Symbiosis College of Nursing (SCON)

REPORT
CPD Programme: Leadership and Conflict Management in Hospital Settings

Organized by: Department of Medical Surgical Nursing, Symbiosis College of Nursing
Institution: Symbiosis International (Deemed University), Pune
Date: April 15, 2026
Venue: Moringa Auditorium, SUHRC Building, Lavale Campus, Pune

Executive Summary
The Continuous Professional Development (CPD) programme on "Leadership and Conflict Management in Hospital Settings" was conducted to address critical, non-clinical competencies required for modern healthcare professionals. The programme brought together experts to discuss leadership styles, ethical accountability, patient aggression management, burnout prevention, interprofessional communication, and conflict resolution. The core objective was to equip nurses and allied healthcare workers with practical frameworks to enhance patient safety, improve team dynamics, and foster personal resilience.

Comprehensive Descriptive Report on the CPD Programme: Leadership and Conflict Management in Hospital Settings
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Institution: Symbiosis International (Deemed University), Pune
Date: April 15, 2026
Venue: Moringa Auditorium, 4th Floor, SUHRC Building No. 2, Lavale Campus, Pune
Accreditation: 10 CPD Points by Maharashtra Nursing Council, Mumbai

Programme Overview & Inaugural Session (08:30 – 09:00 AM & 11:15 AM – 12:00 Noon)
The day began with the registration of participants followed by a pre-test designed to assess the baseline knowledge of attendees regarding leadership principles, ethical decision-making, conflict resolution, and communication strategies. The formal inaugural ceremony took place mid-morning, setting the tone for the programme. The ceremony emphasized that in contemporary healthcare, clinical expertise alone is insufficient; nurses and allied professionals must also possess robust leadership, communication, and conflict management skills to ensure patient safety, reduce medical errors, and prevent staff burnout. The inaugural address highlighted that leadership is no longer confined to administrative roles but is expected at every level of patient care.

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Technical Session I: Decision Making and Leadership
Time: 09:00 AM – 09:45 AM
Speaker: Dr. Sonopant Joshi, Professor & Director, Symbiosis College of Nursing
Descriptive Summary:
Dr. Sonopant Joshi opened the first technical session by drawing a clear and practical distinction between management and leadership. He articulated that while management is concerned with checklists, tasks, and procedures—the "to-do" concept—leadership is fundamentally about motivation, inspiration, and achieving extraordinary outcomes through people. He stated that in the modern healthcare environment, power has shifted toward patients and clients, technology has created a global village, and knowledge has become the new currency. In this fragmented and often cynical world, leaders must base their actions on evidence, practices, and inspiration.

The core of the session revolved around matching leadership styles to specific situational demands. Dr. Joshi introduced a strategic framework plotted on two axes: **urgency** and **team input needed**.

- **Autocratic Style ("Decide and Announce"):** He described this as the fastest decision-making method, suitable only for crisis situations such as active cardiac arrests, security breaches, or regulatory compliance mandates. The leader retains full control, and communication flows top-down without deliberation.
- **Democratic Style ("We Decide Together"):** This approach involves majority vote or consensus building. While slow and sometimes prone to "analysis paralysis," it generates high ownership and is ideal for culture change initiatives or complex problems where no single leader holds all the data.
- **Consultative Style ("I Seek Input, Then I Decide"):** Dr. Joshi identified this as the most versatile and effective style for most clinical situations. The leader actively solicits open-ended input from the team, listens genuinely, but retains final decision-making authority. This approach ensures team members feel heard without entitlement to a vote.
- **Delegative Style ("You Decide"):** Reserved for subject matter experts, senior researchers, or highly autonomous teams. The leader provides tools, budget, and boundaries, then steps back. The speaker warned that without clear accountability, delegation becomes abdication. Dr. Joshi concluded by listing essential leadership qualities: decisiveness, integrity, enthusiasm, imagination, willingness to work hard, analytical mind, emotional stability, human relations skills, and the ability to adapt to change. He famously contrasted a boss who "drives his men, depends on authority, and evokes fear" with a leader who "inspires, depends on goodwill, and radiates love." The session ended with reflective questions for participants: *What are my strengths and weaknesses? How can I inspire my team? How do I put more joy and celebrations into motivating my team?*

