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Chapter 7 **Courageous conversations**

Jamie Ripman and Philippa Williams

> '*Very great change, comes from very small conversations, held amongst people that care.*' (Margaret Wheatley, 2002)
>
> '*A problem only exists in the absence of the right conversation.*' (attributed to Werner Erhard)
>
> '*The conversation is the relationship.*' (Susan Scott, 2002)

These wise words reflect something that we suspect few would argue with: the depth of our relationships and the effectiveness of our leadership are dependent on the quality of the conversations we have. Our relationships with others are built piece by piece through the interactions we have, which of course include many different conversations. These can be corridor conversations, chats over coffee, meetings, appraisals, hand-overs, bed planning and so on. They will be conversations with patients, with other healthcare professionals, with relatives, with your line manager, with members of the admin team and many more. It sounds obvious, perhaps because it's the water we swim in and perhaps because many of those interactions are focused on the task, on getting the job done. So we don't stop to think deeply about them because there is no time or apparent need. Yet all these interactions count. As Ken Blanchard (2002) wrote: 'While no single conversation is guaranteed to change the trajectory of a career, a business, a marriage, or a life, any single conversation can'. And sometimes it might be a series of conversations that makes the difference.

> '*I used to find it difficult going to the wards. Everyone suddenly went on red alert and put their gloves on. "What's wrong? What have we done?" I hated it because I just want to be liked! But I kept chipping away – just*

How to be a Nurse or Midwife Leader, First Edition.
Edited by David Ashton, Jamie Ripman and Philippa Williams.

> *dropped in for 10 minutes and said "Anything I can help you with? Any questions?". Then I got back from maternity leave and was greeted with open arms – they said "Nobody comes down to see us any more".'* (Infection Control Lead Nurse)

Inevitably we find some people easy to deal with and some more difficult and the conversations we have will reflect that, as they are likely to reflect how busy we are, how we are currently feeling and what our current priorities are.

The title of this chapter is 'courageous conversations'; this implies that some conversations need courage, which in turn implies that these conversations will be the ones we perceive as 'difficult'. This might be breaking bad news to a patient or relative and it might also be challenging some behaviour in a colleague, or making a request of your line manager, or managing the performance of one of your team. And when faced with 'difficult' issues, many of us experience a tension; on the one hand, saying too little and avoiding the issue, on the other hand, saying too much, upsetting people and jeapordising a working relationship.

The authors of this chapter, Jamie and Philippa, started working within the NHS many years ago. A story, told by the late Professor Aidan Halligan, has stuck with us from the early days as an example of leadership in practice. The story concerns a ward round on a care of the elderly ward, led by a professor. There were about 12 people on the ward round, including the youngest member, a newly qualified nurse. They stopped at the bed of an 84-year-old man who was confused and probably suffering from dementia. Unfortunately, the young doctor who was speaking about him also became confused. The professor became impatient and eventually turned to the group, saying 'I'm fed up dealing with these stupid people'. Everyone suddenly became extremely interested in their shoes, nobody said anything, and the professor walked away in irritation. But after the ward round, the young nurse (who incidentally was an ex-estate agent who had retrained at the age of 24) found a moment to catch him and said: 'Nobody speaks to patients like that on my ward'. I'm sure you will agree that this was an act of courage on the part of this nurse. When Aidan told the story, he stopped there and asked the audience, 'What do you think happened next? Did this nurse have a job within the next six months?'. He also asked, 'How do you think the professor responded?'. The answer was yes, she did keep her job – and she became a sister on that ward soon after. And the professor apologised to her at the time: he said' 'I'm really sorry, I had a row with the kids this morning. Let's go back and apologise to the patient together'. He was not a bad man, he had just reacted badly under stress.

> '*Our lives begin to end the day we become silent about the things that matter most.*' (attributed to Martin Luther King)

Aidan's story, which is a true one, is a great example of a courageous conversation in practice, which had far more positive outcomes than the young nurse might have expected when she chose to speak out. Let's explore another example in a bit more depth.

Imagine it's the beginning of the day on a busy specialist stroke ward. Jackie Hanson is a ward sister who has put aside some time to do some administration. She is continually interrupted by phone calls so is feeling a little fraught and then one of the junior nurses, Mirembe, arrives in tears. She tells Jackie that the consultant (Simon Garner, a relatively new appointment who has replaced Tanvi, a very well-liked and respected consultant) has shouted at her. He was running late in his ward round, she tried to raise the issue of protected mealtimes with him and he reacted angrily. She claims that it's not the first time that he has done so. 'He shows me zero respect,' she says. She also tells Jackie that she's thinking of asking for a transfer to a different ward as a result of Simon's behaviour. This is also not the first time that Jackie has heard similar stories and, indeed, has experienced Simon being a bit brusque herself. She knows she has to say something to him. She manages to catch him in the corridor and asks him to drop in to see her, which he does (begrudgingly, she feels) towards the end of the day. The resulting conversation goes a bit like this.

Simon: What did you want to talk about? I'm in a bit of a rush.
Jackie: Please sit down, Simon.
Simon: I'd rather stand, if it's all the same to you.
Jackie: I wanted to talk to you about your ward round earlier. I had one of my staff nurses in who was quite upset.
Simon: Who? Why was she upset?
Jackie: It was Mirembe. She said that you had a go at her.
Simon: I don't think so …
Jackie: Well, like I say, she was very upset … she said you were very dismissive of her opinion and she says you snapped at her.
Simon: Jackie – I'm sorry if she was upset but I have a job to get on with. And anyway, I didn't snap at her … from memory, she was trying to make some point about mealtimes, I felt it was irrelevant and so I moved on to the next patient.
Jackie: Well, she says you snapped – and anyway, how do you know it was irrelevant if you didn't speak to her about it? And it's not just that, I've seen you be dismissive with other people as well …
Simon: When?
Jackie: Look, my point is you are very different to Tanvi in your style. Tanvi was very popular with the nursing staff.
Simon: And I'm not? I didn't know it was a popularity contest.

We'll leave them there at this point and come back to them. In the meantime, consider the following questions.

- What are you thinking and feeling about how Jackie handled this conversation?
- What are you thinking and feeling about Simon?
- How do you think Jackie was feeling?
- How do you think Simon was feeling?
- What might his intention have been?
- How would you have handled this conversation?

You'll notice that there are a lot of questions about feeling. What's your response to that? For example, are you thinking 'it doesn't matter how they're feeling, they should behave professionally', or 'they should be able to manage their feelings', or 'they're both obviously feeling bad and need to acknowledge that to themselves and the other person'? Or none of the above and something completely different!

The point here, of course, is that, whether we like it or not, feelings and emotions are part of our everyday interactions and drive our behaviour – sometimes in more ways than we wish to admit. In nursing, or indeed any kind of medical, social or clinical care, the 'emotional labour' (referred to in Chapter 1) that is needed can be overwhelming at times. The research that has been done on emotional intelligence (for example, by Daniel Goleman, 1996) explores how the most effective leaders are able to harness their emotional intelligence through self-awareness, self-management and empathy with others.

Our focus in this chapter is exploring how we can create the best conditions to enable us to have the conversations about the things that matter most. We will explore practical approaches to managing conflict and diversity of opinion, working with emotion, creating learning conversations and having effective conversations about performance. We will look at how we can plan and prepare for difficult conversations as well as seizing time 'in the moment' when appropriate.

We have structured the remainder of the chapter into three sections: Managing Conflict, Compromising and Collaboration, and Effective Conversations about Performance.

Section 1: How to manage conflict

Before we continue with this section, we invite you to undertake a short exercise.

1 Write down your definition of conflict.
2 Write down a few words to describe how you feel when you experience conflict.
3 Describe your preferred approaches to dealing with conflict by completing this sentence: 'Whenever I experience conflict I tend to…'

In our work with individuals and groups on managing conflict, we have had a wide variety of responses to these questions. In terms of a definition, the spectrum can range from 'being at war' to 'having a mild disagreement'. The feelings generated when experiencing conflict can range from feeling nervous, sick and stressed to feeling energised, excited and confident. Not surprisingly, therefore, personal preferences for how to approach conflict also vary significantly.

A quick search of online dictionary definitions of conflict reveals the following.

> '*A serious disagreement or argument, typically a protracted one*' (www.oxforddictionaries.com) '*an active disagreement between people with opposing opinions or principles*' and '*fighting between two or more groups of people or countries*' (http://dictionary.cambridge.org)

Clearly, the word 'conflict' means different things to different people and will have different significance depending on your context. Of course, we are trying to define conflict in the context of nursing and midwifery leadership and, for us, there are some helpful reference points that have guided our thinking and our approach to working with nurses and midwives on handling conflict. Two such bodies of research are those done by Dr Elias H. Porter who developed his Relationship Awareness Theory® (Porter, 1996) which has since been developed into the Strength Deployment Inventory® (SDI®) (Porter, 2005), and the work done by Drs Kenneth Thomas and Ralph Kilmann which has resulted in the development of the Thomas–Kilmann Conflict Mode Instrument (TKI) (Thomas and Kilmann, 1974).

The SDI is a helpful diagnostic tool that we have used with individuals and groups that can help to create greater awareness about how we deploy our personal strengths at times when things are going well for us and also when we are in conflict or opposition with others. There are plenty of published resources available in print and online (www.personalstrengths.uk).

One helpful distinction that we have come across through this research is that between what they call 'warranted' and 'unwarranted' conflict.

- *Warranted conflict* – occurs when the people involved do not agree on the desired outcome.
- *Unwarranted conflict* – occurs when there is agreement as to the goal, but disagreement about the approach to accomplishing the goal.

Other chapters of this book (particularly Chapters 4 and 6) also deal with how we organise and energise others around a common purpose and goal and, in this chapter, we are also going to explore the challenges arising from unwarranted conflict, where a common purpose and the outcomes have been broadly agreed but the conflict arises due to differing styles, approaches, personalities and preferences.

In our experience, the theory and practical application of the TKI is a very helpful guide to get us started. So, our aim here is to give a brief introduction to the TKI and to encourage you to do further research and personal diagnosis. Again, there are plenty of published resources available (www.kilmanndiagnostics.com).

Let's start with their definition of conflict, which is 'Any situation in which the concerns of two people appear to be incompatible'. For us, this is a helpful definition as it refers to 'concerns' and to 'apparent' incompatibility. What concerns somebody is not always evident from their behaviours, as can be seen in our imagined scenario between Jackie and Simon. Jackie may have a hunch about her differing and apparently incompatible concerns with Simon but it feels like both parties are responding more to the strategies, language and behaviour of the other rather than investigating each other's underlying concerns.

How did you respond earlier to our questions about your thoughts and feelings about Simon? How would that affect your behaviours should you need to resolve any differences with him? If Jackie is thinking and feeling that Simon is 'typically arrogant and disrespectful to nurses', we can imagine that her responses are partly governed by this belief about him. Thinking about the Thomas–Kilmann definition of conflict, we believe that if Jackie is going to help resolve the apparent conflict between them, she will need to become more interested in Simon's underlying concerns and be less affected by his behaviours, which may be caused by multiple factors, some of them unrelated to the issues that Jackie wants to address.

However, sitting down with Simon and exploring his underlying concerns is only one strategy available to Jackie. What else might she try? Again, we think the TKI offers us some helpful pointers. It invites us to explore our options for responding to conflict along two different dimensions.

- The extent to which we seek to satisfy our own concerns – *assertiveness*.
- The extent to which we attempt to satisfy the concerns of others – *co-operativeness*.

In Figure 7.1 we show those dimensions expressed graphically along with the five modes or styles of handling conflict associated with this framework.

So, there are five different options available to Jackie. What might they look like and when might they be appropriate? And that latter question is crucial. One of the discoveries we can make when we explore the TKI for ourselves is a greater awareness of our preferred styles of handling conflict. Once we've got a greater understanding of this, we can start to become more aware of whether we are using our preferred styles appropriately or not and whether we might make some conscious decisions to use a style that is more appropriate for the situation. It's generally the rule that we are more skilful at

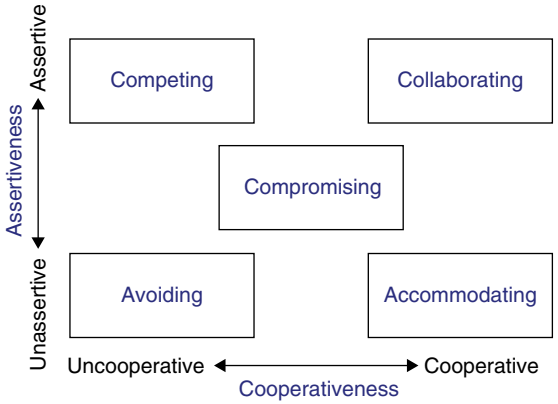

Figure 7.1 Thomas–Kilmann Conflict Mode Instrument. Source: Thomas, K.W. and Kilmann, R.H. (1974) *The Thomas–Kilmann Conflict Mode Instrument (TKI) Assessment*. Santa Clara, CA: Xicom, Inc. Reproduced with permission from the publisher, CPP, Inc. Copyright [1974]. All rights reserved. Further reproduction is prohibited without CPP's written consent. For more information, please visit www.cpp.com.

using our preferred styles (of anything) because we are more practised at them – even our bad habits! For the next part of this chapter, we want to explore what three of these five options (Avoiding, Accommodating and Competing) might look like, in practice, when executed with skill by Jackie. We're going to look at the strategies, behaviours and mindset required to be skilful at Compromising and Collaboration in the next section.

Avoiding

When to use

- When an issue is trivial or when other, more important issues are pressing.
- When you perceive no chance of satisfying your concerns.
- When the potential costs of confronting a conflict outweigh the benefits.
- To let people cool down.
- When gathering more information outweighs immediate action.
- When others can resolve conflict better.

How to execute with skill

To execute this style skilfully, it really helps to create a constructive mindset about your choice of this strategy. Be positive about your reason for using it – to yourself and to others.

In our scenario, Jackie may not have considered that it could be a helpful strategy to employ some appropriate 'avoiding'. Quite understandably, she has responded to a distressed member of her team and initiated some contact

with Simon. She could have avoided doing this so quickly, recognising that her behaviours might still be affected by her negative feelings about his behaviour. On reflection, she might have considered avoiding the conversation for an hour or so until she felt calmer and had done some further planning for their first encounter after this incident.

Accommodating

When to use

- When you realise that your perception of the situation isn't helping.
- When the issue is much more important to the other person than to you.
- To build up credits for later use.
- When you feel outmatched and losing.
- When preserving harmony is important.
- To allow others to develop and learn from their mistakes.

How to execute with skill

Again, it's important to create a positive mindset about your use of this strategy. If 'backing down' or 'giving in' or 'admitting defeat' are the last things you would ever consider doing, then you'll need to create a different mindset about satisfying the concerns of others. In his research into the 'science of persuasion', Robert Cialdini (2001) identified 'reciprocity' as one of the deeply rooted human drives to which we can appeal when seeking to persuade others. It appears that humans are likely to reciprocate in kind, and if we offer an act of kindness or generosity to another person, we stand a better chance of getting something positive in return.

So, how might Jackie 'accommodate' with skill as part of her strategy of influencing Simon? Let's look at the issue of protected mealtimes that, in this scenario, led to the original incident between Simon and the junior nurse, Mirembe. Whilst holding firm to her belief of the importance of protected mealtimes, what if Jackie accommodated Simon's need to work at pace by offering him the following?

- He can have access to patients during mealtimes when he deems it essential.
- She will talk to her staff to explain the change of policy.
- She will monitor the impact of this on patients and get back to him if she feels it is having a negative impact on patient care.

If she was willing to offer this to Simon, our belief is that she could move on to the front foot with any eventual negotiation with him. She could proactively recognise and empathise with his need to work at pace, offer to help him out, and reiterate her passion not to compromise on patient care. According to Cialdini's research, she stands a good chance of Simon offering her something in kind in return.

THEORY INTO ACTION

Avoiding and Accommodating are both strategies where you are actively choosing not to satisfy your own concerns.

- In any of your own conflict situations, think of one example where you might consciously change your style and employ a constructive Avoiding or Accommodating style.
- Try it out.
- Reflect on your attempt at this change of style.
  - What were the benefits?
  - What were the negative consequences to you?
  - How might you refine your use of these styles to even greater effect?

Competing

When to use

- When quick decisive action is needed.
- On important issues where unpopular courses of action need implementing.
- On issues where you are determined to stick to your values and principles.
- To protect yourself against people who take advantage of non-competitive behaviour.

How to execute with skill

Competing is the high assertion and low co-operation style where you are aiming to satisfy your own concerns. There are many challenges to being skilfully assertive and we have provided a framework for having assertive conversations on our chapter on influence (see Chapter 6).

Another great thing about this assertive tool is that you can slide up and down the scale of assertion depending on how assertive you want to be. If we imagine assertion on a scale from 1 to 10, then up at the high end of that scale, where you have limited vested interest in the relationship, you can use words that are strong and direct. For example, if you are having problems of late delivery with a supplier of medical products to your department, you could be highly assertive about your request for change.

- We like your products and they are good value for money.
- We don't like the delays in delivery – sometimes as late as a month.
- So, we now need the deliveries to be made on time, every time.
- If you do, we'll continue to use you as our supplier.
- If not, we'll move to another supplier who offers a prompt delivery service.

In the case of Jackie, she definitely has an interest in developing her relationship with Simon and she will want to adapt her language whilst including the

component parts to help her to be appropriately assertive. Here's our version of a short script she might write and memorise before starting the meeting with Simon.

- What I really appreciate are your plans for developing the stroke service and your passion and determination.
- What's concerning me is when this comes into conflict with established patterns on the ward and the impact on our nurses.
- What I want is a frank and honest conversation about the best way for us to work together.
- If you are willing to negotiate with me, I know we can help you achieve your goals.
- If we don't resolve this soon, my concern is that our nurses will disengage and it will be harder for you to realise your ambitions.

Jackie would then be ready to weave in these component parts during her conversation with Simon. She probably won't deliver this in one go but she has prepared the important elements and can include them at appropriate points in the meeting.

'*I have found this assertion strategy enormously useful in a variety of situations and have shared it with all my ward/unit managers and nurse specialists, several of whom have been amazed by its effectiveness.*

An example would be a staff nurse who I have had to speak to several times before about negative attitude to staffing and being very vocal in front of ward visitors about staff numbers on the ward. Previously conversations with her about behaviour were quite difficult and ended with neither party feeling happy with the outcome. Using the assertion format has gone something like this:

"*I really appreciate your passion and I understand you feel strongly about patient safety and supporting your colleagues. However, it's not always effective to express your feelings to everyone on the ward or in front of patients. I would really like it if you speak to the ward manager about your concerns in a more private environment and we can try to address them. Would you like to join some of the work stream groups looking at safer staffing levels across the trust, maybe do some work with the acuity groups as I think your passion and insight into ward staffing issues would be really valuable?*"

This person is now working on some of these work streams and has expressed their feeling that it was good to be listened to and feels that they have had some good input into the trust safer staffing strategy.' (Surgical Matron)

In Section 3 of this chapter, we will look at how to respond to the potential emotional reactions that can arise when we offer feedback to others. No matter how skilful you become at giving assertive feedback, you will also need to be ready for some very natural emotional responses to hearing an assertive request for change.

THEORY INTO ACTION

Think of a situation where it would be helpful for you to make an assertive request of someone. Use the guidelines above for how to structure an assertive conversation to prepare the component parts of your 'script'.

- Write down your assertive script.
- Practise the script out loud with congruent physical and vocal energy and refine if necessary.
- Learn the script sufficiently so that you can incorporate it easily into your conversation.
- Assess the pros and cons of having the conversation.
- If you are clear you want to go ahead, commit yourself fully to the style and be clear about your positive intention behind having the conversation.
- After having the conversation, reflect on what happened and how you can improve on what you achieved.

Section 2: How to compromise and collaborate

The two styles of handling conflict in the TKI that we haven't yet explored are Collaborating and Comprising. This is moving us into the 'win-win' territory of courageous conversations that we often aspire to occupy.

The decision between whether to collaborate or compromise will be different depending on the situation and the time and resourcea available. Here are some indicators.

Collaborating

When to use

- To find an integrative solution when the concerns of both parties are too important to be compromised.
- To merge insights from people with different perspectives on a problem.
- To gain commitment by incorporating others' concerns into a consensual decision.
- To work through hard feelings that have been interfering with an interpersonal relationship.
- When the objective is to learn.

Compromising

When to use

- When goals are moderately important but not worth the potential disruption of using more assertive modes.
- When two opponents with equal power are strongly committed to mutually exclusive goals.
- To achieve temporary settlements to complex issues.
- To arrive at an expedient solution under time pressure.
- As back-up mode when collaboration/competition fails.

How to execute with skill

Importantly, in our view, before we get to decisions about whether to compromise or collaborate, we feel it's essential to learn how to engage with others in a way that removes any potential blame, criticism or attack from the conversation. We explored the idea of empathic inquiry in the last chapter in the context of influencing others – let's see how this works if we add in a further intention of keeping our conversations free of blame and apply it to the conversation between Simon and Jackie.

We often witness conversations around differences which focus on attempts to prove that 'I am right' and that 'you are wrong' in the different positions taken over a particular issue. In our education, we are often schooled in having logical debates that will persuade others that our rationale is more powerful than another's.

An alternative strategy is to recognise that my position is only one version of reality, one 'perspective' on the situation, and that it is legitimate for you to have an alternative perspective.

> '*This is true AND this is true. Multiple realities are not competing. They just exist. You own a piece of the truth, and so do I. Let's figure out what to do.*' (Scott, 2002)

Informed by the wisdom gleaned by the research of Roger Fisher, William Ury and Bruce Patton (1992) and Susan Scott (2002), we have been experimenting with a framework for having blame-free, collaborative conversations that are proving to have some success. There are, of course, strong links here back to our chapter on influencing.

> '*I've been practising NOT jumping in with solutions and getting to know how others feel about the situation. I always found negative people difficult to deal with; people who cannot immediately grasp the advantages used to really annoy me. With practice, I have been able not only to see their points of view, but patiently accept starting from where they*

actually are. I have led a recent demanding pilot project in our CCG and spent a lot of time "holding hands" with anxious nurses. This time has paid dividends as 88% have completed the challenge, many to a very high standard, and are now, by their own admission, confident and prepared for the real thing.' (Nurse Practitioner and CCG Locality Nurse Member)

Let's build this framework using Jackie and Simon's conversation as an example. If we consider their respective opening 'positions' for this conversation, we could characterise their differences as follows.

Jackie: Protecting mealtimes is vital and you are a bad person for treating my staff like that. Tanvi would never have done that.

Simon: Protected mealtimes are irrelevant and your nurse wasn't being helpful to me. Comparing me with Tanvi is insulting.

In the scenario, we can see how both parties are sticking to these positions and having a 'yes, but …' type of conversation in which they are trying to out-reason each other over the 'rightness' of their respective positions.

Step 1: Blame-free inquiry

Do you remember this quote from Chapter 3? 'Seek first to understand, then to be understood' (Covey, 1989). If Jackie is going to break this pattern, she could try exploring Simon's reality without laying blame. We shared this quote with you in Chapter 5: 'The person who can most accurately describe reality without laying blame will emerge as the leader' (Scott, 2002). To do this she needs to inquire into Simon's version of reality without judging his reality as right or wrong, good or bad. Her questions need to be genuinely exploratory and she will need to listen empathically to his responses.

'*Most people do not listen with the intent to understand; they listen with the intent to reply. They're either speaking or preparing to speak. They're filtering everything through their own paradigms, reading their autobiography into other people's lives.*' (Covey, 1989)

Step 2: Summarise the reality of the other person – without laying blame

This is often a magical moment in a collaborative conversation. If your inquiry has been free of blame and you have listened empathically, you are now in a position to summarise back to your colleague 'the world according to them'. You are not agreeing or disagreeing with them; you are demonstrating that you have heard and understood their reality.

Here's how that might go for Jackie.

> '*So, Simon, what you're saying is that you're under a lot of pressure to develop the stroke service here and, consequently, you've got a huge amount on your plate. You are working at a furious pace and when Mirembe challenged you over protected mealtimes, you felt she was being unhelpful and it seemed reasonable to you to speak to her in that way.*'

Sometimes you will discover that the other person's reality includes a perspective about you that will be difficult to hear and very different from your intentions. Try hard to resist the temptation to defend yourself at this stage and, instead, add this as part of your summary of the other person's perspective.

