

## Chapter Twenty

# Leadership

by Anne McMurray

## Overview

This chapter examines the potential of leadership development in practice nursing as well as the advantages of leadership for building personal and professional capacity. The resulting improvement in patient outcomes is also considered. The distinction is made between leadership and management and the discussion outlines the synergies between the two. The foundation of clinical leadership is explained and implications for practice addressed, particularly in the context of collaborative practice. The chapter ends with a discussion of mentorship and the importance of networking and mentoring programs for the ongoing development of practice nursing.

## Objectives

At the completion of this chapter you will:

- describe the characteristics of good leaders;
- compare the differences between leadership and management;
- explain your leadership strengths in practice and their impact on client outcomes;
- identify the leadership role of practice nurses in collaboration and teamwork; and
- describe the advantages of mentorship, the qualities of leadership mentors and strategies for developing mentoring programs.

## Leadership

Leadership has been described as ‘the capacity of a human community to shape its future’ (Senge 2002, p. 13). This is based on the notion that leadership creates an avenue for influencing the way members of a community develop and sustain their common goals. Good leaders help develop this capacity by combining their innate skills and abilities with considerable hard work to challenge, inspire, empower and act as a role model for others. For some, this is embellished with artistic flair and charisma. For others it is a deliberate, conscientious and committed progression towards excellence achieved through rational planning and hard work. The best leaders are able to balance both sides of the coin (or the brain) sometimes simultaneously, sometimes sequentially. A charismatic personality which draws on personal charm can be helpful but it must be accompanied by the substance of strategic thinking, change management skills, personal strength, confidence, negotiation skills, knowledge management and willingness to form strategic alliances (Jooste 2004).

Leadership is widely acknowledged as an essential foundation for nursing practice across the entire continuum, from basic nursing care to making decisions that affect systems, policies or professional regulation. Nurses in all settings need leadership skills that are responsive to people's health needs, appropriate in the social and regulatory context, and visionary in terms of balancing current workforce and professional needs with the demands of home and community life and planning for an uncertain future (Davidson, Elliott & Daly 2006). This is a big ask.

Leadership at the point of service, such as occurs in practice nursing, is challenging, but it can sometimes be more rewarding in that context than in other nursing settings. Patients in hospital often feel 'processed' rather than cared for, being moved through the system quickly, with a sense of urgency and little time to discuss their ongoing needs, especially for information. In general practice there is an opportunity to engage with people on a more meaningful level, making sure that their needs for treatment, guidance, information and follow-up are met. This is both an opportunity and a challenge. It requires leadership skills to oversee the smooth transitions involved in a person's care, to promote continuity of services, and to ensure that the practice clients are provided with safe, high quality care and appropriate advice on maintaining their health and preventing illness or injury. Leadership skills that enable these activities are cultivated in working with others and interacting across personal and professional settings.

<reflections>Is continuity of care a priority in your practice?

Do you use a particular strategy for maintaining continuity of care?

How does your practice documentation system affect continuity of care?

To help shape 'the human community' of practice nursing the following definition of good leadership behaviours as described two decades ago by Kouzes and Posner (1988) remains the gold standard.

Good leaders

- challenge process, learning from the past but living in the present;
- inspire a shared vision, creating a force that invents the future;
- enable others to act, by mentoring, turning followers into leaders;
- model the way by example, living the values and planning for their successors; and
- encourage the heart by celebrating the achievements of themselves and others.

(Kouzes & Posner 1988)

The ideal image of a good leader epitomises courage. Courageous leaders practise with their eye and their intellect on the big picture; however, they also create cycles of personal and professional affirmation and confidence that are fuelled by small, incremental successes.

Courageous leaders become adept at articulating their contribution and that of their team, which makes visible their acceptance of the leadership role, attracts support from those around them, and inspires others to become leaders.

Good leaders go where there is no path and leave a trail. They embrace the change agent role willingly, understanding that managing change is the primary role of a leader, and that role modelling for others will help grow their own as well as others' strengths (Graetz 2000; Porter-O'Grady & Malloch 2003). When change is rapid and substantial they take time to reflect, creating a natural space for themselves and other members of the team in the new version of the workplace, so each of them can find a level of stability and renewal (Sullivan 1999). They live out of imagination, not history. They trust others. They flatten and reshape hierarchies by building alliances. This is extremely important in practice nursing, where, just as in rural areas, it takes a concerted effort to connect nurses who are geographically isolated. Networking is therefore a critical, fundamental element of good leadership (Borbasi & Gaston 2002).

