisfaction. By seeking out and valuing contributions from staff, you can promote a climate in

which information is shared, decisions at the staff nurse level are supported, and the coordination of work helps retain staff and decrease job stress (Boyle, Bott, Hanse, Woods, & Taunton, 1999).

Clear and open communication is a crucial skill for leaders to model and support. If nurse leaders cannot confront verbally abusive physicians or clients, how will staff members learn? Although all nurses receive some education in communication skills, only psychiatric/mental health nurses tend to master this aspect of their work, and even they may not zero in on assertive skills.

Box 7-2 provides ideas for being assertive in planned meetings.

Even nurse leaders who believe that they possess good communication skills could benefit from attending assertiveness workshops. By demonstrating their willingness to learn new skills, such leaders are more likely to convince staff members that it is not only safe but also useful to attend an assertiveness workshop.

Enhancing Supportive Communication during Shift Reports

The majority of a nurse leader's time is spent communicating with other nursing personnel. Staff interaction is key to nursing outcomes, satisfaction levels, and retention (Hays, 2002).

Curtin and Flaherty (1982) have called for nurses to improve their relationship with one another and suggested that educators need to teach nurses how to give and receive criticism, support, direction, and guidance.

Supportive behaviors are believed to result when two persons verbally and nonverbally influence each other to ease doubt and anxiety about themselves, the situation, and their relationship, leading to an increased sense of personal control over an otherwise unpredictable and confusing situation (Albrecht & Adelman, 1987). Supportive behaviors also occur when leaders listen and reassure, and reframe and redefine, situations (Albrecht & Halsey, 1991; Peterson, Halsey, Albrecht, & McGough, 1995).

This kind of supportive behavior can even occur during shift reports, which are an important and recurrent example of leader-follower communication (Hays, 2002). Although Wolf's (1998) 12-month study of a hospital unit found that shift reports served as a forum where "negative criticism prevailed, not praise for work well done," interaction during shift reports can affect staff retention and quality of client care because of the intensity of the exchange of information and the potential for reducing anxiety and increasing confidence (Hays, 2002).

Using Hersey and Blanchard's situational leadership theory (see Chapter 1) as the guiding framework for a repeated-measures single-case study, Hays (2002) set out to videotape 16 nurse leader-follower dyads (i.e., the off-going shift RN nurse leader and the oncoming RN) during shift reports in a hospital setting.

BOX 7-2 HOW TO BE ASSERTIVE IN PLANNED MEETINGS

- **Set up an appointment well in advance whenever possible, and prime the other person.** For the purpose of an upcoming interview or meeting, speak to the person, or send a memo or e-mail, stating the objective for the meeting and any requests (like that the appointment not be interrupted). A written reminder is preferable because it stands as a permanent record of the purpose of the meeting.
- **Role-play upcoming anxiety-provoking situations with a friend or colleague.** Anticipate intimidating or unclear comments, and practice responding to them before the actual meeting or interview.
- **Write down important points or statements on an index card, and bring it with you to the meeting.** If necessary, read them aloud to the other person, saying something like "I've written this down because it's very important, and I don't want to forget anything." Reading your points aloud is preferable to stumbling or forgetting to stay on the topic.
- **When the meeting begins, structure the discussion environment for clear and open communication.** Move chairs to face one another (without desks in between), use direct eye contact, and stick to the topic.
- **Restate the purpose of the meeting.** For example, say, "I'm here to clarify . . ." or "I want to talk with you about . . ." or "I'd like us to work together to solve the problem of . . ."
- **Avoid getting sidetracked by irrelevant issues.** Keep the discussion on the identified issues with such comments as "Before you go on, I'd like to clarify . . ." or "I'd like to finish discussing . . ."
- **Concentrate on the words the other person says.** This is especially important if the other person's tone of voice, facial expressions, or nervous movements intimidate you.
- **Use relaxation exercises and deep-breathing techniques to remain calm.** Write a reminder like "Breathe in your abdomen" or "Picture peace and serenity" on your index card.
- **Determine what motivates the other person, and use that information to support your argument or purpose.** If the other person is motivated by budgetary concerns, use that to support your argument. For example, say, "Not only will this program help employees be more effective, but it will also save money because participants will have learned to be more efficient in their communication and everyday work."
- **Keep time limitations in mind.** Move the meeting along. If necessary, make such comments as "We have 10 minutes left, and I'd like to come to an agreement on . . ." or "If I don't hear from you about this by Thursday, I'll call you."

Source: Adapted from *Holistic Assertiveness Skills for Nurses*, by Carolyn Chambers Clark, 2003, New York: Springer. Copyright 2003 by Carolyn Chambers Clark. Used with permission.

Hays used the target behavior instrument, an investigator-developed research tool based on Hersey and Keilty's interaction influence analysis, to identify individual and dyad communication. Interrater reliability was 100% when the behaviors were analyzed in a 2-day period (Hays, 2002).

GUIDED LEADERSHIP TIP**ASSERTIVENESS OPPORTUNITIES FOR NURSE LEADERS**

- Implement a plan so staff have more influence and input in their work assignments. Describe your plan:

Date to implement:

Date to monitor program effectiveness:

- Devise a plan to ensure ongoing monitoring of head nurses (e.g., supervisors, assistant directors of nursing, clinical nurse leaders) so they provide verbal and visible support for those they supervise.

Date to implement:

- Ensure that all employees attend an assertiveness training class or a 2-day assertiveness workshop.

Date to implement:

Dates to monitor program effectiveness and plan follow-up consultations:

- Start an employee suggestion box that is regularly read and implemented.

Date to implement:

Dates to monitor program effectiveness:

- Open up communication so that it flows up, down, and across all organizational levels. Start with a newsletter that shares information from all levels, including anticipated organizational changes, achievements, and rewards.

Date to implement:

Dates to monitor program effectiveness:

Source: Clark (2003).

The findings included:

- Few supportive behaviors were observed, and none were observed among the leaders.
- The supporting behaviors exhibited by both men and women were all non-verbal head nods.
- Neither the nurse leaders nor the staff nurses used verbal statements of praise or acknowledgment.
- RN followers who demonstrated supporting behaviors were younger but had longer current employment.

- Education level appeared not to relate to supporting behaviors. In this study, nurse leaders with master's degrees exhibited no supportive behaviors.

Based on her findings, Hays made the following recommendations for shift reports:

- *Develop an in-service nursing leadership course to elevate self-esteem among nurses by promoting a sense of value and respect of others.* Value clarification exercises can help nurses assess their values and learn to recognize and appreciate others. A planned brief socialization period before or after a report could enhance feelings of belonging and approval among nursing leadership and staff.
- *Review the selection process of the current leaders.* It is vital to select, educate, and retain staff who share similar values and goals.
- *Explore the significance of various dyads.* Female-male dyads, cross-cultural dyads, and other groupings may lead to rejection, negativity, and other signs of nonsupport.
- *Link the shift report process to performance appraisals.* Such an action acknowledges that this act of exchanging information is significant and part of the unit's reward system.

See **Boxes 7-3** and **7-4** for value clarification exercises that could bring staff to a greater understanding and acceptance of their differences.

Communicating with Different Generations

Today's nursing workforce is composed of staff and nurse leaders from as many as four different generations. Their differences in attitudes, beliefs, work habits, and expectations can be viewed as potential strengths. Communicating with nurses from different generations can be a challenge. As a nurse leader, you will be responsible for helping bridge gaps between generations and create unique solutions that appeal to different belief and operating systems (Sherman, 2006).

Some communication suggestions follow:

- *Veteran nurses, born 1925–1945.* Nurses in this generation are most comfortable with inclusive communication systems that build trust. Face-to-face or written communication may be more effective than communication that involves technology, but query individual nurses about which communication channels they're most comfortable with (Duchscher & Cowin, 2004).
- *Baby boomers, born 1946–1962.* This generation prefers communication that is open, direct, and less formal. Boomers enjoy processing information as a group and value staff meetings that provide an opportunity for discussion. They prefer face-to-face or telephone communication but will use e-mail (Duchscher & Cowin, 2004).

BOX 7-3 CONTROVERSIAL ISSUES EXERCISE**Objective:**

To communicate feelings about a controversial issue and to allow others to communicate theirs.

Directions:

- Read the controversial issue statement below.
- Without signing your name, make one comment illustrating how you feel about the statement or issue (Part A).
- Route this paper around the group. Each person reads every other person's comment without judging it. The idea is to communicate your feelings and allow others to do the same.
- Reroute the paper, read other people's reactions to the exercise, and decide whether you feel the same or different about the issue now. Give a rationale for your response (Part B).
- If you wish, record your reactions to the exercise itself (Part C).

Controversial issue statement:

Whenever a doctor writes, "Do not call code 99" for a client, the nurse should not call the cardiac arrest team for that person.

Part A: My reaction to this statement is:

Part B: Now that I have read others' reactions, I feel the following way about the issue (give a rationale for your reaction):

Part C: My reactions to this exercise are:

- *Generation X, born 1963–1979.* This is the first generation that experienced technology as a part of daily life. Gen Xers may become bored with meetings that include considerable discussion (Karp, Fuller, & Sirias, 2002).
- *Millennials, born 1980–2000.* This generation grew up with instant messaging and cellular phones. Millennials prefer immediate feedback and may become frustrated if they do not get it. They appreciate team meetings and use them as a forum for communication. They read less than other groups, so limit the distribution of lengthy policies and procedures to them. Chat rooms and e-mails are good ways to provide communication updates (Sherman, 2006).

BOX 7-4 UNDERSTANDING OTHER VIEWPOINTS**Objective:**

To share values with others and understand their viewpoints.

Directions:

- Using the list below, all participants choose a topic of interest about which they have a strong point of view.
- They share their point of view regarding that topic with all other participants either in writing or verbally.
- Each participant reads or listens to value statements from others without commenting and tries to understand their point of view.
- In one month, all participants examine their point of view on the topics that were discussed.

Topics:

Health	Physical appearance
Aging	Abortion
Sex	Family relationships
Handicapped people	Friendship
Rules	Euthanasia
Salary	Drugs
Lifestyles	Learning
Work	Institutions
Leisure	

I choose the following topic:

My position on this topic is:

I have come to this position based on:

Other people or situations that have influenced my position are:

Follow-up: It is now one month later; my evaluation of my position on the topics discussed is:

LEADERSHIP CHALLENGE How can you use this generation information to enhance your nurse leadership skills?

Enhancing Collaborative Communication with Physicians

Collaborative communication is associated with positive client, nurse, and physician outcomes (Boyle, 2004). When nurses are dissatisfied, angry, or anxious during their interactions with physicians, nursing care can suffer. Collaborative communication can also increase client survival, shorten hospital stays, improve the staff's ability to meet family needs, and enhance professional relationships (Boyle, 2004).

Research Box 7-1 provides information about one study that improved collaborative communication between nurses and physicians.

LEADERSHIP CHALLENGE How can you use the findings from this study to improve your nurse leadership skills? Think out of the box, and don't censor your ideas.

Communicating with Groups

Is there a difference between face-to-face communication and virtual communication in terms of staff satisfaction? A study by Hoyt (2003) examined this question in a laboratory experiment.

Transformational and Transactional Leadership in Virtual and Physical Environments

Crystal Hoyt of the University of Richmond and Jim Blascovich of the University of California, Santa Barbara, examined the effect of leadership style (transformational or transactional) and group setting (face-to-face, immersion in virtual environment, or intercom) on three-person ad hoc work groups.

Results indicated that, compared to transactional leadership, transformational leadership was associated with decreases in quantity of performance but increases in quality of performance, leadership satisfaction, and group cohesiveness. Trust appeared to play an important role, but group performance and cohesiveness were similar across group settings and group members were most satisfied with their leader when the leader interacted with them face to face.

RESEARCH BOX 7-1 STUDY OF COMMUNICATION BETWEEN NURSES AND PHYSICIANS

Collaborative communication is associated with positive client, nurse, and physician outcomes. Using a pretest-posttest repeated-measures design incorporating baseline data collection, implementation of the intervention over 8 months, and immediate and 6-month post-data collection, Boyle (2004) tested an intervention to enhance collaborative communication among nurse and physician leaders (e.g., nurse manager, medical director, clinical nurse specialist) in two diverse ICUs.

Seven nurse (all women) and three physician (two men, one woman) leaders participated in the intervention, which consisted of six core development dimensions modules: leadership, core skills for communication, guiding conflict resolution, helping others adapt to change, teams, and trust. Collaborative skills included agreeing and focusing on the goal, checking for understanding, agreeing on a plan of action, acknowledging good ideas, and following through; relationship skills included the key principles of esteem, empathy, involvement, sharing, and support.

Each intervention incorporated multiple learning activities, small-group skill practice and problem-solving sessions, feedback and

reinforcement of newly learned skills, a planning assignment for on-the-job application, and assessment and feedback after the intervention. Total training time was 23.5 hours, and participants received continuing education credit for each module they attended and a certificate upon completion of the intervention. All participants participated in a collaboration skills simulation vignette of seven sequenced situations that included all elements of the interaction process and tested participants' collaborative skills. Repeated-measures of multivariate analysis of variance were used to analyze data.

Findings provided evidence that nurse-physician collaborative communication can be improved, specifically:

- Communication skills of ICU nurse and physician leaders improved significantly.
- Leaders reported increased satisfaction with their own communication and leadership skills.
- Staff nurses reported lower personal stress (e.g., more respect from coworkers, physicians, and managers), even though they perceived significantly more situation stress (e.g., fewer staff members and less time).

Communicating about Being a Leader

Being a manager does not automatically mean staff or clients will view you as a leader. To boost others' perception of you as a leader, it is important to communicate like a leader. Follow the advice of Hodson (1998). To be viewed as a nurse leader:

- *Be visible as a leader.* Give a short presentation, or plan an event, letting staff or clients know about it in advance.
- *Give 60-second informationals.* Talk about successes and how they've benefited your unit or institution.

- *Invite staff or clients to help with a project.* Organizing an event makes others perceive you as a leader.
- *Provide sincere praise.* Address important staff behavior—saying, for example, “Your comment was very helpful to me.”
- *Validate opinions.* Comment on what you have in common—saying, for example, “That’s a wonderful idea. I had a similar situation a few months ago.”
- *Resolve problems.* Come up with solutions, and ask people to participate in them. For example, instead of reprimanding two feuding staff members, invite them to come to your office and state their side of the story. Even better, ask feuding staff to meet with you and come up with suggestions for how to solve the problem between them. When staff are involved in decision making, they own the solutions and are more apt to follow their own advice.

Communicating by Involving Others

Whether communicating with a boss, a supervisee, or a client, it is important to remember the 90-20-8 rule.

According to Pike (1998), adults can either listen for 90 minutes and understand what they hear or listen for 20 minutes and retain content. To maintain interest, they need to be involved in the presentation every 8 minutes.

Long-winded leaders can lose listeners after 8 minutes. To keep their interest, ask a question to provide a dialogue at least once every 8 minutes.

Determining How Often to Communicate as a Nurse Leader

Many meetings are unnecessary, yet groups continue to meet. Sometimes, it is just out of habit. Use the following guidelines to make meetings more effective:

- *Huddle spontaneously* for no more than 15 minutes to brainstorm, give vital updates, boost enthusiasm, and renew collaboration.
- *Meet daily* for no longer than 30 minutes when you must direct team activities, discuss emerging changes, or make announcements that everyone needs to know to complete work that day.
- *Meet weekly* for less than an hour to check progress on reports or projects and to review employee, staff, or client concerns.
- *Meet monthly or quarterly* for less than 90 minutes to review long-term program progress, assess group or team progress, or analyze performance patterns. (Humphrey & Stokes, 1998)

Communicating in the Managed Care Environment

Hospital nurses must cope with the changing healthcare environment. They must deal with radically redefined roles that include collaboration and coordination

with others (Miller & Apker, 2002). As a nurse leader, it will be your responsibility to help nurses and nurse assistants adapt to their roles. Steps you can take to improve communication include the following:

- Directly communicate to staff nurses about how client-centered environments are designed to heighten collaborative decision making. Strengthen this message by holding regular brown-bag lunches for nurses and establishing central nursing lounges for RNs to gather and communicate informally. These strategies can replace vital relational resources that may be depleted in the move to client-centered hospitals.
- Communicate to staff nurses that they are change agents and can successfully transition to different work situations and be positive role models for clients and caregivers. These messages can be disseminated through organizational newsletters and town hall meetings, giving staff nurses a greater voice in the changes occurring in their work environments.
- Few workers can adequately anticipate the extent to which their roles might change in response to managed care. The more information that you can provide, the more apt nurses and others will be able to adjust. (Miller & Apker, 2002)

Communicating by Empowering Staff

Although the competencies identified by the Nursing Leadership Institute (2002) are certainly ideals to strive for, the reality for many work environments is that they have limited resources and their clients are very ill. This can lead to increased stress and pressure to complete a seemingly endless list of assignments, which, in turn, can result in anxiety and blame.

