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Preparing nurse leaders for 2020

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Aim: This article highlights eight leadership competencies likely to be an essential part of the nurse leader's repertoire in 2020.
Background: Planning for the future is difficult, even when environments are relatively static. When environments are dynamic, the challenges multiply exponentially. Unfortunately, few environments have been more unpredictable in the 21st century than health care. The healthcare system is in chaos, as is much of the business world. It is critical then that contemporary nursing and healthcare leaders identify skill sets that will be needed by nurse leaders in 2020 and begin now to create the educational models and management development programs necessary to assure these skills are present.
Results: Essential nurse leader competencies for 2020 include: (i) A global perspective or mindset regarding healthcare and professional nursing issues. (ii) Technology skills which facilitate mobility and portability of relationships, interactions, and operational processes. (iii) Expert decision-making skills rooted in empirical science. (iv) The ability to create organization cultures that permeate quality healthcare and patient/worker safety. (v) Understanding and appropriately intervening in political processes. (vi) Highly developed collaborative and team building skills. (vii) The ability to balance authenticity and performance expectations. (viii) Being able to envision and proactively adapt to a healthcare system characterized by rapid change and chaos.
Conclusions: Nursing education programmes and healthcare organizations must be begin now to prepare nurses to be effective leaders in 2020. This will require the formal education and training that are a part of most management development programmes as well as a development of appropriate attitudes through social learning. Proactive succession planning will also be key to having nurse leaders who can respond effectively to the new challenges and opportunities that will be presented to them in 2020.

Keywords: future, leadership, nurse leadership competencies, leadership succession, management, year 2020

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Introduction

Planning for the future is difficult, even when environments are relatively static. When environments are dynamic, the challenges multiply exponentially. Unfortunately, few environments have been more unpredictable in the 21st century than health care. 'The healthcare system is in chaos, as is much of the business world. Traditional management solutions no longer apply and a lack of strong leadership in healthcare

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Table 1
Essential nurse leader competencies for 2020

A global perspective or mindset regarding healthcare and professional nursing issues.
Technology skills which facilitate mobility and portability of relationships, interactions, and operational processes.
Expert decision-making skills rooted in empirical science.
The ability to create organization cultures that permeate quality healthcare and patient/worker safety.
Understanding and appropriately intervening in political processes.
Highly developed collaborative and team building skills.
The ability to balance authenticity and performance expectations.
Being able to envision and proactively adapt to a healthcare system characterized by rapid change and chaos.

systems has limited the innovation needed to create solutions to the new and complex problems that the future will bring' (Marquis & Huston 2009, p. 146).

It is critical then that contemporary nursing and healthcare leaders identify the skills which will be needed by nurse leaders in 2020 and begin now to create the educational models and management development programmes necessary to assure these competencies are present. This article presents eight leadership competencies likely to be an essential part of the nurse leader's repertoire in 2020 (see Table 1).

A global perspective or mindset

The first competency needed by nurse leaders in 2020 is a global perspective or mindset about healthcare and professional nursing issues. Gupta *et al*. (2008, para 2) define a global mindset as 'one that combines an openness to and awareness of diversity across cultures and markets with a propensity and ability to synthesize across this diversity' and argue that developing a global mindset which recognizes and bridges such cultural differences is essential to the success of any organization. The benefit of a global mindset to the nurse executive is that it allows him or her to proactively identify and respond to emerging global healthcare and nursing trends which potentially impact national, regional or even local healthcare planning.

Indeed, Huston (2008, para 3 & 4) suggests that:

> 'One only has to look at the headlines to realize most healthcare and nursing issues must now be viewed from a global perspective. The threat of pandemics and epidemics such as Acquired Immunodeficiency Syndrome (AIDS), Severe Acute Respiratory Syndrome (SARS), drug resistant tuberculosis, poliomyelitis, West Nile virus, and bird flu, combined with a world increasingly characterized by global travel, reminds us that the health threats faced by any one country are ultimately faced by all countries. In addition, many professional nursing issues are now recognized as global issues. There has never been a greater urgency to establish international standards for nursing education or to identify global standards or competencies for the novice nurse, than right now. In addition, the current global nursing shortage has resulted in the unprecedented trans-national migration of nurses',
>
> leading to complaints of 'brain drain' from donor countries and an increased risk of unethical, if not illegal, employment practices for foreign nurses in their host country, as a result of the lack of regulatory oversight.