<reflections> Identify the most useful networks you have either established or joined in practice nursing.

Which of these are within your geographic area or personal?

Which are 'virtual' networks?

What are the strengths and weaknesses of personal versus virtual networks?

Good leaders also design opportunities for ideas to flourish with good timing and good judgment. This creates mutual respect and an environment wherein difference, diversity and ambiguity are not just tolerated; they are celebrated (Porter-O'Grady & Malloch 2003). As individuals, good leaders are self-regulating, stretching their capacity, rather than their ego, recognising their prejudices and shortcomings as well as their talents (Kouzes & Posner 1988). In nursing practice, they understand the 'bi-cultural' nature of professional leadership, retaining professional values on one level while recognising and influencing the wider social and policy context of health care on the other (Antrobus & Kitson 1999). They are confident in their own skills but not rigid. And they know that when leadership becomes an obligation rather than an opportunity for change, it's time to bail out (Drucker 1999; Kotter 1990; Porter-O'Grady & Malloch 2003).

Accepting a leadership role does not always come easily to nurses, especially when their practice experience has been predominantly in a rigid, hierarchical environment, such as a hospital or other institution. This type of organisational culture often prohibits self-development and creative thinking, although this is beginning to change with the pressure to increase nurses' satisfaction to promote greater retention of the workforce. Another barrier to the development of leadership

behaviours lies within nurses themselves. The motivation to develop leadership capacity can sometimes be sabotaged by nurses' propensity to bypass, downplay or devalue their work. This creates misunderstandings about the importance of nursing where it is most vital, that is, at the point of service, and perpetuates the myth that practising nurses are virtuous, meek and self-sacrificing (Miller et al. 2008). This couldn't be further from the reality of contemporary nursing practice, especially in the context of today's significant financial constraints and the pressure to manage effectively and efficiently.

<reflections> How do you convey the scope of your practice role to others in the practice?

How do you gain acceptance within the practice for your leadership skills?

To what extent do the financial aspects of the practice affect your leadership role?

## Leadership and management

Because leadership and management are often confused as similar processes, it is helpful to look at the distinctive and complementary elements of both. Kotter, a well-known Harvard professor of business, contends that too many workplaces are over-managed and under-led. In his view, what our turbulent and rapidly changing workplaces need is active recruitment of people with leadership potential, who can then be exposed to capacity-building career experiences (Kotter 2001). He explains leadership as something that is designed to create change. It is a strategic endeavour, focused on promoting the aspirations of the group. Leaders establish direction, aligning people by helping empower them, and motivating and inspiring them to achieve the vision. Management is about controlling complexity to bring order and consistency to the work. It revolves around planning, budgeting, organising, staffing and problem solving (Kotter 1990). So although both leaders and managers may play a part in decision making and planning, management is primarily concerned with operational activities, such as coordination and resource allocation, which are intended to meet organisational goals (Leach 2008). Table 20.1 illustrates these differences.

<table title>Table 20.1 Comparison of management and leadership tasks

<b>Managers</b>		<b>Leaders</b>
Create an agenda	plan and budget	set direction
Develop a human network	organise and staff	align people, groups
Execute the agenda	control, solve problems	motivate, inspire
<b>Impact:</b>	<b>Create order</b>	<b>Produce change</b>

<source line>Source: Kotter 1990

Practice nursing requires a management skill set that is developed over time and on the job. This is especially relevant for the skills required for negotiation, advocacy and lobbying (Halcomb, Davidson & Patterson 2008). Advocacy is a necessary part of good and best practice to ensure appropriate, effective, responsive and safe patient care (Watson 2008). Negotiations are a cornerstone of both leadership and management interactions, especially in managing information and communication. The fine art of lobbying ranges from requesting resources for self-development to those needed to service the breadth of clients attending the practice. At another level, lobbying also involves the politics of professional practice in lobbying the profession and the health care system for greater visibility in what practice nurses are doing, clarifying what is changing in the context of practice or education, and anticipating how and when change or the lack of change is affecting the health of people. It requires courage to hold practice, its knowledge base and its outcomes up to scrutiny, even when this causes reconsideration of a course of action.

<reflections>To what extent does your practice involve you in planning and budgeting?

How would you go about gaining recognition for your problem-solving skills?

What strategies would you develop to 'align people' to achieve the goals of the practice?

