Relational leadership: A contemporary and evidence-based approach to improve nursing work environments

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The healthcare world has been transformed over the past 2 years with workforce shortages and seismic shifts unlike anything experienced in the past century or more. Turnover, migration, the gig economy, burnout, and attrition from the nursing profession are a result of the perfect storm created by the COVID-19 pandemic and its persistence of high-acuity, high-volume patients.[1,2]

Multiple research studies and surveys from the past year indicate nurses and their leaders are growing weary waiting for an end to the pandemic

or return to "normal," with anywhere from 11% to 22% of nurses stating their intent to leave their position.[1,3] Nurse leaders are feeling the strain as well, with 17% indicating they're considering leaving and 3% stating they are leaving their roles.[4] To translate the monumental nature of these statistics, consider this: if there are approximately 4 million nurses in the US, and 22% of frontline nurses along with 20% of nurse leaders either plan to or are considering exiting their jobs, this equates to an astounding migration of 1,680,000 nurses.[1,4,5] Leaders have valiantly tried to mitigate the exodus with a mix of innovative strategies, such as offering mental health support, flexible scheduling, and bonuses; increasing float pools; adding support staff; and partnering with nursing schools to increase output.[2,4] The verdict is still out on the effectiveness of these operational strategies. At the same time, momentum is gaining around exploration of how healthcare leaders' styles and the subsequent influence on work environment may provide the tipping point for either retaining or losing nurses.[3,6]

The purpose of this project was to test the potential influence of a relational leadership style, Human-Centered Leadership in Healthcare (HCL-HC), can have on staff perceptions of work environment, nurse retention, and nurse leader turnover, and to test it against proposed outcomes identified in the theory, such as healthy work environment standards, nurse leader retention, and frontline nurse retention. HCL-HC is unique in its foundational concepts of relational leadership and is distinctively aligned with the complexity of humans and the healthcare system itself.[7,8]

Literature review

Relational leadership. The association between a leader's style and the team's engagement, retention, and satisfaction drives the culture on a unit. As the old saying goes, culture eats strategy for breakfast. In this line of thinking, the leader becomes a central component in the complex people-focused nature of healthcare teams. There's no question that leaders must be schooled in operations and the mechanics of management; however, the relational component of leadership is often seen as a softer, less rigorous dimension. The irony of this is that healthcare is predominantly about people, relationships, and communication. Relational leadership styles such as authentic leadership, HCL-HC, servant leadership, and transformational leadership align with concepts central to nursing, such as being others-oriented, caring, and authentically present.[7,9-12] When comparing relational styles with traditional leadership, it's obvious that linear, top-down approaches may have worked in the past, but the complexity and chaos of the current healthcare environment are much better aligned with a relational, inside-out approach. More recent evidence shows that sustainable and successful change rarely comes from the top of any system; rather, change originates at the system's center (point-of-service team members) and emanates outward, influencing all parts of the micro and macro system (metrics and culture).[6,8] Further, when considering that healthcare is a complex adaptive system of self-organizing parts (people) with interdependencies (interprofessional teams), the influence that relationships can have on how the people engage, respond, and work becomes clear.[13,14]

HCL-HC is a contemporary, evidence-based leadership approach developed with the essence of nursing at the core.[7] HCL-HC fills the gap in healthcare's enduring use of borrowed, non-nursing, and non-healthcare-specific theories and approaches to leadership. In contrast to traditional, transactional, or "the way we've always done it" ways of leading, HCL-HC brings forth a relational style aligned with complexity science and systems theory. This approach also uniquely focuses on the leader's ability to care for self and then emanate the same energy outward to the staff through the dimensions of Awakening, Connecting, and Upholding.[6] See *Figure 1* for a conceptual model illustrating the dimensions of HCL-HC, and see *Table 1* for conceptual definitions of each dimension and its associated attributes.

