

Pizza Parties Don't Fix Broken Systems

Why clinical staff need operational competence from hospital leadership

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If your strategy for bridging the gap with clinical staff involves a catered lunch or a “heroes work here” banner, you have already lost them. Frontline healthcare workers do not want performative appreciation; they want operational competence.

A sincere thank-you matters. So does a meal during a difficult shift. But neither repairs the equipment that keeps failing, provides relief for an exhausted nurse, or gives a technologist enough time to complete an examination safely. Appreciation becomes hollow when leadership celebrates the people absorbing operational failures while leaving those failures intact.

Consider a hypothetical imaging department. The schedule ignores examination complexity. Incomplete orders arrive at the last minute. Transport is unavailable. Staff repeatedly interrupt patient care to chase information that should have been collected upstream. The department finishes the day through overtime, improvisation, and missed breaks. The next morning, leadership congratulates everyone for their flexibility.

What, exactly, has the organization rewarded? It has rewarded employees for concealing the true cost of a poorly designed process.

Tucker and Edmondson's foundational research examined how nurses responded to process failures in nine hospitals. Their analysis showed how everyday problem-solving can keep care moving while leaving the organization unable to learn from recurring failures (Tucker & Edmondson, 2003). The practical lesson remains uncomfortable: when capable people repeatedly rescue a broken process, their competence can make the underlying failure harder for leadership to see.

Hospitals should thank people for extraordinary effort. They should also investigate why extraordinary effort has become an ordinary assumption in staffing.

The usual engagement exercise can miss this distinction. Employees answer questions, consultants produce a benchmark, and managers receive a score. Yet a hospital can learn that staff is frustrated without identifying which operational decisions are causing that frustration.

First, broad questions can conceal specific failures. An employee might strongly believe in the organization's mission while lacking reliable equipment or adequate support. Pride, commitment, burnout, and intention to stay are different constructs. Combining them into one favorable percentage can obscure a workforce that still cares deeply but is struggling to continue.

Second, hospital averages can conceal the conditions of a particular shift. Daytime administrative staff, emergency nurses, night-shift technologists, and transport personnel do not experience the same workplace. A reassuring organizational average should never close an investigation into a department's repeated missed breaks, unresolved safety concerns, or deteriorating staffing. Examine meaningful differences by role, location, and shift while protecting confidentiality in small groups.

Third, asking for candor does not establish that candor is safe. Leaders should examine whether employees expect retaliation, are identified through free-text comments, or have their concerns dismissed. Low participation can be explained by several factors, including time pressure and survey burden. Treat it as a reason to investigate, rather than proof that employees are disengaged or satisfied.

Fourth, collecting feedback can become a substitute for making decisions. Huebner and Zacher’s systematic review identified follow-up and action planning as important, frequently neglected parts of the employee survey process. It also emphasized the resources managers need to support change (Huebner & Zacher, 2021). A manager cannot solve a staffing establishment, purchasing restriction, or broken enterprise technology system with a departmental morale committee.

Well-designed questionnaires remain useful. The failure occurs when leadership treats a measurement exercise as the intervention. Human resources can help assess the problem, but executives and operational leaders must own the decisions needed to address it.

This is the work the **Emrick Employee Engagement Model** is designed to organize. Its published structure connects **foundations, growth drivers, and results**. Foundations include psychological safety, adequate staffing, dependable tools, and fair compensation. Growth drivers include professional development, autonomy, shared governance, and recognition. Results include retention, patient experience, clinical quality, and financial sustainability (Emrick, n.d.).

The sequence establishes a practical leadership priority: investigate the conditions under which people work before asking them to demonstrate greater commitment. Development and recognition can proceed alongside repairs, but they cannot compensate for unresolved safety risks or an unmanageable workload.

The broader framework adapts the Irresistible Organization approach to healthcare through six domains (Emrick, 2026): Meaningful Work, Hands-On Management, Positive Environment, Health and Wellbeing, Growth Opportunity, and Trust in Leadership. The table translates those domains into operational questions and proposed evidence for local review. These are practical applications of the framework, not validated scoring thresholds.

Table 1. Translating the Emrick framework into observable leadership responsibilities

Model domain	Question leadership must answer	Evidence to examine
Meaningful Work	Can clinicians use their skills and judgment effectively?	Avoidable rework, task allocation, participation in care decisions
Hands-On Management	Do managers remove recurring barriers?	Issue age, escalation response, staff-confirmed resolution
Positive Environment	Can staff challenge decisions and report problems safely?	Confidential feedback, handling of concerns, recurring incivility
Health and Wellbeing	Does work permit safe performance and recovery?	Missed breaks, overtime, fatigue reports, staffing relative to demand
Growth Opportunity	Can employees actually access development?	Protected learning time, access across shifts, transparent advancement
Trust in Leadership	Do commitments produce visible action?	Dated commitments, explained delays, verified completion

Source: Domains from Emrick’s published framework; operational questions and evidence examples are recommendations developed for this article.

In practice, meaningful work requires protecting time for patient care. Hands-on management requires leaders to understand where work breaks down. A positive environment requires respectful challenge and a

credible response to concerns. Wellbeing requires attention to workload and recovery. Growth requires opportunities that staff can actually use. Trust requires leaders to do what they said they would do, or explain openly why circumstances changed.

Fair compensation belongs in that discussion. So do equipment reliability, physical safety, and the staffing needed to cover essential tasks. Employees should not have to trade these fundamentals for a compelling mission statement.