Elizabeth Tonkin, a chief nursing officer at Westside Regional Medical Center in Plantation, Florida, contends that it is still possible to be a positive communicator. According to Tonkin (1995), the greatest gift a leader can offer staff who blame other shifts for leaving them too much work is to shift from being a controller of behavior to being a facilitator of empowerment.

A suggested intervention is to call a series of staff meetings that overlap shifts, explain how blaming wastes energy, and ask employees to identify and correct the root of the problem. By enlisting two staff members from each shift to serve on a task force or quality circle to resolve issues, and by establishing a cooperative relationship that puts clients first, blame can be eliminated or at least reduced. With this intervention, it is important to provide guidelines for the group because not all solutions may be feasible in the work setting (Tonkin, 1995).

It may seem easier to dictate an expected outcome, but Tonkin reminds nurse leaders to “trust the process” of letting staff members take leadership of their own destinies. In her experience, all empowered staff flourish.

Using Positive Feedback

Praise can reinforce positive behaviors and inspire hard work. Sometimes, praise can backfire if it makes employees or clients complacent and encourages them to slack off. Nelson (1998) suggests taking the following actions to reduce that possibility:

- Link praise to results.
- Find another way to provide inspiration if verbal praise disrupts work.
- Ask employees or clients what type of praise they value most. Verbal praise, written notes or memos, certificates, approving special requests, and occasional perks are all possible positive feedback actions.
- Use praise to build up other performance areas that need growth. For example, say, “That was well done. Excellent work. What about complimenting your clients once in a while to show them you respect their work, too?”

Giving and Accepting Criticism

Criticism is one of the most important forms of communication, yet it can carry a hurtful sting if not presented in a respectful way. One way to criticize painlessly is to:

- *Begin with two positive statements.* “You really have presented some very good ideas, and I like working with you.”
- *State the criticism.* “I’d like us to stay on topic and not stray off it.”
- *Add another positive statement and a ray of hope.* “You’ve shown the ability to work on complex goals, and I believe we’ll get this accomplished by tomorrow.”

Receiving criticism can be difficult especially if you catastrophize, obsess over the comment, or allow negative self-talk. It is important to recognize criticism as a problem-solving tool. When you heed reasonable criticism, you can avoid greater conflict.

When receiving criticism, it is useful to:

- *Avoid catastrophizing.* For example, do not assume that one criticism is tantamount to being fired.
- *Acknowledge the criticism.* “You’re right, I did . . .” (If the criticism is true.)
- *Use assertiveness techniques to counter unfair criticism.* See **Box 7-5** for suggestions.
- *Vow to learn from the mistake.* Bemoaning what should have been done will not help. Instead, focus on what you can do in the future to prevent criticism. When you’re successful, vow to repeat the successful behavior.

BOX 7-5 ASSERTIVENESS TECHNIQUES WHEN BEING CRITICIZED

- **Fogging/negative assertion.** Fogging means that you offer no resistance yet are persistent and independent, admitting errors while refusing to be manipulated. One way to do this is to agree with any truth in the other person's statement—for example, "That's right, I am 5 minutes late," "You're right, I haven't finished the report," or "I guess I did make an error."
- **Negative inquiry.** Negative inquiry can help you desensitize yourself to negative criticism so that you can listen to what you are being told, decrease others' repetitive criticism, and reduce the idea that there is a strict right or wrong method of interaction. Negative inquiry is a method of clarifying the other person's point of view. Examples include "I don't understand; what are you basing that on?" or "What exactly do you think I didn't do?"
- **Assertive probing.** Assertive probing can help you decide whether criticism is constructive or manipulative. The aim of assertive probing is to clarify unclear comments. Examples include "What is it about my work that bothers you?" and "What is it that you are displeased about?"
- **Broken record.** When others won't listen to your viewpoint, sometimes continuing to repeat your opinion works. A short, specific statement that is repeated again and again may eventually be heard. This technique is like saying no except that the objective is to get the other person to accept your criticism or comment. Examples include repeating the same statement no matter how the other person tries to make you feel guilty, appeal to your sense of fairness, order you to do something, or whatever—for example, repeat, "I can't, I have other priority items to complete" until the other person runs out of options.
- **Content-to-process shift.** When the focus of conversation drifts away from the original topic, because of strong feeling or some other reason, a content-to-process shift can help move you back on course. Examples include "Let's get back to what we were discussing," "I really don't want to argue about this," and "You seem upset; do you want to talk about it?"
- **Momentary delay.** Take your time. You don't have to answer right away. Take a moment to think of your answer and reply.
- **Time out.** When you or the other person is angry, it's always wise to call for a time out to cool down. A day or more is preferable.
- **Deflection.** Changing the topic can deflect or redirect an attack. For example, saying, "Is that a new suit?" can help you take the criticism less seriously and free you from stress.
- **Joining the attacker.** When you join with the attacker, you agree with the other person's right to experience a feeling.
- **Parley.** This approach is most effective when you are involved in no-win situation. Use comments such as "Let's try to work out a compromise," or "Let's see if we can iron out the problem."
- **Fighting back.** When there is no other option, when it is a question of life or death, or the problem has a high priority, express your anger directly and stand up to insults with comments such as, "I'm angry about what you said, and I'd like to talk about it," or "I feel insulted. Please don't talk to me like that. I deserve respect."
- **Multiple attack.** It can feel quite intimidating when you are attacked by several people at once. Keep one of your attackers between you and the other by asking one of the group what he or she sees as the main problem, and then practice deep breathing and listening skills.

Source: Adapted from *Holistic Assertiveness Skills for Nurses*, by Carolyn Chambers Clark, 2003, New York: Springer. Copyright 2003 by Carolyn Chambers Clark. Used with permission.

- *Use positive self-talk.* Everyone talks to themselves about situations. Talking about how having an error pointed out can benefit you, how learning and change can occur, and how everyone makes mistakes or grows can go a long way. Examples are such comments as “I can handle this” and “This isn’t so bad,” or “focus on your positive points.”
- *Count to 10.* When emotion wells up, count to 10 to provide time to sort out thoughts and feelings. If the criticism turns into a harangue, ask the person to take a moment so they might state their complaint more clearly.
- *Seek support.* Reach out to support persons for help in clarifying reactions to the criticism and in recognizing that it isn’t the end of the world.
- *Acknowledge truth.* Think through the criticism, and look for a grain of truth. If you don’t find one, communicate that the criticism seems inaccurate, and allow time for additional discussion.
- *Recognize that time heals.* The sting of criticism will fade as days pass. Carry on with your daily activities, and focus on your goals.

Communicating with Supervisors

Everyone has a supervisor, someone they report to. It is important to have a positive relationship not only with peers and supervisees but also with your supervisor. Krieff (1996) provides the following strategies:

- *Learn about your supervisor’s goals, and align with them.* If you help supervisors achieve their goals, you will be viewed as a valuable resource.
- *Anticipate problems.* Avoid waiting until a problem occurs by addressing issues as they surface and reporting actions to supervisors.
- *Close gaps.* Tackle tasks that your supervisor cannot or does not want to deal with.
- *Keep your supervisors informed.* Provide them with needed information.
- *Use positive reinforcement.* Avoid emphasizing your supervisor’s bothersome behavior; instead, comment on the times when he or she models effective behavior. For example, if your supervisor allows phone calls and other interruptions to prevent work from getting done, say things like “It’s amazing how much we accomplished by ourselves” or “Thank you for giving me the chance to finish the project with just you and me working on it.”

Disagreeing with Supervisors

All nurse leaders eventually have a supervisor who asks that they do something unreasonable or unethical. In these cases, it is important to ask yourself, “Isn’t it my responsibility to speak up when I see something wrong?”

GUIDED LEADERSHIP TIP

Some ways to disagree in a positive way include:

- Having a positive attitude and always communicating a willingness to cooperate and be helpful.
- Presenting ideas in the form of a question. For example, you could say, "I wonder if Sarah might be helpful with this; she's dealt with it quite a bit."
- Agreeing to disagree and offering to help with some of the work. You might say, "I'll get right on it, but Dan does this kind of thing a lot. He's already established a protocol and could probably get faster results. Do you mind if I call him and ask him to make the calls?"
- Offering to begin the work and then consulting with or passing the task onto a more experienced person. Novice nurse leaders can say, "I'll get started, but do you mind if I take this to Esther? She's much more qualified and experienced in this kind of action."
- Asking for clarification on the goal. Say, "Help me understand why we're doing it this way." Once you understand the goal, you may be able to say, "I think this will work quite well if we just change _____. What do you think?"
- Explaining your personal ethics in advance. When hired or shortly thereafter, state, "I notice it is common practice here to _____. I have a personal ethic that won't allow me to do that. I just wanted to let you know that up front so you won't unknowingly put me into a position where I can't follow your directive." (McDonald, 1988)

McDonald (1988) states that although it is important to obey a directive, it is also important to provide supervisors with information that could help them make better decisions.

Things to avoid when disagreeing with a supervisor include:

- Assuming you are right and your boss is wrong
- Implying you refuse to do what has been ordered
- Saying the action is not in your job description
- Implying the directive won't work
- Claiming the action is unethical (even if it is)

Avoiding Communication Mistakes

The pressure of day-to-day activities can lead people to ignore the importance and power of good manners. To improve morale and serve as a positive role model, it is important to:

- *Greet everyone.* Saying "good morning" or "good afternoon" sets a tone of openness, warmth, and caring.

- *Avoid misusing beepers and cell phones.* Turn off beepers and/or cell phones during meetings. On the rare occasions when you must stay in touch, set your beeper or cell phone to vibrate.
- *Take invitations seriously.* Accepting an invitation and then not showing up or showing up late is rude and gives the impression that you're disinterested or disorganized. Invitations must be replied to within a week. If you accept, you should attend. Unless the invitation specifies bringing a guest, it is not wise to bring one.
- *Return phone calls and e-mails.* Set aside a certain time during the day to return phone calls and e-mail. Not doing so may convey an air of self-importance. And even a seemingly unimportant message could be a vital one.
- *Apologize after a mistake.* After making a verbal or nonverbal gaffe, it is important to apologize in person and then follow it up with a phone call apology. For serious mistakes, a small thoughtful gift accompanied by a note of apology is in order.
- *Listen carefully.* Avoid getting caught up in personal agendas. When someone needs to talk with you, listen. Do not forget that important information may be transmitted during even a short communication. If there is an emergency, set a time to talk with the person later, and then follow through and be available as agreed.
- *Say no.* Learn to say no to unreasonable demands or invitations that do not support nurse leader priorities. (Baldrige, 1994)

Summary

This chapter defined communication, described communication theories and research findings, provided ways to communicate with staff and supervisors, and suggested assertive ways to give and take criticism.

Key Term Review

- **Cognitive dissonance theory** holds that when individuals are presented with information that is inconsistent with their beliefs, they will strive to reach a balance.
- **Contagion theories** explain how networks of people spread “infectious” attitudes and behavior.
- **Contagion by cohesion** refers to the influence of those with a tendency toward direct communication on those with a tendency toward indirect communication.
- **Contagion by structural equivalence** refers to the mutual influence of those who have similar communication patterns.
- **Effective communication** is a message that is easily understood and accepted.
- **Elements of communication** include words, gestures, movement, posture, eye contact/gaze, adornment and other artifacts, rate of speech, pauses, facial expression, silences, touch, sound effects, intonation, and proxemics or use of space.
- **Language expectancy theory** holds that language is a rule-governed system and that people develop expectations about message strategies that others employ in their attempts to persuade. It explains how speakers vary language intensity to make their messages more persuasive.
- Human communication is **multimodal**, which means that more than one piece of information is interpreted to convey meaning, and includes verbal and nonverbal aspects.
- **Social cognitive theory** posits that if people are to perform a behavior, it is important to communicate what the behavior is and how to achieve it, to support the behavior, to model or observe the behavior, and to build confidence that the behavior will appear.

Leadership Development Exercises

■ Leadership Development Exercise 7-1

Identify which of the characteristics in Box 7-1 (p. 138) match up with your leadership style. Devise a plan to incorporate at least three characteristics into your work relationships in the next 3 months, and then monitor your progress and share your findings with three classmates or colleagues.

■ Leadership Development Exercise 7-2

Examine the goals in the section on assertive communication, pages 139–142. Make three recommendations for involving the nursing staff in the implementation of three goals. Present your findings to three classmates or colleagues.

■ Leadership Development Exercise 7-3

From the list of ingredients of effective interpersonal communication (see Effective One-on-One Communication, pages 137–141) select one and identify at least one personal goal to take action on. Write up a plan, and set an implementation date. Share your findings with three other learners.

■ Leadership Development Exercise 7-4

Identify at least two ways to use emotional intelligence to communicate with others, and draw up a plan for using this concept with staff. Monitor your results, and share your findings with three other learners.

■ Leadership Development Exercise 7-5

Sit in on four or more nurses' intershift reports. Summarize your findings, and share them with three other learners. If you observed problems, identify a solution, and discuss your suggestion with one head nurse, if possible.

■ Leadership Development Exercise 7-6

Describe communication strategies for various generations in the workforce. Identify a plan for enhancing communication between generations, and try it out. Write up your results, and share them with three other learners.

■ Leadership Development Exercise 7-7

Identify ways to enhance collaborative communication with physicians by rereading pages 146–147. Decide on a plan for enhancing communication between nurses and physicians. Discuss your ideas with three other learners. Together, find a way to try out or participate in an action that enhances nurse-physician communication.

■ Leadership Development Exercise 7-8

Sit in on a staff meeting. Describe the group communication that you observe. Share your findings with three other learners. Brainstorm together, and come up with at least four possible solutions for enhancing group communication.

Advanced Leadership Development Exercises**■ Leadership Development Exercise 7-9**

Develop a problem statement to study one aspect of leader communication.

■ Leadership Development Exercise 7-10

Teach communication skills to novice leaders. Write up your experience, and share it with three other learners.

■ Leadership Development Exercise 7-11

Plan and complete a small research project related to leader communication. Write up your findings, and share them with three other learners.

Optional: Submit an article based on your findings to an appropriate journal.

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Managing Conflict

CHAPTER OBJECTIVES

After reading this chapter, answering the leadership challenges, and participating in the leadership development exercises, you will be able to:

- Define conflict
- Compare and contrast conflict resolution models
- Analyze one example of nursing conflict
- Examine the concept of conflict in nursing work environments
- Identify sources of generational conflict
- Assess your conflict resolution skills
- Facilitate the development of conflict resolution skills in your staff

Advanced nurses will be able to:

- Teach conflict resolution skills to two clients, staff on a nursing unit, or a group of colleagues
- Formulate a problem statement for a nursing project related to conflict
- Design a research project related to conflict

Introduction

In many nursing settings, conflict between nurses is a significant factor in job dissatisfaction. It occurs in every work environment because of differences in people's goals, needs, desires, responsibilities, perceptions, and ideas. Unresolved conflict can result in job dissatisfaction, absenteeism, and turnover, whereas resolved conflict can lead to better relationships. Resolving issues leaves staff feeling more integrated, adjusted, powerful, and competent (Almost, 2006).

For these reasons, you need conflict resolution skills based on a strong conceptual framework. This chapter focuses on helping you learn both skills and the theories behind them.