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Technical Session II: Ethical Leadership & Professional Accountability
Time: 09:45 AM – 10:30 AM
Speaker: Dr. Supriya Pottal Ray, Associate Professor, Bharati Vidyapeeth (Deemed to be University), College of Nursing, Pune
Descriptive Summary:
Dr. Supriya Pottal Ray delivered a profound session on the moral foundations of nursing leadership. She began by defining ethical conduct succinctly as "doing the right thing even when no one is watching." This includes adhering to nursing codes, ensuring patient safety, being transparent about risks and errors, and respecting cultural and workplace diversity. She then distinguished between *responsibility* (the obligation to perform a task) and *accountability* (being answerable for the outcome of that task). Accountability, she emphasized, is not about punishment but about ownership and growth.
The session was structured around the core pillars of bioethics:

- **Autonomy:** Respecting the patient's right to make their own decisions.
- **Beneficence:** Acting in the best interest of the patient.
- **Non-maleficence:** The fundamental principle of "do no harm."
- **Justice:** Ensuring fairness in care and resource distribution.
- **Fidelity:** Keeping one's word to patients with honesty and loyalty.
- **Veracity:** Being completely open and honest with patients, even when the truth causes distress.

Dr. Pottal Ray introduced the concept of a **"Just Culture"** —a system that moves away from blame and shame toward identifying systemic failures while still holding individuals accountable for reckless behavior. She explained that this approach increases the reporting of near misses, which ultimately improves patient safety.
A significant portion of the session was dedicated to the **Participative Ethical Decision-Making (PEDM) model**, a seven-step framework: (1) Identify the concern, (2) Involve stakeholders, (3) Review professional standards, (4) Identify patient values, (5) Review aims and emotions, (6) Select ethical framework, and (7) Decide and act.
The speaker illustrated the model with a compelling case study: *Mr. Patil, a 72-year-old with chronic kidney disease and severe sepsis, who consciously refuses intubation and dialysis despite his distraught daughter insisting on life-saving measures.* Dr. Pottal Ray walked participants through the ethical conflict between Autonomy and Beneficence, the need for formal capacity assessment, facilitating a family meeting to explain that respecting the father's wishes is the highest form of advocacy, and shifting the care plan to palliative support if the refusal stands. Additional case scenarios included medication errors (requiring immediate reporting and transparency), confidentiality breaches, end-of-life care, resource allocation for a single ICU bed, and professional misconduct among colleagues.

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Technical Session III: De-escalation & Safety – Managing Aggressive Patients in the Clinical Setting

Time: 10:30 AM – 11:15 AM

Speaker: Dr. Manisha Mistry, Assistant Professor, Symbiosis College of Nursing

Descriptive Summary:

Dr. Manisha Mistry addressed one of the most challenging realities of hospital practice: managing aggressive patients and relatives. She opened with alarming statistics: healthcare workers are four times more likely to require time off due to workplace violence than workers in private industry, yet only about 30% of incidents are formally reported. Common triggers include long emergency department wait times, delirium, dementia, substance withdrawal, traumatic brain injury, hypoxia, and fear-induced loss of control.

The session was anchored in the **Aggression Cycle**, a five-phase model:

1. **Triggering Phase:** Baseline stressor appears.
2. **Escalation Phase:** Anxiety rises, voice changes, early warning signs emerge.
3. **Crisis Phase:** Verbal threats or physical assault occur.
4. **Recovery Phase:** Patient returns to baseline with possible confusion or remorse.
5. **Post-Crisis Depression Phase.**

Dr. Mistry emphasized a critical clinical point: *Intervention is most effective in Phases 1 and 2. Once Phase 3 (Crisis) is reached, safety trumps communication.*

Participants learned to recognize early warning signs: non-verbal cues such as clenched fists, pacing, flushed face, glaring stare, and invasion of personal space; verbal cues such as louder or higher-pitched voice, rapid speech, swearing, or threatening language.

The speaker introduced the **"5 S's" for Prevention** before entering a room with a known agitated patient:

- **Scan:** Remove loose objects that could become weapons (scissors, IV poles, cords).
- **Stand:** Never block the door; always know your exit path.
- **Space:** Maintain an arm's length plus one step distance.
- **Support:** Do not see the patient alone; have a colleague nearby with the door open.
- **Silence:** Turn off loud TVs or alarms that may cause sensory overload.

For verbal de-escalation, Dr. Mistry provided a clear "Do This / Avoid This" table. Recommended actions included respecting personal space, listening actively, agreeing to disagree (e.g., "You're right, that wait was long"), setting calm limits, and offering choices. Actions to avoid included crossing arms, pointing fingers, matching the patient's volume, challenging logic during rage, threatening restraint, or cornering the patient.