Work environment. The tsunami-type impact of the pandemic on healthcare work environments, nursing teams, and patient safety has been well-documented. Since the onset of the COVID-19 pandemic, the evidence is clear that nurses report high levels of stress, burnout, depression, and discontent with their work.[15-17] Murat and colleagues studied data from 750 nurses who worked in hospitals during the pandemic.[16] They found that those with fewer

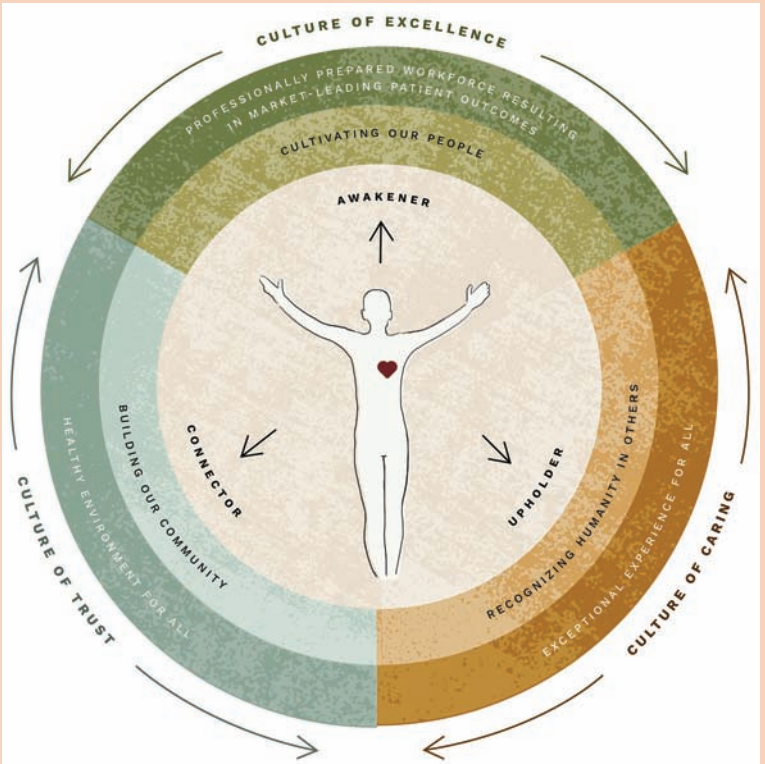
years of work experience had even higher levels of stress and burnout. A 2020 survey of more than 1,000 healthcare workers found that a startling 84% reported feeling at least mildly burned out and 18% felt totally burned out.[5] An alarming 90% said they get less than 8 hours of sleep per night, and one in three admitted to getting 4 hours or less. It's also not surprising that one in three healthcare workers feel they've been making more mistakes at work. Nearly half, 48%, have considered retiring, quitting their job, or changing their career altogether.[5]

In 2019, Vivian and colleagues studied the impact of workplace stress and burnout on nurses' physical and emotional well-being and the correlation to patient satisfaction scores.[17] They found that nurses who reported higher perceived stress belonged to units that, on average, had lower Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores. Abdollahi researched the buffering role of self-compassion regarding frontline nurses' perceived stress and job burnout, showing that improvements in self-care, specifically the emotional aspect of improved self-compassion, mitigated stress.[18]

Finally, Nelson and colleagues performed a research study across eight countries, which showed how the practice of self-care among nurses positively impacted job satisfaction and that job satisfaction was associated with decreased sick time and decreased turnover.[19] The work environments for frontline nurses and their nurse managers are in dire need of attention, given the high number of nurses and leaders either planning to or considering exiting their jobs.[1,4,5] According to a study by Berlin and colleagues in 2021, the top five reasons to move on from a nursing job include: 1) insufficient staffing; 2) intensity of the workload; 3) emotional toll; 4) no voice, no support; and 5) physical toll.[1] In contrast, the top reasons to stay were concepts aligned with standards of the American Association of Critical-Care Nurses (AACN) Healthy Work Environment (HWE) assessment: 1) recognition, 2) communication, and 3) well-being.[1,20]

Figure 1: Human-Centered Leadership in Healthcare

The visual framework reflects an innovative approach to leadership in healthcare that starts with the leader's mind, body, and spirit as the locus of influence within local and larger complex systems. The human-centered leader realizes success in connecting leadership dimensions of the Connector, Awakener, and Upholder to Cultures of Excellence, Caring, and Trust, which reflect industry-leading metrics.[7]