## **Clinical leadership**

Clinical nursing leadership is typically described in terms of the leader's behaviours, the particular situation requiring leadership, or the needs of followers (Shaw 2007; Sullivan & Decker 2005). By far the most prevalent theory of nursing leadership is *transformational leadership*, which is based on the idea of the nurse as *facilitator*; working with others to inspire and empower others, and help build capacity (Burns 1978; Leach 2008; Porter-O'Grady & Malloch 2003).

Transformational leaders are often charismatic and work towards engendering trust in those around them (Porter-O'Grady & Malloch 2003). Members of the work team tend to gravitate to them because they seem to understand themselves and their place in the scheme of things. This self-understanding and consistency between values, beliefs and actions complement other skills, such as expertise, flexibility and the ability to articulate expectations for the future (Ward 2002). These characteristics embody what has been described as emotional competence (Malloch & Porter-O'Grady 2005). As these authors suggest, the emotionally competent leader understands that:

- leadership is all about relationships;
- leadership requires emotional balance;
- conflict is present in all relationships;
- communication skills are not leadership optional;
- the leader never owns others' issues or resolves others' problems;

- accountability means that the leader sees that defined outcomes are attained;
- friendship is not a component of the role; and
- the leader keeps no secrets, in fact, favours disclosure.

(Malloch & Porter-O'Grady 2005).

Nurses gravitate to transformational leadership theory because it is visionary, dynamic and focuses on 'doing' rather than 'creating' (Stanley 2008). This fits well with practice nursing, where the nurse can influence others by being a good communicator, building relationships, being motivational and articulating their clinical and leadership competence and knowledge (Stanley 2008).

There is a view that in practice, leadership and management should coexist, with all clinical leaders having some managerial responsibility to ensure operational effectiveness (Christian 1998; Sullivan & Decker 2005). However, as Kotter (1990) cautions, care must be taken to ensure that in assigning responsibility for effectiveness or efficiency, the practice does not become 'overmanaged' and 'underled'.

<reflections>Which aspects of your practice tend to require too much management or too little leadership?

Are you able to control the flow of work to negotiate improvements in efficiency?

How do you know when your leadership is enhancing practice effectiveness?

## **Collaboration, teamwork and leadership**

One of the most challenging leadership issues in practice nursing lies in fostering genuine collaboration among all members of the practice team. Whenever teamwork is required in a workplace there must be complementary skills, commitment to a common purpose and goals, and mutual accountability (Javellana-Anunciado 2007). Good teamwork has a number of advantages. These include organisational benefits, benefits to team members themselves and, for the patients, enhanced satisfaction, acceptance of treatment and improved health outcomes (Mickan 2005). Ideally, the practice team focus is on instances of parallel, independent care around patient needs (Phillips et al. 2008). Putting patients at the centre of care ahead of managerial throughput and professional 'gatekeeping' is a major step towards collaborative thinking (Donaldson 2001; Patterson & McMurray 2003). This reflects today's inclusive approach where patients are seen as partners in care, capable of making informed but autonomous decisions and participating in their own care (Iedema et al. 2008; Kravitz & Melnikow 2001). Good leaders nurture this type of participation.

Practice collaboration is a term that is readily accepted, but the notion of autonomy is often misunderstood. Autonomy implies authority, freedom and discretion in making judgments (Wiggins

2008). In nursing, *clinical* autonomy applies these principles to the care of patients, whereas *work* autonomy involves freedom and discretion in scheduling work, initiating processes and procedures, goal setting and evaluation (Weston 2009). Neither clinical autonomy nor work autonomy means that a person acts exclusively or independent of others, especially in a situation such as practice nursing where all members of the practice are accountable for outcomes. In a well-functioning team a nurse can make independent decisions within a nursing sphere of practice, and interdependent decisions in those spheres where nursing overlaps with other disciplines (Kramer, Maguire & Schmalenberg 2006). Depending on how the practice is managed, this could involve making some autonomous decisions in relation to health maintenance, prevention, caring and disease management, and participating in shared decision making in diagnostic, prescriptive or curative decisions, or alternatively, deferring these to medical management. Clearly, there is no reason why autonomy and teamwork cannot coexist, and this has been substantiated by research demonstrating that the interaction between the two can create synergies rather than conflict (Rafferty, Ball & Aitken 2001; Waldman, Smith & Hood 2003).