The **non-verbal "PAL" Stance** was demonstrated:

- **Palms** up and visible to show no concealed weapon.
- **Angle** the body 45 degrees to the side to appear less confrontational.
- **Lower** center of gravity by sitting down if safe, reducing the power differential.

Physical restraint and chemical sedation were described as absolute last resorts, requiring physician orders (verbal in emergency, written within one hour), with monitoring of vital signs, circulation, skin integrity, and psychological status every 15 to 30 minutes. The session concluded with a post-incident debriefing protocol for staff, for the patient (once calm), and for objective documentation.

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Technical Session IV: Burnout & Resilience Among Healthcare Professionals – A Leader's Perspective
Time: 12:00 Noon – 12:45 PM
Speaker: Dr. Sheela Upendra, Deputy Director, Symbiosis College of Nursing
Descriptive Summary:
Dr. Sheela Upendra delivered a deeply insightful session on the silent epidemic of burnout in healthcare. She began by clarifying that burnout is not merely fatigue after a long shift; it is a clinical state characterized by three dimensions: **emotional exhaustion**, **depersonalization** (becoming detached or indifferent toward patients), and a **reduced sense of personal accomplishment**. She poetically described burnout as "when the body continues to work… but the mind and heart start to withdraw."
The speaker argued forcefully that burnout is not a personal problem but a **system and leadership issue**. It directly affects patient care, safety, and quality outcomes. Burnout leads to medication errors, low morale, staff absenteeism, and ultimately, nurses leaving the profession. Dr. Upendra warned that "ignoring burnout today will create a bigger crisis tomorrow" and that leaders have the power—and the duty—to create supportive environments.
She presented the root causes of burnout: excessive workload and staff shortages, long working hours without adequate rest, high emotional demands of patient care, administrative burden and documentation overload, lack of control or decision-making autonomy, poor work-life balance, inadequate leadership support, lack of recognition, and workplace conflicts.
The session then transitioned to **resilience**, which Dr. Upendra defined as the ability to adapt, recover, and stay strong during stress and challenges. She clarified that resilience is not about avoiding pressure but about staying steady within it. She emphasized both individual and **collective resilience**—the organizational capacity to support staff through difficult times.
Organizational strategies to foster resilience included: ensuring adequate staffing and fair workload distribution, reducing administrative burden, providing regular breaks and rest periods, offering mental health and wellness support programs, encouraging teamwork and peer support, providing formal training on stress management and resilience, and creating a positive, respectful work culture.
Dr. Upendra concluded with a powerful call to action: leaders must create a culture of well-being by promoting open communication and psychological safety, recognizing and appreciating staff regularly, supporting mental health without stigma, fostering teamwork and mutual respect, encouraging regular breaks and self-care, and most importantly—**leading by example**. She stated that leaders cannot expect staff to practice self-care if they themselves do not model it.

Technical Session V: Communication & Interprofessional Collaboration
Time: 12:45 PM – 01:30 PM
Speaker: Mrs. Ritika Dhasmana, Tutor, Symbiosis College of Nursing
Descriptive Summary:
Mrs. Ritika Dhasmana addressed the single most common contributor to adverse events in hospitals: **communication failure**. She opened with a provocative question to the audience: *"In the last six months, have you witnessed a near-miss or error caused by a breakdown in communication between nurses and doctors, pharmacy, or therapy?"* She then cited that communication failures are repeatedly identified as major contributors to serious adverse events and unsafe handoffs, with some studies suggesting that up to 80% of serious errors have communication at their root.
She emphasized that effective nursing communication is collaborative, explicit, and responsive to both the clinical situation and the perspectives of patients and other professionals. "If miscommunication is common," she stated, "then safer communication must become a clinical skill, not a personality trait."

Mrs. Dhasmana addressed the psychological barriers to speaking up: rigid hierarchies that make junior staff reluctant to question senior decisions, fear of backlash or embarrassment, and the need for team norms that prioritize psychological safety. She reminded participants that "silence is not agreement; silence may reflect hierarchy, uncertainty, or fear."