In Jackie's case she might say:

> '*And you're feeling frustrated with me for requesting some time to explore this when you're so busy.*'

The great thing about developing the skills to make this sort of summary in courageous conversations is that you don't have to get it right first time. If you haven't accurately summarised your colleague's reality, they will correct any errors and you will often get some extra information into their perspective on things.

Assuming that Jackie has got to the moment in the conversation where she has accurately summarised Simon's reality, she will have arrived at what we sometimes refer to as the 'absolutely' moment, as that is often how the other person will respond at this point!

'Now what?' we hear you wonder! Well, often what is needed now is what you might call … an elegant transition!

Step 3: An elegant transition

This is a transition from blame-free inquiry about the reality of the other person to a blame-free disclosure of your version of reality. It's really important that this bit doesn't sound like 'That's great, now let me tell you why you're wrong!'. The language here needs to reflect your ultimate desire to build on the common ground between your realities, to acknowledge where your perspective is different and to offer your positive intention to find a collaborated solution (or compromise, if necessary).

In Jackie's case it could go something like this.

> '*Thanks Simon, that's very helpful to understand your perspective. Let me tell you how I see things. There's a lot of common ground between us and I do see some things differently so please hear me out while I explain my perspective.*'

Step 4: Blame-free disclosure

> '*Your version of reality is as good as anybody's. As you describe reality from your perspective, do not lay blame.*' (Scott, 2002)

During this step, you are disclosing your perspective using language that doesn't blame, criticise or attack your colleague. We will explore the skills required to give (and receive) feedback in the next section of this chapter so, for now, try this as an exercise. You don't have to have the conversations for real … yet!

THEORY INTO ACTION

- Go back to the scenario between Jackie and Simon at the start of this chapter and read the text a few times.
- When you feel you have understood Jackie's perspective, try to articulate it in a way that doesn't sound critical of Simon.
- How have you adjusted your language to enable Simon to hear your perspective without feeling the need to defend himself?
- Think of a situation that you are facing where your perspective is different from others. How will you articulate this in way that doesn't sound critical of others?
- Make a start. 'Let me tell you how I see things …'

Step 5: Share your desire to collaborate (or compromise)

Once you have each shared your perspectives on the situation, it is important to express your desire to build on the common ground you have uncovered and to work through the differences. We are not yet at the point of agreement or resolution of differences but we have avoided the tit-for-tat or 'yes but …' scenario where we started. To echo the sentiment from Susan Scott, you have described the reality of both parties, without laying blame, and you have emerged as the leader in this conversation. You are now well placed to lead the conversation that moves towards compromise (where each party gets some of their needs met) or full collaboration (where each party gets all their needs met).

Our recommendation for how you lead the next part of the conversation is to invite the other person to work with you to generate ideas for how to take things forward for mutual benefit. Let's finish this section by imaging how Jackie might lead Simon into the next part of the conversation.

Jackie: That's my take on things, Simon, and, as I said, it feels to me like we have a lot of shared views about the stroke service. We're both

absolutely committed to make it the best we can and I appreciate there are a few differences between us in terms of how to do that. I'm really keen to develop our working relationship and to (either) find some compromises (or) collaborate with you. What are your thoughts?

Simon: I'd agree. It was helpful to hear your views but I'm not sure where we take things from here.

Jackie: Can we put aside a bit of time to explore that? I'd really like to work with you to generate some options for organising things a bit differently; I'd be happy to take a look at how you and the other consultants work with my ward team and me. Generate some different ideas and see if we can find some solutions that work for all of us. How does that sound?

Of course, we can't guarantee the extent to which Simon will engage with Jackie and she is still likely to need the range of influencing skills and strategies explored in Chapter 6.

What would be your approach at this point?

In our experience, this structure for having blame-free conversations has helped nurses and midwives to move courageously from the despair of wrestling with a challenging conflict situation into the possibility of negotiating a positive way forward. Here is one of the many examples that have been reported back to us.

> '*I have a member of staff who was being very distracted by issues away from work. She was making a lot of mistakes and causing other people a lot of extra work; showing a definite lack of interest at work and being very inconsiderate towards her colleagues. This was causing discomfort in the team.*
>
> *I was able to confidently sit down with her and explain I had serious concerns. I was very honest and told her I felt she just did not want to be here, which is fine but unfair on the team when it affects work and the team dynamic. It prompted her to be honest about her issues and we were able to have a really open and honest conversation. She looked visibly relieved when we had talked, like a weight had been lifted. And I had a better understanding of why she was behaving as she was.*
>
> *We made plans to help and support her. Ultimately this turned things around and she is back to her old self again, the team are happier and less stressed out too.*' (Pulmonary Rehabilitation Clinical Lead, district care trust)

Section 3: How to have effective conversations about performance

I think people want to be magnificent.
It is the job of the leader
to bring out that magnificence in people
and to create an environment
where they feel safe and supported
and ready to do the best job possible
in accomplishing key goals.
This responsibility is a sacred trust
that should not be violated.
The opportunity to guide others
to their fullest potential is an honor
and one that should not be taken lightly.
As leaders, we hold the lives of others in our hands.
These hands need to be gentle and caring
And always available for support. (Blanchard, 2000)

Because the nurses and midwives we have worked with on this project have come from a range of grades and organisations, you won't be surprised to discover that the formal structures and processes in place for managing performance have varied significantly across their teams, organisations and trusts. You will have had your own experience of this both in terms of how your own performance is managed and also how you have managed others.

The way that some departments, teams and wards are organised has meant that we have met nurse and midwife leaders who have had as many as 40 staff to appraise. While we would recommend that no manager has more than 15 appraisals to do in a year, this chapter isn't aiming to tell you how to reorganise your staffing structures to help you keep on top of your appraisals.

What interests us are the regular interactions between leaders and the people for whom they are responsible. What can be done through regular conversations about performance to build the confidence, capability and, indeed, the magnificence of individuals and teams?

In this section we'd like to touch on a number of ideas that can help leaders to have effective conversations about performance. We'll cover:

- the cycle of performance conversations
- a structure for discussing and reviewing performance
- establishing clarity of the performance and standards required

- diagnosing the reasons for poor performance
- using appropriate management styles to develop performance
- guidelines for giving and receiving feedback
- dealing with the emotions involved.

The cycle of performance conversations

Your organisation will have its own formal cycle of appraisals and managing performance and it's important that you become familiar with this. A typical cycle goes something like the one shown in Figure 7.2.

As a leader in your system, you have an opportunity to model a positive attitude and culture towards managing the performance of others.

THEORY INTO ACTION

- What are the formal processes for appraisals and managing the performance of others in your trust?
- Where you are unsure, speak to a colleague in HR and ask them to get you up to speed.
- What is your current belief and attitude about the importance of having regular performance conversations?
- How is this reflected in your behaviours and strategies?
- What could you stop, start or continue to do to model a positive mindset and approach to managing the performance of others?

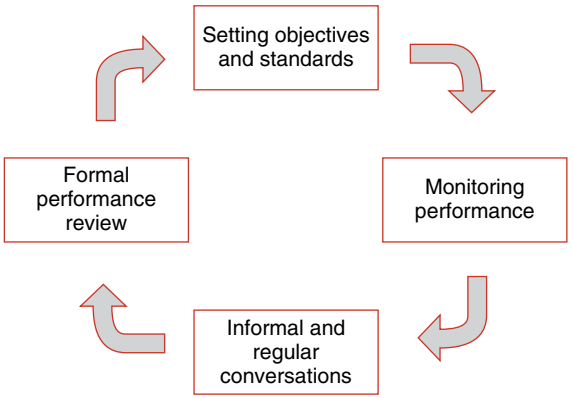

Figure 7.2 A typical performance management cycle.

As well as engaging in the formal processes that are organised by your trust, it is essential to have regular one-to-one catch-ups with your staff to explore how things are going for them and to discuss their performance. Ideally, these meetings should be once a week; they can be short and focused and an opportunity to consolidate or reinforce anything that has arisen in the last seven days.

It's important that performance issues are picked up as quickly as possible and you don't have to wait a week to appreciate someone for their high standards, positive attitude and putting in some extra effort. We have heard the argument that this is what is expected of nurses and midwives and thanking someone for doing a good job isn't appropriate. A more common belief is that there are not enough conversations of thanks, appreciation, success and good practice and, as a leader, you can have a significant impact on the culture of your team by regularly thanking and appreciating staff for their efforts. The other benefit of recognising and appreciating the efforts of others is that you will have credit in the bank when you need to address an issue of poor performance. This also should be done as close to the incident as possible. You don't have to wait a week before having a quiet word with a colleague if you have observed them falling below the expected standards. We'll explore this more in the section below on giving feedback.

A structure for discussing and reviewing performance

The aim with this approach is to have regular and informal conversations about performance so that both manager and team member come to formal performance meetings with 'no surprises'. These meetings often include some paperwork from the trust, which gives guidelines as to the structure of these meetings. These meetings, therefore, need good preparation with both parties ideally exchanging written evidence to support their perspective on the individual's performance. The introduction from the manager should include some clarity about the nature and purpose of the meeting, which will be different from the regular, informal conversations that have been taking place. Once both parties are settled into the meeting, it is helpful if the manager begins by asking the team member for their perspective of their own performance. See Figure 7.3 for a potential structure for these types of meetings. With regular, informal meetings taking place, it is very likely that the formal meeting will progress along the top line of this structure and move quickly to the formation of an agreed action plan.

If the meeting is moving into the lower parts of this chart, you can employ the strategies we explored earlier with blame-free conversations. Get interested in why you and the team member have different views and perspectives on their performance. Acknowledge where you are in agreement and where

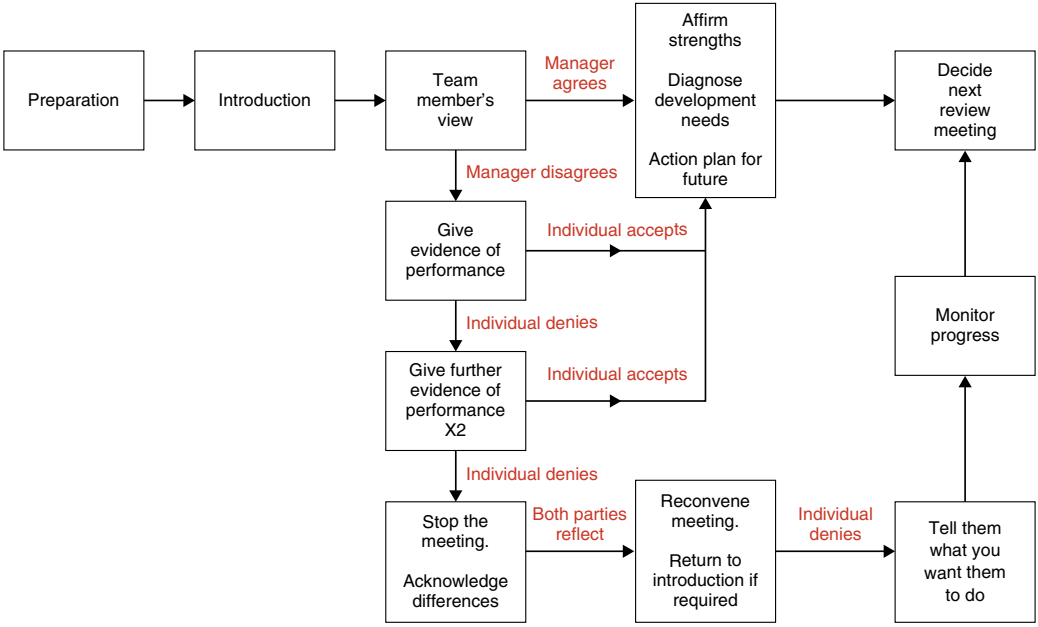

Figure 7.3 Discussing and reviewing an individual's performance.

there are differences and, if you feel the meeting is getting stuck around the differences of view, stop the meeting and ask to reconvene once you have both had a chance to reflect on things. This will sometimes allow you and the team member to break the emotional state of the meeting and the reconvened meeting can start with a fresh impetus.

The difference in this scenario is that if you can't resolve your differences with your team member, you now have positional authority to tell them what you want to happen and the benefits and consequences to them if they do or don't respond to your request. For us, this is a position of last resort and, to do this with skill, you can use the assertive structure we explored in Section 1. In a performance management context it can sound something like this.

> I appreciate and respect that you are operating to the clinical standards expected of you. Where you are falling below the mark is when working under pressure you make remarks to other staff and to patients that they find distressful and rude. I want to be really clear about this – I expect you to put a complete stop to this from now on. If you do, I believe you can become a valued member of the team and your clinical skills will be even more appreciated. If you can't make this change you'll be falling below the standards expected of your role and we'll have to move towards a more formal process for managing your performance.

> '*The session on assertiveness was fabulous. I came back and showed it to my team; they all have it written in their diaries and use it all the time … often on me!*' (Pulmonary Rehabilitation Clinical Lead, district care trust)

Establishing clarity of the performance and standards required

In our experience, one of the challenges of managing the performance of others is helping individuals to get clarity about what is expected of them. The role of the manager here is to assess the performance of team members over time.

In the graph in Figure 7.4, we have plotted the performance of a newly qualified nurse, Jason, over time. Not surprisingly, Jason starts in the role below the standards expected of him; he develops to meet and then quickly exceed the expected standards and then his performance starts to drop and we end this period with his actual performance being well below what is expected. We'll come on to explore what might be causing this rise and fall of performance but the issue we want to look at first is how we get agreement about the expected standard. What are you doing to create a clear agreement with your staff about what is expected of them in their role?

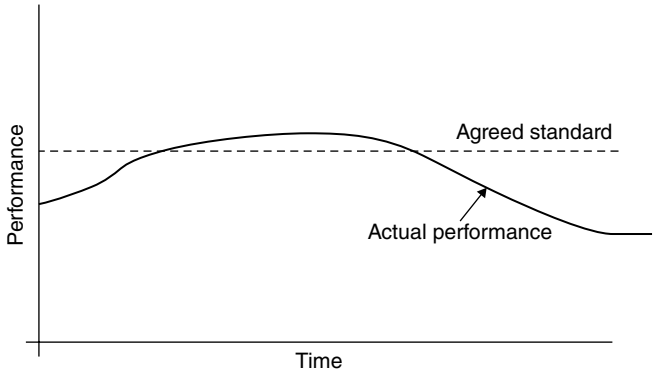

Figure 7.4 Establishing standards of performance.

Of course, there are a number of clear performance indicators and reference points that give guidelines as to what is expected. Here are a few.

- Job description
- Personal specification
- Trust values
- 6Cs
- The NMC Code

Your trust may have other indicators and there's often a lot to get your head around. It really helps to become familiar with these standards as they will assist you to identify quickly how an individual's performance relates to the standards. We're not suggesting an exhausting trawl through this literature with your staff but reminding individuals of these performance indicators can be helpful. An initial discussion that makes it clear that, as part of your role, you need to support them and hold them to account to meet these standards can allow you to return to these if you feel the standards are not being met.

This was brought to life for us recently when we worked with a trust on their Preceptorship programme. Providing the newly qualified staff (preceptees) with informative induction sessions and documents, a six-month probation period, ongoing support from a line manager, and up to a year of support from a nominated preceptor gave the newly qualified staff a clear understanding of what was excepted of them as they made the daunting move from being a student to a qualified nurse. Preceptors and line managers were encouraged to have regular conversations with preceptees about where they were exceeding, meeting and falling below the standards that were expected of them at that trust.

Diagnosing the reasons for poor performance

Let's return to our graph of Jason's performance over time (see Figure 7.4). We might reasonably expect that the lower than expected performance at the start is due to him getting up to speed with the requirements of the new role. As indicated, good induction and some clear direction at the start will enable Jason to meet and then, in his case, exceed expectations.

In a moment we'll come on to explore what might be causing the drop-off in Jason's performance but our questions for now are:

- How are you helping to induct new colleagues into their role?
- What more could you do?
- What are you doing to appreciate, support and encourage those members of your team who are doing more than is expected of them?
- What else could you do?
- What's the risk to you and them if you do nothing?

So, there's our first potential answer to the question about what might be causing the drop in Jason's performance. Without thanks, appreciation and further opportunities to develop and grow, he might have become disillusioned and lost interest.

We can only speculate about this and any other reasons why Jason's performance has fallen below the standard expected so let's do a more useful exercise.

- Think of somebody in your team who is not performing to the standard expected of them.
- Write down some specific examples of what they are doing and your explanation of why that is below the expected standard.
- Write down anything you know and any assumptions you have about why they are not meeting the standards.
- Looking at your list, try to divide your reasons into two different categories.
  - The first category is about ability: where does this person lack skills, competence or knowledge?
  - The second category is about will or attitude: where does this person lack motivation, confidence, commitment or the right attitude?

This diagnostic exercise can help you to identify the best style of leadership to use for developing your colleague. One way of thinking about the factors contributing to performance is look at the dimensions of 'willingness' and 'ability'. Ken Blanchard, who provided the quote at the start of this section, explores this to great effect using his Situational Leadership® model (Blanchard, 2001) and we encourage you to discover more through investigating this body of work

(www.kenblanchard.com). Like many of the other models to which we refer in this book, there are tools available to help you to diagnose your preferred styles and reflect on whether you are using the best styles for the situation you are in.

Using appropriate leadership styles to develop performance

Taking some time to assess your staff's varying levels of motivation and skill, or willingness and ability (see Situational Leadership® above), can help you to make deliberate and appropriate changes in your leadership style to develop the performance of your staff.

The behaviours required for each of the styles are broadly as follows.

1 For staff who are motivated, keen and willing but lack skills and ability, take time to show them how to do things. Use a **Directing** style of leadership that can include the following behaviours:
   - Showing and telling how
   - Teaching and instructing
   - Checking / monitoring
   - Giving feedback.

2 For staff who are low in confidence or motivation and who also lack skills and ability, try a more **Coaching** style of leadership. This can include the following behaviours:
   - Exploring/asking
   - Redirecting
   - Praising
   - Encouraging.

3 For staff who have the skills and ability to do their job but lack confidence, motivation or the right attitude, you won't need to give them much direction. They have the skills already but need a more **Supporting** style of leadership to encourage and facilitate their development. This can include the following behaviours:
   - Asking/listening
   - Facilitating self-reliant problem solving
   - Encouraging feedback
   - Collaborating.

4 For staff who are motivated and willing and have the appropriate skills and ability, you need to find opportunities for them to spread their wings. This **Delegating** style of leadership can include the following behaviours:
   - Allowing /trusting
   - Empowering
   - Affirming
   - Challenging.

Review the work you did in the previous exercise.

- In which category of this model have you put the team member from the previous exercise?
- Which leadership style are you currently using to develop that individual?
- What could you stop, start or continue doing to help that individual develop further?

Guidelines for giving and receiving feedback

Giving feedback

Skilfully sharing your perspective about a situation or about the impact of the behaviour of another person is an important aspect of any leader's repertoire. Done well, it can be a powerful tool for influence and change. Done badly, it can be ignored and potentially harmful. Here are a few suggestions for how to keep refining your ability to give constructive feedback.

1 Always give feedback with a positive intention to help the other person.

- Resist the temptation to offer feedback when you feel the need to get something off your chest or because it will make you feel better.
- Phrase and time your feedback to give maximum benefit to the person receiving feedback.

> *Example: 'I want to share my perceptions of this with you because they seem to be different from how you are seeing things'.*

2 Focus on their behaviour, not their character.

- Try to describe the behaviour you have observed as objectively as possible and resist words or phrases that refer to any inferences you have made or to any judgements of character or personality.

> *Example: 'I've noticed you raising your volume and saying "as a junior nurse you need to understand …" on three occasions when you spoke to Mirembe' as opposed to 'You are very aggressive and patronising when you speak to Mirembe'.*

3 Distinguish between intention and impact.

- What you are giving feedback on are your perceptions of the other person's behaviours. As we discussed in Chapter 2, this is the 'impact' on you of what they are doing.
- It can help to understand or imagine what is the positive intention for the other person in behaving in this way. Think of your own behaviours and what motivates them. How often are you driven by an intention to cause upset or to do harm to others? For most people, it's the same. For Simon, what might be his positive intention for 'snapping' at

Mirembe? He is probably trying to deal with the challenge from Mirembe as quickly and efficiently as he can so that he can get on with his objective of seeing his patient. He may also not yet have learnt to do this with skill.

> *Example: 'I appreciate you had an urgent need to see your patient. By responding in the way you did it came across that you didn't respect an important member of my team who was also trying to do her best for the patient'.*

4 Take a positive approach to the other person's 'weaknesses'.
- Sometimes our weaknesses are our strengths that we overdo or misapply. Where this is the case, it can be helpful to acknowledge this.

> *Example: 'I can see how determined and passionate you are to improve the service. I've noticed that sometimes that strong determination makes it difficult for you to respond to people who are offering a different perspective without sounding defensive'.*

5 Don't overload.
- As we will explore in the next section, people take time to adjust to difficult messages.
- Plan the timing and amount of feedback to create maximum benefit to the recipient.

6 Get the other person to provide solutions where possible.
- Invite the other person to work out how they can close the gap between their positive intentions and any negative impact that is causing.

> *Example: 'So how can you change what you're doing so that you keep your determination and passion and engage more with others who have a different perspective to add?'.*

Receiving feedback

In the next part of this section, we offer some ideas for how to respond to others who might react emotionally to being given some feedback. It is a perfectly natural reaction and it can happen to all of us.

When it is your turn to be on the receiving end of feedback, be aware that your emotions might follow a similar journey to the one we will describe in the next section. So, when you are being given feedback try to:
- keep listening
- avoid jumping in with reasons and excuses
- ask questions to seek clarity on anything that isn't clear or for more detail if the feedback is too general

- give yourself some time to reflect on the feedback and absorb the messages
- add the feedback to other data you have on the situation
- create a constructive plan for how you are going to respond to the feedback.

Dealing with the emotions involved

Through your clinical work, you may be familiar with the work of Elisabeth Kübler-Ross, the Swiss-American psychiatrist who did pioneering work into the emotional reactions to death and dying, described in her book *On Death and Dying* (1969). In this book, Kübler-Ross explores the stages of grief and, in our experience, there are some similarities between this and the emotional reactions experienced by many people in response to hearing bad news of varying forms. For example, we've seen and experienced versions of this when observing people responding to assertive requests to change and other developmental feedback.

Of course, not everybody follows the pattern shown in Figure 7.5 precisely, but in preparing to give challenging feedback, it's also worth thinking about how you are going to respond should you encounter a reaction that includes elements of this emotional journey.

Sometimes it can be very challenging to be with someone who is experiencing these emotions and it's easy to make negative judgements of people when they subject us to their denial, blame or anger. This research and our experience show us that these are not bad people doing shocking things. These are typical people doing typical things and here are some ideas for how

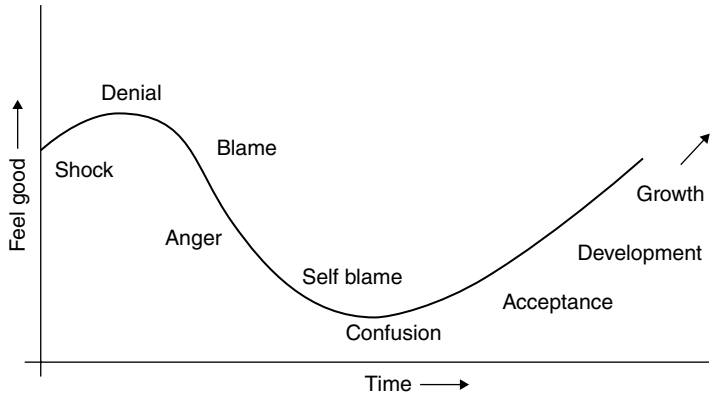

Figure 7.5 The Change Curve – people take time to adjust to difficult messages.

to care for yourself and the other person when they are in the grip of these emotions. To support someone through:

Shock:	Empathise. The old adage is 'tough on the issue, not on the person'.
Denial:	Repeat the message. Make sure the other person has clearly understood the feedback you have given. In the early stages of denial, it can be very tempting to rescue the other person and soften the message. This is very understandable and not helpful. The bad news for you is that by sticking to your guns, the situation is potentially about to get worse because once the message sinks in for your colleague, you are likely to experience an emotional journey from them that might include blame, anger, self-blame, etc.
Blame:	Sometimes they will say it's the organisation's fault, sometimes it's the fault of other team members and sometimes it will be you who is being blamed. For example, 'Why didn't you tell me this earlier?'. Try not to take this personally and don't be inclined to defend yourself at this point. Encourage your colleague to tell you more.
Anger:	Again, this can be directed at many targets. Your colleague will be speaking from a very emotional place (heart-felt) so try not to respond with reason or logic (head-space). Say as little as possible and listen hard. If anything, ask them to tell you more about what they are saying. Like a boiling cauldron, your colleague needs to vent their emotions and if you give them the time and space to do that, you can help them let off steam. Reasoning with them is like pushing down the lid on the boiling cauldron and they will retain their heat for longer. And remember, you can offer your colleague some time to think things through. Not everything has to be achieved in one meeting and giving them (and you) a break can enable you both to reconvene with a different energy.
Self-blame:	Empathise and remain curious. How do they feel they have played a part in this?
Confusion:	Listen and empathise.
Acceptance:	Appreciate and encourage.
Development:	Offer support.
Growth:	Appreciate.