Some practice nurses have developed innovative ways of dealing with GP shortages and high practice demands in regional and rural areas by conducting home visits for clients with chronic conditions or intermittent needs that can readily be dealt with in the home. This has increased efficiency while maintaining safe high quality care. The system has helped maintain patient flow as well as patient and staff satisfaction, which is important in a practice with frequent changes of locum practitioners.

<reflections>What leadership skills would be most important in developing this type of approach? How would you build a business case for developing this type of system?

Successful team leaders are able to persuade all members of the team to collaborate in working toward shared goals, and to develop a shared language with which to communicate (Carroll & Quijada 2004). This includes genuine attempts to help transform apprehensions about the change in status and relationships, to accommodate one another's vested interests, and to reframe relationships. Like all changes, it requires time, energy and a collegial environment that helps build inclusiveness and solidarity. As nurses we tend to come from diverse backgrounds with few opportunities to consolidate our views or share our needs, especially when we practise in isolation. Most medical practitioners do not experience the same communication barriers because of their background and education, which often results in them forming strong bonds that become reinforced over time (McPherson, Smith-Lovin & Cook 2001). Unfortunately, the reality of work pressures, the subjugation of roles to the dominance of medical practitioners and continuation of a hierarchical model of practice often interfere with collaborative relationships. Perpetuating an

'expert' hierarchical model of practice wherein each level of practice is under the direct control of the practitioner dilutes nurses' willingness or ability to articulate an expansion of roles or capacity to make judgments on the basis of individual cases (Brown, McWilliam & Ward-Griffin 2006; Carryer et al. 2007). It is also a barrier to teaching and creating partnerships with patients, especially in situations where nurses know intuitively how important the transfer of knowledge would be to them. Other barriers to practice collaboration include a lack of explicit, appropriate tasks and role definitions, an absence of clear leadership, insufficient time for team building, the 'us and them' effects of professional education and socialisation, and frustration from power and status differentials (Zwarenstein & Reeves 2003).

## **Mentorship**

Like other professionals, nurses become socialised to the profession and its core values primarily through mentoring and modelling (Campbell, Dardis & Campbell 2003). A mentor is typically an experienced (and often wiser) person who guides, supports and nurtures a less experienced person (Sullivan & Decker 2005). Professional values are learned when significant individuals or 'champions' model desirable behaviours. This can be invaluable in helping to clarify the ambiguities and contradictions that sometimes arise when a nurse is isolated, such as in rural practice or when new to a role, and can be reassuring to those new to practice nursing (Heartfield & Gibson 2005; Mills, Lennon & Francis 2006).

Mentorship programs can be formalised or simply be the spontaneous bonding that occurs informally between mentors and mentees. Mentoring can also be enjoyable and a source of personal satisfaction and growth as well as an effective pathway to leadership development (Campbell, Dardis & Campbell 2003; Van Eps et al. 2006). Currently, the Australian General Practice Network (AGPN) has initiated a pilot project to inform development of a national structured mentoring program to support practice nurses in dealing with a range of challenges. Most of these have been identified in the Commonwealth review of practice nurses (Australian General Practice Network 2009). They include fragmentation of the sector and variation in size and structure of practices; diversity of roles and cultures; a system of accreditation that does not link continuing education to registration; the need to share across settings; the need to integrate nurses' career plans with practice plans; the challenge of developing shared understandings between general practitioners and nurses; and funding for appropriate and sustainable mentoring programs (Heartfield & Gibson 2005). Expectations are that the AGPN mentorship program will help address at least some of these.

Mentoring programs vary to some degree, but there is widespread agreement on the fundamental characteristics of a mentor. These include the following:

- trust;
- openness to new ideas;

- valuing knowledge;
- compassion;
- presence – being able to ‘walk’ the journey;
- mindfulness;
- passionate optimism;
- resilience;
- balance;
- impulse control, and
- emotional competence.

Emotional competence allows the mentor to demonstrate optimism and emotional availability (Porter-O’Grady & Malloch 2003).