Huston (2008) also suggests:

> 'It is readily apparent that no one country has all the answers to the worldwide health care dilemmas we face today, including abuse of women and children; care of people with HIV or AIDS; hunger and lack of access to clean drinking water; the multiplicity of ethical issues facing nurses and other health care providers, as well as nations; and health care worker shortages'.

The eight United Nations Millennium Development Goals, which range from 'eradicating extreme poverty and hunger to halting the spread of HIV/AIDS and providing universal primary education, all by the target date of 2015, form a blueprint for all the world's countries and leading development institutions' (United Nations 2008, para 1). Working together and sharing technologies, strategies and successes worldwide will be an important part of addressing these global health care dilemmas.

A working knowledge of technology

A second competency required by nurse leaders in 2020 is the ability to integrate technology which facilitates mobility and portability of relationships, interactions and operational processes. Electronic health records (EHRs), clinical decision support (CDS) and biometrics are examples of such technology, as all will continue to impact not only what healthcare data are collected, but how they are used, communicated and stored.

In January 2004, US President George Bush set a goal that most Americans would have an EHR by 2014 (Office of the Assistant Secretary of the Defense (Health Affairs) and the TRICARE Management Activity 2008). Similarly, Canada Health Infoway predicts that

50% of Canadians will be able to access their own EHRs by 2009 (Pooley 2006). Indeed, most developed countries are actively moving towards the establishment and implementation of EHRs. Australia has proposed a strategy known as 'Health Connect', to facilitate the adoption of common standards by all e-health systems in the Australian, State and Territory Governments (Health Connect 2006). Czernowalow (2005) identified the testing of EHRs at 15 State Hospitals in Africa's Northern Cape, Western Cape and the Free State as of 2005 and reported that the Department of Health had tasked the State IT Agency to initiate national implementation of the system. **The** National Health Service in the United Kingdom (UK) began an EHR system in 2005 and has developed a national system to transfer records directly and securely from one general practitioner (GP) to another. More than 100 000 patients in 4000 GP practices in the UK are now using this system (GP2GP 2008).

The process, however, to make such system wide changes is not easy. Nor is it cheap. A lack of funding, debates about who 'owns' the data in the system and the challenges of getting computers to 'talk to each other' will exist for some time to come (Pooley 2006).

In addition, 'clinical decision support' (CDS), defined broadly as 'a clinical system, application or process that helps health professionals make clinical decisions to enhance patient care' (Healthcare Information and Management Systems Society 2008, para 1), will likely be commonplace by 2020, giving providers the promise of access at the point of care to cutting edge research, best practices and decision-making support to improve patient care. For example, Isabel Health, an online diagnosis decision support application, 'combats diagnosis error by reminding clinicians of potential diagnoses. After users input free-text symptoms, Isabel searches published literature for possible diagnoses, with relevance attached. Isabel also provides access to annotated images for visual confirmation as well as suggestions for next steps, and can integrate with a hospital EMR' (The Advisory Board Company 2006).

Biometrics, 'the science of identifying people through physical characteristics – fingerprint, handprint, retinal scan, voice recognition and facial structure' (Huston 2006), will increasingly be used as a technology to safeguard client data by 2020. Andrews (2006) suggests there are as many as 15 000 users for one customer in healthcare and that 45 000 to 50 000 caregivers use fingerprint technology on a regular basis. Indeed, fingerprint scanning is the most commonly used biometric technology in healthcare today, although Andrews suggests that the use of handprints, retinal scans, facial geometry and dynamic signatures will increase in the future.

Expert decision-making skills

A third competency essential for 21st century nurse leaders is expert decision-making, rooted in empirical science. Marquis and Huston (2009, p. 1) suggest that 'decision making is often thought to be synonymous with management and is one of the criteria on which management expertise is judged. Indeed, the quality of the decisions leader-managers make is the factor that often weighs most heavily in their success or failure'. Using systematic, scientific approaches to problem solving does increase the likelihood of making quality decisions, although the role of intuition as an adjunct to quality decision-making should not be overlooked. In addition, decision-making based on empirical science and research-based, best practices also increases the likelihood that decisions made will achieve the desired outcome.

Yet, Camillus (2008) warns that decision-making in complex environments will only become more difficult in the future, despite gathering additional data, defining issues more clearly and breaking dilemmas down into smaller problems. This is because problems faced by organizational leaders are often 'wicked' – meaning that they have innumerable causes, they are tough to describe and there is no right answer. 'Not only do conventional processes fail to tackle wicked problems, but they may exacerbate situations by generating undesirable consequences' (p. 100).