The session introduced several structured communication tools:

1. **Advocacy Plus Inquiry:** State what you see and what concerns you (advocacy), then invite the other clinician to explain their thinking (inquiry). For example, "I'm concerned about the potassium level and this dose. Help me understand how this dose is safe for this patient."
2. **The 2-Second Pause:** Before any communication, take two seconds to ask: *Am I clear? Is it urgent? Who else must know?* This simple habit prevents incomplete or misdirected messages.
3. **SBAR (Situation, Background, Assessment, Recommendation):** This structured framework reduces rambling and missing information. It pushes the nurse to make an assessment, not just report data, and ends with a clear recommendation so the call has a purpose. A comparative example showed how "Room 212 is breathing funny" (unstructured) fails to convey urgency, while "Mr. Jones is post-op day 1, SpO2 88% on 2L, has COPD, crackles, and JVD. I'm concerned about flash pulmonary edema. Please assess now" (SBAR) drives appropriate action.
4. **CUS (Concerned, Uncomfortable, Safety issue):** A three-step escalation framework for when initial concerns are ignored. Step 1: "I am concerned." Step 2: "I am uncomfortable." Step 3: "This is a safety issue." Each step increases in urgency.
5. **Two-Challenge Rule:** Assertively voice a concern at least two times in two different ways. If still ignored, the decision-maker must acknowledge the concern, and escalation to higher authority is justified.
6. **Closed-Loop Communication:** The receiver repeats the message back exactly as heard, and the sender confirms. "No task is complete until the sender hears their own message repeated back accurately."
7. **I-PASS for Shift Handoffs:** A standardized handoff tool covering Illness severity, Patient summary, Action list, Situation awareness, and Synthesis by receiver.

The session concluded with a commitment exercise: each participant pledged to use one new communication tool (SBAR, CUS, I-PASS, or closed-loop communication) within the coming week.

Technical Session VI: Conflict Management in Hospital Settings

Time: 01:30 PM – 02:15 PM

Speaker: Mr. Husain Nadaf, Assistant Professor, Symbiosis College of Nursing

Descriptive Summary:

Mr. Husain Nadaf delivered the final technical session on conflict management, using a powerful metaphor: the **Iceberg Model of Conflict**. He explained that visible conflicts—arguments, raised voices, open disagreements—are merely the tip of the iceberg. Beneath the surface lie much larger, hidden issues: unaddressed stress, excessive workload, conflicting values, poor communication channels, personality clashes, and systemic pressures. Effective conflict resolution, therefore, requires looking beyond the visible argument to address the submerged causes. Mr. Nadaf described nurses as sitting at the **intersection** of multiple stakeholders: patients, families, physicians, administrators, pharmacists, therapists, and support staff. This unique position makes nurses particularly vulnerable to conflict but also uniquely positioned to resolve it. He introduced the concept of **"filters"** —the personal and professional lenses (biases, past experiences, cultural backgrounds, stress levels) through which individuals interpret messages. He noted that while filters can distort communication, consciously acknowledging and managing them actually promotes teamwork.

The speaker outlined **six steps in conflict resolution** (as derived from his slides):

1. **Acknowledge the conflict** exists rather than avoiding it.

2. **Understand each party's perspective** using active listening.
3. **Identify the underlying needs and interests** beneath stated positions.
4. **Generate multiple options** for resolution.
5. **Agree on a mutually acceptable solution**.
6. **Document and follow up** to ensure lasting resolution.

Mr. Nadaf also discussed **natural defense mechanisms**—the internal toolkit individuals unconsciously use in high-stress situations, such as denial, rationalization, projection, or displacement. He encouraged participants to recognize these defense mechanisms in themselves and others, as unconscious defenses often escalate conflict. By bringing these mechanisms into conscious awareness, healthcare professionals can choose more constructive responses.

Several **conflict scenarios and solutions** were presented:

- **Nurse-Physician conflict** over a treatment plan: Use SBAR and the Two-Challenge Rule.
- **Nurse-Nurse conflict** over workload distribution: Use democratic leadership and transparent task allocation.
- **Nurse-Family conflict** over visiting hours or care decisions: Use empathetic listening, clear limit-setting, and offer choices where possible.
- **Interprofessional team conflict** (e.g., speech therapy, physical therapy, nursing, and physician all having conflicting priorities for the same patient): Use team huddles and structured communication tools to synthesize a unified plan.

The session emphasized that conflict, when managed well, can be constructive—leading to better problem-solving, innovation, and stronger team relationships. However, unresolved conflict leads to emotional exhaustion, medical errors, and staff turnover. Mr. Nadaf concluded that leaders must model healthy conflict resolution by remaining calm, listening actively, and separating people from problems.