'*I made a decision on working patterns because I wanted to increase the presence of the senior nurses on the shop floor during key working hours. The Matrons and Heads of Nursing wanted to work fewer days but*

longer hours whereas I needed more senior people around during the day when some of the difficult things were being tackled like resolving bed-flow problems, seeing patients and talking to relatives. It was much better for patient care.

It was very challenging because I was breaking the set patterns of people's working lives and they reacted emotionally to this. There were tears, they wrote me an angry letter and they worked to rule for a while.

What I really valued through understanding the Change Curve was feeling reassured that I wasn't doing something badly; this was a normal response to the changes I had asked of them. I stayed calm, listened and empathised with their feelings, compromised on a few issues and, eventually, the angry reactions stopped as they accepted the changes.' (Divisional Director of Nursing)

We've been told many examples of nurses and midwives who have tried to address challenging performance issues with colleagues and found themselves on the receiving end of 'bullying' accusations. When someone is given a clear message about their poor performance and heard it for the first time, we think the Kübler-Ross research can help us to understand the range of emotions that this will provoke. It's tough on them and it can be tough on you too so we encourage you to be vigilant and honest with yourself about how you treat others when you are addressing issues of underperformance. In the heat of the moment, ensure that you are being assertive and not aggressive. It's your job to address issues of performance in your team and how you go about it is critical. We hope this chapter has provided some ideas, frameworks, tools and techniques that can help leaders to manage conflict and poor performance with skill and to prepare for courageous conversations. And here's a note of warning attributed to a nineteenth-century German Field Marshall, Helmuth von Moltke the Elder, that encourages us to keep learning from our experiences and to keep on our toes at all times:

'*No battle plan survives first contact with the enemy.*'

Even more courage required ...

Before we leave this chapter on courageous conversations, we'd like to return to the scenario between Simon and Jackie at the start of the chapter. The issues to which we haven't yet paid attention are the potential issues of power, equality and diversity arising from the gender, race and social background of the characters involved. Here are a few questions we'd like you to consider.

- When you read about the interaction between Simon and Mirembe, what did you envisage?
- Did issues of race, privilege, power and gender come to mind?
  - If so, why?
  - If not, why not?
- How have you reacted to us drawing your attention to this?
- How did you react earlier when we didn't draw your attention to this?

What we know is that issues of power, equality and diversity play into the dynamics of our relationships in the workplace. They are often difficult subjects to raise with others and to admit to ourselves. We will explore this topic further later in the book and it feels important to recognise that within your repertoire of courageous conversations, you will probably need to find ways of starting conversations that help to pay attention to this. As we finish this chapter, how about this as a courageous starter for Jackie?

> '*Simon, I've been speaking with Mirembe about helping her to become more influential on the ward. She's been very open with me about some cultural issues that make it difficult for her to speak up with confidence and I've been working with her and other members of the team to talk about this and explore how we can enable a better balance of contributions. Put simply, I want all the staff on my ward to be treated fairly and equally and I've observed that isn't always the case. I'm not saying this was a relevant issue in this case but I am asking for your support on this issue. How does that sound?*'

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18 Delegation, Assignment, and Supervision of Patient Care

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A collaborative and communicating team.
Source: jsmith/Getty Images

But again, to look to all these things yourself does not mean to do them yourself. . . if you do it, it is by so much the better, certainly, than if it were not done at all. But can you not ensure that it is done when not done by yourself? Can you ensure that it is not undone when your back is turned? This is what being "in charge" means. And a very important meaning it is, too. The former only implies that just what you can do with your own hands is done. The latter that what ought to be done is always done.

(Florence Nightingale, 1898, Notes on Nursing p. 40)

OBJECTIVES

Upon completion of this chapter, the reader should be able to:

1. Discuss the correlation of RN delegation, assignment, and supervision and optimal safe patient care.
2. Define delegation, assignment, accountability, authority, supervision, **Unlicensed Assistive Personnel** (**UAP**) or **Nurse Assistive Personnel** (NAP) or **Assistive Personnel** (**AP**).
3. Review the 2016 National Guidelines for Nursing Delegation, **National Council of State Boards of Nursing** (**NCSBN**).
4. List the Five Rights of Delegation.

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5. Identify responsibilities of Employer/Nurse Leaders, Licensed Nurses, and Delegatees to support delegation.
6. Identify potential delegation barriers.
7. Outline three individual team member characteristics that could affect team communication.
8. Review a memory device used for hand-offs between shifts, departments, or points along the health care continuum, i.e., the 4 Ps, Purpose, Picture, Plan, and Part.

OPENING SCENARIO

Inappropriate delegation can be life threatening as in the following example.

A patient was admitted to 3C with the diagnosis of ***Transient Ischemic Attack*** *(**TIA**). She required neurological assessments to be performed at the onset of every shift and whenever necessary as indicated by a change in the patient's condition. The night nurse assessed the patient at the beginning of her shift, noting that the patient's neurologic status was fully intact. During the night, the nurse periodically checked on the patient every 2 hr but did not awaken or re-assess the patient. The house supervisor had secured a UAP, working a double shift, as a sitter to keep the patient safe. The sitter had assured the nurse that the patient was "doing fine." The sitter did not report that when the patient had been assisted to the bathroom initially, she had no difficulty. Upon assisting the patient a second time, the sitter noted that the patient was leaning to one side so badly that she could not stand and required help from two additional UAPs. No one reported this to the nurse. When the nurse checked the patient at 6 a.m., she noted that the patient was not able to move her right side.*

1. *How could the nurse have avoided the delay in diagnosis and treatment?*
2. *What are the responsibilities of the nurse and the UAP sitter?*
3. *How would you find out their job responsibilities?*
4. *How could delegation and supervision have been appropriately performed in this situation?*

Registered nurses, through the public trust embedded in their licensure, are expected to lead teams of health care workers to deliver optimal quality, safe nursing care. Throughout all practice sites, RNs delegate and assign tasks based on their knowledge of each patient's condition. They must also apportion and coordinate necessary work processes and supervise the completion of tasks while evaluating the patient's progress toward their intended outcomes. Managing care for more than one patient and working closely with other health care professionals and technicians has been a crucial part of nursing's role for more than a century. This chapter first presents a patient scenario that illustrates why delegation, assignment, and supervision skills are essential to optimal patient safety and quality of care. Key terms will be defined: delegation, assignment, accountability. Authority, supervision, UAP or NAP or AP (Assistive Personnel). As key terms are defined, further detail is provided, such as more in-depth description of the support personnel an RN assigns or delegates care to, and how to decide what to delegate. Further clarification of delegation and supervision decision-making includes a review of the National Guidelines for Nursing Delegation, National Council of State Boards of Nursing (NCSBN, 2016). Tools such as the five Rights of Delegation will be used to help describe the thinking processes nurses use to make patient care decisions. An emphasis on the importance of teamwork and communication to promote patient safety and care quality will be maintained throughout the chapter, including the responsibilities of Employer/Nurse Leaders, Licensed Nurses, and Delegatees for best delegation and assignment practices.

Barriers to delegation and team communication on the part of both the RN and the UAP team members will be explored. A memory device used for hand-offs between shifts, departments, or points along the health care continuum will be reviewed, that is, the 4 Ps, Purpose, Picture, Plan, and Part. Real life examples gleaned from nurses' experiences will be used to illustrate key points.

The Correlation of RN Delegation, Assignment and Supervision and Optimal Safe Patient Care

Nurses must work closely with other health care personnel and use excellent team communication to get the necessary tasks completed for the best patient care. In our current world, it is essential for each person to work at the top of their skills

Table 18.1 Adverse Outcomes of Inadequate Delegation, Assignment, and Supervision

Inadequate Delegation, Assignment, and Supervision by the Nurse May Lead to:	Missed Care such as:	With Patient and Care Team Results such as:
	• Ambulation • Positioning • Turning • Hydration • Nutrition • Hygiene • Observation • Rounding • Toileting • Vital Signs • Oral Care	• Patient Deconditioning (loss of physical strength and/or function) • Extended length of stay • Pressure injuries/ulcers • Deep vein thrombosis and possible emboli • Pneumonia • Constipation • Falls • Urinary Tract Infections • Mouth Sores • Dehydration • Debilitation • Readmission to acute care • Admission to other care sites • Failure To Rescue (FTR) Deteriorating Patients • Poor Patient Satisfaction Scores • Poor RN and Care Giver Job Satisfaction • Possible Job and License Jeopardy

Source: Created by R. Hansten & P. Kelly.

and abilities so that we don't misuse scarce financial and human resources that could be used for others in need of care. Competent entry-level workers performing routine, uncomplicated tasks can multiply the scope of an RN's in-depth global knowledge and ability to create care and healing for more persons overall, while amplifying scarce health care system resources. A well-led health care team also offers patients and their families additional, diverse individuals to observe, assist, and complete care tasks that would be left undone by an overwhelmed RN attempting to do all the care alone. Entry-level assistants may also grow into new health care roles with additional education.

Some novice nurses have believed that leading care teams is a skill best left for developing later in their practice, because it is difficult to assign tasks to others when one is learning the timing and difficulty of the tasks. However, expert delegation, assignment, and supervision are essential for patient safety. Employers of new graduates state that inexperienced nurses allow care to be omitted through ineffective delegation and supervision and that a lack of communication and teamwork skills create patient safety hazards (Diab & Ehrahim, 2019). Experienced RNs self report that these leadership abilities (delegation, assignment, and supervision) are some of the weakest of their professional practice skills, and that role confusion about which team member should be completing which task all contributes to job dissatisfaction (Hansten, Nurse Leader, 2014a).

Care omissions (sometimes called "missed care") due to inadequate RN delegation, assignment, and supervision are often a root cause of errors, health care acquired conditions, and lack of patient progress. When care is not done well or at all, the following negative outcomes can result: pressure injuries, dehydration, pneumonia, falls, urinary tract infections, debilitation, deep vein thrombosis and emboli, constipation, extended patient lengths of stay, patients being sent to additional care sites due to lack of progress, hospital readmissions, and **Failure To Rescue** (**FTR**) deteriorating patients, etc. (Table 18.1) (Kalisch 2015; Mushta et al. 2018). If the RN doesn't delegate well to competent people such as UAP and make certain that nursing care tasks are being done consistently and well, patients suffer. Nurses and other caregivers often feel frustrated with a lack of teamwork and find themselves unhappy with their jobs. Nurses that delegate poorly can put their licenses at jeopardy as well (Brent, 2019; Brous, 2014). The Opening Scenario illustrates a situation in which an RN does not give thorough initial direction to a UAP to take vital signs and report immediately any changes, and has not made patient rounds for initial assessment. Perhaps the RN was involved with one patient and a change in another assigned patient went unheeded. Perhaps the RN merely expected to hear if abnormal signs had been noted. Late in the shift, the RN finally made rounds and finds that the patient has deteriorated and called a rapid response team. This FTR shows inadequate leadership, uncoordinated teamwork, and missed execution of task assignments. In a situation in which UAPs are left unsupervised and are unable to give care due to workload or other problems, the UAP may not report patient observations and care omissions to the RN. If the RN is unable to observe a patient by making rounds and/or direct observation, then a patient can swiftly develop a problem from missed care. Without adequate intervention, this missed care could result in hospital-acquired conditions that may be deadly, painful, expensive, and/or lengthen the patient's recovery.

The ability to lead a group of health care workers and manage the care that needs to be done using principles of delegation, assignment, and supervision, is such an important part

of nursing, that in the National Council of State Boards of Nursing Licensure Examination (NCLEX) a student will often encounter test questions that assess the ability to delegate care. The **Quality and Safety Education for Nurses** (**QSEN**) Institute Prelicensure Competencies include knowledge, skills, and attitudes related to teamwork, communication, and collaboration, all of which are necessary competencies in leading teams and safeguarding patients. To ensure that these responsibilities are met, nurses are accountable under the law for nursing care rendered by both themselves and other personnel.

If these team leadership skills seem too hazardous or complex, remember that nurses rarely work alone without help from others. Mastering delegation, assignment, and supervision will not only enrich nurse's professional life but also those of their patients and team members. This chapter will help novice nurses feel safe and confident in performing the steps of delegation, assignment, and supervision correctly. Additionally, nursing care support roles are crucial to an environment of timely, safe, cost-effective, high-quality care. Significant demands on the health care system will likely see expansion of the types of nursing support workers and more rules related to their use, so the expert delegating nurse will be in high demand. (Maningo & Panthofer, 2018). Remember that UAPs are equipped to assist—not replace—the nurse. In order to assure that a competent UAP can safely assist the nurse within their own level of practice and job description, RNs must know what aspects of nursing can be delegated and what level of supervision is required to ensure that the patient receives safe, high-quality care.

Overview of Terms

In order for the student nurse to develop team leadership skills through expert allocation of work, a brief overview of terms is given in this section, necessary so that the student will not be confused by unfamiliar concepts (Table 18.2). Each term will be discussed more extensively in the appropriate following section of the chapter, along with information about how to implement that term in daily practice. These terms are closely linked: for example, a nurse that delegates or assigns care tasks must also supervise the personnel that were assigned the care and be certain that the care was done correctly and completely. The RN must also understand and differentiate team member roles. The RN has the authority within state nursing practice law to delegate tasks to competent other personnel delegates (sometimes referred to as "delegatees") such as UAPs. For this chapter we will most often use the term UAP for these unlicensed delegates. NAP is another term used for the same group of unlicensed delegates in some state nurse practice acts or advisory statements. The term, Assistive Personnel (AP), was adopted by the **American Nurses Association** (**ANA**) and NCSBN in their 2019 National Guidelines for Nursing Delegation to connote UAPs (ANA/NCSBN, 2019). The terms "delegates" or "delegatees" are used interchangeably as the personnel who have been delegated to do some work by another health care professional. A delegate or delegatee is described by the NCSBN as "one who is delegated a nursing responsibility. . . and is competent to perform it, and verbally accepts the responsibility" and could refer to an "RN, LPN/LVN or UAP" (NCSBN, 2016, p. 7). In this text we will most often use the term, "delegate" rather than "delegatee," unless quoting an organization that uses that terminology. RNs may also assign work to, direct, and supervise Licensed Practical Nurses/Licensed Vocational Nurses (LPN/LVNs). RNs who delegate and assign patient care are accountable for their professional decision making and for the nursing care of their patients, no matter which nursing support personnel (LPN/LVNs and/or UAPs) may be delivering some of the care. RNs may never delegate the nursing process or nursing clinical judgment (Anderson, 2018, p. 51).

Delegation Definition

Nursing delegation was discussed by Nightingale in the 1800s and has continued to evolve since then. The American Nurses Association (ANA) defined **delegation** as the "transfer of responsibility for the performance of a task from one individual to another while retaining accountability for the outcome" (ANA, 2014, p. 22).

Delegation was defined by the NCSBN in 2016 as, "Allowing a delegatee (NAP, for example) to perform a specific nursing activity, skill, or procedure that is beyond the delegatee's traditional role and not routinely performed." (NCSBN 2016, p. 6).

The ANA and National Council of State Boards of Nursing 2019 Joint Statement, National Guidelines for Nursing Delegation, states that, "The decision of whether or not to delegate or assign is based upon the RN's judgment concerning the condition of the patient, the competence of all members of the nursing team. and the degree of supervision that will be required of the RN if a task is delegated" (ANA, 2019, p. 1). The National Council of State Boards of Nursing states that, "The licensed nurse must determine the needs of the patient and whether those needs are matched by the knowledge, skills, and abilities of the delegatee and can be performed safely by the delegatee. The licensed nurse cannot delegate any activity that requires clinical reasoning, nursing judgment, or critical decision making. The licensed nurse must ultimately make the final decision whether an activity is appropriate to delegate to the delegatee based on the Five Rights of Delegation" Sources: National Council of State Boards of Nursing, 1995, 1996.

Who Are the Delegates? UAP or NAP or AP and LPNS/LVNS

State nurse practice acts define the legal parameters for nursing practice. Most states authorize RNs to thoughtfully delegate patient care activities, and all states expect RNs to be able to assign care. Individual state nurse practice acts may have different definitions and rules for delegation, assignment, supervision, and the roles permitted for various levels of personnel.

Table 18.2 Definition of Terms

Term	Definition
Delegation	Delegation is the transfer of responsibility for the performance of a task from one individual to another while retaining accountability for the outcome. (ANA, 2014, p. 22). Each state may have a different (similar) definition.
To assign (Verb)	To allocate "routine care, activities, procedures that are within the authorized scope of practice of the RN or LPN (LVN) or part of the routine functions" of the NAP (NCSBN 2016, p. 6, 7).
Assignment (noun)	The "routine care, activities, procedures that are within the authorized scope of practice of the RN or LPN/LVN or part of the routine functions" of the AP (NCSBN, 2016).
Supervision	Supervision is "the active process of directing, guiding, and influencing the outcome of an individual's performance of a task."
Accountability	Accountability is defined as "to be answerable to oneself and others for one's own choices, decisions, and actions as measured against a standard" (NCSBN, 2016, p. 7). Nursing accountability includes the preparedness and obligation to explain or justify to relevant others (including the regulatory authority) the relevant judgments, intentions, decisions, actions, and omissions, as well as the consequences of those judgments, intentions, decisions, actions, and omissions.
Authority	**Authority** is the right to act or to command the action of others; (NCSBN, 2016, p. 6). Authority occurs when a person who has been given the right to delegate based on the state nurse practice act also has the official power from an agency to delegate.
Competence	**Competence** is the "ability to accomplish specific skills safely and effectively under various circumstances" and true competency is confirmed as nurses "consistently display appropriate behaviors and sound judgments at the point of care" (Alfaro-LeFevre, 2017, p. 61).
Clinical judgment (or professional clinical judgment)	**Clinical judgment** is the "outcome of critical thinking or clinical reasoning, the conclusion, decision, or opinion you make after thinking about the issues" (Alfaro-LeFevre, 2017, p. 6).
LPNs/LVNs Licensed practical nurse or licensed vocational nurse	LPN/LVNs are licensed nurses that perform routine uncomplicated nursing care in a dependent role under the delegation (or "direction" depending on the state) and supervision of RNs or other licensed care providers such as nurse practitioners, physicians, dentists or others. Their roles vary depending on practice site and state.
UAP (Unlicensed assistive personnel) Or NAP (Nursing assistive personnel)	**UAP** job class is "an umbrella term to describe . . .paraprofessionals who assist individuals with physical disabilities, mental impairments, and other health care needs with their activities of daily living and provide care—including basic nursing procedures—all under the supervision of the registered nurse, licensed practical nurse (in some states), and other health care professionals (ANA, Duffy & McCoy, 2014)."
Or AP (Assistive Personnel)	AP (Assistive Personnel) is a term used to describe any assistive personnel trained to "function in a supportive role, regardless of title, to whom nursing responsibility may be delegated. This includes but is not limited to nursing assistants or aides (CNAs or certified nursing assistants), patient care technicians, CMAs (certified medication aides), and home health aides (formerly referred to as 'unlicensed' assistive personnel (UAP)" (ANA, 2019), www.nursingworld.org/globalassets/practiceandpolicy/nursing-excellence/ana-position-statements-secure/ana-ncsbn-joint-statement-on-delegation.pdf)
Delegates or delegatees	"Delegates" or "delegatees" are used interchangeably as terms for the personnel who have been delegated to do some work by another health care professional. A delegate, as described by the NCSBN, is "one who is delegated a nursing responsibility. . .and is competent to perform it, and verbally accepts the responsibility." A delegatee may be an RN, LPN/LVN or UAP (NCSBN, 2016, p. 7).

Source: Compiled by R. Hansten & P. Kelly.

Unfortunately, research also shows that UAP are sometimes delegated tasks beyond their capabilities and that caregivers are also sometimes confused about their role boundaries (NCSBN 2016, Journal of Nursing Regulation, pp. 7–8). The ANA defines the **UAP** job class as

> *an umbrella term to describe . . . paraprofessionals who assist individuals with physical disabilities, mental impairments, and other health care needs with their activities of daily living and provide care—including basic nursing procedures—all under the supervision of the registered nurse, licensed practical nurse (in some states), and other health care professionals. (ANA, Duffy & McCoy, Delegation and You, 2014).*

In 2019, the ANA updated their term to Assistive Personnel (AP) to describe these same personnel trained to function in a supportive role, regardless of title, to whom nursing responsibility may be delegated. This includes but is not limited to nursing assistants or aides, Certified Nursing Assistants (CNAs), patient care technicians, CMAs (certified medication aides or Medication Aides-certified), and home health aides

(formerly referred to as Unlicensed Assistive Personnel (UAP). (ANA, 2019, and NCSBN, 2019)

The Joint Statement of the ANA and NCSBN (2019) uses the term, Assistive Personnel (AP), to delineate unlicensed employees that aid the licensed nurse with nursing activities. The NCSBN has also stated that the term UAP can be used to identify the helpful unlicensed group that includes certified nursing assistants, patient care technicians of various types (i.e., psychiatric, rehabilitation), home health aides, certified medication aides, and certified medical assistants (CMA or MA) in ambulatory care (NCSBN, 2016, p. 7).

The term, UAP, also includes nurse aides, nurse technicians, patient care technicians, personal care attendants, unit assistants, and other non-licensed personnel. School nurses may work with school secretaries to deliver carefully-regulated care in the absence of the RN on-site; ambulatory nurses may supervise **Medical Assistant**s (**MA**s); long-term-care or assisted-living nurses work with rehabilitation aides and Certified Medication Aides (CMAs) in some states; perioperative RNs may supervise surgical technicians; home health RNs delegate to home care aides with specific regulations and public health nurses coordinate and lead community health workers. Many of these roles are regulated separately within each state's practice regulations. In some states, medications and select injections can be given by Certified Medication Aides in long-term care or home care and Medical Assistants in ambulatory care (Beeber et al., 2018, p. 1–9; Maningo & Panthofer 2018, 1–2). All of these UAPs are considered unlicensed and their roles can vary from state by state.

Supportive unlicensed health care personnel may or may not hold various training certifications. Unlicensed personnel such as UAPs could be referred to as "delegates" or "delegatees" in state nurse practice acts or specialty nursing organization practice documents. LPN/LVNs are licensed, however, so these nurses are not considered a UAP, but an RN may be delegating to or directing them, assigning care to them, and supervising them. For novice nurses, role terminology can be confusing but this chapter will clarify how to apply the ideas of delegation and assignment to work with others in practical, daily nursing practice. The decision-making principles remain the same whether assigning or delegating, because an RN should not delegate or assign to a person any task beyond the RN's scope of practice, nor beyond the delegate's state-allowed practice or organization's job description, or beyond the delegate's competency. A competent RN would never assign nor delegate a task that does not match the individual patient's needs.

The nursing profession is responsible for determining the scope of nursing practice and may supervise the care given by such personnel as **Health Care Assistant**s (**HCA**s) or Medical Assistants (MAs), even though they do not necessarily train them. The RN may also coordinate the care of a patient receiving care by other inter-professional health care team members and technicians such as respiratory therapists, physical therapists and technicians, and social workers, while not delegating, supervising, or assigning them care. The RN is in charge of nursing care and determines the appropriate utilization of any UAP involved in providing direct nursing care. The nurse who delegates to a UAP retains accountability for that patient and the completion and results of the task that was delegated. "The licensed nurse maintains accountability for the patient, while the delegatee (UAP, for example) is responsible for the delegated activity, skill, or procedure" (NCSBN, 2016, p. 11). A task delegated to a UAP cannot be re-delegated by the UAP.

Multiple levels of UAP give care to patients in various settings. LPN/LVNs may be able to delegate (or not) in certain states within some areas of practice and circumstances. Their scope of practice is also variable nationally.