One strategy nurse leaders of the future may increasingly use to address wicked problems and improve the quality of their decision-making is the use of commercially purchased 'expert networks' – communities of top thinkers, managers and scientists – to help them make decisions (Saint-Amand 2008). Such network panels are typically made up of researchers, healthcare professionals, attorneys and industry executives. Camillus (2008) also recommends involving stakeholders in brainstorming sessions when wicked problems emerge, so that an appropriate strategy can be developed and to better align decision-making throughout the organization.

In addition, management science has produced many tools to help decision makers make better and more objective decisions. For example, Mind Tools Ltd (2008) identifies a number of decision-making tools including 'Six Thinking Hats' (developed by Edward de Bono), Pareto analysis, paired comparison analysis, grid analysis, decision trees, force field analysis and cost-benefit analysis, just to name a few. Marquis and Huston (2009) warn, however, that most decision-

making tools are subject to human error, and many do not adequately consider the human element. Their judicious use is therefore advised.

Prioritizing quality and safety

A fourth leadership competency for nurse leaders in 2020 is creating organizational cultures that recognize quality healthcare and patient/worker safety as paramount. Bob King, founder and CEO of GOAL/QPC, a non-profit company directed at continuous improvement, quality and organizational transformation, suggests that healthcare is running 10 to 20 years behind in applying the quality technology that other industries have embraced successfully (iSix Sigma Europe 2008). King also suggests that most healthcare organizations are still unprepared for the cost squeeze coming in the next 3–5 years related to improving the quality of health care.

Indeed, a plethora of studies exist which suggest the current healthcare system continues to be riddled with errors and that patient and worker safety are compromised. Some experts suggest this is occurring because the health care industry has historically been comfortable striving for three sigma processes (all data points fall within three standard deviations) in terms of healthcare quality, instead of six (Huston 2006). 'Sigma' is a statistical measurement reflecting how well a product or process is performing. Higher sigma values indicate better performance, while lower values indicate a greater number of defects per unit. By achieving six sigma, the failure rate is minimized to 3.4 defects (errors) per million opportunities or a 99.9996% success rate (Lanham & Maxson-Cooper 2003).

Experts also suggest that current quality problems are exacerbated by organizational cultures which focus on blame instead of identifying how and why such errors are made, and then addressing the processes which increase the likelihood of errors occurring. Stumpf (2007, p. 61) agrees, arguing that safety aspects of care should be discussed at every opportunity: 'on rounds, at department meetings, in discussions with administrators, and in teaching residents and medical students'. In addition, Stumpf suggests that creating or supporting protocols and guidelines and improving communication among all members of the healthcare care will reduce the chance of errors occurring. Similarly, Jessee (2006) suggests that an organizational climate must be created in which safety is an integral part of day-to-day operations, that adequate resources must be devoted to patient safety and that organizational policies must be in pace to support patient safety. White (2006) suggests that organization leaders in the 21st century will be those that lead in identifying and adopting innovative safety and quality improvement approaches.

Being politically astute

A fifth competency for nurse leaders in 2020 is understanding and being able to appropriately intervene in political processes. Blass and Ferris (2007, p. 6), incorporating a number of definitions, define political skill as 'managing interactions with others in influential ways that lead to organization goal accomplishment amid rapidly changing contexts'. The politically skilled individual is focused outward (toward others) and is able to maintain a balance on accountability to others as well as self. Marquis and Huston (2009) define political skill as the art of using legitimate power wisely and suggest that it requires clear decision-making, assertiveness, accountability and the willingness to express one's own views. It also requires being proactive rather than reactive and demands decisiveness.

Because politics is a part of every organization, nurse leaders must have a clear understanding of the politics in the organization where they work. Nurse executives often lose hard-earned power because they make political mistakes. Marquis and Huston (2009) suggest that the most important strategy is to learn to 'read the environment' through observation, listening, reading, detachment and analysis. This allows the nurse leader to understand relationships and communication within the organization as well as informal power structures. Blass and Ferris (2007) agree, arguing that politically skilled leaders not only accurately interpret different social situations at work, they know how to act in these situations and do so in a manner that does not appear to be self-serving.