Post-Test, Feedback, and Valediction (02:15 PM – 02:30 PM)

The programme concluded with a post-test to objectively measure knowledge gain from the six technical sessions. Participants then completed feedback forms, providing qualitative and quantitative assessments of each speaker, the relevance of topics to clinical practice, and suggestions for future CPD programmes.

Mrs. Harshita Bagewadi, Tutor at Symbiosis College of Nursing, delivered the formal vote of thanks. She expressed gratitude to:

The Maharashtra Nursing Council for accrediting the programme with 10 CPD points.

All speakers—Dr. Sonopant Joshi, Dr. Supriya Pottal Ray, Dr. Manisha Mistry, Dr. Sheela Upendra, Mrs. Ritika Dhasmana, and Mr. Husain Nadaf—for their expert contributions.

The coordination team: Dr. Manisha Mistry and Mr. Husain Nadaf.

The registration desk team: Mrs. Payal, Mrs. Priya, and Mrs. Harshita.

All participants for their active engagement throughout the day.

The programme officially closed at 02:30 PM, with participants receiving their CPD certificates.

9. Overall Summary and Key Institutional Takeaways

Session	Core Takeaway for Clinical Practice
Leadership & Decision Making	Match your leadership style to situational urgency and team input needs. No single style works for all situations.
Ethical Leadership & Accountability	Accountability means being answerable for outcomes, not just tasks. Use the PEDM model for ethical dilemmas.

De-escalation & Safety	Intervene during the escalation phase, not the crisis phase. Use the PAL stance and 5 S's. Restraint is a last resort.
Burnout & Resilience	Burnout is a system failure, not a personal weakness. Leaders must model well-being and create supportive cultures.
Communication & Collaboration	Use SBAR, CUS, and closed-loop communication. Silence endangers patients. Safer communication is a clinical skill.
Conflict Management	Visible conflicts are the tip of the iceberg. Address underlying causes. Nurses at the intersection can be master resolvers.

Conclusion

The CPD Programme on **Leadership and Conflict Management in Hospital Settings** successfully equipped participating healthcare professionals with evidence-based frameworks, practical communication tools, ethical decision-making models, and resilience-building strategies. By addressing both external challenges (aggressive patients, interprofessional conflicts) and internal stressors (burnout, moral distress), the programme provided a holistic and immediately applicable blueprint for safer, more compassionate, and more resilient hospital environments. The high level of engagement, the quality of case discussions, and the positive feedback collectively indicate that the programme achieved its objectives and will translate into measurable improvements in patient safety, team dynamics, and staff well-being.

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PHOTOS

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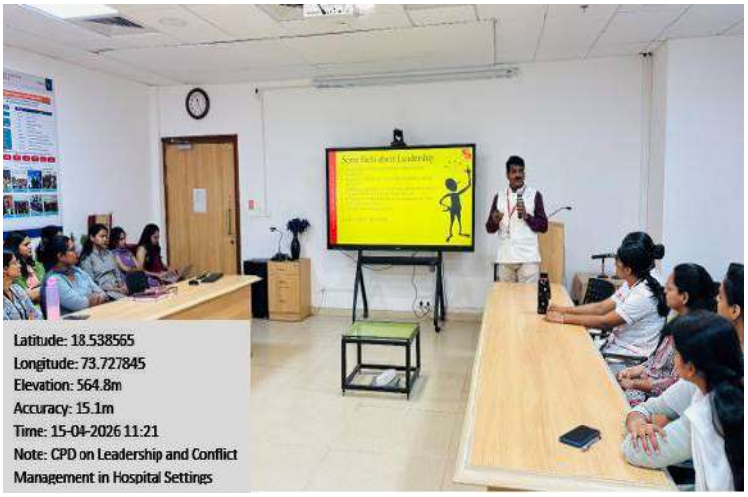