In all cases, RNs must know the state practice statute, state rules, and State Board of Nursing advisory opinions for each team member's role in their state. The state practice statute may describe whether or not LPN/LVNs can delegate and in which setting. For example, the Washington State Nursing Care Quality Assurance Commission (the Washington State Board of Nursing's title) Advisory Opinion 13.01 clarifies the independent role of the RN and the interdependent and dependent role of the LPN. In that state, LPNs can delegate but only in certain settings: acute care, nursing homes, clinics, but not community settings or schools. (www.doh.wa.gov/Portals/1/Documents/6000/NCAO13.pdf). For an example of another state variance, in Texas, Licensed Vocational Nurses (as LPN/LVNs are titled there) are not allowed to delegate and their practice is "directed and supervised." (p. 2 of FAQ of Texas Board of Nursing Rule 224 Board Rule 224 at www.bon.texas.gov/faq_delegation.asp#t6).

State documents to guide your decisions are available online by visiting www.NCSBN.org, and linking to, Nursing Regulation. Then, click on, About U.S. Boards of Nursing, then scroll down to, Contact a nursing member, and find your state; and/or by visiting your state nursing board or quality assurance commission online. View not only the statute (law) but also the administrative code, rules, and advisory opinions that you will find at your state board's website.

How to Decide What to Delegate or Assign

As described by the ANA (Duffy & McCoy "Delegation and You," 2014), nurses must first know their patients, or perform an assessment of the needs of the patient/population. Secondly, a plan must be designed with the patient and his family before the RN can be certain about what tasks can and should be delegated, based on the patient/family's desired outcome. Thirdly, the nurse must analyze key factors before delegation, such as the scope of practice of the desired tasks, laws or regulations that guide nursing practice and the state practice guidelines for the UAP, the job description and policies of the employing organization, the competence of both the RN and the UAP, and the type and availability of supervision, given the

circumstances. Next, the delegated tasks must be supervised, monitored, and evaluated, along with the patient's response to the tasks. The UAP must also be evaluated and feedback should be given. The RN is the final decision maker about delegation decisions because of their unique understanding of each particular patient, delegate, and situation and the RN should not be over-ridden by any organizational policies (ANA, 2014, Duffy& McCoy, Delegation and You, pp. 14–19.)

Accountability

Nurses are legally liable for their actions and are accountable for the overall nursing care of their patients. Professional nurses are accountable for their expert clinical leadership and decision,making, including decisions related to delegation, supervision, and assignment. **Accountability** is defined as, "to be answerable to oneself and others for one's own choices, decisions, and actions as measured against a standard" (NCSBN, 2016, p. 7). Being accountable as a nurse means being "answerable for what one has done" or said, or not done and "standing behind that decision or action" (Hansten & Jackson 2009 p. 79.)

Licensed nurse accountability involves compliance with legal requirements as set forth in the jurisdiction's laws and rules governing nursing. The licensed nurse is also accountable for the quality of the nursing care provided; for recognizing their own limits, knowledge, and experience, for asking for help or clarification when uncertain, and for planning for situations beyond the nurse's expertise (NCSBN, 2005)**.** Nursing accountability includes the preparedness and obligation to explain or justify to relevant others (including the regulatory authority) the relevant judgments, intentions, decisions, actions, and omissions, as well as the consequences of those decisions, actions, and behaviors. Nurses are accountable for following their state nurse practice act (including rules and advisory opinions), the standards of professional practice from their board of nursing and/or their professional specialty, the policies of their health care organization, and nursing ethics. Nurses are also accountable for the full nursing process (assessment, nursing diagnosis, planning with the patient/family, implementation, and evaluation), monitoring changes in a patient's status, noting and implementing treatment for human responses to illness, and assisting in the prevention of complications.

The RN uses nursing judgment in all aspects of the nursing process. Professional **clinical judgment** is the "outcome of critical thinking or clinical reasoning, the conclusion, decision, or opinion you make after thinking about the issues" (Alfaro-LeFevre, 2017, p. 6). The monitoring of more stable patients cared for by the LPN/LVN and UAP may involve the RN's direct, continuing presence or the monitoring may be more intermittent. The assessment, nursing diagnosis, planning, and some parts of implementation such as teaching, and the evaluation stages of the nursing process may not be delegated to the UAP. Delegated activities or tasks usually fall within the implementation phase of the nursing process**.** Note that data collection such as taking vital signs or collecting intake and output information is not assessment. Assessment includes the interpretation of data for a particular patient. Remember that UAPs also have accountability to keep current in their particular certification, to communicate with the delegating nurse about their ability to accept and complete their assignment, and to complete the assignment they accepted.

Authority

The right to delegate duties and give direction to UAPs places the RN in a position of authority. **Authority** is the right to act or to command the action of others; it comes with the job and is required for a nurse to take action. The person to whom a task and authority have been delegated must be free to make decisions regarding the activities involved in performing that task. Without authority, the nurse cannot function to meet the needs of patients. In Washington State's administrative code, a definition of nursing supervision highlights that authority: **"Supervision** of licensed or unlicensed nursing personnel means the provision of guidance and evaluation for the accomplishment of a nursing task or activity with the initial direction of the task or activity; periodic inspection of the actual act of accomplishing the task or activity; and the authority to require corrective action." Source: Washington Administrative Code 246-840-010 Definitions. Public Domain. The fact that RNs possess this authority is sometimes surprising to practicing RNs, and questions about the RN's authority to require UAPs to correct their performance or task completion may be reflected in the NCLEX licensing examination.

Assignment

In 2016, the NCSBN updated the definition of delegation "to allow a delegatee (person to whom delegated tasks are allocated, a UAP, for example) to perform a specific nursing

Critical Thinking 18.1

No matter where RNs work in health care teams, they are busy. Delegating or assigning others some tasks could mean they could possibly miss changes in a patient's condition. How might nurses avoid omitting care or missing changes in patient's conditions that may have occurred in their delegated or assigned patients?

activity, skill, or procedure that is beyond the delegatee's traditional role and not routinely performed" (NCSBN, Journal of Nursing Regulation, 2016, p. 6). An **assignment** is the "routine care, activities, procedures that are within the authorized scope of practice of the RN or LPN/LVN or part of the routine functions" of the UAP (NCSBN, 2016, p. 6). This definition of assignment would clarify that when the RN is assigning care to another RN, it is not delegation, it is assignment. If the RN assigns routine care within the LPN/LVN job description, then the process is considered by the NCSBN as "assignment" rather than "delegation," although some states call this process "delegation" or "direction." of routine activities. Your state may or may not use the term "direction" but it may refer to task allocation when the delegate is licensed. The NCSBN also includes RN, LPN/LVNs, and UAP as "delegatees to whom the activity, skill or procedure has been delegated" thus inferring that "delegation" rather than "assignment" occurs when the task assigned is beyond the delegate's basic education level (NCSBN, 2016, p. 6). The ANA simplifies assignment with the definition that it is "the distribution of work that each staff member is responsible for during a given work period" (ANA, 2014, Delegation and You, p. 22). While this differentiation between assigning and delegating could be confusing to newly licensed nurses, the principles of delivering safe care through competent others remain the same. Whenever care performance is being transferred from the RN to another care provider, the assigning RN must ensure that the education, skill, knowledge, and judgment levels of the care provider being allocated to perform a task are commensurate with the assignment. In acute care settings, a charge nurse or manager may allocate care on an assignment sheet, taking into consideration the skill, knowledge, and judgment of the RNs, LPN/LVNs, and UAP. Assignments are given to team members that have the appropriate knowledge and skill to complete them. Assignments must always be within the legal scope of practice. Assignment sheets are used to identify patient care duties for RNs, LPN/LVNs, and/or UAP. Table 18.3 shows a basic concept of task assignment to help the student nurse think through the process.

An assignment designates those activities that a team member is responsible for performing as a condition of employment. This is consistent with the team member's job position and description, legal scope of practice, and education and experience. Scope of practice refers to the parameters of the authority to practice granted to a nurse through licensure (NCSBN, 2005). Experienced RNs are expected to work with minimal supervision of their nursing practice. The RN who assigns care to another competent RN who then assumes responsibility and accountability for that patient's care will not need to closely supervise that nurse's work unless the RN is a novice, a temporary float, or expresses concern about the assignment. The RN can assign or delegate or direct patient care (term used depends on the state) to the LPN/LVN or delegate or assign tasks to the UAP, but the RN retains accountability for the patient's nursing care. LPN/LVNs and UAP both work under the direction of the RN. LPN/LVNs could also work under the supervision of a dentist, MD, or advanced practice nurse, as well as an RN, for example in ambulatory care clinics. The LPN/LVN could be delegated, assigned, or directed specific tasks or patients for whom to perform care, but the RN remains responsible for supervising the nursing care of those patients. It is crucial to recognize that LPN/LVN roles are highly state and site specific. The LPN/LVN roles can vary from giving oral medications to administering intravenous fluids and intravenous medications (with special training and restrictions by state and site) and some standard treatments and data gathering based on state and organizational permissions. Blood product administration and total parenteral nutrition through central lines are often prohibited tasks for LPN/LVNs, but this can also vary by state and practice setting.

Table 18.3 Assignment Sheet

Unit
Date
Shift
Charge nurse
_____
_____
RN

LPN/LVN
UAP
_____
_____
Breaks/Lunch

Room	Patient Name	Dx[a]	IV	Feed, I&O. Weight	Bath/ Type	Amb[b] X____	Code Status, Other

[a] Dx = Diagnosis.
[b] Amb = Ambulation.

Source: Created by R. Hansten & P. Kelly.

Typical tasks that could be delegated or assigned to a UAP in acute care settings may include passing meal trays, feeding uncomplicated patients, assisting with transfers, positioning and ambulation, toileting, vital signs, transporting patients, hygienic care, and stocking supplies. The RN must know patients' conditions before delegating or assigning. The RN must understand patient circumstances, i.e., the patient's level of consciousness, vital signs, physical status, changing needs, complexity, stability, multisystem involvement, and technology requirements, such as the need for cardiac monitoring. The RN would also consider patient teaching and emotional support needs and plans for discharge or transfer as well as other family needs when delegating or making assignments. A key principle in nursing practice is that RNs are accountable for the nursing care of their patients, whether they do the care themselves, or delegate or assign these tasks to others (Table 18.4).

The student or novice nurse need not spend precious time learning whether they are "delegating" or "assigning" tasks to their co-workers while attempting to learn how to be a professional nurse themselves. The NCSBN has stated that asking personnel to do tasks within their basic educational program coursework is "assignment" rather than "delegation." However, novices and experienced nurses alike would have difficulty being current and cognizant of the basic educational competencies for the 100 or more UAP roles in use in the United States across the continuum of care. The process of nursing task allocation remains the same for safe, effective "delegation" and/or "assignment."

Five Rights of Delegation

Once nurses know what their own state board has promulgated related to rules for delegating, assigning, and supervising, and they are clear on the state role definitions or scopes of practice, each job description and role must be understood definitively. Then the nurse, with knowledge of the particular patients in their assignment and their intended outcomes, can match the competencies of the team members with the tasks that need to be done, delegate and/or assign these tasks, and then supervise appropriately. Remember that supervision is a multifaceted process of appropriate guidance, direction, oversight, and evaluation. An RN should never ask team members to perform a task that is not within the nurse's own competency or scope of practice, nor to step beyond the individual team member's role, competency, or approved job description, whether they are "delegating" or "assigning." Mental checklists such as the five Rights of Delegation (Table 18.5) apply to both processes of "delegating" and "assigning."

The five Rights of Delegation (NCSBN, 2016) is a memory tool for safety and confidence in delegating or assigning. Similar to the six Rights of Medication Administration checklist, this five Rights of Delegation checklist helps a nurse standardize their mental processes.

Right Task

Base all task assignments on the patient's desired outcome. What is the patient wanting to achieve from this episode of care? Two patients, one a new postop patient that would like to go home soon with a new hip, or another patient being allowed to die with dignity and comfort at a Hospice are very different desired patient outcomes. An RN's choices about who performs each patient's vital signs and what parameters an RN would give to the UAP for reporting vital signs would be very different. The task must fit with a particular patient's plan of care and should not be a "rote" choice, since there will be exceptions to tasks that are usually within the normal range of duties. For example, the task of "gathering vital signs" may not make sense for the dying patient or for a stable person that needs to sleep uninterrupted. Any task an RN would delegate or assign to a competent person must first be within the

Table 18.4 Key Delegation and Assignment Principles in Nursing Practice

RNs are accountable for the nursing care of their patients whether they:

- Do the care themselves or
- Delegate or assign and supervise tasks done by others

Once nurses are clear on:

- State board rules for delegating, assigning, and supervising
- State board role definition or scope of practice for each delegate
- Each delegate's organizational job description and role

Then the nurse, with knowledge of their patients' needs and their intended outcomes, can:

- Match the competencies of the team members with the tasks that need to be done, and
- Delegate, or assign these tasks appropriately.

When RNs delegate or assign a nursing task, they must also supervise, including:

- Appropriate initial direction,
- Monitoring the activity and its documentation,
- Periodic follow up,
- Evaluation of the results, and
- Feedback to the delegate.

Source: Adapted from: National Council of State Boards of Nursing (NCSBN), 2019. NCSBN and ANA National Guidelines for Nursing Delegation.

Table 18.5 The Five Rights of Delegation

Right task	The activity falls within the delegate's job description or is included in part of the established written policies and procedures of the nursing practice setting. The facility needs to ensure the policies and procedures describe the expectations and limits of the activity and provide any necessary competency training.
Right circumstances	The health condition of the patient must be stable. If the patient's condition changes, the delegate must communicate this to the licensed nurse and the licensed nurse must re-assess the situation and the appropriateness of the delegation.
Right person	The licensed nurse along with the employer and the delegate is responsible for ensuring that the delegate possesses the appropriate skills and knowledge to perform the delegated activity.
Right directions and communication	• Each delegation situation should be specific to the patient, the licensed nurse, and the delegatee. • The licensed nurse is expected to communicate specific instructions for the delegated activity to the delegatee; the delegatee, as part of two-way communication, should ask any clarifying questions. This communication includes any data that needs to be collected, the method for collecting the data, the time frame for reporting the results to the licensed nurse, and any additional information pertinent to the situation. • The delegatee must understand the terms of the delegation and must agree to accept the delegated activity. • The licensed nurse should ensure that the delegatee understands that she or he cannot make any decisions or modifications in carrying out the activity without first consulting the licensed nurse.
Right supervision and evaluation	The licensed nurse is responsible for monitoring the delegated activity, following up with the delegatee at the completion of the activity, and evaluating patient outcomes. The delegatee is responsible for communicating patient information to the licensed nurse during the delegation situation. The licensed nurse should be ready and available to help and intervene as necessary. The licensed nurse should ensure appropriate documentation of the activity is completed. Source: National Council of State Boards of Nursing (NCSBN), 2019. NCSBN and ANA National Guidelines for Nursing Delegation.

RN and UAP scope of practice, job description, and written policies and procedures of the facility. "The facility needs to ensure the policies and procedures describe the expectations and limits of the activity and provide any necessary competency training" Source: National Council of State Boards of Nursing (NCSBN), 2019. NCSBN and ANA National Guidelines for Nursing Delegation. The UAP must also be competent and willing to perform the assigned task.

Right Circumstance

Be aware that each practice arena (home health, long-term care, schools, acute care) may have different state rules related to delegation and assignment to team members. Also, each nurse must know that the patient's health condition is stable (NCSBN & ANA, 2019) and have enough knowledge of the patient's condition before knowing what can be delegated or assigned. How much supervision will be necessary and what are the number and type of personnel available? In home care, for example, a list of written, detailed instructions may be used to delegate or assign tasks to home health aides, since the RN is only available by phone or computer and/or on intermittent joint visits. "If the patient's condition changes, the delegatee must communicate this to the licensed nurse, and the licensed nurse must reassess the situation and the appropriateness of the delegation" Source: National Council of State Boards of Nursing (NCSBN), 2019. NCSBN and ANA National Guidelines for Nursing Delegation.

Right Person

The potential delegate must be competent as the organization's job descriptions and the delegate's skills checklist would specify. The task for each particular patient should match the UAPs abilities and willingness to perform the work.

"The licensed nurse along with the employer and the delegatee is responsible for ensuring that the delegatee possesses the appropriate skills and knowledge to perform the activity" Source: National Council of State Boards of Nursing (NCSBN), 2019. NCSBN and ANA National Guidelines for Nursing Delegation.

Consider the personalities and learning needs of each individual and use those criteria also. For example, think about whether the friendly and talkative nature of a UAP would match well with a patient needing extra socialization, or if a new LPN/LVN needs to get more comfortable with a particular skill and you or the nurse educator has time to teach them and evaluate their progress. Consider that the very hard-of-hearing patient may not communicate well with a soft-spoken, newly English-fluent UAP.

Right Direction and Communication

This is where supervision starts. When RNs delegate or assign patient care, they must supervise the delegates. Initial direction as a part of the supervisory process must be clear, concise, correct, and complete (ANA & NCSBN Joint Statement, 2006; Hansten, 2021 in Zerwekh and Garneau, p. 316).

"This direction and communication includes any data that need to be collected, the method for collecting the data, the time frame for reporting the results to the licensed nurse, and any additional information pertinent to the situation" Source: National Council of State Boards of Nursing (NCSBN), 2019. NCSBN and ANA National Guidelines for Nursing Delegation. Delegates must understand the instructions, ask any clarifying questions, and be willing and able to do the work

as described. "The licensed nurse should ensure that the delegatee understands that she or he cannot make any decisions or modifications in carrying out the activity without first consulting the licensed nurse" Source: National Council of State Boards of Nursing (NCSBN), 2019. NCSBN and ANA National Guidelines for Nursing Delegation. Be certain to add parameters for reporting, for example, what patient conditions would mean "call me immediately," versus "wait to tell me when we huddle again before lunch." Best practices include offering initial direction to a UAP while making first rounds with them during the off-going shift report in acute care. This off-going/oncoming shift handoff report allows for the patient/family, RN, and UAP to understand the plan for the shift and may mean improved follow up and task completion. Check points along the shift must be planned early in the shift so that each team member can count on time to report patient care activity, patient condition changes, what's been accomplished, and variations in the shift's plan.

Right Supervision and Evaluation

Evaluation of the care and the UAP's work, along with offering and receiving feedback about how the work was done, is one of the lowest self-ranked professional leadership abilities and most in need of improvement in experienced RNs (Hansten Healthcare PLLC confidential database, 2019). Nursing evaluation (as a part of the supervision process) includes review of patient outcomes and response to care, sharing the information accrued by both the UAP and RN jointly throughout the care process, ongoing monitoring, evaluation, and follow up with the delegatee at the completion of the activity, review of how the care was completed by the UAP, and documentation of all completed patient activities in the organization's electronic health record or paper chart in accordance with the organization's standards. Ongoing checkpoints throughout the episode of care between RNs and delegates are essential to share patient and care progress information in order to update and change course when needed. A number of checkpoints or "catch up huddles" can be held before and after breaks, meals, and certainly before change of shift. For longer-term caseloads, these checkpoints may be weekly (e.g., in home care or assisted living settings).

Practical Application of the Five Rights of Delegation to a Legal Case

Because patient safety and care quality is a major emphasis of this chapter, practical application of the five Rights of Delegation to a legal case in which a patient died as a result of negligent task delegation or assignment will illustrate the importance of the five Rights of Delegation memory tool. Discussed in the *American Journal of Nursing* as an example of poor delegation contributing to an untimely death, an RN assigned an unfamiliar UAP (in this hospital, called a nursing assistant) to feed a patient with dysphagia. This patient with dysphagia was fed a sandwich without feeding precautions. The patient then choked, aspirated, and died (Brous, 2014).

1. **Right task?**

   No. The task of feeding a patient with dysphagia could possibly be delegated or assigned, but only if the RN was certain the delegate was competent and the patient was stable. "The facility needs to ensure the policies and procedures describe the expectations and limits of the activity and provide any necessary competency training" Source: National Council of State Boards of Nursing (NCSBN), 2019. NCSBN and ANA National Guidelines for Nursing Delegation. Many health care organizations will evaluate a UAP's competency on this feeding task with careful education and review and often record this evaluation on a competency check-list. This is a delegable or assignable task in a stable patient with a trained and experienced UAP, but not in this case, due to the fragility of the patient and the incompetence of the UAP.

2. **Right circumstance**?

   No. In this case, the RN had not assessed the patient's stability and ability to swallow, even though she had allegedly been told about his feeding plan and aspiration precautions by the patient's wife and physician. In the acute care hospital, it is possible that an RN could safely delegate or assign a competent UAP to feed a stable dysphagic patient if the RN knew that the UAP was competent and had possibly observed how well a particular UAP was able to feed a patient. When the RN does not know the patient's or team member's abilities well enough to safely assign tasks, no situation can be the "right" circumstance.

3. **Right person?**

   No. The UAP's competency was unknown to the RN. "The licensed nurse along with the employer and the delegatee is responsible for ensuring that the delegatee possesses the appropriate skills and knowledge to perform the activity" (NCSBN & ANA, 2019, p. 4). There could have been a lucky "near miss" situation had the UAP been trained and competent. The RN should never delegate or assign a task for which a person's competency is unknown.

4. **Right direction and communication?**

   No. If the RN had asked the UAP about their ability with feeding precautions, and asked, "what steps would you take to make sure Mr. T. doesn't choke?," she would have initiated two-way communication and discovery of the UAP's lack of understanding of feeding a dysphagic patient and aspiration precautions. Better direction and communication could have involved: rounding with the UAP to the patient's room to discuss the feeding steps, directing the UAP at the patient's bedside, and demonstrating feeding to the UAP during the first time this patient was fed. If the RN had never worked with the UAP before and then questioned the UAP before the task was delegated, and the UAP said, "Yes, I know how to do this," it would still be incumbent on the RN to further evaluate the situation

and the UAP's ability and to supervise the feeding of this unstable patient, as needed. The UAP should not be pressured and should be encouraged to clarify her discomfort with procedures openly and honestly. "The licensed nurse should ensure that the delegatee understands that she or he cannot make any decisions or modifications in carrying out the activity without first consulting the licensed nurse"(NCSBN & ANA, 2019, p. 4).

5. **Right supervision and evaluation?**

   No. "The licensed nurse is responsible for monitoring the delegated activity, following up with the delegatee at the completion of the activity, and evaluating patient outcomes" Source: National Council of State Boards of Nursing (NCSBN), 2019. NCSBN and ANA National Guidelines for Nursing Delegation. It is unclear whether or not the RN had set up routine times for the UAP to check in with her and receive ongoing clarification or whether the supervisory RN was making rounds to observe care being completed. The right supervision and evaluation could have saved this patient's life.

Safety errors are often multifactorial in origin and present multiple points at which the correct supervision and evaluation could stop the adverse event and save a life. Applying and using the five Rights of Delegation appropriately could have put a stop to a mistake that these RNs and UAPs will never forget. In the case of Mr. Travaglini, had the RN applied the five Rights of Delegation, the patient and his wife may have enjoyed more time together, rather than experiencing a harrowing death with a subsequent lawsuit.

Competence

Competence is the "ability to accomplish specific skills safely and effectively under various circumstances" and true competency is confirmed as nurses "consistently display appropriate behaviors and sound judgments at the point of care" (Alfaro-LeFevre, 2017, p. 61). All professionals would agree that maintaining competence is essential to expertly lead the care team, and expert clinicians grow not only in clinical knowledge but also emotional intelligence and ethical personal attributes. Licensed nurse competence is built upon the knowledge gained during a nursing education program, orientation to specific settings, learning experiences in their care specialty, reflection on their own strengths and challenges, and ongoing continuing education based on self-assessment, evaluation, and ongoing clinical changes.

UAP competence is built upon formal training and assessment, orientation to specific settings and groups of patients, interpersonal and communication skills, and the experience of the UAP in assisting the nurse to provide safe nursing care.

Chief nursing officers (**CNO**s) and managers are accountable for establishing systems to assess, monitor, verify, and communicate ongoing competence requirements in areas related to delegation and clinical issues (ANA & NCSBN, 2006). Written documentation of these competencies is maintained in the employee's personnel file. Some organizations ask UAPs to carry laminated cards that show their completed task competencies or maintain a frequently updated online list. Most health care organizations require employees to undergo annual competency training for elements of care unique to their practice setting. Annual competency testing for RN, LPN/LVN, and UAP may include: patient safety, infection control, resuscitation, chain of command, privacy protection under **Health Insurance Portability and Accountability Act** (**HIPAA**), use of restraints, and a variety of other skills.