Being politically skilled can also promote leadership development in subordinates. As leaders gain political skill, they become role models for their followers. This in turn becomes an informal indoctrination and socialization process whereby more empowered and politically astute leaders can be created (Blass and Ferris 2007). 'By understanding how organizational politics are passed along through social learning and mentor relationships, and reinforced through organizational structures, leaders can more effectively understand political behaviors, the changing nature of organizational contexts, and the complex dynamics that are reflected in the development of leader reputations' (Blass and Ferris, p. 16).

Collaborative and team building skills

A sixth competency essential to nurse leaders in 2020 is highly developed collaborative and team building skills.

Scott (2006) contends that a paradigm shift took place early in the 21st century, with a transition from 'industrial age leadership' to 'relationship age leadership'. Industrial age leadership focused on traditional hierarchy management structures, skill acquisition, competition and control. Relationship age leadership focuses primarily on the relationship between the leader and his/her followers, on discerning common purpose and working together cooperatively (Scott).

Marquis and Huston (2009) suggest, however, that contemporary healthcare leaders can not and must not focus solely on relationship building, as assuring productivity and achieving desired outcomes are essential to organizational success. Similarly, while building teams and collaborative relationships was identified as one of four critical leadership competencies by the Center for the Health Professions at the University of California, San Francisco, the development of vision (purpose) and the task to implement that vision (process) were identified in a survey of nurse leaders as more important than relationship building (people) (O'Neil *et al*. 2008). The key then appears to lie in being able to integrate the priorities of both the industrial age and relationship age paradigms.

The other reality is that creating positive and productive working relationships is often very difficult. The healthcare team in 2020 will increasingly be characterized by highly educated, multidisciplinary experts. While this would appear to ease the leadership challenges of managing such a team, Gratton and Erickson (2007, p. 102) suggest such challenges actually increase, as the greater the proportion of experts a team has, the more likely it is to disintegrate into a non-productive conflict or stalemate. This occurs because teams of experts are 'less likely-absent other influences – to share knowledge freely, to learn from one another, to shift workloads flexibly to break up unexpected bottlenecks, to help one another complete jobs and meet deadlines, and to share resources – in other words, to collaborate' (p. 102). Gratton and Erickson (2007) contend that leaders can counteract this, at least in part, by demonstrating a commitment to collaboration, role modelling highly collaborative behaviour themselves, and by creating a sense of community as a result of mentoring, resolving conflicts appropriately and communicating clearly.

Nurse leaders in the 21st century will also likely have to coordinate decentralized decision-making involving multiple stakeholders including boards. A study by Mastal *et al*. (2007) of 73 hospital leaders across the United States found significant differences in the perceptions of Chief Nursing Officers (CNOs) regarding leader's abilities to manage quality of care in hospitals compared with those of board chairs and Chief Executive Officers (CEOs). For instance, CNOs perceived board members to have only moderate engagement in initiatives about quality of care, whereas CEOs and board chairs gave higher ratings to board members' abilities to integrate planning for quality with overall strategic planning. The authors concluded that CNOs play an important role in influencing board members and helping them to integrate quality goals with key business goals.

Balancing authenticity and performance expectations

The seventh competency essential for nurse leaders in 2020 is the ability to balance authenticity with performance expectations. Authentic leaders are those who are true to themselves and their values and act accordingly. Stanley (2006, p. 132) calls this phenomenon 'congruent leadership', and defines it as 'a match (congruence) between the activities, actions, and deeds of the leader and the leader's values, principles, and beliefs'. Authentic or congruent leadership differs from more traditional transformational leadership theories which suggest that the leader's vision or goals are often influenced by external forces and that there must be at least some 'buy-in' of that vision by followers. 'In authentic leadership, it is the leader's principles and their conviction to act accordingly that inspires followers' (Marquis & Huston 2009, p. 58).

In 2005, the American Association of Critical-Care Nurses released a landmark publication identifying authentic leadership as one of the six standards necessary to establish and sustain healthy work environments in healthcare (Shirey 2006a). Authentic leadership was described as the 'glue' needed to hold together a healthy work environment. George (2007) concurs, suggesting that 21st century organizations can not develop sustained growth without authenticity in leadership. Kerfoot (2006, para 1) also agrees, suggesting that 'the leadership traits of the person in charge works either as a magnet to attract, retain, and inspire, or as a force that repels' as 'people hunger for personalized leadership that speaks to their hearts and inspires them to do things they didn't know they were capable of accomplishing'.