LEADERSHIP IN ACTION

Rose L., a nurse leader on a busy medical-surgical unit, noticed signs of unrest among nurses when the unit moved from a total patient care delivery model to a team nursing model, and she feared that she'd done something wrong to disturb the peacefulness she usually experienced at work. Individual nurses complained about changes in their workloads, and arguments broke out between staff. Some nurses refused to help colleagues. Many were bitter and angry, and their feelings carried into their relationships with clients.

LEADERSHIP CHALLENGE What concept is being enacted by the nurses?

KEY TERM

Conflict is a normal occurrence and a multidimensional construct whose antecedents are individual, interpersonal, and/or organizational. Conflict can be either beneficial or detrimental, and either internal or external.

Conflict Defined

Conflict is a normal phenomenon in nursing (Stroeder, Znaniecki, & Brennerman, 2006) and part of the ebb and flow in any human relationship (Lederach, 2003). Conflict is a multidimensional construct whose antecedents are individual, interpersonal, and/or organizational (Almost, 2006). Conflict can be either beneficial or detrimental, and either internal or external. It develops when values or beliefs clash, and when

leaders use conflict to increase communication within a healthcare team, it can be turned into a learning event.

Intrapersonal conflict can occur when you (or someone else) have two opposing goals. When you are not sure whether to uphold unit policy or support individual nurse's attempts to be creative with client care, you can experience conflicting feelings. When you are not sure whether to confront a staff member who never completes an assignment or to overlook it because confronting him or

her intimidates you, intrapersonal conflict can arise. Intrapersonal conflict is even more likely to occur when staff begin to complain about how little work their peers do.

Interpersonal conflict can occur when you are involved with one or more staff members and one of you perceives opposition from the other. If you are modeling a leadership behavior that clashes with another learner's, client's, or staff member's values, conflict can occur.

Conflict can also occur in groups, such as staff meetings, nursing reports, or other group gatherings. Group conflict is caused by opposing forces within the work group and can be experienced by an individual member, by subgroups, or by the entire group. Conflict may be disguised and covered up at first, but it can soon burgeon into hostility or out-and-out warfare if not subdued or resolved. Subgroups may appear as one or more group members vie for control of the group, but subgroups can also be a sign of group growth (Clark, 2003).

Other authors have viewed conflict as positive. As early as 1964, Blake and Mouton claimed that complete resolution of conflict might stifle growth and creativity.

KEY TERM

Intrapersonal conflict can occur when an individual has two opposing goals.

KEY TERM

Interpersonal conflict can occur when two or more individuals are involved and one perceives opposition from the other.

LEADERSHIP CHALLENGE What kind of conflict was Rose identifying? Give a rationale for your answer.

Before attempting to manage, resolve, or transform conflict, it is a good idea to understand the context within which it developed. Theory and models can assist you.

Conflict Theory and Models

We'll examine several models and theories of conflict and conflict management, including Almost's model of antecedents and consequences of conflict, Kupper-schmidt's model of multigenerational conflict, the human needs theory of conflict, Wehr's model for conflict mapping, Lambourne's model of reconciliation, and Lederach's theory of conflict transformation.

Almost's Model of Antecedents and Consequences of Conflict

Almost (2006) developed her model for conflict within nursing work environments by using concept analysis. The model provides a thorough understanding of the sources and outcomes of conflict and could enable preventive action.

Almost's model includes the following parts:

- Conflict antecedents (including individual characteristics, interpersonal factors, and organizational factors)

- Perceived conflict
- Conflict consequences

See **Figure 8-1** for a more in-depth look at Almost's model.

LEADERSHIP CHALLENGE How might Almost's model of conflict help Rose identify what to do on her unit. Give a rationale for your answer.

Kupperschmidt's Model of Multigenerational Conflict

Today, four generations of RNs often work side by side in nursing situations. Because they bring different values and cultures to the work environment, conflict is common.

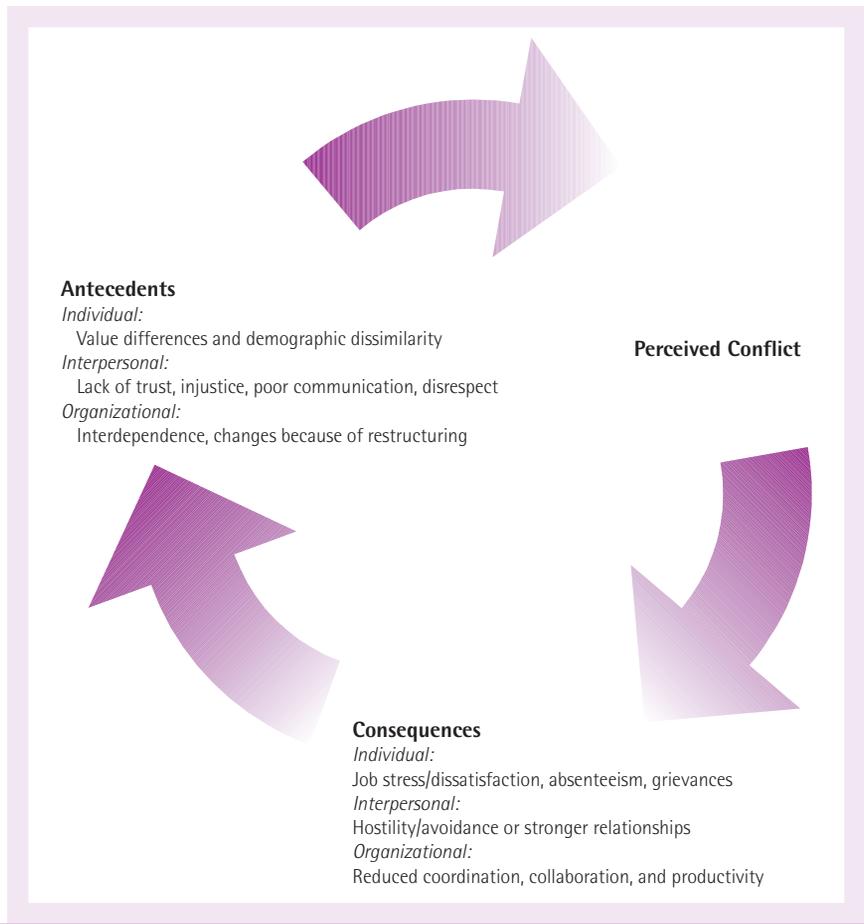


Figure 8-1
Antecedents, Perceived Conflict, and Consequences in Almost's Model

Kupperschmidt (2006) developed a model to address multigenerational conflict in nursing, and that model provides an explanation for the recent exodus of nurses from the profession. The **Kupperschmidt model of multigenerational conflict** describes four generations—from traditional professionals to Net generation professionals—and explains how differing values may cause conflict:

- *Traditional RNs* were born before 1944; they value hard work, respect authority, and may tell younger nurses to “do it because I say so.”
- *Baby boomer RNs* were born between 1944 and 1960; they value teamwork and like to reach consensus.
- *Generation X RNs* were born between 1961 and 1980 and value self-reliance; they might say that they will do the job themselves.
- *Net generation RNs* were born between 1981 and 2000; they value achievement and might not care who does the job as long as it gets done.

KEY TERM

The **Kupperschmidt model of multigenerational conflict** explains the challenges faced by nurses who work side by side with colleagues from a variety of generational cohorts and value systems.

LEADERSHIP CHALLENGE How could Rose use these generational differences to understand conflict on her unit? Give a rationale for your answer.

The Human Needs Theory of Conflict

The **human needs theory of conflict** is based on the writings of psychologist Abraham Maslow (1998). He theorized that all people are driven to fulfill fundamental human needs for safety, security, love, a sense of belonging to a group, self-esteem, and attaining their goals.

A group of conflict theorists—among them, Herbert Kelman (1997)—adapted Maslow’s ideas to conflict theory, suggesting that these needs underlie many deep-rooted conflicts. When needs are denied, conflict can continue indefinitely.

If this theory is true, it explains why needs conflicts can be so intractable—a person’s needs or a group’s needs do not run out. But providing security, safety, or a sense of belonging to one individual or one group does not deny them to others. In fact, needs are often mutually reinforcing. If one individual or group stops threatening, the opposition will also stop because the mutual reinforcement ends (Maiese, 2003).

KEY TERM

The **human needs theory of conflict** suggests that people are driven to fulfill fundamental human needs for safety, security, love, a sense of belonging to a group, self-esteem, and attaining their goals.

LEADERSHIP CHALLENGE Which needs may have been denied, leading to conflict, on Rose’s unit? Give a rationale for your answer.

KEY TERM

Wehr's model for conflict mapping includes the context of the conflict, parties involved, causes and consequences of the conflict, values and beliefs, goals and interests, dynamics, functions, and any regulations or rules that affect the conflict.

Wehr's Model for Conflict Mapping

Conflict has many elements. Wehr (1979) theorized that if mediators or those involved in a conflict could produce a road map, it would be easier to understand the dynamics of specific conflicts, enabling participants to solicit cooperation from their opponents.

Important elements identified by **Wehr's model for conflict mapping** include the context of the conflict, parties involved, causes and consequences of the conflict, values and beliefs, goals and interests, dynamics, functions, and any regulations or rules that affect the conflict. For more specifics on how to identify and use these elements, see the section "Conflict Assessment" on pages 166–167.

LEADERSHIP CHALLENGE How could Wehr's model for conflict mapping help Rose?

Lambourne's Model of Reconciliation

Lambourne (2004) developed a model of reconciliation that may be helpful. The model includes five elements:

1. *Truth*. This element includes an acknowledgment of past injustices and wrongs committed, a validation of pain and suffering, and an apology for harm caused.
2. *Mercy*. This element includes forgetting and letting go to end the cycle of revenge, releasing pain and identifying pain in the other, and engaging in rituals of healing and joint sorrow.
3. *Justice*. This element includes sharing power, responsibility, or resources.
4. *Identity*. This element includes replacing animosity with mutual acceptance and respect and accepting the other's autonomy.
5. *Recommitment*. This element includes a commitment to risk, trust, and change; the assurance that hurtful actions will not be repeated; and an anticipation of mutual security.

LEADERSHIP CHALLENGE Which elements of Lambourne's model of reconciliation could Rose use on her unit?

Lederach's Theory of Conflict Transformation

John Paul Lederach's theory of conflict transformation may help you understand what happened on Rose's unit. Lederach advocated the pursuit of conflict transformation, as opposed to conflict resolution or conflict management. He asserted that conflict resolution implies that all conflict is bad and should be ended and that, while conflict management correctly assumes that conflicts are long-term processes that cannot be quickly solved, the notion of management suggests that people can be directed or controlled as though they were objects (Lederach, 1995, 2003).

Conflict transformation goes beyond eliminating or controlling conflict and recognizes and works with conflict's interactive nature. Once conflict appears, it transforms the people and events involved, altering relationships, communication patterns, social organization, and people's images of themselves and others (Lederach, 1995, 2003).

Conflict transformation takes place at both the individual and organizational levels. At the individual level, conflict transformation includes the pursuit of awareness, growth, and commitment to change that occurs once a person identifies his or her fear, anger, grief, or bitterness. At the organizational level, justice and equality in the social system as a whole is pursued. This may involve eliminating oppression, improving the sharing of resources, and resolving conflict between groups in nonviolent ways. Key to both kinds of transformation are identifying the truth about what happened, righting any wrongs, extending forgiveness, empowering people to right wrongs, and establishing interdependence.

Lederach (1995, 2003) also counsels that the process of how conflict is resolved is more important than the outcome. During times of heated conflict, too little attention is often paid to the conflict resolution process, including how the issues are approached, discussed, and decided, and when discipline must be used to create an adequate and clear process for achieving an acceptable result.

KEY TERM

Conflict transformation theory suggests that people, events, and relationships are altered by a conflict but that destructive consequences can be prevented by transforming perceptions of issues, action, and other people or groups to improve mutual understanding.

LEADERSHIP TIP

Conflict can have destructive consequences that can be prevented by transforming perceptions of issues, action, and other people or groups to improve mutual understanding. Even when interests, values, and needs differ, progress can be made by gaining a relatively accurate understanding of each other.

LEADERSHIP CHALLENGE How could Rose use conflict transformation theory with staff on her unit?

Conflict Assessment

Wehr's (1979) conflict map provides a systematic way to plot out the origins, nature, dynamics, and possibilities for conflict resolution. Categories to consider include:

- *Conflict context.* Gather information about the history of the conflict and its physical and organizational settings. Use geographic boundaries, political structures, relationships, communication networks and patterns, and any legal jurisdictions. Look for conflicts nested within conflicts. For example, an ongoing conflict between medicine and nursing at the highest levels can be played out at the unit level.
- *Parties.* Individuals involved in the conflict can be primary (the ones who oppose another's values and goals and who have a direct stake in the outcome), secondary (those who have an indirect stake in the outcome), or third parties (mediators or peacekeepers who facilitate resolution). All these individuals have some stake in the conflict's outcome.
- *Causes and consequences.* Causes and consequences may blend; for example, hostility may be a consequence of one phase of a conflict and the cause of another. A basic cause of social conflict is incompatible goals and interests. Cultural differences, especially language, can create separateness and cause a group to become defensive.
- *Contrasting beliefs and values.* This category includes such things as one side's negative images of its opponents, opinions about a Supreme Being, the need to argue or fight, and a low capacity or priority for cooperation.
- *Goals and interests.* Goals are specific positions or demands made by one party or the other. Interests are what motivates those involved: security, recognition, respect, justice, and so on. Mapping can help opposing parties distinguish their positions from their needs and bring them as close to unity as possible.
- *Dynamics.* Conflicts can change. Mapping changes in escalation and polarization can make dynamics more visible. Other dynamics to map include precipitating events that led to the dispute, escalatory and de-escalatory spirals (during which time participants can be carried away from cooperative resolution and toward greater hostility). Stereotyping opponents only reinforces these runaway responses.
- *Functions.* Conflicts can have positive consequences for those involved, such as the release of tension or aggression. A conflict has a purpose for those involved and new alliances may be formed. The group may even become more unified as it defends itself against unfair accusations. Studying the consequences of these functions can help understand ways to move the conflict toward resolution.

- *Regulation potential.* Each conflict contains its own conflict-limiting elements, such as the wish to maintain the relationship, laws or policy, or a higher authority.

Now that you've learned about conflict theories and models, including Wehr's conflict assessment, read **Box 8-1**.

LEADERSHIP CHALLENGE How could Rose use this conflict assessment? What other information would she need to understand the conflict?

Conflict Approaches

“Clients can sense immediately when nurses are not working as a team,” says Terri Irwin, an RN and college practice consultant (Stroeder, Znaniecki, & Brennerman, 2006, p. 14). As a nurse leader, it is important for you to “recognize, manage and deal with conflict before it becomes an issue that affects client care” (Stroeder et al., 2006, p. 14).

Once you have assessed the conflict and have sufficient information, you will need to choose a conflict approach. Conflict approaches include using Weiss's model of conflict patterns, managing strong emotions, using “I” statements,

BOX 8-1 ASSESSING MY CONFLICT RESOLUTION SKILLS

Directions: Answer yes or no for each statement.

- I know how to assess conflict by using Wehr's conflict assessment.
- I have filled out Wehr's conflict assessment for at least one conflict situation.
- I can identify Almost's antecedents and consequences of conflict.
- I can describe Kopperschmidt's four generations.
- I can identify elements for each of Kopperschmidt's generations that could lead to conflict.
- I can describe how Maslow's theory of fundamental human needs relate to conflict.
- I can identify the five areas of Lambourne's model of reconciliation.
- I can describe Lederach's conflict transformation theory.
- I have chosen a conflict resolution model or theory to resolve a conflict.
- I can describe five approaches to conflict resolution, management, or transformation.
- I have tried out at least two approaches to conflict resolution, management, or transformation.

Reread the items that you've answered no to, and complete the related leadership development exercises at that end of this chapter.

Source: Adapted from Almost (2006).

dealing with needs conflicts and reconciliation, conflict resolution programs, problem-solving workshops, analytical problem solving, transformative mediation, and fostering dialogue.