Supervision

Supervision is the provision of guidance or direction, evaluation, and follow up by the licensed nurse for accomplishment of a nursing task delegated to UAP (NCSBN, 1995). ANA (2014, Duffy & McCoy, Delegation and You) states that supervision is "the active process of directing, guiding, and influencing the outcome of an individual's performance of a task" (ANA, 2014, Duffy & McCoy, Delegation and You, p. 23). Supervision of licensed or unlicensed nursing personnel means:

- "the provision of guidance and evaluation for the accomplishment of a nursing task or activity with
- the initial direction of the task or activity;
- periodic inspection of the actual act of accomplishing the task or activity; and
- the authority to require corrective action" (Washington Administrative Code 246-840-010).

The type of clinical supervision discussed in this chapter does not include administrative supervision that is present in a managerial job description that allows for hiring and firing ability. Clinical supervision can be categorized as on-site, in which the nurse is physically present or immediately available while the activity is being performed, or off-site, in which the nurse has the ability to provide direction through various means of written, verbal, and electronic communication (ANA, 2005). On-site supervision generally occurs in the acute care setting where the RN is immediately available. Off-site supervision may occur in home care, group homes, or community settings such as schools. A nurse who is delegating, assigning, and supervising care will provide clear direction to the team about what tasks are to be performed for specific patients. The supervising nurse must identify when and how the care is to be done, what patient/family outcomes are expected from the care, what information must be collected and reported, the times for reporting information and results, and any other patient-specific information. The supervising nurse will also monitor patient status and staff performance and obtain feedback from staff and patients in an ongoing manner, intervening as necessary to ensure compliance with established standards of practice, policy, and procedure.

Feedback

Feedback is a part of the evaluation process that is required in supervision. If the LPN/LVN or UAP performs poorly, the RN should tell them about mistakes, privately as much as possible, in a supportive manner, with a focus on quality of patient care and learning from mistakes so that all can complete their work effectively. If a team member, whether an RN, LPN/LVN, or UAP (or with unsafe activity by any other professional), performs in an inappropriate, unsafe, or incompetent manner, the RN must intervene immediately and stop the unsafe activity, discuss it with the team member, document the facts, and report the situation to the nurse manager or nursing supervisor as soon as possible. It is important to note that regular feedback should be given to the team, both positive and negative when necessary. Frequent, detailed, specific feedback strengthens team motivation and reinforces positive traits in team members.

What to Assess Before Delegation or Assignment

Even though the development of working skills in delegation is an outcome expectation of baccalaureate nursing program graduates (AACN, 2019), as well as all nursing graduates, the new graduate nurse may feel overwhelmed by the amount of patient care required and the lack of time to complete the care. The new graduate may be consumed by feelings of inadequacy and failure. For instance, not knowing how to answer the phone or find supplies, as well as not finding time for a meal break, can be exhausting. All of these feelings and behaviors may be a result of trying to do it all and not asking for help. New graduate nurses may quickly realize that if they do not delegate, the patient's care will not be completed in a timely and effective manner. The consequences and likely effects must be considered when delegating patient care. Hansten (2020, in LaCharity) suggested assessment of a variety of factors that must occur before deciding to delegate:

- Potential for Harm and Dynamics of Patient Status: The nurse must first know the patients and the competencies of the available delegates. The RN should determine if there is a risk for the patient in the activity delegated or assigned based on the current circumstances. The highest priority in all factors for decisions about what can be delegated or assigned is patient safety.
- Complexity of the Task and the Overall Care: The RN can potentially delegate or assign simple tasks. These tasks often require psychomotor skills but should not include the need for nursing judgment or on-site readjustment of a complex task.
- Individual Safety or Infection Control Precautions: The RN must be aware of each patient's specific safety or infection control needs. These needs could preclude delegating or assigning the task completely or may mean two or more personnel would be more effective working together to meet the patient's needs.
- Special Technology or Skill Involved: The RN should fully understand the implications of care tasks, including if an unfamiliar technology is present. If personnel have not been fully in-serviced regarding unfamiliar technology's use, this would preclude delegating or assigning the task to a person who is not yet competent in the new unfamiliar technology.
- Amount of Problem Solving and Innovation Required*:* An RN must think through whether or not tasks might require creative problem solving and innovation in approach with special adaptation or special attention needed to complete the

Critical Thinking 18.3

Steve, RN, is working with a new RN, Nadia. Steve tells Nadia that when she assigns patient care to another RN, that RN assumes accountability for the care. Each licensed nurse is accountable for their own level of licensed practice. When Nadia delegates or assigns to a UAP, she delegates or assigns responsibility for the tasks but keeps the accountability for that patient's care. Each person on the team is accountable for being aware of their competencies and limitations, only accepting tasks and duties they are able to safely complete, and completing the tasks and duties they have accepted.

When Nadia asks Jill, the UAP, to give a bath, what does Nadia retain accountability for?

What is Jill accountable for?

Critical Thinking 18.4

The RN continuously monitors unstable, complex patients who have imminent threats to their airway, breathing, circulation, or safety. Examples of these unstable, complex patients might include a patient on a ventilator or an unconscious patient. The RN may be helped by UAPs for some tasks for these patients such as patient repositioning. The RN can delegate some of the care of stable patients to the LPN/LVN or UAP.

What are some other examples of unstable patients?

task. When the RN knows the patient's condition before delegating or assigning, the potential for unnecessarily putting delegates and the patient at risk during an unanticipated modification or interruption of a conventional task is decreased.

- Unpredictability of Outcome: An RN should avoid delegating tasks in which the outcome is not clear or the patient's response is unpredictable.
- How much Supervision will be Needed and RN Availability*:* The RN delegating and assigning must also consider the need for supervision and the current staffing level. If the RN must supervise five students or novice nurses at once, even the best supervisory efforts may be fragmented and the RN may have difficulty responding to all the questions in a timely fashion.
- Physical Location: The assigning RN must consider physical location of patients on the unit and the work traffic patterns. How close are the patients geographically? Does the assignment make sense in the allocated available time?
- Level of Patient Interaction and Continuity of Care*:* The supervisory RN should consider each patient's emotional needs and recognize the need for RN interaction and continuity of care time at the bedside with the patient and the patient's family. An RN making the best assignments also reviews the last shift's work plan, and notes how much time is saved with nurse-patient familiarity and continuity of care. The RN does not expect or encourage UAPs to perform teaching or counseling of patients/families, because this is beyond their scope of practice and requires use of professional nursing judgment.

Attention to the above factors will improve patient safety associated with delegation decision making. Additionally, the availability of a competent, willing delegate is essential to assess prior to decisions to delegate.

Employer/Nurse Leader Responsibilities

The employer and the nursing leader are accountable to set up a safe and effective positive culture/work environment for optimal teamwork. They must acknowledge that delegation is a professional nursing right and responsibility; provide training and education on delegation; communicate information about the delegation process and delegatee competence level; and develop and periodically evaluate the delegation process and delegation policies and procedures (ANA & NCSBN, 2019)

1. A nurse leader (possibly a Chief Nursing Officer [CNO]) must be identified for oversight at the health care organization**,** no matter what the setting.
2. A nurse leader will develop a group, committee, or task force to determine nursing responsibilities that can be delegated, to whom, and under what circumstances. A nurse leader will review delegation activities and job descriptions for each team member so that role confusion can be eased. In some organizations this would occur in a unit/department meeting or in a shared governance or professional practice council (NCSBN, 2016, pp. 9–10).
3. The nurse leader is responsible for orienting and helping all nurses develop their ability to delegate and assign. New graduates need guidance because they may want to be regarded favorably and may not ask UAPs to do many tasks. New graduate classes sponsored by a health care organization include such topics as delegation and assignment policies and procedures and health team members' roles. These classes or online modules are where graduate nurses learn the job descriptions of health care team members. This information is needed to determine what and to whom to delegate and assign tasks. The new graduate must also explore the state nurse practice act regarding delegation as well as their department's job descriptions.
4. The organization researches that each individual is licensed or certified by state agencies, as needed, prior to hire.
5. The organization is responsible to set up, communicate, and periodically evaluate delegation policies and procedures so that all caregivers are trained and educated in the specific skills they are required to perform and that they are checked for a basic level of competency. The organization must provide ongoing in-services and updates to help nurses hone their delegation and assignment skills and alert nurses to changes in professional roles, laws, or advisory opinions.
6. The nurse leader will determine the appropriate resources and staffing mix of personnel on a nursing unit. The nurse leader may have personnel with a variety of skills, knowledge, and educational levels. The acuity and needs of the patients usually determine the personnel mix. From this personnel mix, the new graduate nurse will begin to identify who can best perform assigned duties. The non-nursing duties are shifted toward UAP, clerical personnel, or housekeeping personnel to make the best use of individual skills.
7. The nurse leader is accountable to follow up with reported team member competency issues so that they are resolved in a manner that keeps patients safe and colleagues trustful.

Table 18.6 displays Employer/Nurse Leader responsibilities for efficient delegation and assignment.

Licensed Registered Nurse Responsibility

The Licensed RN is responsible and accountable for the protection of patients and the provision of nursing care. The RN is always responsible for patient assessment, diagnosis, care

Table 18.6 Employer/Nurse Leader Responsibilities for Efficient Delegation and Assignment

- Identify a Nursing Leader
- Follow professional standards for education, licensure, and competency in all hiring decisions, orientation, and ongoing continuing education programs.
- Have clear job descriptions and ongoing licensing and credentialing policies for nursing and medical providers, LPN/LVNs, UAP, and other health care staff. The organization must ensure that all staff members are safe, competent practitioners before assigning them to patient care. Orient staff to their duties, chain of command, and the job descriptions of RN, LPN, and UAP.
- Facilitate clinical and educational specialty certification and credentialing of all health care practitioners and staff.
- Provide standards for ongoing supervision and periodic licensure/competency verification and evaluation of all employees.
- Provide access to evidence-based, professional health care standards, policies, procedures, library, Internet, and medication information, with unit availability and efficient library and Internet access.
- Facilitate regular evidence-based reviews of clinical standards, policies, and procedures.
- Develop and regularly evaluate and communicate clear policies and procedures for delegation.
- Clarify nursing chain of command during nursing orientation and identify how to report patient care issues.
- Communicate nursing responsibilities that can be delegated, to whom, and under what circumstances.
- Communicate information about the competence level of all delegatees.
- Provide administrative support for supervisors and employees who delegate, assign, monitor, and evaluate patient care.
- Clarify health care provider accountability; e.g., if a health care provider, e.g., nursing or medical practitioner or physician assistant, delegates a nursing task to a UAP, the health care provider is responsible for monitoring that care delivery. This should be spelled out in hospital policy. If the RN notes that the UAP is doing something incorrectly, the RN has a duty to intervene and to notify the ordering health care provider of the incident. The RN always has an independent responsibility to protect patient safety. Blindly relying on another nursing or medical health care provider is not permissible for the RN.
- Try to provide for continuity of care by the same staff when possible, and consider the geography of the unit and fair, balanced work distribution among staff when assigning care.
- If delegates don't meet standards, talk with them to identify the problem. If this is not successful, inform the delegate that you will be discussing the problem with your supervisor. Document your concerns, as appropriate. Follow up with your supervisor according to your organization's policy.
- Develop a physical, mental, and verbal "no abuse" policy to be followed by all professional and health care colleagues. Follow up on any problems.
- Consider applying for ANA Magnet Recognition, ANA Pathways for Excellence Designation, or other designation for your facility. ANA Magnet Recognition is awarded by the American Nurses Credentialing Center to acute care nursing departments that have worked to improve nursing care, including the empowering of nursing decision making and delegation in clinical practice.
- Monitor patient outcomes, including nurse-sensitive outcomes, staffing ratios, and other patient, clinical, financial, and organizational quality outcomes.
- Develop ongoing clinical quality improvement practices.
- Benchmark with national groups.
- Maintain ongoing monitoring of incident reports, sentinel events, and other elements of risk management and performance improvement of the process and outcome of patient care.
- Develop Electronic Health Records (EHR), including systematic, error-proof systems for medication administration that ensure the six rights of medication administration, that is, the right patient, right medication, right dose, right time, right route, right documentation. Develop safe computerized order-entry systems and staffing systems.
- Provide documentation of routine maintenance for all patient care equipment.
- Maintain the National Patient Safety Goals (www.jointcommission.org).
- Develop intra-hospital and intra-agency safe transfer policies.
- Do not delegate if in a high-risk situation. The RN may be at risk if the delegated task can be performed only by the RN according to law, organizational policies and procedures, or professional standards of nursing practice; if the delegated task could involve substantial risk or harm to a patient; if the RN knowingly delegates a task to a person who has not had the appropriate training or orientation; or if the RN fails to adequately supervise the delegated activity and does not evaluate the delegated action by reassessing the patient (ANA, 2019).
- Develop a positive and just work culture and environment to help keep patients safe and employees supported in reporting near misses or other safety and quality issues.

Source: Kelly Patricia.

planning, evaluation, and teaching. The RN must identify patient needs and when to delegate. UAP may measure vital signs, intake and output, and other patient status indicators, but it is the RN who interprets this data for comprehensive assessment, nursing diagnosis, and development of the plan of care. UAPs may perform simple nursing interventions related to patient hygiene, nutrition, elimination, or activities of daily living, but the RN must ensure availability to the delegatee, evaluate the patient outcomes, maintain accountability for any delegated responsibilities, and is ultimately accountable for the patient's overall nursing care. Asking a UAP to perform functions outside their roles is a violation of the state nursing practice act and is a threat to patient safety.

As the RN prepares to care for the patient, he or she should describe the health care team to the patient, ideally with the UAP present on first rounds and during shift report at the bedside. For example:

> *Hello Mrs. Jones, my name is Luke Ellingsen. I am a Registered Nurse, and I will be responsible for your care until 7 p.m. today. This is Thelma Marks, a nursing assistant, who will be working with me and will be in to take*

your vital signs and help you with your bath. Please use my cell phone number if you need me, or use your call light if you have any questions for Thelma or for me.

The below 8 points help clarify RN responsibilities:

1. The RN, based on their own practice setting, their state laws and regulations, and job descriptions, must have assessed and understand their patients well enough to be able to protect their patients and determine their needs and current condition in order to know what, when, and if to delegate.
2. The RN must then also delegate or assign tasks to competent persons who agree they are willing and able to do this RN-chosen task from their job descriptions for this particular patient.
3. The RN must use clear, two-way communication (written, oral, and/or demonstration) to describe what needs to be done and in what manner, and must be available to the UAP or delegate to answer questions that arise.
4. The RN must set up normal patient data parameters for the UAP to monitor, identify checkpoints for two-way feedback, and identify timelines for reporting back data and task completion to the delegating RN.
5. The RN must evaluate the outcomes of care and the manner in which the patient responds as frequently as needed within the RN's professional judgment.
6. The RN must offer feedback and evaluation to the caregivers they supervise. The best RN leaders also ask for feedback from their co-workers and the team members they supervise about their own communications and abilities.
7. If competency or education needs become apparent, the RN must follow up with the correct nurse manager or nursing supervisor to report the issues (NCSBN, 2016, pp. 10–11.)
8. The RN is accountable for reporting to a nursing supervisor or manager and using their organization's reporting chain of command if unit problems or conditions exist that inhibit optimal patient care. The RN should also participate in finding solutions to these identified issues that impact patient care or workplace effectiveness.

New Graduate RN Responsibility

Hansten (2019) reports that discrete competencies (such as making assignments, following up with UAPs, and offering feedback) within delegation, assignment, and supervision are self-reported by registered nurses as their least proficient leadership abilities (www.linkedin.com/pulse/another-look-rn-leadership-skill-level-patient-hansten-rn-mba-phd). New graduate nurses have a need to focus on the duties and activities for which they are directly responsible while they develop clinical judgment abilities. They must accept duties and activities based on their own competence level and maintain their competence for delegated responsibilities. They must also maintain accountability for delegated activities and ask themselves, what duties can I delegate and to what extent? What do UAPs do? What do LPN/LVNs do? Reviewing the nurse practice act for a nurse's individual state is important and applies to all licensed nurses, regardless of whether the nurse is a new graduate or not. The nurse practice act is the legal authority for nursing practice in each state. In the individual states, the definitions, regulations, or directives regarding delegation may be different. The state nurse practice acts also determine what level of licensed nurse is authorized to delegate (NCSBN, 2005). The RN also reviews any other applicable state or federal laws; patient needs; job descriptions and competencies of the RNs, LPNs/LVNs, and UAPs; the agency's policies and procedures; the clinical situation; and the professional standards of nursing in preparation for delegation. Table 18.7 includes delegation or assignment suggestions for RNs. Table 18.8 (Kelly and Marthaler 2012) includes additional delegation and assignment suggestions for RNs.

Licensed Practical Nurse/Licensed Vocational Nurse (LPN/LVN) Responsibility

Licensed Practical Nurse/Licensed Vocational Nurse (LPN/LVN) are caregivers who have undergone a standardized training and competency and licensing evaluation. Their scope of practice varies in each state. Patient care may be assigned to an LPN/LVN, in keeping with their scope of practice as designated by state regulation. LPN/LVNs are able to perform duties and functions that UAPs are not allowed to do, and they are also responsible for their actions. LPN/LVNs usually care for stable patients with predictable outcomes, though they may assist the RN with seriously ill patients in **Critical Care Unit**s (**CCU**s). The LPN/LVN is not assigned initial patient assessment. After the RN has completed the patient's initial assessment and the plan of care, the LPN/LVN might be allowed to perform the ongoing head-to-toe assessments and monitor vital signs, Intravenous (IV) sites, IV fluids, breath sounds, etc. Duties of the LPN/LVN include the duties of the UAP and also may include, depending on state rules and job descriptions: passing medications; performing simple sterile dressing changes, colostomy irrigations, respiratory suctioning, and insertion of retention catheters; and in some states, teaching from a standard patient care plan under the direction of an RN.

If the LPN/LVN is certified in IV therapy and the policy of the state and the employing institution permits LPN/LVNs to provide IV treatment, LPN/LVNs may administer or start IV sites and fluids and monitor the IVs. The RN should not have an inordinate duty to supervise IV work by the LPN/LVN after the LPN/LVN skills in this area are verified. Note that prior competency certification of the LPN/LVN may have been done

Table 18.7 Delegation or Assignment Suggestions for RNs

Delegation or assignment suggestions	Examples
Be clear on the qualifications of the delegate, i.e., education, experience, and competency. Require documentation or demonstration of current competence by the delegate for each task. Clarify patient care concerns or delegation problems. Consult ANA and NCSBN position papers on delegation and your state board of nursing guidelines, as necessary. Know your job descriptions.	The charge nurse will assign a new graduate nurse a team of patients less complex than the assignment of an RN who has several years of experience.
Assess what is to be delegated or assigned and identify who would best complete the assignment.	The RN will ask a UAP to pick up specific equipment, e.g., a pediatric pulse oximeter from a stock room. The UAP has worked on this unit for 5 yr and is familiar with the type of equipment the nurse needs.
Communicate the duty to be performed and identify the time frame for completion. The expectations for personnel should be clear and concise.	The charge nurse tells another nurse, "While I am at lunch, Mr. Jones, the patient in bed 34-2 may ask for something for pain. Please make him comfortable, replace the ice pack, and tell him that it is too early for another pain medication for 60 more minutes."
Avoid changing tasks once they are assigned when team members request a change unless there are compelling reasons to disrupt plans already in progress. Changing duties should be considered when the task is above the level of the personnel, as when the patient's care is in jeopardy due to a change in status, or if there are other important reasons such as infection control or personnel developmental and learning needs.	The UAP was delegated the task of taking vital signs on a set of patients. One of the patients is receiving a blood transfusion and is very ill. The nurse may transfer the delegated task of taking vital signs on this patient to an RN.
Evaluate the effectiveness of the delegation of duties. Monitor care and check in with UAP frequently. Ask for a feedback report on the outcomes of care delivery.	After the patient was assisted to the bathroom, the nurse asked the UAP, what amount of assistance did the patient require? Is the patient safely back in bed?
Accept minor variations in the style in which duties are performed. Individual styles are acceptable as long as the duty is performed correctly within the scope of practice and all accepted ethical and/or scientific norms (such as sterile technique when necessary) and there is a good outcome.	Both of the following nurses are successful at providing care using different and acceptable methods. One nurse assesses the assigned patients, documents care, and then passes medications. Another nurse assesses the patients while passing medications and then documents care.
Take action when delegate does not carry out their assigned duties.	If a delegate does not carry out their assigned duties, the RN must take action to assure patient safety. Talk to the delegate and determine why the assigned duty was not carried out. Depending on the delegate's response, the RN may need to take one or more of the following actions: • Explain to the delegate the importance and method of performing assigned duties, • Report the incident to the nursing supervisor, and • Complete an evaluation form about the delegate's lack of performance if requested by the nursing supervisor. If any personnel continue with poor performance, the person may lose their position. The manager or supervisor is accountable for hiring and firing decisions.

Source: Kelly Patricia.

through evaluation on a skills day or through a competency validation under direct supervision of an RN, only in states where this IV therapy practice by an LPN/LVN is allowed.

In other states, LPN/LVNs are allowed to maintain existing IV lines and fluids under the supervision of an on-site RN but they are not allowed to start IVs. RNs should not rely on "word of mouth" information regarding LPN/LVN and UAP roles from other employees; instead the RN should review actual state rules and organizational documents such as job descriptions and competency checklists.

In Beeber et al. (2018) and Mueller et al.'s (2018) studies of the importance of nurse delegation policies in assisted living and residential care, it became clear that some nurses are confused about roles for RNs, LPN/LVNs, and medication technicians. As previously stated, the roles of LPNs/LVNs and some UAPs vary by state and by type of practice setting.

In some states, in nursing homes, the LPN/LVN may assume the charge nurse role with an on-site supervising RN. LPN/LVNs report their findings to the RN. The RN is still primarily responsible for overall patient assessment, nursing

Table 18.8 Additional Delegation and Assignment Suggestions for RNs

Consider prior to delegating

- Who has the time to complete the delegated task?
- Who is the best person for the task?
- What is the urgency of the task?
- Are there any time restraints?
- Who do you want to develop their skills?
- Who is the best person to meet the patient's needs?
- Who would enjoy completing the task?

Be clear on the qualifications of the delegate, that is, education, experience, and competency. Require documentation or demonstration of current competence by the delegate for each task. Clarify patient care concerns or questions about the delegated task. Find ANA position statements at www.nursingworld.org, the NCSBN at www.NCSBN.org and at your state board of nursing yearly to keep up to date with changes that may occur regarding delegation of nursing care.

Speak to your team members as you would like to be spoken to. There is no need to apologize for your need to have another team member perform a task. Remember that you are carrying out your professional responsibility. Assure the delegates that you will help them when you can. Be sure to do so.

Communicate the patient's name, room number, the task to be performed, and identify the time frame for completion. Best practices include the patient/family and the UAP in this discussion. Discuss any changes from the usual procedures that might be needed to meet special patient needs and any potential or expected changes that should be reported to the RN. The expectations for personnel before, during, and after task performance should be stated in a clear, pleasant, direct, and concise manner.

Identify the expected patient outcome and the limits on UAP authority.

Verify the delegate's understanding of delegated tasks, and have the delegate repeat instructions as needed. Verify that the delegate accepts the responsibility for carrying out the task correctly. Require regular, frequent mini-reports or check points of information about patients from the health care team including UAP, LPN/LVNs, etc.

Avoid removing tasks once assigned. This should be considered only when the task is above the level of the personnel, such as when the patient's care is in jeopardy because the patient's status has changed, or when time does not permit completion of previously assigned tasks.

Monitor task completion according to standards. Make frequent walking rounds to assess patient outcomes. Intervene as needed.

Accept minor variations in the style in which the tasks are performed. Individual styles are acceptable as long as patient standards and accepted scientific and ethical principles are maintained and good outcomes are achieved.

Try to meet team's needs for learning opportunities and consider any health problems and work preferences of the team members as long as they don't interfere with meeting patient needs.

If a delegate doesn't meet standards, talk with them privately to identify the problem. If this is not successful, inform the delegate that you will be discussing the problem with the supervisor. Document your concerns, as appropriate. Follow up with the supervisor according to your organization's policy.