Background

The pandemic has shown us that leadership must have a balanced focus between metrics and recognizing the humanity and health of each team member. Hospital executives can set an expectation for patient satisfaction, reduced healthcare-associated infections, reduced falls, and decreased length of stay but without a healthy team and healthy work environment, these metrics will consistently fall

Table 1: Human-Centered Leadership in Healthcare dimensions and attributes with definitions

Awakener	**Cultivates our people**
Motivator	Establishes a learning culture with high expectations for ongoing learning for self and others
Coach	Provides honest feedback; addresses behaviors inconsistent with a learning culture
Mentor	Advises on member accountability for individual growth plans
Architect	Designs structures/processes so innovation can emerge
Advocate	Ensures resources are available for best practices and professional growth
Connector	**Builds our community**
Collaborator	Unifies others around a shared mission and vision
Supporter	Supports, recognizes, and appreciates independent problem-solving and individual contributions at the point of service
Edgewalker	Embraces change/chaos by endorsing the experimentation of ideas to generate innovation
Engineer	Ensures people are plugged into processes/structures for the emergence of new ideas
Authentic communicator	Builds mutual respect and trust by nurturing intentional connections with others
Upholder	**Recognizes humanity in others**
Mindful	Focuses attention, awareness, and energy on present
Others-oriented	Supports with respect, kindness, empathy, and empowerment
Emotionally aware	Recognizes and embraces humanity at all levels; self-reflective
Socially and organizationally aware	Leads with an open mind
Personally well and healthy	Practices self-care, self-compassion, and self-awareness

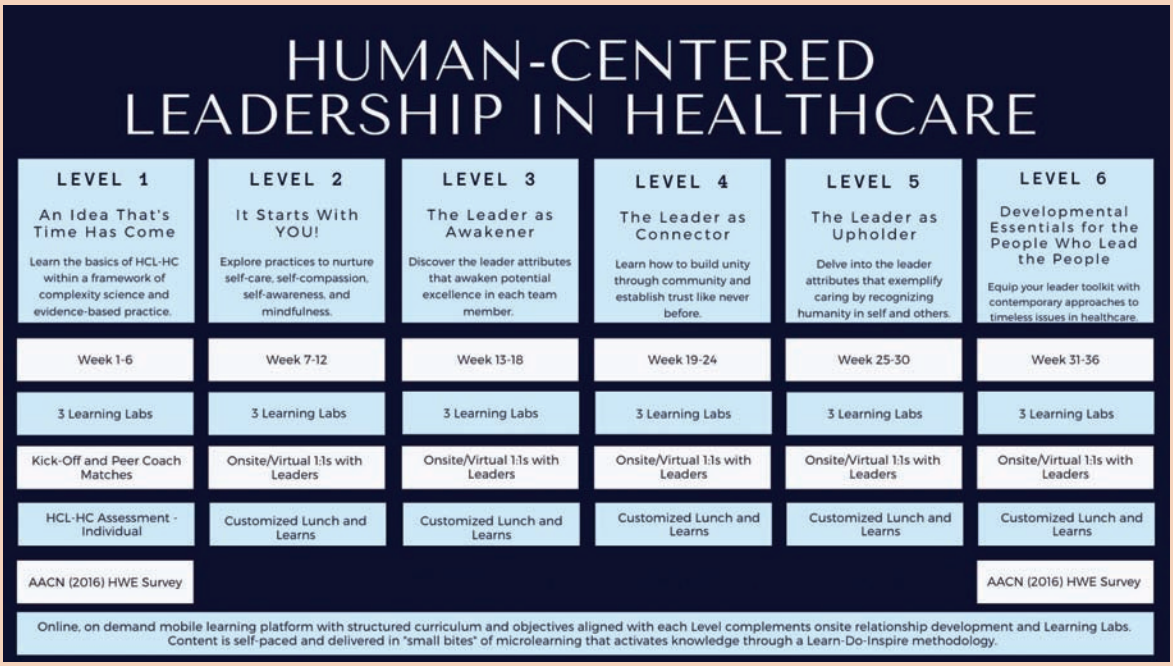
short. A rural health system in Louisiana stepped forward during the pandemic to implement a structured 9-month program to integrate HCL-HC within the leadership team (see *Figure 2*). Of the leaders in place, 90% were new to the role, and according to the current leaders, the morale was exceptionally low due to the former leadership team's lack of transparency in communication and support of the frontline nurses and team members. According to local leadership, staff turnover, callouts, and trust were at an "all-time low." The CEO, also new to the role, acted with urgency to implement a relational leadership approach in an attempt to influence work environment, retention, quality metrics, and ultimately the success of the new leaders.