Weiss's Model of Conflict Patterns

One model that may be helpful for choosing a conflict approach is Weiss's (1988) model of three basic patterns of reaction:

1. *In control and unresponsive.* An example of this pattern is an individual who is aggressive with other people, which easily sets up conflict. When confronted in a group, this individual can either become more aggressive or ignore the confrontation. Taking this person aside and asking what he or she thinks could resolve the conflict. Unresponsive behavior can change when the individual gets credit for solving the conflict.
2. *Not in control and responsive.* An example of this pattern is a demanding individual who starts conflicts by promising to complete work tasks but then doesn't fulfill those promises.
3. *Not in control and unresponsive.* An example of this pattern is an individual who stammers, trembles, and cannot speak.

Weiss (1988) also discussed conflict-ridden patterns of game playing that can add havoc and stress to a work setting. Some patterns of game playing include:

- *Gotcha.* This game includes blaming other people, using exaggerated sarcasm, and enjoying watching other people's discomfort.
- *Woe is me.* This game includes constant whining or complaining without taking appropriate problem-solving steps for the purpose of winning sympathy.
- *Let's fight.* This game involves starting arguments for the purpose of fighting or winning a fight.
- *How about you two fight?* This game involves instigating fights between other people, usually over trivial or petty matters, for the purpose of watching other people fight.
- *Why don't you . . . ?* This game includes offering unsolicited advice (often to "woe as me" players) for the purpose of appearing to be helpful while really wishing to control the other person.

LEADERSHIP CHALLENGE Which of these games, if any, might Rose have to deal with? What advice would you give her?

No matter how difficult a conflict is, there's a specific method of taking action:

1. Find a private room, and engage the involved individuals in a discussion.
2. State the purpose of the meeting in nonthreatening terms, accepting responsibility for working on the problem by using "we" statements rather than "you" statements.
3. Ask the other persons to express their opinions and solutions first; then express yours.
4. Resolve any disagreements by returning to step 2.
5. Design an action plan for ending the difficulty, including deadlines and progress review dates. (Weiss, 1988)

That action plan contains the following items:

- Describe the way that the involved individuals act.
- Decide what exact action to take when the identified behaviors occur.
- Write out and rehearse the plan.
- Carry out the plan at the first opportunity.
- Evaluate the outcome.
- Revise the plan as necessary. (Johnson, 1993)

Managing Strong Emotions

Strong emotions can be the cause and effect of conflict. These emotions can mask the issues in dispute, so they must be dealt with. Some strategies to use include:

- *Use symbolic gestures to express respect and defuse negative emotions.* These include apologies, sympathetic notes, shared meals, or handshakes.
- *Help participants identify their emotions.* Are they angry or just excited?
- *Model how to express feelings.* For example, say, "I feel angry because I don't like to be shouted at" or "I'm confused about what's happening on the unit," rather than "You made me angry."
- *Acknowledge that everybody's feelings are legitimate.* Allowing feelings to be expressed and recognized often defuses them.
- *Avoid retaliating to outbursts with anger.* If you feel as if you're losing control, step out of the room for a new perspective, and take some deep breaths. Leaving the scene gives you a chance to calm down and plan an effective response rather than reacting automatically, which can escalate the situation. A useful response is to acknowledge the outburst with active listening and to paraphrase what you hear; this shows that you understand the strength of the speaker's feelings.

KEY TERM

"You" statements, such as "You aren't really listening to me," are intrusive, blaming, or attacking.

KEY TERM

"I" statements can halt defensive and hostile escalation because they tend to invoke trust and create space for the parties to explore their unacknowledged feelings.

Using "I" Statements

"You" statements, such as "You aren't really listening to me," are intrusive, blaming, or attacking. They can be manipulative or coercive because they seek to change another person's behavior, and they can provoke a defensive reaction, counterattack, or withdrawal and escalate a destructive communication cycle. These aggressive statements often mask insecurities.

"I" statements, such as "I feel as if I'm not being understood," disclose your feelings without attacking others, invalidating their feelings, or criticizing them. "I" statements can halt defensive and hostile escalation because they tend to

invoke trust and create space for the parties to explore their unacknowledged feelings. Such communication has the potential to transform situations. "Personal growth is largely a function of our capacity to be with feelings in an accepting, sensitive manner" (Amodeo & Wentworth, 1995, p. 210). By risking honest self-expression and taking responsibility for your feelings, you can encourage others to change their behavior.

LEADERSHIP CHALLENGE How could Rose use "I" statements with her staff? Give some examples of what she might say.

Needs Conflicts and Reconciliation

When conflict is a result of the denial of one or more essential needs, fighting can go on until those needs are filled (Marker, 2003). As a nurse leader, it is important for you to identify the legitimate needs of all staff and begin to meet those needs. If safety or security needs have top priority, then they should be the focus. If staff do

not feel part of the work group, then that should be the priority. When self-esteem is low, make attempts to raise self-esteem by praising staff attempts and pointing out staff strengths.

KEY TERM

Distributive negotiation is focused on each party winning as many concessions as possible; this can result in a win-lose situation.

KEY TERM

Integrative negotiation is focused on parties discovering solutions that embody mutual self-interest; this can result in a win-win situation.

Conflict Resolution Programs

Conflict resolution programs use negotiation to settle conflicts. Negotiation can be distributive or integrative. **Distributive negotiation** is focused on each party winning as many concessions as possible; this can result in a win-lose situation. **Integrative negotiation** is focused on parties discovering solutions that embody mutual self-interest; this can result in a win-win situation.

The face-to-face conversations involved in direct negotiation can influence people to act in the group's interest. Talking with the opposition sends the message that both parties are committed to positive resolution and tends to be integrative (Kagan & Gall, 1998).

Conflict resolution skills overlap with social competence skills and include:

- Awareness of others
- Awareness of the distinctions between self and others
- Listening skills (see chapter 11)
- Awareness of and ability to express one's own thoughts and feelings
- Ability to respond to others' thoughts and feelings

LEADERSHIP CHALLENGE If you were a nurse leader on a unit where staff did not possess these skills, what could you do to ensure that they are learned?

Problem-Solving Workshops

Problem-solving workshops have been shown to contribute to transforming the relationship between conflicting parties. Interacting in this type of workshop promotes and models a new kind of relationship between the parties, one that is based on equality and reciprocity.

During the workshop process, a facilitator encourages participants to gain an understanding of the other side's needs, fears, and constraints. As a result, group members try to shape solutions that respond to the fundamental concerns of both sides. The group searches for ways to provide mutual reassurance. Such ideas emerge from acknowledgments participants make to each other while interacting. Empathy for the other side begins to develop, and trust grows. Workshop participants then return to their community or workplace and teach their respective colleagues not only ideas about transforming relationships but also the results of their workshop experience. They can testify that a mutually enhancing relationship is possible because they participated in one (Kelman, 1997).

LEADERSHIP CHALLENGE What could Rose take from that information on problem-solving workshops to use on her unit?

Analytical Problem Solving

Analytical problem solving is a social-psychological approach to dealing with protracted conflicts that is based on the human needs theory of conflict. During

KEY TERM

Analytical problem solving is a social-psychological approach to dealing with protracted conflicts that is based on the human needs theory of conflict.

this process, a great deal of emphasis is put on identifying and examining both parties' perspectives on the problem, including their values, interests, prejudices, hopes, fears, and needs. Emotions are not avoided; they are dealt with directly. Much emphasis is placed on recognizing each other's needs and empowering parties to approach their mutual problem in new ways. Although long-term conflict resolution is a primary goal, the short-term goal is increasing mutual understanding. This can be achieved in a workshop (Burgess & Burgess, 1997).

Some questions that such a workshop process could raise include:

- What are your interests, hopes, fears, and needs related to this situation?
- What feelings has this conflict brought forth that you are comfortable sharing?
- What do you believe are the other party's needs?
- How are these interests, hopes, fears, and needs similar to yours?

LEADERSHIP CHALLENGE How could Rose use analytical problem solving with her staff? What if she couldn't bring her staff together in one place at the same time? In what other ways could she promote this kind of problem solving?

Transformative Mediation

Transformative approaches do not seek resolution of the immediate problem. They seek the empowerment and mutual recognition of the parties involved (H. Burgess, 1997).

KEY TERM

Empowerment means increasing the skills of all involved to make better decisions for themselves by learning how to clarify their goals, to find out about resources and options, and to choose their preferences.

Empowerment means increasing the skills of all involved to make better decisions for themselves by learning how to clarify their goals, to find out about resources and options, and to choose their preferences (Bush & Folger, 1996).

Transformative mediators help disputing parties deal with issues by providing a forum for discussion with a neutral third party present. This process can help clarify the nature of the problem from both parties' points of view and develop a range of options. In this approach, the involved parties are believed to be the experts who have the motivation and capacity to solve their own problems with minimum help (such as encouraging the expression of emotion and examining the past as a way of persuading the parties to recognize each other's accomplishments and discuss important issues even if such issues are not easily negotiable). The transformative mediator lets parties set goals, direct the process, and design the ground rules.

You can implement transformative mediation by using the information in the Guided Leadership Tip “Helping Combatants Resolve Their Difficulties.”

LEADERSHIP CHALLENGE What problems might Rose anticipate using conflict transformation, and how could she overcome those obstacles?

Fostering Dialogue

In dialogue, participants speak as individuals, not as representatives of groups or positions. Parties speak directly to one another, and facilitators strive to create a safe atmosphere for discussion and to promote respectful exchanges.

Facilitators encourage participants to question the dominant public view and to express fundamental needs that may or may not be reflected in formal workplace directives. Three approaches foster dialogue:

1. Collaborating with participants
2. Refusing to take the role of expert
3. Acknowledging the parties are the best experts in their own experiences and wishes (Chasin et al., 1996)

Extensive preliminary work may be necessary with individual participants. Setting ground rules for conducting the sessions will help facilitators prevent each side from reenacting old patterns of interaction. Common ground rules include:

- Participants can decline to answer a question without explanation.
- Respectful language must be used.

GUIDED LEADERSHIP TIP

HELPING COMBATANTS RESOLVE THEIR DIFFICULTIES

Comments to help combatants include:

- “What ground rules do you want to use?”
- “Your goals are legitimate and should be considered seriously. You might want to clarify them. How you do that is up to you.”
- “These resources are available to you to help you make informed choices” or “It’s important to find out what resources you need to make an informed choice. How you do that is up to you.”
- “Here is a list of your options for you to examine the relative costs and benefits of each.”
- “It’s important to reflect and deliberate on your preferences so you can make a conscious decision based on the strengths and weaknesses, advantages and disadvantages, of both sides. How you do that is up to you.”
- “It’s up to you how much you recognize the views of _____ [name of opponent] _____.”

- Attempts to persuade others or use rhetorical questions are forbidden.
- No one is to share the specifics of the sessions outside the meetings. (Chasin et al., 1996)

Four tactics that help foster new patterns of communication are:

1. Making sure that the parties speak as individuals, not as representatives of their position
2. Exploring ideas and experiences that are usually dismissed or ignored by the mainstream discussion
3. Discovering new differences by asking sincere questions about unclear points
4. Using de-stereotyping exercises to break down polarization (Chasin et al., 1996)

Roth (1994) made the following additional suggestions for constructive dialogue:

- Address participants as coinvestigators in finding a solution.
- Request that participants avoid interrupting each other, pass if they don't want to speak (no questions asked), and keep their replies to 2 minutes.
- Begin by asking participants to talk about their life experiences in relation to the issue.
- Ask, "We would like to hear a little about your beliefs and perspectives about this issue. What is at the heart of the matter for you as an individual?"
- Then ask, "What dilemmas, struggles, and conflicts do you have about your prevailing view of this issue? Include any mixed feelings that you wish to share."

LEADERSHIP CHALLENGE If Rose decides to foster dialogue on her unit, what specific actions must she take to ensure that staff follow the tactics that help foster new patterns of communication?

Establishing an Environment of Care

Generational conflict and lack of respect can lead nurses to be abusive to other nurses. Kupperschmidt (2006) pointed out that nurses should respect each other and that when a nurse is disrespected, he or she should adopt an assertive attitude, not fall into silent withdrawal. An environment that's conducive to caring for colleagues needs to be established in the workplace. Failing to confront disrespect is "not kindness; rather it is a form of lying" (Augsburger, 1973, p. 25).

An article in *Nursing Management* (Sanford, 2005) described a toxic work environment that was allowed to continue for 14 years because nursing staff and

managers refused to confront the disrespectful behavior of one RN. Allowing the RN's behavior to continue gave other nurses permission to be disrespectful. The article stressed that nurse leaders and staff nurses should learn confrontation skills to set the expectation of mutual respect.

Some ways to do that include using honest communication that confronts and addresses disrespectful behavior, such as:

- “I want and deserve to be treated with respect.”
- “You and I have an ethical imperative to treat each other with respect.” (See Chapter 10.)

When nurse leaders provide access to information, support and resources, and an opportunity for development, nurses perceive that they are being treated with respect (Laschinger & Finegan, 2005).

LEADERSHIP TIP

As a nurse leader, you can ask for cultural diversity education to address issues of generational diversity, and you can teach ways to confront disrespectful behavior.

Other Conflict Approaches

Other ways to deal with conflict and even prevent it are:

- Acknowledge conflict so it can be resolved before it escalates.
- Develop conflict prevention and management guidelines so staff can refer to them.
- Focus on behavior that contributes to the conflict, not on the person.
- Identify conflicting values or beliefs that may be fueling conflict.
- Avoid postponing dealing with conflict.
- Use open body language, and display a respectful attitude.
- Develop efficient reporting systems to help nurses manage conflict before it escalates.
- Allow concerns to be raised at team meetings.
- If you're a manager, adopt an open-door policy, and take actions to make a fair workplace environment (Stroeder, Znaniecki, & Brennerman, 2006).
- When you're at fault, give the other persons what they want or request.
- Strive to understand the problem from all viewpoints.
- Work with other parties to create a solution that meets everyone's needs.
- Work toward a win-win solution for all involved, or at least achieve a middle ground where everyone involved gives and gets a little.
- Always use tactful messages—for example, “I have a problem, can you help me?” “I need your help with . . .” “I feel this way about . . .” (Johnson, 1993).

Specific suggestions for dealing with difficult situations appear in **Box 8-2**.

BOX 8-2 SUGGESTIONS FOR DEALING WITH DIFFICULT SITUATIONS**Verbally Abusive Individuals**

- Encourage a more relaxed situation by asking those involved to sit down and discuss the problem.
- Encourage people to vent their emotions by using open-ended questions ("Tell me what you're upset about"), but set rules ("No swearing, cursing, or attacking, please").
- Stand up for yourself ("I've listened to your views; now please listen to mine").
- Maintain eye contact, and hold your ground; bullies often back down and become friends when someone stands up to them.
- Focus on solving a problem, not the person's behavior ("What do you hope to accomplish; what are your goals?" or, in a group, "Does anyone else feel the way _____ does?").
- Avoid getting in between the aggressive person and a third party, and avoid counterattacking. Stay focused on solving the problem, not on group dynamics.
- Relay your perceptions of people's behavior and its effect on others in a neutral, nonjudgmental way.
- Empathize with others' needs ("I hear what you're saying and what you're asking for").
- When you understand an inkling of the other person's motivations, voice them ("I wonder if you're upset about . . ." or "Do you think _____ is affecting you?").
- State your objections to the other person's behavior, and request that he or she stop ("I don't like verbal abuse; please stop it").
- Never remain silent on an issue you disagree with; at least say, "I disagree with that last statement."

Naysayers

- State the worst possible thing that could happen, and ask, "What would you do if that happened?" (This demonstrates that even the worst-case scenario is controllable.)
- Respond positively to any valid reservations.
- Identify the rewards that naysayers will miss out on if they don't come on board.
- Be prepared to replace these team members if they still refuse.

Those Who Speak without Data to Back Them Up

- State the correct facts.
- Provide alternative opinions and perceptions ("Here's a new survey that shows . . ." or "A new study shows that . . .").
- Have individual meetings; without an audience, this behavior often ends.
- Never suggest that you may be wrong, but be sure that you have your facts right.
- Request proof for assertions and allegations that you believe are false.

Procrastinators

- Help procrastinators get started by having a task for them to work on.
- Develop solid reporting and follow-up procedures to track progress.
- Identify omissions, misinformation, and clues of problem areas.
- Never accept excuses.
- Follow up on any performance difficulties until work is back on track.

For All Problem Situations

- Reward high achievers by letting them mentor low achievers.