Avoid high-risk delegation or assignment. Do not delegate or assign a task to a LPN/LVN or UAP if the task can be performed only by the RN according to law, organizational policies and procedures, or professional standards of nursing practice; or if the delegated task could involve substantial risk or harm to a patient. The RN should not knowingly delegate a task to a person who has not had the appropriate training or orientation; or fail to adequately supervise the delegated/assigned activity and must evaluate the delegated action by reassessing the patient and the results of the delegated or assigned activity. (ANA, 2005, 2014 in Duffy & McCoy)

Sources: Marthaler, M., & Kelly, P. (2012). Delegation of nursing care. In P. Kelly, Nursing leadership and management (3rd ed.). Clifton Park, NY: Delmar Cengage Learning,Boucher (1998); Zimmermann (1996); and ANA, (2005), ANA 2014 in Duffy and McCoy, ANA and NCSBN (2019).

diagnosis, planning, implementation, and evaluation of the quality of care delegated. Remember to consult your own state practice rules and organizational job descriptions about this highly variable role.

Unlicensed Assistive Personnel (UAP) Responsibility

UAP are delegatees and are trained to perform duties such as bathing, feeding, toileting, and ambulating patients or other tasks based on the state and their individual specialty education, such as education related to Emergency, Psychiatric, or Perioperative, or Rehabilitation, HCAs of various levels, and Certified Medication Aides (CMAs). UAP are expected to document and report information related to patient care activities based on organizational guidelines. The RN will delegate or assign work to the UAP and is liable for those delegation decisions. According to the ANA (2005), if the RN knows that the assistant has the appropriate training, orientation, and documented competencies, then the RN can reasonably expect that the UAP will function in a safe and effective manner. However, each situation must be assessed based on the nurses' knowledge of the specific

patient's condition and the individual abilities of the delegatee. Remember that state guidelines for UAP task roles vary.

An overview of basic UAP responsibilities would include:

1. Accepting only those activities or tasks they feel comfortable with and are able to perform competently.
2. Completing the tasks or activities successfully and as agreed upon, or update the RN promptly if unable to do so.
3. Maintaining competence levels for the UAP's delegated or assigned responsibility (NCSBN, 2016, p. 6).
4. Asking questions to clarify when unsure.
5. Maintaining open communication and feedback with all team members.
6. Maintaining accountability for delegated activities.

Health care organizations use UAP in all settings in order to ensure wise stewardship of health care costs; freeing RNs from duties that do not require an RN to do them; and allowing time for RNs to complete assessments of patients and RN-only care, as well as patient evaluation. It is more cost effective to have UAP perform non-nursing duties than to have nurses perform them. UAP can deliver supportive care; they cannot practice nursing or provide total patient care. The RN must be aware of the job description, skills, and educational background of the UAP prior to the delegation or assigning of duties. Delegation also allows entry-level workers to learn about the health care environment and provides a great stepping stone to a career in nursing and other health care roles after further education. Table 18.9 allows students to test themselves on delegation and assignment.

Table 18.9 Test Yourself

Questions	Yes	No
1. Do you recognize that you, as an RN, retain ultimate accountability for the nursing care of your assigned patients?		
2. Do you spend most of your time completing tasks that require an RN and that could not be done by someone else on your team?		
3. Do you trust the ability of your team to complete assignments successfully?		
4. Do you allow UAPs sufficient time to solve their own problems before intervening with advice (if this is reasonable, considering patient safety)?		
5. Do you clearly outline expected outcomes when delegating and hold your team accountable for achieving these outcomes?		
6. Do you support your team with an appropriate level of feedback and follow up?		
7. Do you use delegation and challenging work assignments as a way to help your team develop new skills?		
8. Does your team know what you expect of them?		
9. Do you take the time to carefully select the right person for the right job?		
10. Do you feel comfortable asking for feedback on your own performance as a leader?		
11. Do you clearly identify all aspects of an assignment to your team when you delegate?		
12. Do you assign tasks to the most entry level team member capable of completing them successfully?		
13. Do you support your team when they are learning?		
14. Do you allow your team reasonable freedom to achieve outcomes?		

Source: Created by R. Hansten & P. Kelly.

Real World Interview

"I have been a nursing assistant for years so as a new RN I am very careful to include my team in our shift report, patient rounding, and I make sure we have checkpoint huddles before and after all breaks and meals. I 'get my hands dirty' in that I help with messy tasks so that no one thinks I consider myself better than them. If they need help when I am on the phone, I explain later what I was doing that was so important, like, 'I was on the phone with the son telling him about Mrs. Joan's sepsis.' I make sure to ask for feedback from my team as well as offer a feedback discussion at the end of the shift. 'What could I have done better? What could we have done better as a team?' and I point out what we achieved together for the patients. 'We saved Mr. Peterson and he is doing better in the Critical Care Unit (CCU)! And look how happy Mr. Jackson was with his new hip and ambulation!' I always get a hand from my team because they know we are together in all of this."

Name Withheld, RN, in Midwest.

Under-Delegation and Over-Delegation

Personnel in a new job role such as a new nursing graduate, new charge RN, or new nurse manager, often under-delegate. Believing that older, more experienced staff may resent having someone new delegate to them, a novice nurse may simply avoid delegation or assigning care tasks. New nurses may seek approval from other staff members by demonstrating their ability to complete all assigned duties without assistance. In addition, new nurses may be reluctant to delegate or assign because they do not know or trust individuals on their team or are not clear on the scope of all their duties or what they are all allowed to do. New nurses can become frustrated and overwhelmed if they fail to delegate and assign appropriately. They may fail to establish appropriate controls such as failing to offer initial direction, failing to set up checkpoint times to regroup with their team, failing to clarify expectations with staff, or failing to evaluate care and follow up properly. They also may not delegate the appropriate authority to go with assigned responsibilities. Perfectionism and a fear of a delegate not doing their work can lead new nurses to feel they are overwhelmed with patient care responsibilities. More experienced nursing staff members can help new nurses by intervening early on, assisting in the delegation and assignment process, and clarifying responsibilities.

Over-Delegation

Over-delegation or assigning too many duties to others can also place the patient at risk. The reasons for over-delegation or assignment are numerous. Personnel may feel uncomfortable performing duties that are unfamiliar to them, and they may depend too much on others. They may be unorganized or inclined to either avoid responsibility or immerse themselves in details. Over-delegation leads to delegating or assigning duties to personnel who are not educated for the tasks, such as expecting LPN/LVNs and UAP to perform RN-only work. Delegating or assigning duties that are inappropriate for personnel to perform because they have been inadequately educated is dangerous and against the state nurse practice act. Over-delegating duties can overwork some personnel and underwork others, creating obstacles to appropriate delegation or assignment of tasks. Table 18.10 reviews some obstacles to team leadership and excellence in delegation, assignment, and supervision. Table 18.11 (Kelly and Marthaler 2012) is a review of the elements to consider when delegating or assigning care.

Critical Thinking 18.5

It was just about 8:30 p.m. on the 7 p.m. to 7 a.m. shift on 2 East. Most of the practitioners had made their rounds, so the evening was calming down. The UAP, Jill, was picking up the dinner trays from the patient's rooms. Steve, the RN, had just sat down to document his patient assessments when he heard UAP Jill yell, "I need some help in Room 2510! Mr. Olson is not breathing." As several of the nurses ran to Room 2510, the UAP ran for the emergency crash cart. The cart was wheeled into the patient's room during the overhead announcement by the operator, "CODE BLUE, Room 2510." The nurses initiated **Cardiopulmonary Resuscitation** (**CPR**). The UAP plugged the cart into the wall, turned the suction machine on, and then assisted the family out of the room and stayed with them until the nurse was able to talk with them.

How does completion of these tasks by the UAP contribute to patient care?

In what ways does the UAP relieve the pressure on the nurse to provide acute patient care?

Table 18.10 Obstacles to Delegation

- Fear of being disliked
- Inability to give up any control of the situation
- Fear of making a mistake
- Inability to determine what to delegate and to whom
- Inadequate knowledge of the delegation or assignment process
- Past experience with delegation that did not turn out well
- Poor interpersonal communication skills
- Lack of confidence to move beyond being a novice nurse
- Lack of administrative support for nurses delegating to LPN/LVN and UAP
- Tendency to isolate oneself and choose to complete all tasks alone
- Inappropriate number and skill or competency mix of personnel for the individual patient population
- Lack of confidence to delegate to staff members who were previously one's peers
- Inability to prioritize using Maslow's hierarchy of needs and the nursing process
- Thinking of oneself as the only one who can complete a task the way "it is supposed" to be done
- Inability to communicate effectively
- Inability to develop working relationships with other team members
- Lack of knowledge of the capabilities of staff, including their competency, skill, experience, level of education, job description, and so on

Source: Kelly Patricia.

Table 18.11 Elements to Consider when Delegating or Assigning

- Federal, state, and local regulations and guidelines for practice, including the state nurse practice act, Board of Nursing Rules and Advisory opinions
- Specialty Nursing Organization standards or policies (e.g., Emergency Nurses Association)
- Job description of registered nurse, licensed practical nurse/licensed vocational nurse, nursing assistive personnel
- Nursing professional standards
- Health care agency policy, procedure, and standards, job descriptions
- Five Rights of Delegation (ANA and NCSBN, 2019)
- Knowledge and skill of personnel
- Documented personnel competency, strengths, and weaknesses (select the right person for the right job)
- NCSBN/ANA Joint Statement, Employer/Nurse Leader Responsibility, Licensed Nurse Responsibility, and Delegatee Responsibility (2019)

RN is accountable for Application of the Nursing Process and KNOWING the Patient
Assessment and Clinical Judgment
Nursing Diagnosis
Planning Care
Implementation and Teaching
(Parts of Implementation, e.g., Some Tasks, Can Be Delegated or Assigned)
RN Delegates or Assigns, As Appropriate
RN retains Accountability
(Note that LPN/LVNs and UAP are also Responsible and Accountable for Their Actions)
Evaluation

RN	LPN/LVN	UAP
RNs assess, plan care, monitor, and evaluate all patients, especially complex, unstable patients with unpredictable outcomes. Intervene quickly to assure patients' physiological, safety, and psychological needs. Administer medications, including IV push. Start and maintain IVs and blood transfusions. Perform sterile or specialized procedures, for example, Foley catheter and nasogastric tube insertion, tracheostomy care, suture removal, and so on. Educate patient and family. Maintain infection control. Administer Cardiopulmonary Resuscitation (CPR). Interpret and report laboratory findings. Triage patients. Prevent adverse nurse-sensitive patient outcomes, for example, cardiac arrest, pneumonia, and so on. Monitor patient outcomes.	LPN/LVNs care for stable patients with predictable outcomes. They work under the direction of the RN and are responsible for their actions within their scope of practice. Gather patient data. Implement patient care. Maintain infection control. *Provide and reinforce teaching from standard teaching plan as directed by RN.*[a] *Depending on the state and with documented competency, may do the following:*[a] *Administer medications.* *Perform sterile or specialized procedures, for example, Foley catheter and nasogastric tube insertion, tracheostomy care, suture removal, and so on.* *Perform blood glucose monitoring.* *Administer CPR (most states)* *Perform venipuncture and insert peripheral IVs, change IV bags for patients receiving IV therapy, and so on.*	UAP assist the RNs and the LPNs and give technical care to stable patients with predictable outcomes and minimal potential for risk, and assist with close RN supervision of those patients that are higher risk. UAP work under the direction of an RN and are responsible for their actions and task completion. Assist with activities of daily living. Assist with bathing, grooming, and dressing. Assist with toileting and bed making. Ambulate, position, and transport. Feed and socialize with patient. Measure intake and output (I&O). Document care. Weigh patient. Maintain infection control. *Depending on the state and with documented competency, may do the following:*[a] • *Perform blood glucose monitoring.* • *Collect specimens.* • *Administer CPR.* • *Take vital signs (most states).*

RN uses Clinical Judgment and is Responsible for Evaluation of all Patient Care.
Clinical judgment is "outcome of critical thinking or clinical reasoning, the conclusion, decision, or opinion you make after thinking about the issues." Alfaro-LeFevre, 2017, p. 6

Source: Developed with information from Kelly & Marthaler (2012) and National Guidelines for Nursing Delegation Effective Date: April 29, 2019.NCSBN—ANA Jointly, available at www.ncsbn.org/NGND-PosPaper_06.pdf (2019). Accessed August 31, 2019.
[a]State practice acts differ: Check your own state nurse practice regulations.

Chain of Command

The chain of command identifies the order in which nurses report problems that impact their practice or patient care. The chain of command is used when a nurse cannot solve a problem on their own, as barriers exist that prevent the nurse from doing their best for a patient in a given situation. These barriers are reported by the nurse to the next supervisory person above them in the chain of command. All health care personnel serve the patient and their family and are accountable to

them and to the community. Nursing Assistive Personnel and Licensed Practical Nurses are accountable to the RN, including new graduate RNs. The RN is accountable to the charge nurse who is accountable to the nursing managers/directors, who are responsible to the house shift administrators or supervisors. The house shift administrators or supervisors are accountable to the Chief Nursing Officer who is accountable to the **Chief Executive Officer** (**CEO**). The CEO is responsible to the Board of Directors, who is ultimately accountable to their patients, the community they serve, the accrediting organizations, and federal and state regulators. (Figure 18.1).

From a practical standpoint, a nurse encountering patient care problems would first talk with their charge nurse and the patient's attending physician in a community setting. In a university setting, the nurse would first talk with their charge nurse and the medical resident on call, then the medical fellow, then the attending physician. The Rapid Response Team or the Code Blue Team is utilized first in critical situations that warrant immediate patient attention. If a problem is not resolved, the nurse and charge nurse will assess the situation, and, if needed, contact the patient's physician and other nursing and medical groups and hospital administrators who would best handle or solve the problem, for example, the Chief Nursing Officer, Medical Director, Chief of the Medical Staff, Chief Executive Officer, etc. Groups that may be called to address an issue could be unit or organizational shared governance or

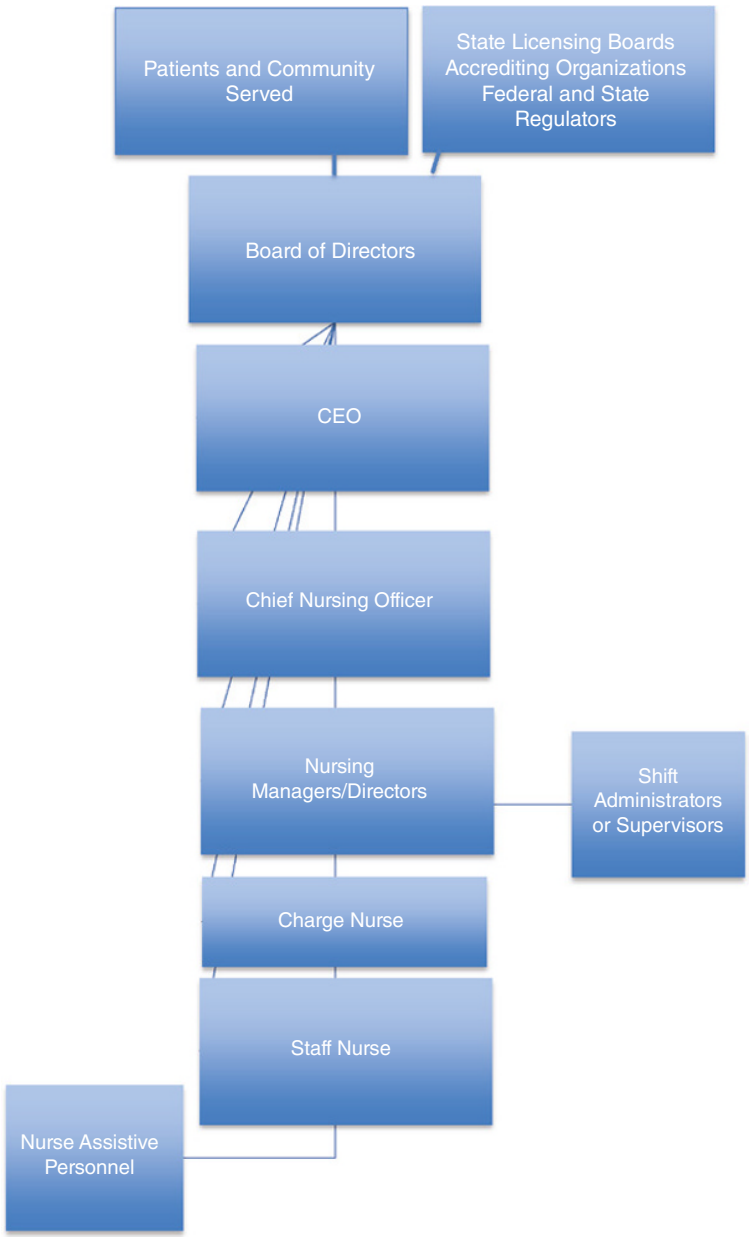

FIGURE 18.1 Organizational nursing chain of command. Created by R. Hansten & P. Kelly.

shared decision-making professional councils or committees such as Patient Safety and Quality, Compliance, Ethics, Pharmacy and Therapeutics, Risk Management, or various other Medical and Nursing Committees, including Union representatives or Bargaining Units in a union environment.

Examples of instances for implementing the chain of command include but are not limited to instances where:

- Impairment of a practitioner is suspected.
- The patient's physician is unable to be reached.
- The physician is acting outside the scope of his/her privileges.
- The physician's orders instruct the nurse to perform something outside the scope of his/her practice and the issue was unable to be resolved between them.
- There is progressive deterioration of a patient's clinical condition and the nurse believes the patient requires medical intervention that cannot be provide by a nurse
- The nurse's assessment of the patient varies significantly from the physician's assessment and the nurse believes that the discrepancy places the patient at serious risk of harm.

Accurate, factual documentation of the facts in the patient's medical record of all contacts with individuals through the chain of command should be done by the person who placed the call/made the contact. The nurse caring for the patient should document initial physician notification, discussion, any refusals, the reason for any refusals of an order, notification of the charge nurse and other people in the chain of command, and specific information given to the physician and others in the chain of command concerning the patient. Documentation of all contacts with individuals through the chain of command should be done by the person who placed the call/made the contact. Every nurse, no matter the practice setting, should clearly understand the chain of command where they are employed. Not knowing the chain of command or not following it can cause serious repercussions to the patient, the nurse, and the institution.

The Nursing Process and Delegation

Ultimately, some professional activities involving the specialized knowledge, judgment, or skill of the nursing process can never be delegated (NCSBN, 2016). Some of these activities could include patient assessment, triage, nursing diagnosis, nursing plans of care, extensive teaching or counseling, telephone advice, outcome evaluations, and patient discharges. Delegated tasks are typically those tasks that occur frequently, are considered technical by nature, are considered standard and unchanging, have predictable results, and have minimal potential for risks (ANA 2014, 5–7). As a professional standard for all nurses in all states, the assessment, nursing diagnosis, planning, and evaluation stages of the nursing process may not be delegated. Delegated activities usually fall within the implementation phase of the nursing process.

State Boards of Nursing

State Boards of Nursing exist to protect the public, not to protect RN licenses. The best way for nurses to protect their licensure has to do with understanding their state regulations and standards of practice and abiding by them. Some states specify nursing tasks that may be delegated in their rules, regulations, standards of care, or advisory opinions. It is crucial that every RN remember: because a task can be delegated, this does not mean you must delegate it, nor does it mean you should delegate that task if your clinical judgment dictates that this task for this particular patient is not wisely delegated or assigned to a UAP. For example, a nurse can assign postoperative ambulation. However, if the patient has been unstable, hypotensive, and this is the first time the patient will sit up and ambulate postoperatively, the nurse can be liable for assigning a UAP to do a task that they are not able to safely complete, given the patient's state. The UAP may try to get the patient up the first time postoperatively alone, and the patient could fall. Although the tasks in the examples in Table 18.12, and Table 18.13 of "tasks that can possibly be delegated or assigned" and "which tasks can be delegated or assigned" are similar to tasks listed in some UAP state guidelines or rules, the nurse must always assess the situation and the patient, as well as check for interstate variation regarding delegation.

Note that state websites offer not only the statute (law), but also administrative codes and/or rules and advisory opinions that provide you with guidelines for practice. Be certain you are checking the correct site for your practice arena; for example, there may be a special portion of the administrative code or rules for home health that are different from acute care, or for such specialized roles as Certified Medication Aide, Surgical Technician, Medical Assistant, and others. Review your nursing specialty website for guidelines regarding what and when to delegate or assign. Some of these nursing specialties include psychiatric, emergency, perioperative, perinatal, rehabilitation, ambulatory care, schools, or public health nursing. Check state requirements with your state board of nursing or link to more suggestions about how to access assistive personnel role information at www.ncsbn.org

Teamwork and Collaboration

Teamwork and collaboration are essential for the best communication. All people communicate and do their work better if leaders respect individual differences in the way the team learns and in the way their brains process information. Communication or work habit differences such as voice, speaking style, and sense of time all may impact teamwork and collaboration effectiveness. For example, patient information can be difficult or simple for team members to understand based on the manner in which it is given and whether the individual being instructed is a visual, auditory, or kinesthetic or tactile learner. If the UAP tends to learn more by visual cues, instructions and work assignments should be printed or be otherwise visual. When a patient discussion is essential because the

Table 18.12 Delegation or Assignment Task Examples

Nursing Tasks Never Delegated or Assigned

- Patient assessment (physical, psychological, and social assessment, which requires professional nursing judgment, intervention, referral, or follow up). Data collection without interpretation is not assessment.
- Planning of nursing care and assessment of the patient's response
- Implementation that requires judgment
- Health teaching and health counseling other than reinforcement of what the RN has already taught
- Evaluation of the patient's response
- Medication administration (In many states, some medication administration can be assigned to LPN/LVNs. In some states, simple medications and some injections can be delegated to certified medication aides, home health aides, and medical assistants with specific training and certification. Refer to your current state nursing practice act to determine is delegation or assignment of medications are allowed or prohibited.)

Nursing Tasks Not Routinely Delegated or Assigned

- Note that the below tasks may sometimes be delegated if the staff has received special credentialing such as education and competency testing and are certified.
- Sterile procedures
- Invasive procedures, such as inserting tubes in a body cavity or instilling or inserting substances into an indwelling tube
- Care of broken skin other than minor abrasions or cuts generally classified as requiring only first aid treatment (without topical medication)
- Intravenous therapy (in some states can be delegated or assigned to LPN/LVNs with limitations)

Nursing Tasks Most Commonly Delegated or Assigned: the RN can decide NOT to delegate any task, no matter how routine, based on the RN's nursing judgment, if the patient or delegate situation dictates.

- Noninvasive and non-sterile treatments
- Collecting, reporting, and documenting data such as vital signs, height, weight, intake and output
- Ambulation, positioning, and turning
- Transportation of the patient within the facility
- Personal hygiene and elimination, including cleansing enemas (no medicated enemas)
- Feeding (depending on patient situation and delegate's competency), cutting up food, or placing meal trays
- Socialization activities
- Activities of daily living

Source: Kelly Patricia.

Table 18.13 Which Tasks Can Be Delegated or Assigned?

Identify which members of the health care team could potentially perform each of the following nursing activities. ***NONE of these tasks may be delegated or assigned if the RN has not performed the 5 Rights of Delegation and knows the patient's condition and stability as well as the competence of the caregiver first. Delegation and Assignment should NEVER be a rote "always" activity. This table is only for the student's use to determine what could be delegated or assigned if the patient care situation was perfectly stable and all team members were competent.***

Nursing activity	RN	LPN/LVN	UAP/NAP/AP
Administer blood to a patient			
Assess a patient going to surgery			
Develop a teaching plan for a patient newly diagnosed with diabetes			
Measure a patient's intake and output			
Provide a bath to an immobilized patient			
Change a dressing			
Give patient report when transferring a patient from ICU to a step-down unit			
Give insulin			
Evaluate a patient's Do Not Resuscitate (DNR) status			
Give an oral medication			
Assist a patient with ambulation			
Give an intramuscular (IM) pain medication			
Give an intravenous (IV) pain medication			

6/23/19

Source: Created by R. Hansten & P. Kelly.