Methods

The comprehensive HCL-HC program was implemented onsite at the Louisiana hospital system as a quality improvement project and included 20 leaders from across all disciplines, including nursing, imaging, laboratory services, ambulatory care, and human resources. The shared vision and intention of the onsite leaders were to remove siloed leadership development in recognition that the complex healthcare system is truly an interprofessional effort. Interprofessional leaders from non-nursing departments have indirect and, at times, direct influence on the nursing departments' leaders, team members, and patients.

The HCL-HC program included the following: 1) 9-month web-based HCL-HC program with six levels of "Learn-Do-Inspire" microlearning activities designed to activate learning within a community; 2) live onsite/virtual learning labs every 2 weeks for a total of 18 1-hour interactions that complemented the online content topics, such as shared leadership, professional development plans, certification, mindfulness, self-awareness, self-compassion, resilience, peer coaching, and more; and 3) monthly onsite coaching and mentoring by HCL-HC experts and trainers to facilitate

Figure 2: Human-Centered Leadership in Healthcare program blueprint



integration of the dimensions. See *Figure 2* for a timeline and overview.

Please note that although the HCL-HC program included interprofessional leaders, the focus of this particular pilot study was to assess AACN HWE standards within the five nursing departments. Other metrics included leader retention rates and nursing retention/turnover. The five nursing departments included in the project were the ED, Surgical Services, Acute Care, Women's Services—Labor and Delivery/Mother-Baby/Nursery, and the ICU. Managers from all departments except the ICU took part in the HCL-HC 9-month leadership program. During the tenure of the HCL-HC program, which coincided with multiple pandemic surges, there wasn't a dedicated ICU manager in place. Due to the pandemic's associated increase in volume and acuity, the team lead acted as an informal leader with oversight by the CNO. This provided an informal control group for the project.

The AACN HWE assessment was administered pre- and post-implementation to measure potential change in the six standards: skilled communication, true collaboration, effective decision-making, appropriate staffing, meaningful recognition, and authentic leadership.[20] The AACN HWE survey consists of 18 items and respondents were asked to indicate their level of agreement or disagreement with each statement using a 5-point Likert-type scale (1 = strongly disagree; 5 = strongly agree). Responses were anonymous; the only demographic information collected was the home department of the respondent. Mean scores were computed for each of the six standards for each nursing department. The mean scores were interpreted as follows: 4.00 to 5.00 = excellent; 3.00 to 3.99 = good; and 1.00 to 2.99 = needs improvement. The AACN HWE assessment is a valid and reliable instrument widely used in healthcare.[20,21]

Results

Prior to implementation of the HCL-HC program, the AACN HWE assessment was completed in five nursing departments whose leaders took part in the program with a 55% response rate (n = 74).[20] The results revealed the following areas for improvement: 1) Surgical Services: skilled communication, meaningful recognition;

3) ED: meaningful recognition; 4) Acute Care: meaningful recognition; 5) Women's Services: meaningful recognition; and 6) ICU: meaningful recognition. The common focus across all departments was to address ways to meaningfully recognize the team members and implement a communication plan that highlighted transparency and timeliness. Post-implementation, the AACN HWE survey was again administered with a 61% response rate (n = 69). Across all five departments, staff identified an improvement in meaningful recognition and skilled communication (see *Table 2*). As the pandemic continued, it was quite a milestone to move these two metrics in a positive direction. Two departments, Acute Care and Women's Services, improved in all six standards of the AACN HWE assessment, whereas Surgical Services improved in five of the six standards and the ED improved in two of the six standards. The ICU was the only department that didn't have any improvement in any of the six standards. See *Table 2* for detailed results for each department.