Yet, there is little doubt that nurse leaders experience intrapersonal values conflicts between what they believe to be morally appropriate and a need to deliver results in a healthcare system, increasingly characterized by pay for performance and rewarded by cost containment. Indeed, a survey by O'Neil *et al*. (2008) found that funding and budgeting were identified as the greatest leadership challenge by nurse executives. In

contrast, it was ranked at the bottom of the top 5 by non-nursing leaders assessing what they saw as the most critical leadership challenge facing nurses in senior leadership roles. This dichotomy points out the personal conflict nurse executives may face in attempting to meet the differing expectations and priorities of organizational stakeholders. George (2007) suggests that leaders should be honest with themselves in acknowledging a temptation to cut corners in pursuit of short-term profits but must resist that temptation and hold devotion to customers at least as important as devotion to stakeholders.

In addition, nurse leaders should realize that becoming an authentic leader is a process that occurs over time and requires self-discovery, self-improvement, reflection and renewal. It is attained not through self-proclamation, but by validation from the leader's followers (Shirey 2006b).

Coping effectively with change

The final leadership competency discussed here, for nurses in 2020, and perhaps, the most important, is being visionary and proactive in response to a healthcare system, increasingly characterized by rapid change and chaos. Marquis and Huston (2009) suggest that most 21st century healthcare organizations find themselves undergoing continual change directed at organizational restructuring, quality improvement and employee retention. Linda Hill, an expert in change and leadership development, concurs, suggesting that 'change is so rapid that one leader can't hope to keep abreast of all developments, much less be responsible for the innovation needed to keep ahead of them' (Hemp 2008, p. 123). Such profound change is not easy as all major change brings feelings of achievement and pride as well as loss and stress.

Porter-O'Grady (2003) agrees, noting that the skills necessary to move reticent groups should not be understated. The leader must use developmental, political and relational expertise to ensure that needed change is not sabotaged. Burritt (2005, p. 482) also concurs, suggesting that, 'putting an organization on a positive, healthier course is about leadership that focuses on re-energizing and empowering a workforce. It is about restoring people's confidence in themselves and inspiring them to embrace and initiate change'.

Contemporary nurse leaders then must be visionary in identifying where change is needed in the organization and they must be flexible in adapting to change they have directly initiated or by which they have been indirectly affected (Marquis & Huston 2009). For example, Malloch & Porter-O'Grady (2005) suggest that the future will increasingly call for a more fluid, flexible and mobile work environment, which requires an entirely innovative set of interactions and relationships as well as the leadership necessary to create them. Increasingly, skills related to complexity, conflict, multi-focal work realities, individual accountability, vulnerability and virtual workplaces will require transformed constructs and shifting foundations for defining leadership and expressing it. Leaders who understand these emerging realities and who can adapt accordingly will continue to thrive in this changing work dynamic. Leaders who do not, will simply cease to be effective (Sigma Theta Tau International 2005). Blass and Ferris (2007, p. 5) agree, suggesting that 'appropriate responses to rapidly changing contexts cannot possibly be scripted. Therefore, leaders are needed who can flexibly adapt to and deal effectively with this ambiguity and change'.

Conclusions

The year 2020 is only 12 years away and inadequate numbers of nurses have the skills that will be needed to lead in an increasingly complex healthcare environment, characterized by competing demands and stakeholders, rapid change, an ever increasing reliance on technology and wicked problems. Hill suggests that cadres of globally savvy executives do not currently exist and warns that many organizations fail to view talented people as potential leaders (Hemp 2008). She suggests this occurs because 'demographic invisibles' – 'people who, because of their gender, ethnicity, nationality, or even age, don't have access to the tools – the social networks, the fast-track training courses, the stretch assignments – that can prepare them for positions of authority and influence' (p. 125). Hill also suggests that other potential leaders are missed as they are viewed as 'stylistic invisibles' – individuals who do not fit the conventional image of a leader, as they do not exhibit take charge, direction setting behavior (p. 125).

Clearly, then nursing education programmes and healthcare organizations must be more open minded about who the profession's future leaders might be and begin now to prepare nurses to be effective leaders in 2020. This will require the formal education and training that are a part of most management development programmes as well as a development of appropriate attitudes through social learning (Marquis & Huston 2009). Proactive succession planning is the key to having nurse leaders who can respond effectively to the new challenges and opportunities that will be presented to them in 2020.

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