(*Note*: check your state practice act in the particular state where you work, and the facility's job descriptions, in order to be certain regarding administering IV fluids, blood, insulin, IM and IV pain medications.)

patient is an auditory learner and processes information best by hearing it, then verbal instructions may need to be repeated and backed up with written assignments. If language proficiency is a barrier or when the UAP is a kinesthetic or tactile processor of information, showing them how to perform a task through action and movement is a good option to set the stage for best task completion. Kinesthetic or tactile UAPs learn best by doing. Individual types of information processing differences will be useful to keep in mind when the RN offers initial direction or instructions for assignments or when the RN perceives that tasks are not being understood or done appropriately. The RN may need to help the UAP organize and understand assignments by creating additional methods to keep track of work assigned and work completed through personalized written notes or voice-recording instructions or videotaped demonstrations.

Family of origin issues such as how fast or how slow people speak, how conflict or questions are handled, and how much space or physical closeness people maintain between themselves can be a barrier to best teamwork and collaboration results. For example, ineffective delegation can take place when an individual's space is violated. Some delegators stand too close when speaking. Conversely, some members of a group may feel left out if they are not sitting close to the delegator. They may not feel included or important. The RN can learn how issues such as voice speed and physical space work best for each person by simple observation, asking, and listening. If the RN has observed the delegate often speaking animatedly at close proximity to others, a few quiet words of instruction or being handed an assignment sheet without further discussion may not be well-understood or appreciated by the delegate. At times, the RN may interpret the individual characteristics of their team members incorrectly and assign blame or think the UAP is "not listening." Asking for feedback about how best to communicate with each individual is helpful.

> *How do you like to receive your assignments? What did your "best team leader ever" do to communicate with you? Would you like more clearly written instructions? Would it be useful to make rounds to discuss patients? What works best for you so we communicate most effectively?*

The above are a few questions that can be used to develop clear communication.

Another individual difference affecting delegation is the concept of time. Some people tend to move slowly and may be perceived as late, whereas other people move quickly and are prompt in meeting deadlines or completing tasks early and volunteering to assist others. The RN must be very clear related to instructions so that the RN's idea of "prompt" or "right away" meets the other person's understanding of expectations, for example, "I need those vital signs by 0900 so I can give the medication." RNs sometimes assume that UAPs or LPN/LVNs are not industrious or don't care, when in fact individual differences in communicating or work habit issues need to be addressed with excellent RN leadership, teamwork, and collaboration.

Teamwork and Collaboration Routines

Engaged and enthusiastic teamwork and collaboration is initiated by the RN who is clear on intended patient outcomes and the plan for the day, shift, episode of care, and/or longer-term results. RNs must lead this teamwork and collaboration for the right care to be completed by the team in an efficient manner. A patient's daily or most emergent needs are foremost. For example, "Mr. Jones would like to focus on improving his pain level today; he can start moving more when he feels he is at a 4." Longer-term and/or discharge plans are also imperative to share for putting the picture of care into place for the team: "Mr. Jones plans to go to a rehabilitation center, probably tomorrow" or "Mr. Jones is going to hospice as soon as this round of chemotherapy has been completed." Clarity about the intended patient results allow the team members to be an engaged part of the process of helping the patient rather than producing a few limited, boring disconnected tasks without context.

One of the most effective ways of solving some of the team's role or task confusion is by offering clear instructions during shift hand-off report at the patient's bedside in acute and long-term care, thus allowing for clarity about the team's plan for the shift. For home health care, an on-site discussion with the patient/family and caregivers would be similar to a shift hand-off report discussion. Holding shift or case updates, checkpoints, or and/or huddles during a shift help clarify plans for the rest of the patient care episode.

Another leadership method an RN can use to make sure the team is clear on the patient care plan and shares expectations of each other, is by debriefing, or reviewing and evaluating the shift or episode of care toward the end of the shift so that each individual can quickly discuss what worked and what didn't. Questions such as, "What worked this shift/case, and what didn't?" and "What would you suggest we do differently if we had the same situation tomorrow?" will help RNs receive feedback and allow for an open team atmosphere for improving safety and quality.

The new graduate RN can use feedback to learn how to better lead the team. Ask, "Because I am trying to learn how to be a better RN, I would really truly appreciate what you would suggest for me to do differently." Then wait. Leave time for others to feel comfortable giving feedback on what they think. The new graduate can also ask, "What were the attributes of those RNs you love working with?" if the team is not forthcoming with feedback at first. Open communication will foster growth of the team's efficiency, effectiveness, and ability to flex with the changes that occur so suddenly in both patients and organizations.

Appreciation of each other and the work that was accomplished and celebrating the outcomes enjoyed by the patients

Case Study 18.1

During your next clinical rotation, review the NCSBN and ANA National Guidelines for Delegation available at www.ncsbn.org/NGND-PosPaper_06.pdf, Accessed October 26, 2019. How does this guide help you decide what to delegate or assign? Identify the patient's needs, and identify what an RN could safely delegate. What did you decide?

is a great way to offer feedback and solidify a team. The more clear, detailed, appreciative feedback offered, the more that RNs find that their team members understand the authenticity of comments, such as,

> *I really appreciate how well the two of you worked together in the isolation room when the incontinent patient needed changing. It was so important to get that done quickly to avoid skin breakdown! You two make such a great part of our team and I appreciate you pitched in and helped while I was working with the case conference for Mrs. Peterson's discharge.*

Delegation, Omitted Care, and Patient Safety: The Swiss Cheese Safety Model

Bittner and Gravlin (2009) first identified the impact of delegation and critical thinking on missed or omitted but necessary nursing care. Nurses don't always know what other people's roles are and don't always feel confident in their clinical judgment and their delegation skills. Bittner, Gravlin, Hansten, and Kalisch (2011) studied the necessity of better teamwork to avoid the negative impact of poor delegation on patients and health care professionals. Kalisch and others have published international studies related to missed care (Kalisch, 2015; Kalankova, Gurkova, Zelenikova, & Ziatova, 2018), noting similar issues in all countries studied. Although health care administrators attempt to supply the very best personnel for the patients' needs, it is impossible to guarantee the right number and type of employees on every shift and every case. However, RNs can augment their delegation and assignment skills so that the personnel available can be utilized in an optimal manner, so that care is not denied or left unfinished on a regular basis. Hansten proposes a Swiss Cheese Safety Model (Figure 18.2) based on James Reason's iconic 1990 model in *Human Error* (1990, Cambridge University Press), to avoid Errors or Health Care Acquired Conditions (Hansten, 2014a,[b]). The Swiss Cheese Safety Model illustrates that the following safety defenses must occur to ensure best teamwork and avoid errors and negative impacts on patients.

1. RN knowledge of accountability. This includes understanding of how to make safe delegation and assignment decisions.
2. UAP knowledge of their role.

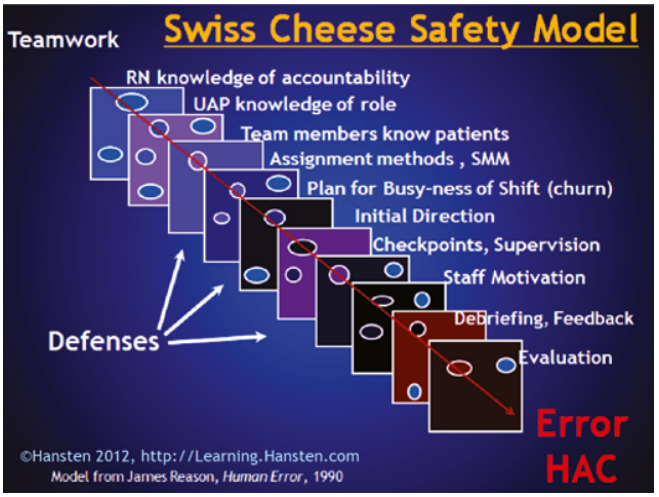

FIGURE 18.2 Swiss cheese safety model to avoid errors and health care acquired conditions.
Source: © Hansten, 2012, http://learning.hansten.com/. Model from James Reason, Human Error, 1990.

3. Team members knowledge of patients and their needs and planned outcomes.
4. Clear patient assignment methods and a **Shared Mental Model** (**SMM**) or plan for patient care. An SMM is a shared understanding, language, or mental roadmap that allows teams to flourish because everyone on the team understands what to expect of each other and how they will proceed with their work.
5. Plan for busy-ness of the shift and churn (churn is a term for changes in patient census with many admissions, transfers, discharges).
6. Clear initial direction of assignments and delegation.
7. Carefully planned checkpoints and supervision throughout the shift.
8. Staff motivation to get their jobs done with a focus on meeting each patient's needs and planned outcomes.
9. Debriefing and feedback completed by the RN and UAPs mutually so that patient care improvements can occur in the future.
10. Evaluation of patient care as is required by principles of expert delegation, assignment and supervision. (Hansten 2014a,b).

The Swiss Cheese Model illustrates that, although many layers of safety defenses lie between potential errors and Health Care Acquired Conditions (HAC), there are flaws in each layer that can allow an error to occur if the flaws are lined up with each other.

Nurses must be aware of the negative impacts of missed care and avoid Errors, Health care Acquired Conditions (HACs), team de-motivation, and burnout by applying these 10 safety defenses to their nursing practice.

Case Study 18.2

You are working with an RN, an LPN/LVN, a UAP, and a sitter. Your patients include the following:

1. 2501/Ms. J. D.: 68-year-old female, post-op day 1, post-shoulder repair, confused; fall risk; half side rails up, fall alarm on bed.
2. 2502/Mr. D. H.: 45-year-old male diabetic, post-op day 1, amputation just below the knee; Insulin sliding scale, complaining of pain; restlessness; diaphoretic.
3. 2503/Mr. H.M.: 35-year-old male, history of alcohol abuse: complaining of abdominal pain; new hematemesis of coffee-ground fluid; IV of 0.9% normal saline at 125 cc/hour; alert.
4. 2504/Mr. J. K.: 20-year-old male college student, just admitted, threatening to commit suicide; alert and oriented.

Which tasks from the list in Table 18.13 would you give to each of them, i.e., the RN, the LPN/LVN, the UAP, and the sitter, if each patient were stable?

Who would you ask to perform afternoon care for all patients, pass water, answer call lights, and pick up supplies?

Who would give the medications and change dressings?

Evidence from the Literature

Source: Adapted from Diab, G., & Ehrahim, R. (2019) Factors leading to missed nursing care among nurses at selected hospitals. *American Journal of Nursing Research, 7*(2), 136–147.

Discussion: In research related to the concept of missed care, or care that should have been done but was not completed, nurses with less than five years of experience were more apt to not only report care omissions, but were also more likely to actually not complete necessary care. Care omissions were linked to a lack of sufficient staff and other resources, as well as problems with communication. Delegation abilities and whether or not care was completed meant that nurses tended to be more dissatisfied with their jobs. These findings are compatible with the confidential Hansten Healthcare nursing professional practice skill self-assessment database (Hansten Healthcare PLLC, 2019).

Implications for Practice: Nurses can feel uncomfortable with their ability to apply their delegation, assignment, and supervision skills. New graduate nurses identified that they needed to learn how to lead, delegate, assign, and supervise well—all skills that are more readily taught in the clinical area as opposed to a classroom. Therefore, it should be a priority for students and novice nurses to learn how to lead a team of UAPs and to begin to use delegation, assignment, and supervision skills. The impact of poor team leadership means missed nursing care, which leads to patients being harmed and nurses being dissatisfied with their work. When competent UAP and adequate supplies are present, excellent RN team leadership skills can result in better patient results and health care worker job satisfaction.

Case Study 18.3

A new nursing graduate, Jamilla, has been assigned to work with Abdul, a UAP, and five patients. Jamilla introduces herself to Abdul and asks him what types of patient care he usually performs. He tells Jamilla that he gives baths and takes vital signs. Jamilla asks Abdul to get all of the vital signs and give them to her written on a piece of paper. She asks Abdul if he documents them. He states that he does document them. Later that morning, Dr. Kent is making rounds on his patients, two of whom are Jamilla's patients. He asks Jamilla for the most recent vital signs. She then asks Abdul for the vital signs on all the patients. Abdul tells her he has not taken them yet. Dr. Kent then asks Jamilla to get the vitals herself. By the time Jamilla returns with the vital signs, Dr. Kent has gone and has written orders she cannot read.

There are several factors in this delegation situation that should have been handled differently. Name them.

Do you think the new graduate was ready to delegate to the UAP? Why or why not?

Were the duties that were delegated or assigned appropriate for the UAP?

Would review of the job description for each health care personnel identified in this case study help solve this problem in the future?

Critical Thinking 18.7

The Joint Commission Sentinel Event Alert of September 2017 highlighted serious patient safety problems with communication, in particular, inadequate hand-off communication between shifts, between departments of the hospital (e.g., perioperative areas, critical care, emergency departments, medical surgical), and between patient transfer stops along the health care continuum (i.e., from acute care to home care or ambulatory care clinics and vice versa) (Joint Commission 2017). Similar serious patient safety problems with communication can occur during inadequate hand-offs between care providers on any team. Clear information about individual patients and their potential safety concerns and desired patient outcomes must occur in shift hand-offs with off-going RNs and oncoming RNs and UAPs. When patient information that is shared from team member to team member is insufficient, delayed, confusing, or inconsistent with patient conditions or needs, patients are at high risk for errors, delays, or omissions. How is patient information shared from team member to team member on the clinical units that you have been on as a student?

The 4 PS, Purpose, Picture, Plan, Part

One template or memory device used for hand-offs between shifts, departments, or points along the health care continuum includes the 4 Ps, Purpose, Picture, Plan, Part (Hansten, *Relationship & Results Oriented Healthcare Planning & Implementation Manual*, 2014b). This memory device helps health care workers focus on what the patient wants, not only what the treatment team would like to achieve with their standardized treatment plan. The 4 Ps are:

- **Purpose**: **Why is this patient here?** "Mr. Jones has probable bacterial pneumonia. He wants to be able to breathe well for his daughter's wedding, which is next weekend."
- **Picture**: **What does he look like now and what does he want to look like later?** "He's reddish blue, respirations 26/min, sputum green/gray, wheezing, pulse oximeter 84%, fever 101.4 F., BP 96/60, awaiting labs." **What is his picture of success?** "He wants to be able to go home as soon as possible to rest up for his daughter's wedding."
- **Plan**: **What is the plan for this patient for the short term (shift) and the longer term?** "We will follow the standard plan of care for a patient with pneumonia. We are using X and Y antibiotics IV until the sputum culture and sensitivity results are back. He's been hypovolemic due to the fever and dehydration but his BP is improving as we replace fluids. Mr. Jones would like to be discharged as soon as possible, with home care support if necessary, because of his daughter's impending wedding."
- **Part: What will each person do? What part does the patient/family play as well as the health care professionals?** "He and his wife are going to a pulmonologist after he improves. He's agreeing to update all vaccinations also, as he hadn't had his pneumonia and flu vaccinations. This shift, I would like you to. . ." The RN can then give instructions to the UAP about assigned tasks. Other members of the inter-professional team, such as respiratory therapists, might be included during hand-offs in a discussion of what each shift needs to complete.

Critical Thinking 18.8

1. During your clinical laboratory experiences, have you observed or received hand-off reports of patient care that were clear?
2. If you have had excellent hand-offs, what were the key data that were emphasized?
3. If you were not given sufficient information during hand-offs to do your job effectively, what other data would have been useful to you?
4. Think about what information you want to be certain to include when offering information and guidance to UAPs. How might you find out whether or not the information you shared was sufficient or too extensive?

Critical Thinking 18.9

Nurses are leaders. When they get a high-risk patient, they move quickly to follow high risk evidence-based patient guidelines, keep the patient warm (95 F (35 C), stop their bleeding, and give Cardiopulmonary Resuscitation (CPR) when needed. Nurses assure their high-risk patients receive oxygen and are intubated quickly, as needed. Nurses check their high-risk patients' vitals (TPR and BP, Pulse Ox), put the patient on a cardiac monitor, start a large bore IV, give warm IV fluids, and draw labwork, as part of their nursing delivery of caring, safe, high-quality, patient-centered, evidence-based patient care. Have you seen a nurse assume this type of nursing leadership during your clinical experiences? How will you prepare to assume this leadership role upon graduation?

KEY CONCEPTS

- If RNs delegate, assign, and supervise poorly and care is omitted or done inadequately or with errors, patients and nurses suffer negative consequences.
- The RN must have a clear understanding of the definitions of delegation, assignment, supervision, and accountability.
- Unlicensed Assistive Personnel (UAP) or Nurse Assistive Personnel (NAP) or Assistive Personnel (AP) are those personnel trained to function in a supportive role to the RN and who have been assigned or delegated a task.
- LPN/LVNs are licensed individuals that perform routine uncomplicated nursing care in a dependent role under the supervision of RNs or other licensed care providers such as nurse practitioners, physicians, dentists, or others.
- The NCSBN and ANA National Guidelines for Delegation is a useful tool when developing skill in delegating patient care.
- State nurse practice acts differ so the RN must be familiar with their own state regulations, rules, advisory opinions, as well as their organization's job descriptions.
- The Five Rights of Delegation are the Right task, the Right circumstance, the Right person, the Right direction and communication, and the Right supervision and evaluation.
- Nurses must know the competencies of delegates.
- Accountability is being responsible and answerable for the actions or inactions of self or others.
- Authority occurs when a person who has been given the right to delegate based on the state nurse practice act also has the official power from an agency to delegate.
- The RN is accountable for decisions to delegate and assign and for the performance of the delegated or assigned nursing duties.
- To assign is when a nurse directs an individual to do something the individual is already authorized to do by state regulations.
- Supervision is the provision of guidance or direction, evaluation, and follow up by the licensed nurse for accomplishment of a nursing task delegated to a UAP.
- Feedback within the team is a necessary part of supervision.
- An assignment is the distribution of work that each staff member is responsible for during a given shift or work period.
- Key elements must be in place in an organization for efficient nursing delegation and assignment to occur.
- Professional clinical judgment is the mental process that a nurse exercises, based on the presenting situation, when forming an opinion and reaching a clinical decision based upon an analysis of the available evidence.
- One template or memory device used for hand-offs between shifts, departments, or points along the health care continuum is the 4 Ps, Purpose, Picture, Plan, Part.
- The Swiss Cheese Safety Model is helpful in visualizing defenses against errors and avoiding Healthcare Acquired Conditions.

KEY TERMS

Accountability
Assignment
Authority
Clinical judgment
Competence
Delegation
Supervision
Unlicensed Assistive Personnel (UAP) or Nurse Assistive Personnel (NAP) or Assistive Personnel (AP).

REVIEW QUESTIONS

1. What issues can occur if the RN does not delegate or assign work effectively and care is not completed? Select all that apply.
   a. Pressure ulcers or injuries from lack of turning the patient
   b. Team members unhappy due to care being done inadequately or poorly organized
   c. Blood transfusion reaction
   d. Deep vein thrombosis
   e. Pneumonia
   f. Dehydration
2. When a nurse considers delegating a task, what five rights should be utilized?
   a. Right patient, right chart, right physician, right results, right information
   b. Right person, right patient, right task, right documentation, right time frame
   c. Right task, right circumstance, right person, right direction/communication, right supervision and evaluation
   d. Right room, right time, right person, right documentation, right directions
3. The nurse has become incredibly busy with discharging two patients and expecting a new patient any second. The following are tasks that need to be completed right away. What task can the nurse delegate to a UAP to help out with managing the nurse's time with patients?
   a. Remove sutures from an incision and apply dressing to the patient's left wrist.

b. Provide tracheostomy care to the patient.
c. Sit with a patient who was recently diagnosed with Crohn's disease who is crying.
d. Perform patient assessment.

4. The staff working on the unit includes four RNs, two LPNs, and a UAP for 25 patients. What assignment is the most appropriate for one of the LPNs?
a. Assess a newly admitted patient.
b. Pass medications to a group of patients.
c. Pass water to all of the patients on the unit.
d. Ambulate stable patients.

5. What is the most appropriate task for the RN to delegate to the UAP?
a. Silence the IV pump until the RN arrives.
b. Notify the family of a patient who has died.
c. Administer a soapsuds enema to a patient who has requested it for constipation.
d. Reinforce teaching to a patient who has had an above the knee amputation.

6. What part(s) of the nursing process is/are usually delegated to a UAP? Select all that apply.
a. Assessment
b. Nursing diagnosis
c. Planning
d. Implementation
e. Evaluation
f. Clinical judgment

7. The charge nurse working with an RN, an LPN, and a UAP is very busy with the group of patients on the unit. One patient's intravenous line has just infiltrated, a practitioner is on the phone waiting for a nurse's response, a patient wants to be discharged, and the UAP has just reported an elevated temperature on a new surgical patient. Who should be assigned to restart the intravenous line?
a. LPN
b. UAP
c. RN
d. Charge nurse

8. A new graduate nurse is assigned a patient who is two days postoperative who has had a colostomy. The patient has an order to have a nasogastric tube inserted immediately. The new graduate has never inserted this type of tube in a patient. How should the new graduate nurse proceed in this situation?
a. Delegate the task to a UAP.
b. Read over the procedure, and then insert the tube.
c. Notify the practitioner of the new graduate's inexperience.
d. Ask an experienced RN for assistance with the procedure.

9. When a nurse considers delegating a task, which of the following are individual personal characteristics of the delegate that should be considered? Select all that apply.
a. Method of processing information (auditory, visual, kinesthetic, or tactile)
b. Competence
c. Length of work experience
d. Willingness to complete work

10. When nurse A asks another nurse B to observe his or her group of patients while at lunch, and one patient falls out of bed, which nurse is responsible?
a. The nurse A originally assigned to the patient who went to lunch is responsible.
b. The nurse B who was observing the group of patients is responsible.
c. Neither nurse is responsible.
d. The actions of both nurses will be reviewed.

REVIEW QUESTION ANSWERS

1. Answers A, B, D, E, and F are correct.
Rationale: Blood checking or administration should not be delegated to anyone, so the RN would be monitoring the blood transfusion (C). However, in a few states LPNs could be involved in blood administration. Check your state. If patients are not cleaned, turned, toileted, with excellent perineal and skin care and receive inadequate hydration and nutrition and movement, pressure ulcers can occur (A), as can deep vein thrombosis, and possible emboli from the thrombus (D). Lack of turning or repositioning and ambulation can predispose a patient to pneumonia (E). Dehydration (F) from lack of attention to feeding and administering fluids can occur in patients without IVs or nasogastric fluids. Team members are dissatisfied when care is done inadequately or poorly organized (B).

2. Answer: C is correct.
Rationale: Right task, right circumstance, right person, right direction/communication, right supervision and evaluation is correct; refer to the 5 Rights as included in the chapter (C). All of the other answers (A, B, and D) may be useful for patient comfort and safety but they are not the Five Rights of Delegation.

3. Answer: C is correct.
Rationale: If the UAP is kind and helpful, he could sit with the Crohn's patient (C) once the RN has talked with the patient initially. A UAP cannot remove sutures (A), or apply dressings to an incision (A), or provide tracheostomy care (B). Patients can only be assessed by the RN (D), although data such as vital signs can be retrieved by others.

4. Answer: B is correct.
Rationale: LPNs pass medications in most states (B). Some medications will be RN-only such as IV push, central line, antiarrhythmics, pressors, etc. Check your state and organization. Admission assessment (A) is in the RN role, although data collection assistance for that assessment could be from either an LPN or UAP. Passing water (C) would be appropriate for the UAP. Ambulating stable patients (D) could be a possible task for the UAPs.

5. Answer: C is correct.
Rationale: UAPs can administer non-medicated enemas (C). Silencing pumps by UAPs (A) is risky since there is often

an important reason the pump is beeping and will need RN intervention to resolve. Notification of death (B) would be an RN-only process and would require astute nursing judgment. UAP are not usually allowed to reinforce teaching (D) (check your area of practice regarding reinforcement of standardized teaching plans, as this could be allowed in some states and in some areas, such as home health, clinics, long-term care).

6. Answer: D is correct.
Rationale: Some interventions (D) or tasks selected by the RN can be delegated if appropriate for that patient. Assessment (A), Nursing Diagnosis (B), Planning (C), and Evaluation (E) cannot be delegated. Clinical judgment (F) is a part of nursing but is not considered a distinct part of the nursing process in that clinical judgment is used throughout the entire process of nursing, so cannot be delegated.

7. Answer: C is correct.
Rationale: An RN (C) can be assigned to restart the IV. The charge RN (D) could restart the line if the RN is responding to the practitioner on the phone. The patient with a fever is also an important priority but either the charge RN or the RN should soon perform additional assessment (B). In some states, LPNs (A) can start IVs, but in some states this is not allowed. If in a state where LPNs can start IVs, the LPN could also restart the line (A). LPNs are not always allowed to take physician orders over the telephone so that choice is eliminated.