Pre-implementation, the leadership turnover rate in the previous calendar year was 60% in the manager and above category for all interprofessional leaders. Post-implementation, only 3 of the 20 interprofessional leaders who took part in the HCL-HC program left their roles, which equates to a reduction in turnover from 60% to 15%. In the nurse leader category (n = 8), two nurse leaders chose to leave the organization in the last month of the HCL-HC program. Pre-implementation, the staff nurse turnover rate was 15% and this rate remained consistent at mid-implementation and post-implementation, which is considered a positive outcome in light of the pandemic's effect on the nursing workforce across the nation.

Two departments improved in all six standards of the AACN HWE assessment, one department demonstrated improvement in five of the six standards, and another department improved in two of the six standards.

Discussion

The two aims of the project were partially met. The first aim was to test the potential influence a relational leadership style such as HCL-HC can have on staff perceptions of work environment, nurse retention, and nurse leader turnover. The nursing departments whose managers took part in the HCL-HC program over a sustained 9-month period with onsite coaching, learning labs, and the accompanying hybrid online program showed significant improvement in the two target areas identified pre-implementation: skilled communication and meaningful recognition. Two departments improved in all six standards of the AACN HWE assessment, one department demonstrated improvement in five of the six standards, and another department improved in two of the six standards. Upon implementation of the program, the ICU manager position had just been vacated, and the stop-gap measure was to have the dayshift team leader act as the informal and interim leader with oversight by the CNO. Because the ICU didn't have a leader participating in the HCL-HC program, a natural control group emerged. The ICU was the only department that didn't have any improvement in any of the six standards.

Another noteworthy finding, considering the significant increase in patient volume and acuity during the pandemic, is that the AACN HWE standard of appropriate staffing increased in all departments except the ICU. This reflects local and organizational focus on and prioritization of ensuring safe staffing standards and safe patient care.

The second aim was to test the recently developed theory of HCL-HC against proposed outcomes identified in the theory such as nurse retention and nurse leader turnover. This aim was partially met with the ability to

Table 2: Pre- and post-implementation results for AACN (2016) Healthy Work Environment Standards

Pre-implementation AACH HWE assessment			
Unit	**Assessments sent**	**Number of responses**	**Response rate**
Acute Care	45	34	76%
ED	44	17	39%
ICU	9	4	44%
Women's Services	20	13	65%
Surgical Services	12	6	58%
TOTAL	130	74	55%
Post-implementation AACH HWE assessment			
Unit	**Assessments sent**	**Number of responses**	**Response rate**
Acute Care	41	31	76%
ED	52	9	17%
ICU	7	6	86%
Women's Services	23	12	52%
Surgical Services	15	11	73%
TOTAL	137	69	61%
AACN HWE standard	**Pre-implementation aggregate mean score**	**Post-implementation aggregate mean score**	
Acute Care			
Skilled communication	3.8	4.1	
True collaboration	3.64	3.99	
Effective decision-making	3.89	4.02	
Appropriate staffing	3.69	3.99	
Meaningful recognition	3.51	3.77	
Authentic leadership	4.01	4.13	
SUMMARY SCORE	3.76	4.0	
ED			
Skilled communication	3.57	3.48	
True collaboration	3.43	3.19	
Effective decision-making	3.47	3.44	
Appropriate staffing	3.45	3.59	
Meaningful recognition	2.78	3.48	
Authentic leadership	3.82	3.59	
SUMMARY SCORE	3.42	3.46	
ICU			
Skilled communication	3.75	2.78	
True collaboration	3.67	2.72	
Effective decision-making	3.33	2.94	
Appropriate staffing	2.83	2.5	
Meaningful recognition	2.67	2.61	
Authentic leadership	3.5	2.83	
SUMMARY SCORE	3.29	2.73	
Women's Services			
Skilled communication	2.92	3.64	
True collaboration	2.92	3.28	
Effective decision-making	3.36	3.53	
Appropriate staffing	2.85	3.14	
Meaningful recognition	2.38	3.31	
Authentic leadership	3.38	3.86	
SUMMARY SCORE	2.97	3.46	
Surgical Services			
Skilled communication	3.44	3.88	
True collaboration	3.61	3.39	
Effective decision-making	3.44	3.85	
Appropriate staffing	2.83	4.15	
Meaningful recognition	2.61	3.39	
Authentic leadership	3.67	4.03	
SUMMARY SCORE	3.27	3.78	

test specific metrics associated with the AACN HWE standards, leader turnover, and nurse retention, but not all metrics associated with the theory's expected culture change were measured.[20]