Source: Based on the ideas of Bramson (1981); Johnson (1993); and Keating (1984).



Summary

This chapter has focused on conflict in the workplace and the nurse leader's role. There is no appropriate or inappropriate strategy to deal with conflict, but detecting symptoms of conflict and adopting the most effective behavior to that specific situation is essential in nursing units (Vivar, 2006).

Key Term Review

- **Analytical problem solving** is a social-psychological approach to dealing with protracted conflicts that is based on the human needs theory of conflict.
- **Conflict** is a normal occurrence and a multidimensional construct whose antecedents are individual, interpersonal, and/or organizational. Conflict can be either beneficial or detrimental, and either internal or external.
- **Conflict transformation** theory suggests that people, events, and relationships are altered by a conflict but that destructive consequences can be prevented by transforming perceptions of issues, action, and other people or groups to improve mutual understanding.
- **Distributive negotiation** is focused on each party winning as many concessions as possible; this can result in a win-lose situation.
- **Empowerment** means increasing the skills of all involved to make better decisions for themselves by learning how to clarify their goals, to find out about resources and options, and to choose their preferences.
- The **human needs theory of conflict** suggests that people are driven to fulfill fundamental human needs for safety, security, love, a sense of belonging to a group, self-esteem, and attaining their goals.
- **Integrative negotiation** is focused on parties discovering solutions that embody mutual self-interest; this can result in a win-win situation.
- **Interpersonal conflict** can occur when two or more individuals are involved and one perceives opposition from the other.
- **Intrapersonal conflict** can occur when an individual has two opposing goals.
- **“I” statements** can halt defensive and hostile escalation because they tend to invoke trust and create space for the parties to explore their unacknowledged feelings.
- The **Kupperschmidt model of multigenerational conflict** explains the challenges faced by nurses who work side by side with colleagues from a variety of generational cohorts and value systems.
- **Wehr’s model for conflict mapping** includes the context of the conflict, parties involved, causes and consequences of the conflict, values and beliefs, goals and interests, dynamics, functions, and any regulations or rules that affect the conflict.
- **“You” statements**, such as “You aren’t really listening to me,” are intrusive, blaming, or attacking.

Leadership Development Exercises

■ Leadership Development Exercise 8-1

Use Wehr’s conflict assessment for at least one real or hypothetical situation.

■ Leadership Development Exercise 8-2

Identify Almost's antecedents and consequences of conflict for at least one real or hypothetical situation.

■ Leadership Development Exercise 8-3

Observe staff members at work, and determine which of Kupperschmidt's four generations each belongs to and possible areas of conflict. Give a rationale for your findings.

■ Leadership Development Exercise 8-4

Pick a real or hypothetical conflict situation, and describe how Maslow's theory of fundamental human needs relates to it.

■ Leadership Development Exercise 8-5

Identify the five areas of Lambourne's model of reconciliation, and explain how you could use them to end a conflict.

■ Leadership Development Exercise 8-6

Describe a real or hypothetical situation and how you'd apply Lederach's transformation theory to it.

■ Leadership Development Exercise 8-7

Choose a real or hypothetical conflict situation, and try out at least two approaches to conflict resolution, management, or transformation with a classmate, staff member, or friend. Write up your findings, and share them with the class.

Advanced Leadership Development Exercises**■ Leadership Development Exercise 8-8**

Teach conflict resolution skills to two clients, staff on a nursing unit, or a group of colleagues using at least two of the methods presented in this chapter.

■ Leadership Development Exercise 8-9

Write up your findings from teaching conflict resolution skills, and make them the basis for a class assignment.

Alternate exercise: Use your findings to prepare a paper suitable for submission for publication.

■ Leadership Development Exercise 8-10

Formulate a problem statement for a nursing project related to some aspect of conflict.

■ Leadership Development Exercise 8-11

Design a research project related to some aspect of conflict.

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Delegating

CHAPTER OBJECTIVES

After reading this chapter, answering the leadership challenges, and participating in the leadership development exercises, you will be able to:

- Define delegation
- Discuss changes in healthcare delivery that make task delegation important
- Identify the essential elements of effective delegation
- Determine whether state law and facility policies permit the delegation of a specific task
- Decide when delegation is appropriate
- Discuss the procedure for delegating tasks to assistive personnel
- Analyze nursing delegation actions

Advanced nurses will be able to:

- Teach delegation skills to student nurses in an undergraduate leadership course
- Formulate a problem statement for a nursing project related to delegation
- Design a research project related to delegation

KEY TERM

UAPs are unlicensed assistive personnel, such as nursing assistants.

Introduction

According to an American Hospital Association survey, nearly all hospitals (97%) now employ unlicensed assistive personnel (UAPs), who carry titles like “nursing assistants,” “nurse extenders,” and “care partners.” So no matter where you work, the use of this kind of worker is apt to increase as hospitals act to preserve their profits (Parkman, 1996). As a result, you will need to know how to delegate tasks effectively.

You may want to do all client care yourself, but the reality of the situation in many facilities is that delegation is a necessity. Because delegating is an expected professional nursing activity, begin to think about the many benefits of assigning appropriate tasks to UAPs. Effective delegation can free you to do what nurses do—make judgments about clients and coordinate their care (Anderson, Twibell, & Siela, 2006). This chapter will provide you with the information you need to practice safely while delegating tasks to UAPs.

To prepare you to delegate tasks to UAPs before you face the situation on a hospital unit, read the Leadership in Action vignette that follows, answer the questions you’ll find throughout this chapter, and complete the leadership development exercises at the end of the chapter.

LEADERSHIP IN ACTION

It’s a busy evening, and you’re assigned to care for eight clients. Because your unit is short staffed, Ray, a nursing assistant, has been floated from another department to help you. Although you’ve worked with Ray before, you still feel uneasy delegating tasks to him because you’re not sure that he has the skills and theory to make decisions about any of your clients. You’re not sure which of the eight clients to delegate to Ray and how often you need to check on his progress. You’re not even sure what the legal ramifications are if he makes a mistake and harms one of the clients. You wish there were more nurses on the unit so you could double-check your delegation decisions with them. As a result, you do most of the care for all eight clients yourself.

LEADERSHIP CHALLENGE How would you evaluate your decision to do most of the care for all eight clients yourself?

The American Nurses Association (ANA, 1995) defines **delegation** as “transfering responsibility for the performance of an activity . . . while retaining accountability for the outcome.” Accountability means being able to explain your actions and results. Responsibility means completing the task at an acceptable level.

Healthcare Changes and Delegation

According to the National Council of State Boards of Nursing (NCSBN) and the ANA, the escalating shortage of nurses, the greater acuity of clients, technological advances, and the increased complexity of therapies all contribute to changes in the healthcare environment. Because of these changes, RNs will be expected to work with assistive personnel and be able to delegate, assign, and supervise them (NCSBN & ANA, 2006).

Both the NCSBN and the ANA believe that mastering the skill and art of delegation is a “critical step on the pathway to nursing excellence and, when used appropriately, can result in safe and effective nursing care” (NCSBN & ANA, 2006).

Some of the problems you may face when attempting to delegate tasks are because of the changes that have occurred in work settings. Since fewer full-time RNs may be on the unit and part-time nursing personnel are often hired, continuity of care may be compromised. As a new and inexperienced nurse, your care may focus on the details of procedures while working within a small number of paradigms. Mentors may not be available because clinical nurse specialists and more-senior nurses have been downsized. Even more experienced nurses may be confronted with delegation problems because they may assume that UAPs make the same complex assumptions about clients as they do (Boucher, 1998).

KEY TERM

Delegation is “transferring responsibility for the performance of an activity . . . while retaining accountability for the outcome (ANA, 1995).

LEADERSHIP CHALLENGE Now that you know what the ANA and NCSBN think about delegating tasks, go back and reevaluate your choice in the Leadership in Action vignette to do most or all of the nursing tasks yourself.

Guidelines for Delegation

The ANA (2005) provided guidelines for delegation, recommending that nurses engage in a critical-thinking process before delegating care responsibilities to assistive personnel. Questions you will need to answer before delegating a task include:

- Will the client receive quality nursing care if the task is delegated?
- Should the task be delegated?
- How much supervision will the person doing the task require?
- Is the person to whom the task is being delegated competent to do the task?
- Is the person functionally able to perform the task based on other assignments?
- Can the person perform the task without an adverse client occurrence?

LEADERSHIP CHALLENGE Which of these questions can you answer about Ray, the nursing assistant in the Leadership in Action vignette at the beginning of the chapter?

Conceptual Models for Delegation

When you delegate a task, you give someone else the authority to carry it out, but you remain accountable. Because you're ultimately accountable, you need a conceptual model to guide your decisions to delegate.

One conceptual model for delegation is called “the rights of delegation.” These rights are:

- *The right task.* You must be sure that the task is one that can be delegated and does not fall within the nurse's scope of practice.
- *The right person.* You must be sure that you delegate only to a person who is qualified and competent to do the job.
- *The right circumstances.* Some of the information you need to make this decision are that the task frequently recurs in the daily care of a client and that there is an established sequence of steps and a predictable outcome.
- *The right communication.* When working with assistive personnel, make sure that you are communicating clearly and concisely about the task, the objective, your expectations for the task (including any unique client requirements and characteristics), and your willingness to be available to guide and provide support. And verify that the assistant accepts the delegation and accompanying responsibility. See **Box 9-1** for ideas.
- *The right feedback/evaluation.* You must consider the healthcare status of the client, the predictability of responses and risks, the complexity of the task, and the required supervision and support (and then you need to provide that supervision and support). While the task is being completed, provide the worker with comments. The final step is to evaluate the outcome and to problem-solve about future delegation processes. Part of that evaluation includes asking the assistant whether the task was performed correctly, whether the client outcome was achieved at a satisfactory level, whether communication from you was timely and effective, what went well and what presented challenges, what the assistant learned, and whether the assistant received appropriate feedback from you (Center for American Nurses, 2006; Parkman, 1996).

LEADERSHIP CHALLENGE Use the rights of delegation and Box 9-1 to help you identify some ways to evaluate and approach the situation with Ray.

BOX 9-1 SUPERVISING UAPS AND MAINTAINING NURSING PRESENCE

When supervising UAPs, think like a UAP, and then communicate the needed information, and be sure to maintain a nursing presence. Steps to take include:

- Anticipate clinical problems that could be encountered by a UAP.
- Think of these problems as cues to help you organize your communication. For example, if you plan to delegate ambulation, what client cues does the UAP need to watch for? Postural hypotension might be one. In a diabetic client, signs of hypoglycemia or shock might be important. Signs of postoperative bleeding would be important for postoperative clients, and so on.
- Develop a clear statement of what the task entails and what outcome you expect from the UAP. You could even write this down on an index card (including important observations that the UAP needs to make) and hand it to the UAP as a reminder of what to watch for.
- Clarify what you expect. Use a tone of voice that says, "This is important, and I expect you to follow through." (You can read from the card if you like.) Be specific in your communication. Say, "Please take Mrs. Albert's temperature right away so we can get packed red cells from the blood bank"—not just, "Please take Mrs. Albert's temperature." Say, "Let me know if Mr. George's blood glucose is above 240"—not just, "Let me know if Mr. George's blood glucose is too high." By specifying the why of your request, you will teach the reason behind the nursing action and more likely receive a positive response.
- Ask UAPs to sign a specific assignment sheet, and/or ask them to repeat back to you what you've just assigned them to do.
- Give a specific time that you will be checking back to evaluate the UAP's performance; make sure that you check back at the agreed-upon time.
- When you check back, find out exactly what has not been accomplished. Provide praise and direction as needed, and always thank the UAP. If the job was not accomplished well, talk to the UAP in private to identify whether inadequate training, a lack of preparation, or an inability to prioritize tasks may be the reason why the UAP did not accomplish the task well. Reiterate why the task is done in a certain way and the benefit for the client. Work out a plan with the UAP for the assignment to be completed.
- Listen carefully to what UAPs say about clients; ask specific questions to learn what you need to know. Your questions will train UAPs to watch for what is important.
- To maintain a nursing presence and build trust, take minireports throughout a shift, and make frequent rounds. Such actions allow you to make your own observations, to supervise UAPs, and to provide a supportive presence for them. Be consistent in word and action; it is the hallmark of trust building.
- Document carefully when you run into problems with a UAP. This will protect you from being sued if a client is harmed by an assistant's actions.
- Remember: Being a leader includes teaching management skills to others so they can learn to be effective.

Source: Adapted from Boucher (1998); Clark (2003); and Parkman (1996).

Another conceptual model for delegation is the nursing process. Delegation shares some common facets with the nursing process, such as assessing, planning, implementing, and evaluating care. After assessing the client and planning care, identify which tasks someone else can perform, and assign and supervise the performance of these tasks. Once the care has been implemented by the nursing assistant, evaluate whether the assistant performed the task properly and whether he or she achieved the planned outcome (Parkman, 1996).

While models can help you understand the delegation process, only your state's nurse practice act and other policies can provide the information you need about what to delegate.

Determining Legal and Facility Delegation Policies

Before delegating a task, you must be familiar with your state laws and hospital policies. In the section defining nursing practice, you will find aspects of care, such as physical assessment and care planning, that belong only to the nurse. Other, more-specific skills, such as wound care, are not delegable. Most states may also identify the RN's actions in providing indirect care by delegating tasks and supervising their completion.

You can also consult your state board of nursing rulings. It can often tell you what can be legally delegated and what cannot. It may also provide job descriptions. According to Parkman (1996), state regulations and nursing board rules dictate that a nursing assistant or other UAP cannot be directly assigned to a group of clients, even though assignment sheets or boards may do so.

Legally, nurses who delegated tasks appropriately based on hospital policy and who followed up and evaluated the UAP's work correctly were not found liable when lawsuits arose (Anderson, Twibell, & Siela, 2006).

Job descriptions for UAPs should be available at your institution. These descriptions usually provide specifics of what UAPs can and cannot do (e.g., take vital signs, position clients, or even gather supplies for a dressing change). UAPs may not always be familiar with what they can do in your setting, so do not assume they are. Parkman (1996) also suggests reviewing policies and procedure skill requirements for specific treatments, the supervision needed, and the protocol for reporting problems or incidents. Also be familiar with standards of care for client safety, including infection control.

Typically, a task that you can delegate is one that does not require nursing judgment (e.g., measuring urine output or vital signs). But even that is not set in stone. UAPs may be assigned to take vital signs on someone who is recovering well from elective surgery, but you may want to take vital signs on a critically ill client because you are more apt to detect a downturn in that client's condition (Parkman, 1996).

LEADERSHIP CHALLENGE Besides measuring urine output or taking vital signs, what other tasks would you delegate? Give a rationale for your answer.

Never delegate tasks that require monitoring chest pain or other complex procedures. Even if your hospital allows you to delegate ambulating a client, only you can decide whether a specific UAP can ambulate a specific client.

Your nurse practice act probably prohibits you from delegating initial assessments, discharge planning, health education, care planning, triage, and the interpretation of assessment data (Anderson, Twibell, & Siela, 2006).

Remember that UAPs are not trained to see a client within a specific context and know the significance of what they observe. They do not possess the critical-thinking ability that you do. They receive training for only a few weeks to a few months. They report observations; they cannot analyze the meaning of what they report. For example, they can record and report the amount of urinary output but not grasp the significance of decreased output (Boucher, 1998).

LEADERSHIP TIP

A general rule for delegation: do not delegate the assessment, planning, and evaluation steps of the nursing process.

LEADERSHIP CHALLENGE Why is it important not to delegate the nursing process to UAPs?

Learning how to keep a nursing presence with clients while delegating simple and repetitive tasks to UAPs will require creative thinking and will be an ongoing challenge. The more you practice, the better you will become at delegation.

Determining When Delegation Is Appropriate

Delegation may be appropriate under the following two conditions:

1. You have assessed the client and have assured yourself that the task you wish to delegate does not require skilled nursing care. Only you can look at a client and use your critical-thinking skills to judge spiritual needs, emotional state, cognitive function, clinical condition, and physiological status.
2. You have assessed the UAP's ability to perform. The more stable the client, the more likely you can delegate aspects of care. There are specific questions that you can ask UAPs to determine their ability, including:
 - Have you been trained to do this task?
 - Have you ever performed this task with a client?
 - Have you ever completed this task unsupervised?