Being a mentor means showing a person how to access the appropriate clinical knowledge and tools, how to make accurate clinical judgments and when to refer on to secure the required expertise. As the mentee develops, the mentor takes on a role as the ‘guide on the side’ rather than the ‘sage on the stage’, helping build the toolkit rather than the outcomes. This is done with a commitment to walk a mile in the other’s shoes, and a deep understanding of the vulnerabilities we all have as learners. The mentor then provides the impetus for mentees to stretch their capacity while preserving egos that are porous and receptive, not ones that become a casualty of the process. The opposite of this is toxic mentoring, where the mentor tries to transfer knowledge rather than building capacity. In this case, the mentor sets up a situation where they try to shape the mentee’s development to mirror their own. This leads to failure to thrive. If people are being mentored toward emotional competence, they will embrace the *next* step in the journey, rather than the last, and rather than mimic the characteristics of the mentor, they will develop their own career openly and decisively (Porter-O’Grady & Malloch 2003). Of course, mentorship is also reciprocal: as a person fosters another’s development they also build their own capacity, which has benefits for both individuals and helps strengthen the profession.

### **How can mentoring programs be developed?**

Little research evidence is available to guide the development of mentoring programs, which makes best practice difficult to define (Smith, McAllister & Snype Crawford 2001). However, leadership programs can help, especially women’s leadership programs. It is difficult for some women to keep up with changes when they have career interruptions, and the longer span of work life adds a multiplier factor to their disadvantage. Goleman (2002) suggests we create a more tribal feel. Like others, he argues that becoming a good leader requires ‘soul’; that is, using the emotion, identity and character that we all have in us, and using it to maximise our leadership potential (Goleman 2002; Shaw 2007). In Goleman’s view, the tribal leader creates the table and invites

others to sit down. This approach celebrates everyone's accomplishments, bringing to the team a sense of safety and encouragement for sharing ideas and working within their own style or comfort zone, which can help create a stronger professional identity.

The implication for change in practice nursing is that all change must begin with developing sensitivity to our own and others' capabilities and tendencies by fostering a culture of self-reflection and a place for the safe exchange of ideas and feedback (Caramanica, Cousino & Petersen 2003; Ray, Turkel & Marino 2002). This type of work culture is energising. Expectations are made explicit, reinforced, and are based on the knowledge that each action has some bearing on client outcomes (Davies, Nutley & Mannion 2000). In contrast, when disillusionment reigns, high levels of stress interfere with clarity of thinking and receptivity to change. The quality of communication suffers, leaving the work unit bathed in suspicion rather than anticipation of success. This creates stagnation rather than the empowerment to be persuasive and to consider new and innovative health care models, which runs counter to the Commonwealth government's vision of the new wave in health care where practice nurses feature prominently. Linking personal affirmation with this type of political savvy is crucial to professional development (McKenna, Keeney & Bradley 2004).

At the organisational level there are some explicit steps that can be taken to make leadership more integral to professional practice. The first and most important of these revolves around making nursing work visible. Knowing and communicating the things that matter, how *you* made a difference, how this fits into the bigger picture, how your ideas and approaches to your work can be justified as strategies for another occasion, how your work helps advance the work of the team, how your mentorship helps pass knowledge and skills onto the next person. The second step involves our professional obligation to socialise successive generations of nurses into the profession and into our specialty areas which is not always guaranteed in our education programs (Aagaard & Hauer 2003). Empowerment, even the perception of empowerment, is contagious. Where the leadership is powerful and there is organisational support, others become empowered by association and everybody's job satisfaction increases. The source of work satisfaction for most of us flows from making a difference, from questioning the possible, pondering the probable and choosing the preferred future (Miller et al. 2008). Where this is valued, rewarded and modelled in the workplace it creates structural empowerment (Patrick & Spence Laschinger 2006).

Even the greatest leaders have moments of personal insecurity, uncertainty in practice judgments or strategies, and times when the busyness of work overrides their ability to act with tact and diplomacy. Yet these are the traits leaders aspire to achieve (Hyett 2003). Enabling 'ordinary people to produce extraordinary things in the face of challenge and change' creates inner leadership that can make a difference to people's lives, and the work of the team or the practice (Jooste 2004, p. 217). It is circumscribed within the simple act of watching over those entrusted to nursing care,

knowing when and how to influence them, being prepared to celebrate your diversity and theirs, your knowledge and theirs, your needs and theirs. This is a partnership mindset. It is a prescription that cuts across all challenges, all settings and all nations. It begins with a clear vision, a willingness to share and a commitment to the work of the health care and practice team, its actions and outcomes. This builds capacity from within and without, perpetrating understanding and shared solutions to the breadth of problems that often seem insurmountable. With strong leadership these can be resolved one step at a time.