For example, the Awakener aims to create a Culture of Excellence through cultivating team members to develop a professionally prepared workforce resulting in market-leading patient outcomes. Although certain metrics such as reduced leader turnover and steady nurse retention were measured, a more informal and less quantifiable improvement in professional preparation was achieved through individual leader coaching sessions around the AACN HWE standards. Although the Awakener also aims for market-leading patient outcomes, the focus of this study was on the leaders' development and the subsequent effect on the teams and their work environment.

The Connector seeks to build a Culture of Trust with a resulting healthy work environment for all, which means the healthcare team, patients, and families. The improved metrics in all six AACN HWE standards illustrate success in testing the conceptual dimensions of the Connector's aim to create a healthy work environment.

Finally, the Upholder intends to create a Culture of Caring by recognizing the humanity in self and others, leading to an exceptional experience for all, which again means the patients, families, and team members. This metric was partially met through the positive improvement in the AACN HWE standards of skilled communication and meaningful recognition. Patient experience scores remained consistently above benchmark throughout the program. During the 9-month journey to integrate HCL-HC, this rural health system embraced the relational and self-care dimensions of the Awakener, Connector, and Upholder (see *Figure 1*). What follows are brief, anecdotal examples of how the leaders operationalized the attributes of each dimension:

Awakener. The interprofessional leaders involved in the HCL-HC program developed and rolled out a clinical ladder program for RNs, LPNs, nursing assistants, and ancillary frontline staff such as respiratory therapists. Meaningful recognition programs, both formal and informal, were developed to highlight the contributions of team members. Each department leader crafted a unique approach to meaningful recognition designed to align with the culture. For example, one leader distributed a "Favorites" form to every team member to better understand how each person preferred to be recognized with simple yet meaningful concepts such as your favorite food or your "words to live by." This particular leader used the information to plan unique ways to celebrate each employee. Another example was the implementation of a formal recognition program using the DAISY award.

Connector. The interprofessional leaders who took part in the HCL-HC program built unity through community by engineering a unique model of professional governance that spanned all disciplines and departments. The steering committee aimed to infuse concepts of shared leadership by minimizing bureaucracy, developing trust, and communicating transparently. The committee also strategically and thoughtfully worked to identify emerging leaders at the point of service to provide a voice around environment, self-care, and process improvement.

Authentic communication was addressed by the CNO and each of the interprofessional managers as they implemented a structured, yet customized, communication plan based on the individual needs and characteristics of each department. Leaders used huddles, a newly developed "communication board," and mindful rounding to garner the voice of the team members on how best to communicate department and organizational information with urgency, transparency, and timeliness. Each leader crafted a unique plan using a combination of venues, including the organization's Workplace by Facebook platform and "Let's fix it!" boards, to track progress toward staff-identified issues.

For example, the ED nurses identified a consistent issue with the medication scanners being inoperable or lacking the Wi-Fi bandwidth necessary to remain in compliance with expected safety standards. The team worked alongside the nurse leader to identify the problem and develop a solution that included acquiring wired scanners until the information technology staff could address the network problem.

An example of transparent communication using Workplace by Facebook included the implementation of virtual huddles,

allowing team members to attend a live huddle or view a recording of it later. This venue provided real-time dissemination of vital information to all staff members. Leaders and staff members noted an improvement in timeliness, urgency, and transparency of communication.

Upholder. Leaders implemented innovative ideas to uphold and recognize their team members. One leader shifted staffing time frames to meet staff needs and patient volumes, and another leader created a beverage station with an espresso and shaved ice machine based on employees' "Favorites." One leader modeled self-care by prioritizing regular exercise and dedicated time "off stage," communicating this to his staff and expecting the same from them, whether it was time with their families, crafts, or quiet pauses to reflect. This expectation wasn't just a flavor of the day; rather it became an expectation for the staff to rest and rejuvenate so they could be better humans with their families, colleagues, and patients, and most importantly, with themselves.