- How confident are you about performing this task correctly?
- What problems have you encountered when completing this task in the past? (Anderson, Twibell, & Siela, 2006)

If you are still not sure, you can demonstrate the procedure and request that the UAP does a demonstration. You can also consult with a senior nurse or your immediate supervisor. Be assertive about obtaining a consultation if you are unsure. Take notes on the conversation, including the date and time of consultation. Be sure to keep a copy.

If you're new to the idea of delegating or prefer to remain in charge of client care, see **Box 9-2**.

BOX 9-2 SIGNS OF DIFFICULTY IN DELEGATING TASKS

If you notice any of these signs in yourself, you may have difficulty delegating tasks:

- Always being very busy
- Needing to be three places at once
- Rushing from crisis to crisis
- Difficulty making and scheduling appointments with others
- Believing you're the only one who can do the task correctly

If you're not the designated leader, you may notice the above signs in the unit leader, and additionally:

- Team breakdown (the team falls apart when the leader is not there)
- Statements from the leader such as, "I'm so busy, I don't have time to do what I need to do."

Source: Adapted with permission from *Group Leadership Skills*, 2003, by C.C. Clark, New York: Springer Publishing Company.

LEADERSHIP CHALLENGE For what procedures could you set up a demonstration for a UAP? Where would you conduct the demonstration? Give a rationale for your answer.

Preparing UAPs

Preparation of UAPs varies widely by state. Competency-based training programs with checklist evaluations have shown positive results. Using a checklist can not only verify what UAPs are capable of doing but also bolster your confidence in a UAP's skill (Lugo, 2007).

Some suggestions for delegating duties to UAPs include:

- Assess client needs and UAP knowledge and skill level.
- Identify tasks that can safely be delegated.
- Prioritize tasks, and provide a time frame for completion.
- Communicate with UAPs, and encourage them to ask questions.
- Evaluate progress toward goals, and give feedback.
- Revise plans as client needs change. (Lugo, 2007)

Explaining Assistive Personnel's Role to Clients

Clients and their families need information about their care and who will be working with them. They also need to know who is a nurse and who is not. You are responsible for naming the types of caregivers on your unit (Anderson, Twibell, & Siela, 2006).

Use simple terms. For example, you could say, “Hello, Mr. Hanson. My name is _____ and I’m a registered nurse. I’ll be overseeing your care until _____ a.m./p.m. My nursing assistant, Ray, will be checking your vital signs and checking your urine. If you have any discomfort or any questions, please ask Ray to let me know. We work as a team, but I have primary responsibility for your care.”

Summary

In summary, use the following steps to delegate tasks to assistive personnel:

- Check your state nurse practice act for delegation information.
- Check state law and facility policy to find out which tasks lie within the scope of your practice and which tasks are delegable.
- Assess the client, and evaluate current needs.
- Assess the UAP’s abilities, and answer his or her questions. (Anderson, Twibell, & Siela, 2006)

Then ask yourself these questions:

- Can I supervise the UAP?
- Would another nurse delegate this task?
- Have I communicated clearly to the UAP? (Anderson, Twibell, & Siela, 2006)

If you answered no to any of those last items, you are not ready to delegate. Go back to the first list, and complete those steps until you can answer yes to the final three questions.

Key Term Review

- **Delegation** is “transferring responsibility for the performance of an activity . . . while retaining accountability for the outcome” (ANA, 1995).
- **UAPs** are unlicensed assistive personnel, such as nursing assistants.

Leadership Development Exercises

■ Leadership Development Exercise 9-1

Look up your nurse practice act, and find out what tasks you can delegate to UAPs.

■ Leadership Development Exercise 9-2

Look up hospital policies where you are a student. Find job descriptions for UAPs.

■ Leadership Development Exercise 9-3

Consult your state board of nursing rulings about what can be delegated. Also see whether it provides job descriptions for UAPs.

■ Leadership Development Exercise 9-4

For each of the following client conditions, formulate a statement to delegate an associated task to a UAP:

- a. Dehydration
- b. Depression
- c. Uncontrolled diabetes
- d. Parkinson’s
- e. Abdominal surgery
- f. Bacterial pneumonia
- g. Congestive heart failure
- h. Labor and delivery
- i. Chronic pain
- j. Bipolar disorder
- k. Urinary tract infection
- l. Asthma

■ Leadership Development Exercise 9-5

- a. Role-play with at least three other students the delegation statements you developed in Leadership Development Exercise 9-4.
- b. Ask for feedback, using Box 9-1 as your guide.

■ Leadership Development Exercise 9-6

You are going to introduce yourself and a UAP to a client.

- a. What exactly would you say?
- b. Role-play with at least two other students.
- c. Obtain feedback from the other students.

■ Leadership Development Exercise 9-7

The UAP you're working with does not follow through on the special skin care regime for clients with spinal cord injuries.

- a. What do you do and say?
- b. Role-play with at least three other students.
- c. Obtain feedback on what you said, and repeat role-playing, if necessary.

Advanced Leadership Development Exercises**■ Leadership Development Exercise 9-8**

Teach delegation skills to student nurses in an undergraduate leadership course.

■ Leadership Development Exercise 9-9

Formulate a problem statement for a nursing project related to delegation.

■ Leadership Development Exercise 9-10

Design a research project related to delegation.

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Acting Legally, Ethically, and Politically

CHAPTER OBJECTIVES

After reading this chapter, answering the leadership challenges, and participating in the leadership development exercises, you will be able to:

- Discuss legal issues that impact nurse leaders
- Describe the relationship between legal, ethical, and political issues
- Discuss legal issues that impact the nursing profession
- Debate ethical issues affecting nursing practice

Advanced nurses will be able to:

- Teach legal, ethical, and political skills to student nurses in an undergraduate leadership course
- Formulate a problem statement for a nursing project related to a legal, ethical, or political issue
- Design a research project related to a legal, ethical, or political issue

Introduction

Law is a result of the minimum level of shared values or ethics of a community of people—in this case, nurses. Nursing law is specific to every state and is published in nurse practice acts (Trott, 1998).

KEY TERM

Law is a result of the minimum level of shared values or ethics of a community of people.

KEY TERM

When working as a **client advocate**, a nurse leader supports professional nursing goals that benefit consumers even when those goals conflict with institutional or medical priorities or the leader's personal ethics.

Law and ethics are related. Nurses may act in ways that are legal but not ethical. Both law and ethics are related to politics. Nurses may believe that politics conflicts with ethical principles.

A significant part of a nurse leader's responsibilities is to act as a **client advocate**. In that capacity, a nurse leader may have a duty to support professional nursing goals that benefit consumers even when those goals are not in agreement with institutional or medical priorities or the leader's personal ethics (Des Jardin, 2001).

Political-ethical conflicts can mean choosing between client care, your job, and your personal ideals. You may never have considered it your place to challenge the existing structure of

health care or the rules guiding that system, but supporting political action sometimes entails demanding a change in the present system. Often, the individual client takes precedence over society as a whole, but could there be times when you support social interventions over one person's needs?

This chapter examines dilemmas that nurse leaders and managers may face and provides guidelines for thought and action related to legal, ethical, and political approaches in leadership situations.

LEADERSHIP IN ACTION

Laurel R., a director of nursing, learns that Sarah R., a young nurse had falsified narcotics records. Sarah R, a new graduate, was terrified: she thought that she had made a mistake in the dosage of a narcotic and that she didn't fully inform the client about the drug's risks. Sarah refused to take a drug screen, even though she hadn't taken the narcotics. She stated that she would rather leave nursing than be caught up in a scandal. (She'd named the client in an e-mail after promising not to disclose the client's prior status as a drug addict and feared that information might come out.)

This incident occurred in a state where rules of administrative procedure for the board of nursing held that a nurse could be disciplined for refusing to take a "for cause" drug screen. Usually, a nurse would not be disciplined in this situation unless random screening was part of facility policy.

Laurel tried to weigh the various facets of the situation. Even though she didn't know all the particulars of the case, she believed the nurse might actually leave nursing. The administrative code requires licensees to report illegal, substandard, unethical, unsafe, or incompetent nursing practice to the board of nursing. Laurel knew this, but she reasoned that the client suffered no harm as a result of the Sarah's action and finally decided against reporting the situation to the board of nursing.

LEADERSHIP CHALLENGE Should Laurel or Sarah receive disciplinary action? Provide a justification for your answer.

Falsification of records is a serious infraction, and the failure to report by a director of nursing (DON) like Laurel would warrant disciplinary action (Eddins, 2004). Sarah should have probably consulted with Laurel or at least talked with someone with more nursing experience and knowledge before falsifying the records. That could have prevented the problem. Sending an e-mail to a novice colleague about the client only added to the problem.

Nurse leaders like this DON can be placed in difficult positions. They must find a comfortable place between overlooking infractions of the law and losing their own license (Eddins, 2004).

Legal Issues for Nurse Leaders

Legal issues of interest to nurse leaders include standard of care, scope of practice, liability and negligence, informed consent, confidentiality, and malpractice.

Standard of Care

A different **standard of care** or conduct applies to nurses than to the public. Once you take care of a client, any future interaction between the two of you now falls in the category of a professional relationship. This means you must speak, write, and act legally, ethically, and responsibly. This applies wherever care is provided, including classrooms where nursing approaches are taught (Hutchinson, 1997).

KEY TERM

Standard of care means a professional nurse must speak, write, and act legally, ethically, and responsibly.

Scope of Practice

Your state nurse practice act defines **scope of practice**, or what you can and cannot do in your state. Nurse practice acts define three categories of nurses—LVNs, RNs, and APNs—and their functions. You must read your nurse practice act to find out what actions are allowed. It is especially important that you know what is acceptable practice in terms of diagnosis and treatment. There is another reason to keep up to date on your state nurse practice act: as a nurse leader or manager responsible for supervising other employees, you need to know the distinctions in practice for various levels of nurses to monitor against potential liability.

KEY TERM

Scope of practice is spelled out in state nurse practice acts and must be carefully monitored to reduce potential liability.

KEY TERM

Liability means that your actions or words caused harm to a client.

KEY TERM

Negligence means that you did not act as another reasonable professional with your training, skills, and experience would.

Liability and Negligence

As a nurse leader, you are responsible for your actions and words. If either your actions or your words cause harm to a client, you can be held **liable** in a court of law. In addition, you can be held **negligent** if you do not act as another reasonable professional with equivalent training, skills, and experience would (Hutchinson, 1997).

LEADERSHIP CHALLENGE Is the DON liable or negligent in the Leadership in Action vignette at the beginning of the chapter? What about the nurse who gave the medication? Give a rationale for your answer.

KEY TERM

Informed consent means that clients fully understand a treatment and its benefits and risks before agreeing that it be done.

Informed Consent

Informed consent means clients fully understand any treatment and its benefits, including any risks or side effects, before agreeing that it be done. Options related to the treatment must be fully explained as well. Hospitals usually require that clients sign a general consent for standard nursing procedures

and then sign for any specific treatments, allowing them to withdraw consent at any time (Hutchinson, 1997).

Confidentiality

Confidentiality means that you, as nurse leader, do not disclose information about clients. If you read a chart, look up results on a computer, talk to a client, or discuss the client with another provider, you should not share information; you should maintain confidentiality. Confidentiality issues between nurses or between a nurse and other healthcare professional may also apply. Potential liability can be reduced by providing access to client data on a need-to-know basis. At all times, clients have a right to copies of their healthcare records, although they may be charged a copying fee.

As of 1996, when the Health Insurance Portability and Accountability Act was passed, healthcare facilities must provide clients with a documented notice of privacy rights, explaining how their healthcare records will be used or shared with other entities. (Find more information on the act at <http://www.cms.hhs.gov/HIPAAGenInfo>.)

Confidentiality also applies to incident reports. They should contain pertinent care information only—no finger-pointing and no interpretation. This will also reduce liability.

LEADERSHIP CHALLENGE What, if any, confidential issues may have been involved in the DON's decision in the Leadership in Action vignette at the beginning of this chapter? Give a rationale for your answer.

Malpractice

Nurses have a duty to act in a specific way toward clients. Malpractice occurs when that standard of care is breached, causing an injury to a client that would not have occurred had the nurse acted in a reasonable and prudent fashion (Trott, 1998).

Legal Trends

According to Trott (1998), major trends that affect healthcare settings include:

- *Documentation of change in a client's condition.* The process—what you do and say in a nursing situation—is of the utmost importance and must be clearly represented in written client records. Two parts of the client assessment process to focus on are documentation and communication. Remember that no part of client assessment can be delegated. It is your responsibility to always personally check out any change in a client's condition, and then clearly chart what you found.
- *Client falls.* Client falls are a leading source of litigation. Important sources of information involve the client's previous assessment, the time frame before the fall, client mentation, and procedures or medication that may have changed the client's mental status. When assessing the client's risk for a fall, a key factor in legal cases is the RN's assessment and what was done to prevent the fall. Some questions to ask include: Did you ensure the client received assistance while getting out of bed and walking? Did you ensure the client wore non-slip footwear? Did you assess strength, lack of dizziness, and ability to stand and move prior to allowing a client to walk without a walker or wheelchair?
- *Physician communication.* Communication between nurses and physicians can be problematic in many instances. Talking over the phone creates a high level of liability exposure. Once your communication with a physician ends, you must document the event and the conversation (Trott, 1998). If you haven't heard a particular complaint from a client before, notify the physician, keep the physician informed of the client's status, make sure you fully understand instructions, and document everything. Never ignore a reported symptom (Eskreis, 1998).

Eskreis (1998) cites the following common legal pitfalls in nursing:

- *Medication errors.* Medication errors kill at least one person a day and thousands each year. As a nurse, you're not protected simply because you followed a physician's order. You remain accountable for your own actions. If you're unfamiliar with a medication, consult *Physician's Desk Reference* or a pharmacist, your supervisor, or the physician who ordered the drug. Pay special attention to the dosage, the potential adverse effects, and the route of administration. (Many medication errors occur when giving oral drugs by IV; in those situations, the drugs are administered at 100 or more times the suggested amount.)
- *Improper use of equipment.* Always read brochures and directions that accompany equipment before using it, and obtain necessary orientation or training. If the equipment appears to be defective or you have a sense that it is not operating correctly, demand that it be inspected before use. Monitor clients using equipment to ensure that it is operating as expected. Take special care when the client is especially young, sedated, anesthetized, or lacking body sensation/interpretation. Burns are common, as are lacerations.
- *Failure to remove foreign objects.* Operating room nurses are most apt to be accused of failing to remove a foreign object. Abide by hospital policy and procedure to protect yourself against liability.
- *Failure to provide sufficient monitoring.* In addition to carefully and regularly monitoring clients' physical status, nurses are also responsible for monitoring their psychological status. If you fail to document such monitoring and the client sustains an injury, you can be charged with neglect. For example, if a client is at risk for aspiration, lung and respiratory status must be assessed and documented, including the client's ability to swallow and response to medication, as well as how often assessments were made.
- *Failure to communicate.* Communication is essential to safeguarding client well-being and must be thoroughly documented. If you are not familiar with a particular somatic complaint, notify a physician and document the information. Nurses can fail to communicate not only with physicians but also with clients and other healthcare professionals. In each case, failure to communicate could result in legal repercussions. Use your communication skills to communicate clearly and often with clients and other healthcare staff.

LEADERSHIP CHALLENGE Which of those pitfalls are exemplified by the following situation? A nurse was assigned to care for a client with a history of stroke and unstable angina. When the client experienced respiratory failure, the nurse called for assistance and then called a code. The client record made no indication that prescribed drugs were given that evening or that the client's physician was notified.

Eskreis (1998) suggested the following preventive procedures:

- Develop a caring, respectful, and attentive relationship with each client, including careful assessment, intervention, and documentation.
- Familiarize yourself with any equipment that is used.
- Follow physician's orders and hospital procedures unless you deem them to be detrimental, and then discuss the situation immediately with your supervisor or a member of the risk management department and document your conversation.
- Notify the physician immediately of any change in client status and document the call or conversation.