The model should be judged by its usefulness in organizing improvement and by outcomes measured during implementation. It should not be presented as a clinically proven cure or a validated predictor of patient outcomes without supporting studies. A framework earns credibility through testing and transparent reporting.

There is substantial reason to take the underlying workplace problems seriously. Li and colleagues' 2024 meta-analysis included 85 studies involving 288,581 nurses. Burnout was associated with poorer patient safety, lower patient satisfaction, and lower assessed quality of care. However, 81 studies were cross-sectional, limiting causal inference (Li et al., 2024). Those findings support treating workforce conditions as a quality concern. They do not justify blaming exhausted clinicians for system failures.

More recent evidence examines organizational change directly. The Magnet4Europe evaluation, published in the February 2026 issue of Medical Care, studied 56 hospitals across six European countries. Greater implementation of organizational changes was associated with improvements in several nurse-reported outcomes. In the group with the largest implementation gains, burnout declined by 6.3 percentage points and intention to leave by 7.6 percentage points (Aiken et al., 2026). The study was quasi-experimental, used hospitals as their own controls, and relied on nurse reports. It supports the promise of work-environment redesign without proving that every intervention will transfer unchanged to American hospitals.

For an executive, the next step should be concrete. Ask staff: **What repeatedly prevents you from providing the care you know this patient needs?** Then ask them to describe the last time it happened. How often does it recur? Who becomes involved? What is delayed? What workaround keeps the service running?

In radiology, this might reveal repeated protocol clarification, missing authorization information, unavailable transport, unreliable equipment, or schedules that ignore patient assistance needs. In nursing, it might reveal missing supplies, delayed medications, inadequate support, or care left unfinished due to competing demands exceeding available time. These examples are starting points for investigation, not assumptions about every department.

Use short, confidential staff assessments alongside direct observation and operational records. Neither self-reports nor dashboards tell the whole story on their own. Track the burden of a recurring problem, including its frequency, time cost, impact on patients, and distribution across shifts. Count care interruptions as well as completed examinations. Examine actual turnover separately from intention to leave.

Then make leadership's response visible. For each priority problem, identify a responsible owner, the authority and resources required, an expected completion date, and a measure of improvement. Escalate barriers that exceed a department manager's control. Let the staff who encounter the problem verify whether the repair works before declaring it resolved.

A closed ticket is insufficient evidence if the same workaround continues every night.

I would begin with a 30-day operational review. During the first week, listen across shifts and examine the work. In the second, select a small number of consequential recurring barriers and assign ownership. Use the remaining weeks to test repairs and report what changed, what remains unresolved, and what requires

executive action. Address immediate safety risks as soon as they are identified. The 30-day schedule is a proposed starting discipline, not a validated implementation standard.

Be honest about constraints. Some repairs require capital, recruitment, negotiation, or changes outside the hospital. Leadership credibility depends on explaining those constraints, choosing interim protections, and returning with updates. It does not require pretending every problem has a quick solution. It does require refusing to let every difficult problem disappear into a committee.

The test is straightforward: **Can employees point to something that became safer, more reliable, or less burdensome because they spoke up?**

Keep the thank-you. Make the lunch welcoming. Recognize the people who deliver excellent care under difficult circumstances. Then repair the conditions that keep making those circumstances unnecessarily difficult.

Pizza parties do not fix broken systems. Leaders are responsible for the repair.

What recurring operational problem would your clinical team most want leadership to fix this month?

References

Aiken, L. H., Sermeus, W., Lasater, K. B., Busse, R., McKee, M., Smith, H., Drennan, J., Maier, C. B., Ball, J., Dello, S., Kohnen, D., Lindqvist, R., Lerdal, A., Griffiths, P., Schaufeli, W. B., De Witte, H., Eriksson, L. E., Rafferty, A. M., Köppen, J., ... McHugh, M. D. (2026). Magnet4Europe intervention to improve clinician and patient well-being: A quasi-experimental study of 56 hospitals in 6 European countries. *Medical Care*, 64(2), 50–58.

<https://doi.org/10.1097/MLR.0000000000002257>

Emrick, K. (n.d.). The Emrick Employee Engagement Model. <https://kellyemrick.com/the-emrick-employee-engagement-model/>

Emrick, K. (2026). The healthcare employee engagement model that gets results: A strategic framework for performance, retention, and patient experience [Author-published framework report].

<https://kellyemrick.com/wp-content/uploads/2026/01/The-Healthcare-Employee-Engagement-Model-that-Gets-Results.pdf>

Huebner, L.-A., & Zacher, H. (2021). Following up on employee surveys: A conceptual framework and systematic review. *Frontiers in Psychology*, 12, Article 801073. <https://doi.org/10.3389/fpsyg.2021.801073>

Li, L. Z., Yang, P., Singer, S. J., Pfeffer, J., Mathur, M. B., & Shanafelt, T. (2024). Nurse burnout and patient safety, satisfaction, and quality of care: A systematic review and meta-analysis. *JAMA Network Open*, 7(11), Article e2443059. <https://doi.org/10.1001/jamanetworkopen.2024.43059>

Tucker, A. L., & Edmondson, A. C. (2003). Why hospitals don't learn from failures: Organizational and psychological dynamics that inhibit system change. *California Management Review*, 45(2), 55–72.

<https://doi.org/10.2307/41166165>