Lessons learned

Many lessons were learned from this implementation of HCL-HC, with the following being the most salient. First, buy-in from leaders such as the CNO and CEO is vital to success. When an organization is being led in a way that highlights and celebrates the human-centered nature of our business through a relational approach, success is organic, and team members will naturally align with the organization's objectives and goals.

Second, consistent communication and onsite connections between the HCL-HC trainers and the hospital's participant leaders were vital to developing trusting relationships. The 18 onsite/virtual learning labs covering a diverse range of topics generated relationships that grew into trusting and safe venues for sharing and growth. Peer coaching by the HCL-HC trainers also influenced success with programs such as the Clinical Ladder and Shared Leadership.

Third, the hybrid approach of micro-learning on a web-based platform with a "Learn-Do-Inspire" methodology, alongside the learning labs and onsite coaching, proved to be a formula for sustained integration or, as healthcare leaders like to say, "hardwiring" of the dimensions and resulting cultures and outcomes.

Limitations

Application to other settings and generalizability. Although the setting for this project was a small rural hospital system, the culture and environment reflect the larger region and the nation. Their issues were no different than the core challenges faced by larger urban hospitals: turnover, unhealthy work environments, leaders overwhelmed by the challenges caused by the pandemic, and low morale. HCL-HC, as a shared approach among an interdisciplinary team, proved fruitful in the shift from a stagnant work environment to a healthy and growth-oriented culture (Awakener); from a less-than-transparent culture to a trusting culture with a voice at the point of service (Connector); and from a transactional culture to a relational, caring culture (Upholder).

HCL-HC is a universal approach that focuses on the human capacity to embrace the dimensions rather than the size of the facility, county, state, or country. In fact, HCL-HC is currently being implemented within two larger organizations, one a university hospital setting and the other a large multi-state organization. The testing of the theory must continue in hospitals and organizations of all sizes and shapes.

Data methodology. The AACN HWE online assessment is limited to reporting means rather than raw data unless users obtain specific permissions from AACN, which didn't occur in this project.[20] Using means rather than raw data limits the ability to establish statistical significance, which affects the reliability of the study results.[22] In contrast to statistical significance, this project and its results can, with confidence, establish clinical significance. Clinical significance reflects the impact of an intervention or program on clinical practice.[22] In future studies, raw data will be collected to explore statistical significance as the primary authors have obtained the necessary permissions from AACN to collect raw data.[20]

Build relationships to build culture

HCL-HC resonates with diverse and interprofessional healthcare providers, not only nurses. It's an approach that resonates with anyone who's in the business of caring for humans. Considering the challenges and chaos in healthcare settings across the

globe, HCL-HC is a structured and straightforward way to shift the focus back to a place many have longed to return to: recognizing humanity in ourselves and in others.

For those who worry about the metrics and results getting lost in this approach, interestingly, the prized metrics organically follow a leader who's solidly grounded in a human-centered, relational approach. The leaders at the rural Louisiana hospital system in which HCL-HC was implemented, specifically the CEO, will tell you HCL-HC is founded on "evidence-based truths" and "not only gives permission, but sets the expectation, that creativity, growth, and innovation are no longer what the few, elite organizations do, but are requirements for any organization's health and survival. Human-Centered Leadership is a timely and essential investment in leaders—in any position and organizational culture—in any industry." NM