Nurse Leader Responsibility for Legal Issues

Although nurses in administration, education, and research have relationships with clients that are less direct, in assuming the responsibilities of any of these roles, you share responsibility for the care provided by those whom you supervise or instruct.

When functioning in management or administrative roles you have a particular responsibility to provide an environment that supports and facilitates appropriate assignment and delegation. This includes providing appropriate orientation to staff members, assisting less experienced nurses to develop the skills and competencies they need, and establishing policies and procedures that protect client and nurse from inappropriate assignment or delegation of nursing activities (American Nurses Association, 2001).

Some areas of legal responsibility you may encounter as a nurse leader include clear communication and documentation, corporate liability, all forms of harassment, and following the Family and Medical Leave Act and the Americans with Disabilities Act.

Communication and Documentation

Nurse leaders have a clear responsibility to educate and support their staff about communicating over the phone with physicians and clients and about appropriately documenting those conversations. Complete and thorough documentation is important because state statutes, insurance standards, and regulatory agencies (such as the Joint Commission on Accreditation of Healthcare Organizations) demand it for accreditation and reimbursement, and the client record is the physical demonstration of continuity of care (Trott, 1998).

Depending on your job description, as a nurse leader, it may be your responsibility to teach and monitor staff so that they:

- Write legibly and clearly
- Avoid defaming the client or other healthcare personnel, which only reinforces a case and makes nurses and the organization look bad from a legal/ethical viewpoint

- Include a listing of what was done to protect the client and the client's response to the intervention
- Document the client assessment and what the client told the RN
- Document all other issues, such as nurse-physician conflict, through the appropriate channels (if there are no appropriate and helpful channels, the nurse leader should develop a procedure and put it in operation, making sure that all staff know how to use it; if nurse-physician conflict is high, expect poor client outcomes [Forte, 1997])

Other Legal Responsibilities of the Nurse Leader

Other legal responsibilities nurse leaders must take on include:

1. Knowing about current legal trends, such as corporate liability for not suspending nurses or physicians who have many complaints lodged against them.
2. Encouraging nurses to speak up when they make clinical errors. More and more nurses are facing criminal charges when mistakes occur. By establishing an atmosphere of trust and learning, nurses will be more likely to take responsibility for their errors and learn from each event.
3. Having a zero-tolerance policy for all forms of harassment can also protect agencies against litigation problems.
4. Following the Americans with Disabilities Act (for more information, see **Box 10-1**) and the Family and Medical Leave Act (for more information, see **Box 10-2**) can provide nurses with support and protect the institution from law suits.
5. Practicing ethical leadership and establishing ongoing relationships with human resources and risk management can help ensure ethics and laws are followed (Trott, 1998).

KEY TERM

Nursing ethics are based on a set of values derived by the nursing profession.

Ethics and Values

Successful application of ethical decision making and action is integral to nurse satisfaction and nurse retention. As a nurse leader, you are key to helping nurses develop these skills and use them in the professional setting (Andrews, 2004).

Ethics in nursing includes making moment-to-moment decisions that are morally responsible and positive. Ethics focuses on doing more good than harm to clients (Clements & Averill, 2006). **Nursing ethics** are based on a set of values derived by the profession.

According to Trott (1998), nursing values include:

- **Beneficence:** doing good by caring for the client
- **Nonmaleficence:** doing no harm to the client

BOX 10-1 FACTS ABOUT THE AMERICANS WITH DISABILITIES ACT

The Americans with Disabilities Act (ADA) took effect July 26, 1992. It prohibits private employers, state and local governments, employment agencies, and labor unions from discriminating against qualified individuals with disabilities in job application procedures, hiring, firing, advancement, compensation, job training, and other terms, conditions, and privileges of employment. An individual with a disability is a person who fits at least one of the following conditions:

- Has a physical or mental impairment that substantially limits one or more major life activities
- Has a record of such an impairment
- Is regarded as having such an impairment

A qualified employee or applicant with a disability is an individual who, with or without reasonable accommodation, can perform the essential functions of the job in question. Reasonable accommodation may include but is not limited to:

- Making existing facilities used by employees readily accessible to and usable by persons with disabilities
- Restructuring jobs, modifying work schedules, or reassigning the person to a vacant position
- Acquiring or modifying equipment or devices; adjusting examinations, training materials, or policies; and providing qualified readers or interpreters

An employer is required to accommodate a qualified applicant's or employee's known disability if it would not impose an "undue hardship" on the business's operation. Undue hardship is defined as an action requiring significant difficulty or expense when considered in light of factors such as a company's size, financial resources,

and the nature and structure of its operation. An employer is not required to lower quality or production standards to make an accommodation, nor is an employer obligated to provide personal-use items, such as glasses or hearing aids.

Medical Examinations and Inquiries

Employers may not ask job applicants about the existence, nature, or severity of a disability. Employers may, however, ask applicants about their ability to perform specific job functions. A job offer may be conditioned on the results of a medical examination—but only if the examination is required for all entering employees in similar jobs. Employee medical examinations must be job related and consistent with the employer's business needs.

Drug and Alcohol Abuse

Employees and applicants currently engaged in the use of illegal drugs are not covered by the ADA when an employer acts on the basis of such use. Tests for illegal drugs are not subject to the ADA's restrictions on medical examinations. Employers may hold illegal drug users and alcoholics to the same performance standards as other employees.

Enforcement of the ADA

The US Equal Employment Opportunity Commission (EEOC) issued regulations to enforce the provisions of Title I of the ADA on July 26, 1991. The provisions originally took effect on July 26, 1992, and covered employers with 25 or more employees. On July 26, 1994, the threshold dropped to include employers with 15 or more employees.

Source: EEOC (1997).

BOX 10-2 THE FAMILY AND MEDICAL LEAVE ACT**What Is the Family and Medical Leave Act, and to Whom Does It Apply?**

- (a) The Family and Medical Leave Act of 1993 (FMLA or Act) allows "eligible" employees of a covered employer to take job-protected, unpaid leave, or to substitute appropriate paid leave if the employee has earned or accrued it, for up to a total of 12 workweeks in any 12 months because of the birth of a child and to care for the newborn child, because of the placement of a child with the employee for adoption or foster care, because the employee is needed to care for a family member (child, spouse, or parent) with a serious health condition, or because the employee's own serious health condition makes the employee unable to perform the functions of his or her job. In certain cases, this leave may be taken on an intermittent basis rather than all at once, or the employee may work a part-time schedule.
- (b) An employee on FMLA leave is also entitled to have health benefits maintained while on leave as if the employee had continued to work instead of taking the leave. If an employee was paying all or part of the premium payments prior to leave, the employee would continue to pay his or her share during the leave period. The employer may recover its share only if the employee does not return to work for a reason other than the serious health condition of the employee or the employee's immediate family member, or another reason beyond the employee's control.
- (c) An employee generally has a right to return to the same position or an equivalent position with equivalent pay, benefits and working conditions at the conclusion of the leave. The taking of FMLA leave cannot result in the loss of any benefit that accrued prior to the start of the leave.
- (d) The employer has a right to 30 days advance notice from the employee where practical. In addition, the employer may require an employee to submit certification from a health care provider to substantiate that the leave is due to the serious health condition of the employee or the employee's immediate family member. Failure to comply with these requirements may result in a delay in the start of FMLA leave. The employer may also require that an employee present a certification of fitness to return to work when the absence was caused by the employee's serious health condition. The employer may delay restoring the employee to employment without a certificate relating to the health condition that caused the employee's absence.

Source: [60 FR 2237, Jan. 6, 1995; 60 FR 16383, Mar. 30, 1995] From *What is the Family and Medical Leave Act?* U.S. Department of Labor. Retrieved May 10, 2007, from http://www.dol.gov/dol/allcfr/ESA/Title_29/Part_825/29CFR825.100.htm

- *Justice*: being fair to the client
- *Autonomy*: preserving the freedom of the client and the nurse
- *Loyalty*: keeping promises made to the client
- *Veracity*: telling the client the truth
- *Confidentiality*: not sharing what was told in private
- *Life*: treasuring the client's existence

Guidelines based on these values come from established standards of care, the nurses code of ethics, and state laws that regulate nursing practice. Legal difficulties can arise when nurses make decisions based on emotion or intuition or when their personal values clash with those professional values (Trott, 1998). For example, if you as a nurse leader hold specific religious or cultural values that differ from any of the professional values listed, you may face an ethical dilemma. There can even be conflict between the values listed. Take the leadership challenge to see how accepted values can conflict.

LEADERSHIP CHALLENGE Which value should a nurse support—autonomy or life—when a client wants to obtain an abortion or refuses care that could sustain life?

Conceptual Frameworks for Ethical Practice

Moral development is an important issue in nursing because nurses increasingly face ethical dilemmas. As a nurse leader, it is your job to help nurses attain higher levels of moral development so they can deal effectively with such dilemmas.

Many developmental psychologists use stage theories to explain moral development. Kohlberg (1981), probably the best-known theorist, developed six stages of moral development.

Stage 1 and 2 of Kohlberg's moral development are **pre-conventional stages**. Stage 1 is characterized by avoiding punishment and deferring to power without question; nurses who attain a moral level no higher than stage 1 are apt to do whatever anyone in power tells them to do, regardless of its effect on patient care. At stage 2, right action consists of what is satisfying to oneself or what is based on reciprocal sharing.

Reciprocal sharing is the idea that “you scratch my back, and I'll scratch yours”; it is not based on loyalty, gratitude, or justice. Nurses at this development level may help clients or doctors only if they are helped in return.

The **conventional level of moral reasoning** includes stages 3 and 4. At stage 3, people choose to behave well so that others will approve of them; nurses at this level will most likely seek out approval and try to be nice to others. At stage 4, the keeping of rules, the completion of one's duty, and the maintenance of the status quo are important. Nurses at this stage are apt to give medications on the dot, not to question rules, and to live up to their job descriptions.

KEY TERM

The **preconventional stage of moral development** is exemplified by nurses who do whatever anyone in power tells them to do (stage 1) and by nurses who do what is satisfying or what is based on reciprocal sharing (stage 2).

KEY TERM

The **conventional stage of moral reasoning** is exemplified by the nurse who seeks out approval and tries to be nice to everyone (stage 3) and the nurse who maintains the status quo (stage 4).

KEY TERM

The **postconventional or autonomous level of moral reasoning** is exemplified by the nurse who contracts with clients about healthcare issues (stage 5) and the nurse who acts based on logical, consistent, comprehensive, and universal ethical principles (stage 6).

Stages 5 and 6 are **postconventional or autonomous levels of moral reasoning**. Since nursing seems to be moving toward independent practice, it would seem reasonable to expect nurses to function at the postconventional level, yet many do not. At stage 5, right action is chosen after a critical examination of all the ethical factors in the situation and coming to an agreed upon action with the client....

The nurse may use a written or verbal agreement. Contracts and free agreements bind obligation. Nurses at this developmental level tend to contract with clients about healthcare issues.

At stage 6, right action is defined by individual conscience in accordance with self-chosen ethical principles based on logical comprehensiveness, universality, and consistency. Universal principles of justice, equal rights, and respect for the dignity of individuals are used as measures.

LEADERSHIP CHALLENGE According to Kohlberg's theory, what stage of moral development is the DON in the Leadership in Action vignette at the beginning of this chapter? Give a rationale for your answer.

Gilligan (1982) proposed a theory of moral development for women. Gilligan took umbrage at basing the theory on justice and guilt. From her careful interviews with women making momentous decisions in their lives, Gilligan concluded that these women thought more about the caring thing to do rather than the just thing to do.

Gilligan's five stages, which she called the "ethic of care," included:

1. *Preconventional stage*. The woman's goal is survival.
2. *Transitional stage* is from selfishness to responsibility to others.
3. *Conventional stage*. The woman recognizes that self-sacrifice is good.
4. *Transitional stage* is from goodness to truth that she is a person too.
5. *Postconventional stage*. This stage may never be attained. It's marked by the principle of nonviolence: do not hurt others or oneself.

LEADERSHIP CHALLENGE According to Gilligan's theory, what stage of moral development is the DON in the Leadership in Action vignette at the beginning of this chapter? Give a rationale for your answer.

Ethical Issues for Nurse Leaders

A survey of nurse executives (Cooper, Frank, Gouty, & Hansen, 2002) found the following ethical issues presented significantly greater problems for nurse leaders than they did for vice presidents of health organizations:

- Perceived failure of healthcare organizations to provide service of the highest quality (because nurses did not follow nursing standards, failed to provide honest information, experienced economic constraints in their departments, showed partiality toward clients or providers who were perceived to be influential, lacked knowledge or skills to competently perform their duties [reflecting the hiring of less qualified nurses because of nursing shortages and limited resources for continuing education])
- Failure of healthcare executives to effectively manage conflict between organizational and professional philosophy and standards
- Offering or soliciting payments or contributions to influence legislation, regulations, or accreditations
- Discrimination
- Drug and alcohol abuse in the workplace
- Employee theft

Being certified as a CAN or CNAA did not improve ethical responses. Those who were certified viewed failure to provide services to insurance companies as being a greater ethical problem than those who were not certified by the American Nurses Credentialing Center (ANCC). Those not credentialed by ANCC viewed employee theft as a greater ethical problem than those certified. This led Cooper, Frank, Gouty, and Hansen (2002) to question whether the current effort to put scarce resources into credentialing really mattered, at least in terms of ethics training. They concluded that putting resources into programs that focus on preparing employees to identify and deal effectively with ethical problems is a key responsibility of nurse leaders.

Principles for Ethical Leadership

Curtin (2000) proposed 10 ethical principles based on universal values and adapted to fit nurse leaders' responsibilities. Those principles appear in **Box 10-3**.

Ethical and predictable decision making and action helps nurse leaders walk the talk and establish trust and cooperation with their staff. Trust and sense of cooperation are the anchors that forestall anger and alienation, which can disrupt continuous and safe client care (Curtin, 2000).

BOX 10-3 TEN ETHICAL PRINCIPLES FOR NURSE LEADERS

1. **Frugality and therapeutic elegance:** includes promoting economy while using the right amount of resources to ensure competent care
2. **Clinical credibility through organizational competence:** requires balancing practice guidelines, peer evaluation, teaching and counseling, and policies that advance the welfare of employees and are designed to provide safe client care
3. **Providing presence:** involves promoting trusting and beneficent relations with peers, colleagues, clients, families, and the general public by communicating decisions in person and altering them as necessary
4. **Representing ethical concerns:** requires that nurse leaders make sure that nurses' concerns are heard at the highest levels of organizational decision making
5. **Loyalty:** forbids advancing one's own career by exploiting the organization
6. **Delegating ethically:** requires an act of faith and demands that nurse leaders delegate sufficient authority when delegating duties
7. **Responsible innovation:** requires that change be examined for its affect on client care and employee morale before implementation
8. **Fiduciary accountability:** ensures that clients receive safe, quality, and relevant services for their money
9. **Self-discipline:** forbids making decisions out of anger, fear, retribution, or vengeance
10. **Continuous learning:** invests time and resources to ensure continued competence of care (Curtin, 2000)

LEADERSHIP CHALLENGE Which, if any, of Curtin's ethical principles did the DON in the Leadership in Action vignette at the beginning of this chapter exemplify? Give a rationale for your answer.

Ethical Helps and Challenges

Research can provide some suggestions for dealing with ethical dilemmas. Cooper, Frank, Gouty, and Hansen (2003) found that resources reported for solving ethical dilemmas differed by position and/or work setting.

Vice presidents viewed a management philosophy that emphasized ethics and clear communication of appropriate ethical behavior by management as significantly more helpful than did directors. Participants employed by for-profit healthcare organizations (HCOs) viewed family and friends as significantly more helpful in dealing with ethical dilemmas at work than those working for non-profit HCOs. Participants who weren't credentialed viewed help from coworkers as significantly more helpful in dealing with ethical dilemmas than did participants who were credentialed.

Important challenges Cooper et al. (2003) identified included that management training programs to help nurse leaders develop skills in identifying and

handling ethical challenges were needed. Another important challenge involved conflict between duty to one's employer and duty to one's employees and clients.