<reflections>1. Think of someone in your sphere of influence (either at work or in your personal network) with a charismatic personality. How does that person seem to influence decisions? To what extent do you think that person is perceived to be more knowledgeable than others? What lessons on leadership would you take from how that person handles themselves in a group situation?

2. What would be some practical strategies for connecting practice nurses with one another? What persuasive arguments could be made for the practice to support your membership in the local and national practice nurse association or network?

3. It can be said that good leaders use their personal characteristics to best advantage. What are some of your personal leadership qualities? How are you able to use these qualities to influence others?

4. One of the most difficult leadership challenges is trying to help co-workers who do not understand their role in the workplace. In this type of situation how would you, as the leader, help build others' capacity to achieve team goals?

5. Consider the extent to which you have *clinical* autonomy and *work* autonomy. Is either or both sufficient for what you would like to achieve in your practice environment? If not, how would you go about securing a change? What obstacles or facilitating factors would you have to deal with to succeed?

6. What are some of the things that promote or enhance collaboration in your practice? What leadership strategies would promote collaboration or ensure its continuity?

7. Think of a mentor who has influenced your career. Describe that person's distinguishing features in rich detail, especially those you'd like to emulate.

## **Conclusion**

Practice nursing is increasingly recognised as a major element of our health care system. Leadership skills are crucial to ensuring the continuing development of this important specialised role. The main objectives of leadership development are to improve client outcomes, enhance practice effectiveness, and advance personal and professional goals. This requires teamwork, collaboration and excellent communication skills, all of which are fundamental characteristics of good leaders.

## **Case study**

### **My experience of leadership and what it has taught me**

**by Judy Evans, president Australian Practice Nurses Association 2007–08**

Working as a sole nurse in a large practice challenged my skills as a leader and my ability to seek mentorship as I pursued a career as a practice nurse. To consolidate my place within the practice team I found I had to defend my decisions, argue my worth and demonstrate the preservation of the nursing process in the medical model of general practice. As I achieved goals, demonstrated my abilities and gained respect from my colleagues my confidence grew and I took on the challenge to understand what was required of a leader.

My first experience of leadership was in organising a local nursing network. Through this I learnt that leadership required clarity of vision, the ability to enthuse others to broaden their potential and to choose goals that were valued and balanced with expected outcomes. I also recognised the value of mentoring. The nursing network that I nurtured grew and when I chose to step aside there were others who had the confidence, skills and vision to become leaders and continue the work that I had started.

Within a few years I found myself as President of the Australian Practice Nurses Association. Between these two milestones I developed a clear understanding of my vision for practice nursing; belief in my abilities to lead, advocate for colleagues and negotiate our position. I sought relationships with others who had similar energy to me, but who had diverse expertise so that we could work together and learn from one another to get the job done. The key elements to building these relationships were reliable and honest communications and inclusivity when making decisions. This was a journey that included the influence of mentors and the privilege of engaging with nursing colleagues. A mentor provided me with a central point in which I could reflect on my achievements and disappointments. It provided me with a forum to build my opinions and the ability to defend and debate them.

My own experience of leadership taught me the worth of questioning and challenging the status quo, and that it is OK to be a lone voice in the discussion. To have independence in your opinion and a questioning mind can open opportunities for learning for yourself and for others. Leadership, I have learnt is not about ownership of the agenda but about encouraging others to take some steps with you through what can be a perilous journey at times, to forge ahead despite setbacks, to inspire and motivate others to achieve their goals as well as your own. The skill of being a good leader requires the time to reflect and build on your vision. Choose where to start; apply critical thinking; and set goals that are achievable but also inspirational. When you

are in the position of a nursing leader, whether it be in your practice or as leader of an organisation, others are watching and observing you. I feel that it is important that leadership be infectious; encouraging others to step into the arena. At all times maintain your enthusiasm for the job and create humour in the process.

By taking on the role of leader, diverse opportunities opened up that I would not have had the privilege to take and grow from.

## **Key messages**

- Leadership skills are essential for practice nurses.
- Leadership skills can affect continuity of patient care and help maintain practice efficiency, effectiveness and quality.
- Good leaders challenge process, inspire a shared vision, enable others to act, model the behaviours they expect of others and celebrate their achievements and those of others.
- Leadership creates change, while management strives for order and consistency. Both require high level communication skills.
- Teamwork and collaboration are fundamental to practice nursing.
- Mentoring and networking are essential for practice nurses to remain connected with one another and stretch their capacity for change.

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