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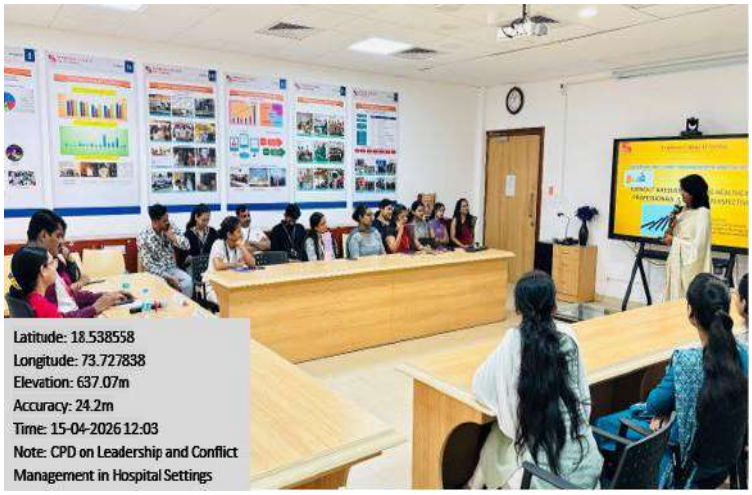

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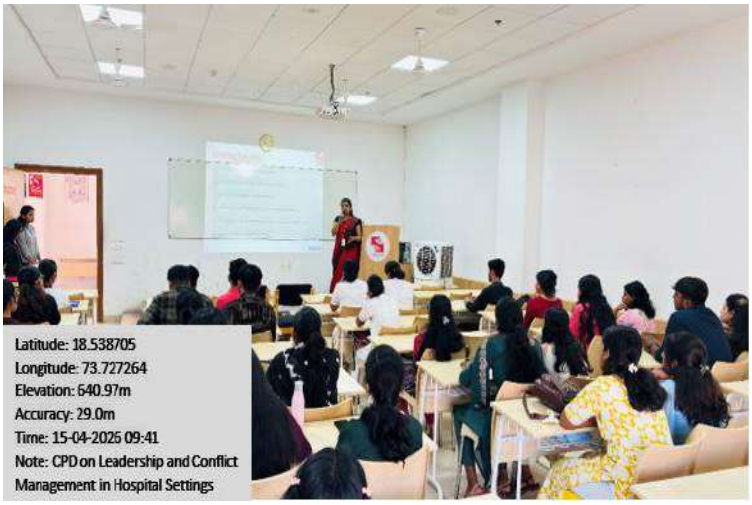

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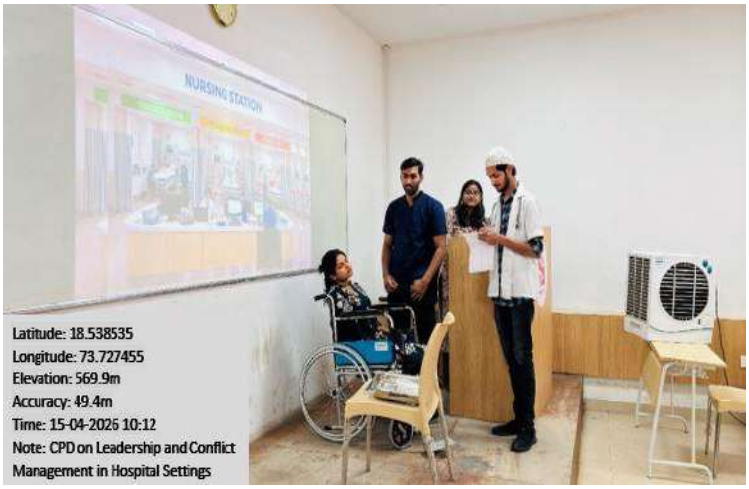

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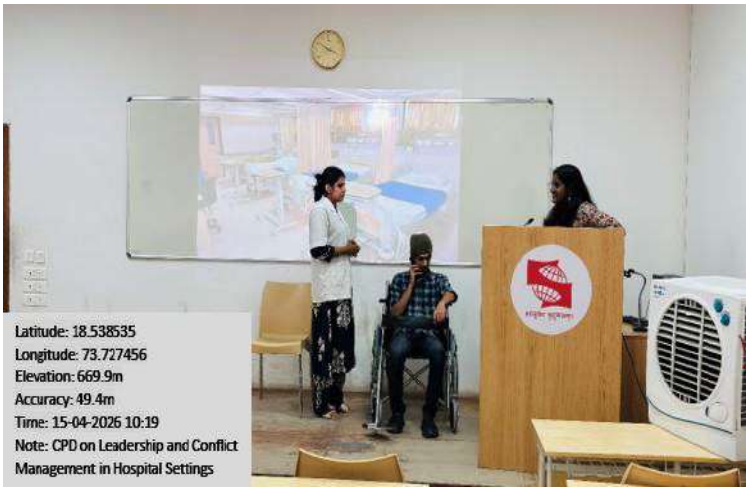

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