According to study findings, one of the best things HCOs can do is to refrain from pressuring managers and employees to compromise their own personal values. HCOs also should ensure that managers are equipped with ways to deal with their own ethical dilemmas and those of their supervisees. Ethics programs in HCOs are most successful in organizations that have three components: codes of conduct, ethics training, and ethics offices. As a result of their study, Cooper et al. (2003) suggested that preparing leaders to identify and manage ethical challenges is the responsibility of the healthcare setting.

Developing an Ethical Work Culture

Silverman (2000) suggested that to achieve organizational integrity, it's important to engage in several processes, including:

- Reexamining vision and guiding values to help employees own the final values statement and ethics program, thus ensuring commitment, rather than just compliance
- Developing an ethics infrastructure, including a code of ethics; forums that address ethics issues at each level of the organization; administrative case rounds in which corporate decisions can be displayed and argued from an ethical viewpoint; an appeals process (to encourage principled organizational dissent to some practice or policy and alignment of performance appraisals and other appraisal and reward systems with ethical matters); provision of ethics training at all levels of the organization; appointment of a high-ranking ethics officer who would ensure that ethics is a corporate priority; an organizational ethics committee that would provide a forum for ethical reflection; a strong ethical climate to support leadership; and monitoring and evaluating ethical performance

Encouraging Nurses to Participate in Ethical Decision Making

A review of the literature on nurses' participation in ethical decision making concluded that nurses play various roles, from being recognized as powerful members of a team that makes decisions to being physician surrogates with little autonomy. Dodd, Jansson, Brown-Saltzman, Shirk, and Wunch (2004) found that nurses were more likely to engage in ethical assertiveness (i.e., coach clients about questions to ask physicians about ethical choices, advocate for clients' requests about ethical issues with physicians, call ethical issues to the attention of physicians, participate in ethical deliberations, and withdraw from ethical situations unless specifically requested to participate) than ethical activism (i.e., seek written protocol to promote nurse participation in ethics deliberations,

seek multidisciplinary training sessions in ethics, and educate physicians about nursing roles in ethics).

Nurses were more apt to engage in ethical assertiveness and activism if they received ethics education during nursing courses, and they more likely to do so in settings that were already receptive to their involvement. The researchers suggested that nurse leaders take action to further enhance nurse assertiveness and activism by:

- Generating administrative support for nurse involvement in ethical behaviors with clients and physicians
- Encouraging daily discussions around ethical issues
- Enhancing participation in the writing of protocols for ethics deliberations
- Ensuring that work settings are receptive to nurse participation in ethics deliberations (Dodd et al., 2004)

Political Issues

To effect change, you must often take a political stance. This section examines the importance of political action, a theory of political development, areas of political influence in which nurses can effect change, and guidelines for political action.

The Importance of Political Development

Although many nurses may believe that political action conflicts with professional practice, nurses as a group are now being encouraged to engage in political action (Albarran, 1995; Winter, 1991).

The push for nurses to take political action is understandable. After all, a significant part of every nurse's responsibility is to act as a client advocate. This goal may not always be in agreement with institutional goals, which is where political action comes in. Sources of political-ethical tension include clashes between cost-effectiveness and quality of care and between personal values and professional ethics and goals (Des Jardin, 2001).

KEY TERM

Political-ethical conflict is the pressure you feel as a result of a difference between your ethical belief system and what you are told to do by someone in a position of power.

A negative view of politics and politicians can interfere with political action and create ethical tension. **Political-ethical conflict** can result when you believe one thing is right but someone in a position of power pressures you to do something else.

Before engaging in political action, you may have to pass through one or more preparatory stages. One theorist (Wilson, 2002), tested four stages of political development developed by Cohen (1996). These stages were:

1. Understanding that political action is important
2. Using political expertise for self-interest

3. Effectively using political activism
4. Providing leadership in the political arena

The researcher found that nurses can be anywhere in the process, but they are more apt to engage in political action to advocate for the public than nonnurses (Wilson, 2002).

LEADERSHIP CHALLENGE Identify what stage of political development you are in. Give a rationale for your answer.

Guidelines for Examining Political-Ethical Dilemmas

A political-ethical dilemma may be more perceived than real. Believing that politics and nursing do not mix may be related to outdated images of fear of power and lack of knowledge about how to proceed. Even if that is the case, guidelines can help you understand when and how to get involved in political processes and determine which public policy issue takes priority (Des Jardin, 2001).

You can use the following process to examine political-ethical dilemmas and decide what to do:

- Identify the problem, including its background and associated issues.
- Choose a potential ethical conflict.
- Identify individuals who might be affected by political action.
- Explore all options and consequences of taking action.
- Proceed with confidence, knowing that you are taking unbiased, informed action.

Developing Coalitions

Coalitions are temporary groups of individuals or organizations that join together to effect change. Everyone involved must have the same need or goal, or the coalition will not be successful.

KEY TERM

Coalitions are temporary groups of individuals or organizations that join together to effect change.

LEADERSHIP IN ACTION

Dr. Saran, a nurse leader with a PhD in nursing, was tired of the physicians referring to themselves as “doctor” but calling nurses by their first name. Every time it happened, Dr. Saran cringed and fell into an angry, depressed mood. She wasn’t sure what to do about it until she brought the issue up at a local nursing meeting. One member told her to just ignore it; another said she should start introducing herself as “Dr. Saran” in meetings and appointments. Another nurse suggested that she form an empowerment committee and ask physicians and nurses to join to discuss the issue of how they could empower each other to help clients.

LEADERSHIP CHALLENGE Which approach would you choose? Give a rationale based on information in this chapter.

Negotiating

Negotiating or bargaining is the process of making trade-offs to attain an objective. To get something in a political process, it is necessary to give up something. At the start of a negotiation, the individuals involved may have radically different positions. As the negotiation proceeds, they may move closer together and find a way to compromise. Negotiators are more likely to be successful if they are well informed about the pros and cons of the opposing side.

KEY TERM

Collective bargaining is a form of negotiation regulated by state and federal labor laws and requires representation from a union or the state nurses association.

Collective bargaining is a special type of negotiation. It is regulated by state and federal labor laws (National Labor Relations Act or NLRA and the Labor Management Relations Act). Section 7 of the NLRA states that employees have the right to self-organize; to form, join, or assist labor organizations; and to bargain collectively through representatives of their own choosing (Michigan Nurses Association, 2007).

LEADERSHIP IN ACTION

Betty T., a nurse practitioner, had been working at the healthcare agency for 10 years. She had heard complaints from other nursing staff about being treated poorly by management regarding work time, salary and related pay, fringe benefits, discipline, grievance procedure, health and safety, discrimination, inservice education, continuing education, leaves of absence, holidays, management rights, layoffs, retraining and termination, staffing, professional practice committees, tuition reimbursement, mandatory overtime, and even benefits after retirement. Betty decided to initiate a collective bargaining procedure to help nurses like her obtain better treatment. The first thing she did was ask voting nurses to sign a petition to obtain formal recognition from their employer. They elected a negotiating committee and reached a tentative agreement for the membership to ratify, because of the need for mediation and the option of establishing boards of inquiry prior to a work stoppage.

Usually a representative of a union or the state nurses association must attend when collective bargaining is involved.

While collective bargaining requires progression through successively high levels of administration and ending in binding arbitration, negotiation may not.

LEADERSHIP IN ACTION

Jennifer S., a nurse leader, organized a meeting with the department director during the budget-planning process to negotiate additional training hours on legal, ethical, and political processes for her nursing staff.

LEADERSHIP CHALLENGE What obstacles might Jennifer face, and how could she overcome them? Give a specific answer and provide a rationale for your response.

Guidelines for Political Action

Many guidelines exist for public policy and political action. A major one is the Code for Nurses with Interpretive Statements (American Nurses Association, 1995). It says, “The nurse collaborates with members of the health professions and other citizens in promoting community and national efforts to meet the healthcare needs of the public.” This means that as a nurse, you must make collaborative efforts outside the clinical arena to improve health care. The code goes on to state that nurses should actively participate in political arenas.

The World Health Organization (WHO) speaks of the safeguarding of health and human rights as a top responsibility. Included in its 2007 agenda is the ethical principle of equity: access to lifesaving or health-promoting interventions should not be denied for unfair reasons, including those with economic or social roots. Commitment to this principle ensures that WHO activities aimed at health development give priority to serving poor, disadvantaged, or vulnerable groups; preventing and treating chronic diseases; and using collective action to reduce health security threats because of environmental mismanagement, the way food is produced and traded, and the way antibiotics are used (or misused).

The United Nations Office of the High Commissioner for Human Rights also provides guidelines for nurses. Although you may think of war-torn countries in terms of human rights, abuses, such as elder abuse, occur in the United States in long-term settings and in the general community at large (Des Jardin, 2001). The declaration appears at <http://www.unhchr.ch/udhr/lang/eng.htm> and should be integrated into your nursing practice.

Political Action Strategies

From Florence Nightingale to Margaret Sanger and Lillian Wald, nurses have always been champions of activism. Although you may believe you need to focus

on client care and let someone else make political decisions, ask yourself, “Who should be making decisions about needle-stick prevention, mandatory overtime, whistle-blowing, environmental hazards, part-time nurses and unlicensed assistants, faulty equipment, the nursing shortage, nursing practice, educating the public about their health and preventing illness, and incompetent healthcare workers?”

Because the American health system is in a crisis of soaring costs and epidemics of preventable disease, new strategies may be necessary. Poor health literacy contributes to many of the healthcare system’s problems. One strategy is to establish an office of the national nurse. Like the surgeon general, the **national nurse** would practice at the highest political level, leading the way to public health education. Nurses calling for innovation, leadership, and inspiration are uniting behind this proposal to provide accessible health information to all Americans and reduce the incidence of preventable diseases

(Mills & Schneider, 2007). For more information, go to <http://www.national-nurse.blogspot.com>.

As a nurse leader, you must participate in political action strategies if you hope to control your practice and practice environment. How and to what extent you do that is your choice. Choose from among the list of political strategies that appear in **Box 10-4**, and make a contract with yourself to begin pursuing your top priority today.

Summary

This chapter has explored legal, ethical, and political issues—from autonomy to beneficence to coalitions—that affect nurse leaders. Moral reasoning, informed consent, ethics, veracity, confidentiality, the national nurse, scope of practice, and collective bargaining were explored. Be sure to complete the leadership development exercises to help integrate your learning, and then move on to Part III, which focuses on advanced skills needed to creatively lead and manage.

KEY TERM

The **national nurse** will provide health information to all Americans to reduce the incidence of preventable disease.



BOX 10-4 POLITICAL STRATEGIES

Prioritize these strategies, and start working on your number one priority today.

- Serve on a nursing organization committee
- Write to elected officials about a healthcare issue
- Write a letter to the editor of a local newspaper about your healthcare views
- Assist local or national politicians or nurses who support nursing views by answering telephones, assisting with mailings, providing written support, or other ways
- Run for a local or national office
- Attend the American Nurses Association's Annual Legislative Day
- Start a Web site or e-zine to keep clients apprised of an important health issue
- Circulate a petition for some healthcare or working condition issue that's close to your heart
- Offer your services to a local hospital decision-making committee
- Join and become an active member of the League of Women Voters or the national nurse effort
- Serve on the legislative committee of a professional or environmental organization
- Join a committee of a local political organization
- Join a quality improvement, ethics, or policy committee at your workplace
- Become an informed voter; avoid listening to paid political announcements; Google the candidates, and find out what they've done in the past, not what they say they will do in the future

Key Term Review

- **Autonomy** includes preserving the freedom of the client and the nurse.
- **Beneficence** means doing good by caring for the client.
- When working as a **client advocate**, a nurse leader supports professional nursing goals that benefit consumers even when those goals conflict with institutional or medical priorities or the leader's personal ethics.
- **Coalitions** are temporary groups of individuals or organizations that join together to effect change.
- **Collective bargaining** is a form of negotiation regulated by state and federal labor laws and requires representation from a union or the state nurses association.
- **Confidentiality** means not sharing what was told in private.
- The **conventional stage of moral reasoning** is exemplified by the nurse who seeks out approval and tries to be nice to everyone (stage 3) and the nurse who maintains the status quo (stage 4).
- **Informed consent** means that clients fully understand a treatment and its benefits and risks before agreeing that it be done.
- **Justice** means being fair to the client.
- **Law** is a result of the minimum level of shared values or ethics of a community of people.
- **Liability** means that your actions or words caused harm to a client. You can be held negligent if you do not act as another reasonable professional with equivalent training, skills, and experience would (Hutchinson, 1997).
- **Life** is the value that includes treasuring the client's existence.
- **Loyalty** means keeping promises made to the client.
- The **national nurse** will provide health information to all Americans to reduce the incidence of preventable diseases.
- **Negligence** means that you did not act as another reasonable professional with your training, skills, and experience would.
- **Nonmaleficence** includes doing no harm to the client.
- **Nursing ethics** are the result of a set of values derived by the nursing profession.
- **Political-ethical conflict** can result when you believe one thing is right but someone in a position of power pressures you to do something else.
- The **postconventional or autonomous level of moral reasoning** is exemplified by the nurse who contracts with clients about healthcare issues (stage 5) and the nurse who acts based on logical, consistent, comprehensive, and universal ethical principles (stage 6).
- The **preconventional stage of moral development** is exemplified by nurses who do whatever anyone in power tells them to do (stage 1) and by nurses who do what is satisfying or what is based on reciprocal sharing (stage 2).

- **Scope of practice** is spelled out in state nurse practice acts and must be carefully monitored to reduce potential liability.
- **Standard of care** means a professional nurse must speak, write, and act legally, ethically, and responsibly.
- **Veracity** includes telling the client the truth.

Leadership Development Exercises

■ Leadership Development Exercise 10-1

Discuss the most ethical response to the following situations with at least three other learners, and give a rationale for your answer based on information in this chapter.

- a. A new RN who believes in information taught in class but observes a teacher breaking technique
- b. An RN who observes a physician acting in such a way that could result in a misdiagnosis
- c. A nurse leader who observes another nurse or physician displaying inappropriate behavior with a client or family member of a client
- d. A nurse leader who observes a nurse who is a friend of a physician performing procedures outside her scope of practice

■ Leadership Development Exercise 10-2

Go back and see if your answers were different based on whether they included an RN observer or a nurse leader observer. If they were different, give a rationale for your answers based on information in this chapter. If they were not different, explain why you believe RNs and nurse leaders should be held to the same code of ethics.

■ Leadership Development Exercise 10-3

- a. Choose a belief or value you hold.
- b. Write down as many ways as you can to demonstrate that value or belief.
- c. Seek opportunities for modeling your beliefs and values even when they differ from those of others.
- d. Journal about your experiences.
- e. Share what happened with at least two other nursing students or nurses.
- f. Have you considered it your place to challenge either the structure of your healthcare system or the official or unofficial rules guiding that system? Discuss with at least two other nursing students or nurses why such action may be part of a nurse's role and how the idea may create tension among nurses.

■ Leadership Development Exercise 10-4

- a. Perform a negotiation process with a client, supervisor, supervisee, friend, or family member.
- b. During the negotiation, look for the other person's point of view, and try to understand it. Ask questions until you thoroughly understand.
- c. Help the other person understand your point of view by discussing it directly and honestly and giving any information to back up your viewpoint.
- d. Indicate to the other person that you have heard the other point of view by maintaining good eye contact and summarizing the key points that you agree on.
- e. Write down what happened, and share your experience with at least two other students; ask for feedback and suggestions.

■ Leadership Development Exercise 10-5

If you haven't already, investigate the proposal for a national nurse at <http://www.nationalnurse.blogspot.com>. Then:

- a. Choose an activity to become involved in.
- b. Share your experience with at least three other colleagues.
- c. Obtain feedback.

Advanced Leadership Development Exercises**■ Leadership Development Exercise 10-6**

Teach legal, ethical, and/or political skills to student nurses in an undergraduate leadership course or LPN students. Share your results with at least two other students in your leadership class, and ask for feedback.

■ Leadership Development Exercise 10-7

Formulate a problem statement for a nursing project related to legal, ethical, or political issues. Share your results with at least two other learners in your class, and ask for feedback.

■ Leadership Development Exercise 10-8

Design a research project related to a legal, ethical, or political issue. Share your design with at least two other learners in your class, and ask for feedback.

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