REFERENCES

1. Berlin G, Lapointe M, Murphy M, Viscardi M. Nursing in 2021: retaining the healthcare workforce when we need it most. *McKinsey Insights*. 2021. www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/nursing-in-2021-retaining-the-healthcare-workforce-when-we-need-it-most.
2. Chan GK, Bitton JR, Allgeyer RL, Elliott D, Hudson LR, Moulton Burwell P. The impact of COVID-19 on the nursing workforce: a national overview. *Online J Issues Nurs*. 2021;26(2):1-17.
3. Raso R, Fitzpatrick JJ, Masick K. Nurses' intent to leave their position and the profession during the COVID-19 pandemic. *J Nurs Adm*. 2021;51(10):488-494.
4. American Organization of Nurse Leaders. AONL COVID-19 longitudinal study August 2021 report: nurse leaders' top challenges, emotional health, and areas of needed support, July 2020 to August 2021. 2021. www.aonl.org/system/files/media/file/2021/09/AONL COVID-19 Longitudinal 3 Written Report.pdf.
5. Brusie C. Survey of healthcare workers reveals high levels of burnout, stress, & thoughts of leaving their jobs. Berxi. 2021. www.berxi.com/resources/articles/state-of-healthcare-workers-survey.
6. Kennedy K, Leclerc L, Campis S. *Human-Centered Leadership in Healthcare: Evolution of a Revolution*. New York, NY: Morgan James; 2021.
7. Leclerc L, Kennedy K, Campis S. Human-centered leadership in health care: a contemporary nursing leadership theory generated via constructivist grounded theory. *J Nurs Manag*. 2021;29(2):294-306.
8. Porter-O'Grady T, Malloch K. *Quantum Leadership: Creating Sustainable Value in Health Care.* 5th ed. Burlington, MA: Jones & Bartlett Learning, LLC; 2018.
9. Fischer SA. Transformational leadership in nursing: a concept analysis. *J Adv Nurs*. 2016;72(11):2644-2653.
10. Giordano-Mulligan M, Eckardt S. Authentic nurse leadership conceptual framework: nurses' perception of authentic nurse leader attributes. *Nurs Adm Q*2019;43(2):164-174.
11. Liao C, Lee HW, Johnson RE, Lin S. Serving you depletes me? A leader-centric examination of servant leadership behaviors. *J Manage*. 2021;47(5):1185-1218.
12. Raso R, Fitzpatrick J, Masick K. Clinical nurses' perceptions of authentic nurse leadership and healthy work environment. *J Nurs Adm*. 2020;50(9):489-494.
13. Crowell DM. *Complexity Leadership: Nursing's Role in Health-Care Delivery.* 2nd ed. Philadelphia, PA: F.A. Davis Company; 2016.
14. CFAR, Inc., Tomasik J, Fleming C, Lessons from the field: promising interprofessional collaboration practices. Robert Wood Johnson Foundation. 2015. www.rwjf.org/content/dam/farm/reports/reports/2015/rwjf418568.
15. D'emeh WM, Yacoub MI, Shahwan BS. Work-related stress and anxiety among frontline nurses during the COVID-19 pandemic: a cross-sectional study. *J Psychosoc Nurs Ment Health Serv*. 2021;59(8):31-42.
16. Murat M, Köse S, Savaşer S. Determination of stress, depression, and burnout levels of front-line nurses during the COVID-19 pandemic. *Int J Ment Health Nurs*. 2021;30(2):533-543.
17. Vivian E, Oduor H, Arceneaux SR, Flores JA, Vo A, Madson Madden B. A cross-sectional study of perceived stress, mindfulness, emotional self-regulation, and self-care habits in registered nurses at a tertiary care medical center. *SAGE Open Nurs*. 2019;5:2377960819827472.
18. Abdollahi A, Taheri A, Allen KA. Perceived stress, self-compassion, and job burnout in nurses: the moderating role of self-compassion. *J Res Nurs*. 2021;26(3):182-191.
19. Nelson JW, Felgen J, Hozak MA. *Using Predictive Analytics tolimprove Healthcare Outcomes.* Hoboken, NJ: John Wiley & Sons, Inc.; 2021.
20. American Association of Critical-Care Nurses. AACN standards for establishing and sustaining healthy work environments: a journey to excellence, 2nd ed. 2016. www.aacn.org/WD/HWE/Docs/HWE Standards.pdf.
21. Connor JA, Ziniel SI, Porter C, et al. Interprofessional use and validation of the AACN healthy work environment assessment tool. *Am J Crit Care*. 2018;27(5):363-371.
22. Ranganathan P, Pramesh CS, Buyse M. Common pitfalls in statistical analysis: clinical versus statistical significance. *Perspect Clin Res*. 2015;6(3):169-170.

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