8. Answer: D is correct.
Rationale: When in doubt, ask an experienced RN for assistance (D). Inserting an NG tube by someone new to the procedure is not permitted (A, B) without assistance. The experienced RN should be able to assist with the tube insertion. There is no need to notify the ordering practitioner (C) unless another problem emerges.

9. Answer: A, B, C, and D are correct.
Rationale: All of the above answers (A, B, C, D) show that the RN is thinking about not only whether or not the delegate is competent, but also how well they may do the job and how best to communicate instructions to that individual understands well and can follow through.

10. Answer: D is correct.
Rationale: The actions of both nurses will be reviewed (D). Did Nurse A leave the patient highly medicated with the bed in high position without bed railings up? Did Nurse A toilet the patient before leaving for her break? Did Nurse B let the patient cry for help to the bathroom before falling? A review of all factors leading up to the fall will be reviewed to determine how to best avoid this kind of problem in the future. Nurse A (A) and Nurse B (B) both have responsibility and accountability for care of the patient and for patient safety so both are responsible (C). In organizational cultures that use just practices, the situation would be assessed and the action of each nurse would be reviewed as well as all the health care system issues that allowed for a fall to occur. Unless the nurses had willful patterns of leaving patients at risk intentionally, the nurses should not fear termination or other counseling but should participate in review of the situation so that falls can be avoided in the future.

REVIEW ACTIVITIES

1. Have you had any clinical opportunities to delegate or assign duties? If so, identify what you delegated or assigned and to whom. Discuss how your delegation or assignment affected the patient and your work. What would you do differently next time? Use the Five Rights of Delegation to help walk through your decision.

2. Observe the delegation and assignment process at your organization. How is the unit, department, or organizational delegation or assignment process set up so that each person on a team communicates well with the rest of the team? What suggestions would you make to improve their delegation procedures or communication process?

3. You are caring for a new patient in Room 2510. You are trying to decide whether to delegate his care to UAP Jill or to UAP Penny. Jill is not certified and is not always easy to work with but usually does her fair share of the work. Penny is certified. She always does her fair share and is easy to work with. She is able to perform dressing changes. Which individual will you choose based on their individual strengths, certifications, competence level, and collaborative or industrious attitude? Which personal factors are most important? What is fair to both Jill and Penny and the patient?

4. Look at the assignment sheet for the shift your clinical day is on. Who is listed on the assignment sheet? What assignments are made on the sheet? During the shift, did you observe an RN ask another RN to do a job for them? If yes, could the UAP have done it?

5. Discuss with a UAP and an RN their preparation in regard to delegation, supervision, and teamwork. How much education or training has each of them received? How long ago did they receive it? What type of education or training did they receive? Is the RN familiar with the "Five Rights of Delegation?" How is the education of the RN and the training of the UAP different?

6. Talk with UAPs regarding how the RNs could better lead their teams and how you could best prepare yourself to be a great team leader.

DISCUSSION POINTS

1. What can you learn from the negative and positive nursing delegation qualities you have noticed in the RNs you have worked with as a student?

2. Did you see care being omitted in your student experiences resulting in hospital acquired conditions?

3. How aware were you of your authority as an RN in delegation, assignment, and supervision?

4. How well did the RNs supervise you in your student experiences and make certain that delegated or assigned work was completed?
5. Do you think the organizations where you have had student experiences are fulfilling their organizational responsibilities for delegation?

DISCUSSION OF OPENING SCENARIO

1. How could the nurse have avoided the delay in diagnosis and treatment?
   a. In order to avoid the patient deteriorating without immediate attention, several initial safeguards would have been useful. First of all, both the RN and the UAP must know their job descriptions: what are the expectations of the UAP working as a "sitter?" Certainly, the RN could not expect the UAP/sitter to perform neurological assessment. If the RN had given adequate initial direction to the UAP, directing her to report any change in movement or mentation immediately, the UAP may possibly have alerted the RN more quickly when the weakness first occurred. If the RN had asked the UAP to perform vital signs every 2 hours, changes may have been identified more quickly. The RN also should have observed the patient more closely and completed a neurological assessment every 2 hours rather than allowing the patient to sleep.
2. What are the responsibilities of the nurse and the sitter (a UAP)?
   a. RNs, Sitters, and/or UAPs job descriptions are usually available in either a policy/procedure manual or online in the health care organization's human resources job descriptions. The RN is accountable to delegate and/or assign responsibilities to the UAP and to supervise the care and the RN is also accountable for the overall nursing care of the patient. The UAP is responsible to keep the patient safe and to report any patient changes in a timely manner. Other tasks such as vital signs may have been assigned to the UAP and should have been reported to the RN.
3. How would you find out their job responsibilities?
   a. As mentioned above, most health care organizations usually keep job descriptions in either a policy/procedure manual or in the online human resources job descriptions, with job responsibilities and competency checklists in an online format searchable all shifts.
4. How could delegation and supervision have been appropriately performed in this situation?
   a. Clear initial delegation and direction to the UAP, identification of the UAP's need to report changes immediately, along with better ongoing observation and supervision by the RN would have speeded up the assessment and treatment of this patient and might have even prevented further neurological damage.

EXPLORING THE WEB

- Log on to www.nursingworld.org the American Nurses Association (ANA) site, to view safety and quality of care issues. Look for delegation policy under nursing practice:
  - www.nursingworld.org/practice-policy/nursing-excellence/official-position-statements/id/joint-statement-on-delegation-by-ANA-and-NCSBN (accessed February 12, 2019).
  - www.nursingworld.org/practice-policy/scope-of-practice (accessed February 14, 2019).
- Go to the www.NCSBN.org website:
  - Search for delegation: www.ncsbn.org/search.htm?q=delegation (accessed February 14, 2019).
  - Find www.ncsbn.org/4516.htm Medication Administration in Nursing Homes: RN Delegation to UAP and review the research (accessed February 14, 2019).
  - Having trouble locating your own state's nurse practice act? Go to the link from the NCSBN.org website to your own state practice website. /www.ncsbn.org/contact-bon.htm (accessed February 142,019).
- Check out these references and online education related to delegation and supervision:
- www.amazon.com/Ruth-I.-Hansten/e/B001IR3H1S (accessed April 8, 2019).
- Online CE including 10 Steps for Professional Practice: at http://learning.hansten.com https://nurse.freecelms.education/by/ms-ruth-hansten-bsn-phd-mba-rn-fache (accessed April 8, 2019).
- Part 1: Delegation, Supervision, and Teamwork: https://nurse.freecelms.education/by/ms-ruth-hansten-bsn-phd-mba-rn-fache/ms-ruth-hansten-bsn-phd-mba-rn-fache/165678/leadership-at-the-point-of-care-part-1-delegation-supervision-and-teamwork (accessed April 9, 2019).
- Blueprint for Successful Clinical Supervision and Teamwork: https://nurse.freecelms.education/by/ms-ruth-hansten-bsn-phd-mba-rn-fache/ms-ruth-hansten-bsn-phd-mba-rn-fache/165677/leadership-at-the-point-of-care-part-2-blueprint-for-successful-clinical-supervision-and-teamwork (Accessed April 9, 2019).
- Making Assignments: https://nurse.freecelms.education/by/ms-ruth-hansten-bsn-phd-mba-rn-fache/ms-ruth-hansten-bsn-phd-mba-rn-fache/165676/leadership-at-the-point-of-care-part-3-effective-assignments-for-rns-and-assistive-personnel-acute-care (Accessed April 9, 2019).
- www.RROHC.com (Relationship & Results Oriented Healthcare resources including videos, accessed April 8, 2019).

INFORMATICS

1. Search the web for your own state's nurse practice act and your board of nursing or state nursing care quality assurance commission. Search for delegation and supervision policies and standards of nursing practice. Look for LPN/LVN scope of practice and note what the parameters of LPN/LVN intravenous treatment or therapy are. Look for Advisory Opinions on your state board website if anything is unclear.
2. Search the QSEN website, http://qsen.org/teamwork-collaboration Look at the question posed for students related to teamwork and collaboration. The question is: "What are some examples of teamwork and collaboration you have seen in health care? These examples can be at a clinical site, in the workplace, or even during a hospital stay?" (accessed February 15, 2019).

LEAN BACK

- When you read this chapter about delegation, what were your thoughts and/or fears about how well you would be able to delegate and lead a team?
- What discrepancies have you have seen in actual care settings as a student that conflict with what is taught here about excellent delegation and supervision?
- What could you as a new graduate do to develop a higher level of teamwork than what you are seeing in your clinical settings?
- How can you guard against errors of omission or commission related to delegation?
- What guidelines or memory assists will you use to help delegate and supervise others effectively?
- What guidelines or memory assists will help you in your NCLEX-RN Examination with questions related to delegation and teamwork?

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16

Leadership to Create Change

Joanne Disch, PhD, RN, FAAN

"We can't have family members roaming the hospital at all hours of day or night without any regard to safety. It's just too dangerous!" said Tony Sargento, head of security for the medical center.

"I wish you could see how important family members are to the patient's well-being. We believe that an open visiting policy is the humane thing to do—plus all of the research supports open visiting," countered Aneisha Tucker, the evening charge nurse of the medical intensive care unit (ICU).

This exchange occurred during the fourth meeting in as many months between members of the security department and nursing leadership. Both sides were strong in their convictions. . . and had been for months. During this meeting, however, Tracy Evans, the day charge nurse, posed two different questions: "Tony, what do you think we're proposing? And what do you worry is the worst thing that could happen?"

Tony thought for a moment and said, "Well, you're talking about open visiting hours, aren't you. . . that any family member can visit at any time? And you know that some of our patients' families are huge—the Swanson boy is one of twelve. How would we begin to manage this? People coming and going, all over the place. We couldn't guarantee the safety of the patients, the staff, or the other visitors."

With this comment, Tracy realized that they were talking about two different scenarios. The phrase "open visiting" had led to a misunderstanding. What the staff had read about and learned from talking to nurses at two other medical centers and were proposing was that family members, a few at a time, could visit as they wished—there were no set visiting hours. She explained what they had really meant and added, "We aren't wanting large crowds either. Maybe one or two at a time. Could that work?"

Tony said he thought so and asked whether it could largely be the same one or two people, so they could have their names on the record downstairs at the Information Desk, and they would have to be checked in when they arrived and wear a name badge.

Both Aneisha and Tracy thought that could work. "Let's give it a try starting Monday and see how it goes. We'd like to achieve both a safe environment and person- and family-centered care. We meet again in three weeks. We'll gather some data on the number of visitors, whether they are adhering to the policy of check-in and name badge, and if there are any other issues we've not thought of."

"I think it's worth a try," said Tony.

Quality and Safety in Nursing: A Competency Approach to Improving Outcomes, Third Edition.
Edited by Gwen Sherwood and Jane Barnsteiner.

Companion website: www.wiley.com/go/qualityandsafetyinnursing3e

In 2015, the National Patient Safety Foundation (NPSF) identified leadership as the number one factor in a set of eight factors critical to improving health care safety. And in a national Rand report from the year before on patient safety in the Commonwealth of Massachusetts (Schneider *et al.*, 2014, p. 9), the authors noted that we have "a vacuum in leadership—and vacuum is not too strong a word—a very major obstacle in making progress in safety." They attributed this to safety not being an institutional priority, and that insufficient attention was paid to creating a safety culture, generating patient engagement, or dealing with health information technology issues.

A basic premise of this chapter is that *all* nurses must be leaders in some way, if leadership means *working with and through others to improve something*. This underscores the fundamental approach that all nurses must take; that is, collaborating with others to improve the quality and safety of care, whether it be working with patients to better manage their pain, communicating clearly with other members of the health care team to revise the plan of care, or developing a better staffing plan or visiting policy. We work with and through others to improve the health of persons, families, and communities; the education of our students; and the nursing profession in general.

The Context for Leadership Today

The reality is that the skills that have enabled most leaders to thrive in society over the past few decades may not help in today's tumultuous environment. Skills such as analytical problem solving, a spirit of control and command, crisp decision-making, and definitive action may not be adequate when society is reeling from the current COVID-19 pandemic, ongoing economic upheaval, and turmoil over racial injustice. And a "return to normal" as a goal is increasingly unlikely. Heifetz, Grashow, and Linsky (2020) discuss leadership requirements in the context of a permanent crisis, noting that with all of the concurrent seismic changes in society today, leaders will not be helping us return to normal, but to a "new normal," as yet to be defined. This requires attention to two distinct phases: managing the crisis and, over the longer term, tackling the underlying systemic issues that will result in a new, more dynamic normal. The usual organizational adaptability is being greatly challenged, traditional strategies are inadequate, and workable solutions are far beyond any one person or discipline. Ram Charan (2015), a world-renowned advisor to CEOs and boards of directors, asserts that taking control of uncertainty is the fundamental leadership challenge of our time. This is not to remove uncertainty, but to function effectively within it—actually to "cultivate confusion endurance" (Gelb, 1998, p. 13).

A roundtable with five corporate CEOs was recently hosted by the *Harvard Business Review* (2020) and the question was asked: "What does it take to be an effective leader right now?" Some common themes emerged: people want to see leaders being human; be calm, have realistic optimism, show up, and be visible; show some vulnerability and acknowledge that this is hard work; be flexible and agile; and over-communicate with everyone. Things are changing so quickly that yesterday's plan may have been modified.

One particular area that leaders today must forcefully address is the need to create environments that are inclusive, promote equity and diversity, and remove barriers such as systemic racism or implicit bias. In "A theory of racialized organizations," Ray (2019) challenges the assumption that organizations are race neutral and suggests that it would be more fruitful to assume that discrimination and the misallocation of resources exist—and then examine where and how this occurs within an organization, and what changes can make significant differences. In June 2020, American Nurses Association (ANA) President Ernest Grant issued a strong statement that condemned racism,

brutality and senseless violence against Black communities (ANA, 2020). Numerous resources exist to help leaders take appropriate action (ANA, 2018; Boekhurst, 2015; Buengeler, Leroy, and de Stobbeleir, 2018; Weaver, 2009). Day and Beard (2019) offer insights into how leaders can create the right environments in schools of nursing.

The Evolution of Leadership

Northouse (2016, p. 6) describes leadership as a "process whereby an individual influences a group of individuals to achieve a common goal." He notes that there are four components central to the concept: (a) leadership is a process; (b) leadership involves influence; (c) leadership occurs in a group context; and (d) leadership involves goal attainment. Historically, the emphasis of leadership was originally on individuals and their characteristics and attributes. The belief was that an individual was innately a leader who could translate into most situations. Eventually, the focus shifted to leadership as arising from the nature of the relationship between the leader and the follower, and the recognition that, without followers, there is no leader.

In latter years, the emphasis has shifted toward leadership being more context dependent, or for a particular purpose, and that an individual is unlikely to be able to lead in all situations. This would certainly seem to be relevant today. Given the need for transformative change in health care, the framework of generative leadership fits particularly well here. Generative leaders are "individuals who create new options or new approaches to old problems, and work with and through others to effect needed change" (Disch, 2009, p. 173). The goal is change to improve an identified problem and to work with and through others to accomplish this. No one person can know everything; bringing together diverse perspectives in pursuit of a common goal is necessary. Generative leaders are

> intellectually curious and never satisfied with the status quo; they are resilient and optimistic, seeing opportunities where others see insolvable problems . . . [they] recognize there are multiple ways of knowing, and surround themselves with other thought leaders, including those with whom they disagree. They use a holistic, systems perspective in their thinking and move beyond perceived limitations of time, space, traditional thought, and their own views of the world. *(Disch, 2009, p. 173)*

The definition of leadership that we will use in this chapter is highlighted in Textbox 16.1. At first glance, this may seem to be an extremely simple concept, yet it is also very comprehensive. It contains two powerful elements:

- A goal of *improving something*, which infers that the leader is knowledgeable about current trends and preferred courses of action; understands the alternatives and the evidence supporting each; has a big picture and systems orientation; and possesses expertise in change management and quality improvement principles and methods.
- The leader is continually *working with and through others*, which requires excellent interpersonal skills, as well as an ability to listen and elicit ideas from others and create a sense of a team and a healthy work environment within which people can do their very best work and feel comfortable speaking up and respectfully disagreeing.

Textbox 16.1 Definition of Leadership

Leadership:
Working with and through others
to improve something

Paradox, Ambiguity and Uncertainty

Being an effective leader today requires a broad set of competencies that will be outlined later in this chapter, and comfort with three counterintuitive strategies: embracing paradox, seeking ambiguity, practicing creativity.

A *paradox* is a statement that is seemingly contradictory or opposed to common sense and yet is perhaps true. Familiar examples include:

- "Art is a lie that makes us realize the truth" (Pablo Picasso).
- "It is only with the heart that one can see rightly; what is essential is invisible to the eye" (Antoine de Saint-Exupéry).
- "To move freely, you must be deeply rooted" (Bella Lewitsky).

Within health care, we encounter a number of paradoxes. Tables 16.1 and 16.2 highlight a number of them.

F. Scott Fitzgerald observed, "The test of a first-rate intelligence is the ability to hold two seemingly opposed ideas in mind at the same time and still retain the ability to function." Rather than focus on one side or the other, for example improve quality or reduce cost, the challenge today is to find what can be termed both/and solutions. This requires us to eliminate thinking in terms of polarities: all or none, right or wrong, good or bad, my way or your way, yes or no, doctor or nurse. Collins and Porras (2004) admonish us to avoid the tyranny of the "OR" and embrace the genius of the "AND." How can this be done? In situations where there are differences of opinion, seek an area or two of agreement and then negotiate other aspects. Explore options by asking "Under what conditions would you be comfortable with XXX?" or "What is your worst fear and how do we set up an approach to minimize or eliminate that from happening?" The vignette at the beginning of this chapter describes a true

Table 16.1 Examples of Paradoxes in Health Care

Do more with less
Improve quality and reduce cost
Operate the business successfully and ethically
Be competitive, yet collegial
Promote your own profession, and create strong interprofessional teams
Expend a lot of energy staying calm

Table 16.2 Examples of Paradoxes in Nursing Education

Be an expert educator, researcher, clinician and professional nursing leader
Incorporate new content on genomics, informatics, cultural diversity, ethics, and complementary therapy without doubling the length of your program
Preserve faculty autonomy while creating a spirit of community
Create personally meaningful, interactive learning experiences in the middle of a pandemic requiring separation
Expand student enrollment in the face of • an imminent faculty shortage • shrinking state and university funding • reduced access to clinical sites

Textbox 16.2 Examples of Ambiguity

How is this possible?

Example #1

Two fathers and two sons went fishing one day. They were there the whole day and only caught three fish. One father said that is enough for all of us, we will have one each. How can this be possible?

Example #2

Two women apply for jobs. They look exactly alike. On their applications they list the same last name, address, and phone number. They were born to the same parents, on the same day, same month, same year. Everything is identical. The receptionist says, "You must be twins." They reply, "No."

Example #3

In the following line of letters, cross out six letters so that the remaining letters, without altering their sequence, will spell a familiar English word.

BSAINXLEATNTEARS

Answers can be found after the Resources section at the end of the chapter.

Sources: https://www.riddles.com; https://riddlesbrainteasers.com/two-identical-women; von Oech (1990).

situation as to how this approach was finally able to help resolve a months-long struggle between nursing staff and the security department.

Ambiguity is a situation or statement that is capable of being understood in two or more possible ways. Textbox 16.2 offers two examples. The answers will be provided at the end of the chapter.

In the work setting, ambiguity can exist if a supervisor says "Just go ahead and do what you think makes the most sense" or "We're not really sure what the goal is so let's all just do our best." Some situations can be clarified with more information, making sure directions are clear and asking the other person if they have any questions or, better yet, to repeat back what they heard being said.

Communication with patients and families is one key situation where this is essential. Many serious complications have occurred when patients either think they understand something or know that they don't but are hesitant to indicate otherwise, not wanting to look foolish. One classic example is in giving directions about taking medications to individuals whose primary language is Spanish, and telling them to take something once a day. The word *once* in Spanish means eleven. As we saw in the vignette, the phrase "open visiting hours" was definitely ambiguous.

In many situations today, however, ambiguity is inescapable: "As change accelerates, we now find that ambiguity multiplies, and illusions of certainty become more difficult to maintain. The ability to thrive with ambiguity must become part of our everyday lives. Poise in the face of paradox is a key not only to effectiveness, but to sanity in a rapidly changing world" (Gelb, 1998, p. 150). In these situations, we can seek as much clarity as can be found—and then work to deal with a situation, become more flexible, more comfortable with uncertainty and the fluid nature of the health care environment.

Sometimes we can actually use the ambiguity to our advantage. For example, simple rephrasing of a goal and introducing some ambiguity can open up possibilities for solutions where none seemed to exist before. Consider the difference in options if a nurse manager tells staff that "we need to hire 10 more nurses" in the face of a significant nursing shortage; *or* is persuaded to reframe the goal to "increase the capacity for providing nursing care," which could be met through several options: allowing nurses to work to full capacity or overtime; bringing in nurses on leave or recently retired; asking nursing faculty who are clinically competent to offer some hours; working with pharmacy to augment their support of nursing staff; adding assistive personnel to perform some of the routine tasks. Or, as we have seen with the COVID-19 pandemic, new options are emerging when nursing faculty ask "What are the different strategies we can use to help our students develop adequate clinical competency" as opposed to "How do we get our students into hospitals for their clinical hours?"

A third counterintuitive strategy is to practice *creativity*, which is the capacity to bring something new into being. Within our society, there are many myths about creativity and creative people, as evidenced by statements such as "Creative people are born, not made," or "Creativity involves play and laughter," or "I'm just not a creative person." In health care, challenges to creativity—and new ways of doing things—can be heard in statements such as "We've always done it this way," or "That's not our way," or "What's the right way?'

The reality is that some people may be more creative in the traditional sense of the word, but if leaders are to work with and through others to improve the quality and safety of patient care, each nurse must develop the capacity for thinking differently, which may require practice. Many people would actually say that nurses are more creative than most people since they may, simultaneously, find themselves having to provide additional nursing staff for evenings, juggle three new admissions, offer home instructions to a homeless person, and console a grieving family member. The person-centered example of a nurse practitioner in Textbox 16.3 illustrates incredible creativity and sensitivity.

Finding new ways to develop solutions for today's challenges often requires hard work and not the play and laughter that are usually associated with creativity sessions. Coming up with ways to staff the evening shift, or providing home care to the homeless, or improving oxygenation of ICU patients by proning them are examples of nursing creativity. Textbox 16.4 shows the creative thinking that Diane Treat-Jacobson used to transform the quality of care of individuals with advanced peripheral vascular disease, which has been adopted as an international best practice.

Textbox 16.3 Clinical Case #1: A Creative Adjustment to a Person's Plan of Care

Barbara Doyle, a nurse practitioner, and Tejar Gandhi, a cardiologist, had jointly managed an outpatient clinic for patients with congestive heart failure for three years. They had developed a collaborative rhythm in diagnosing problems and developing treatment plans. For one patient, they agreed that a course of diuretics was warranted. Dr. Gandhi took the lead with this patient, providing a thorough description of the drug, their rationale for ordering it, any anticipated side effects, and asked the patient to give Barbara a call if he gained more than 3 lb within a week. The patient was able to adequately repeat this information back. As they were saying goodbye, Barbara recalled a significant fact in the patient's profile: he was homeless and, thus, unlikely to have access to a scale for his weight. Instead, Barbara asked him if he would let her know if his shoes became tighter within the three days, and to give her a call if they did. She also made a note to talk with the social worker about a housing consult.

Source: Adapted from Disch, J. (2021) Nursing as a force for health equity. In M. Moss and J. Phillips (Eds.), *Health Equity and Nursing*. New York: Springer, p. 11.

Textbox 16.4 Clinical Case #2: An Example of Nursing Creativity Preserving the Quality of Life

For decades, Dr. Diane Treat-Jacobson has been involved in the care of individuals with profound peripheral vascular disease, both as a clinical nurse specialist (CNS) and as the President of the Society for Vascular Nursing. As part of a surgical team planning postoperative care regimens, she began to question what could be done to prevent even the need for surgery; that is, were there any treatments that could improve circulation to the lower extremities and possibly eliminate, or slow down, the need for surgery that occasionally ended in amputation, with significant quality of life implications for the patients and their families? Treadmill exercises were often used but, for patients with profound pain from minimal activity, this was not an option. Locating a study that had been done in Europe on using upper body ergometry (bicycling movements) to improve distal circulation, Dr. Treat-Jacobson collaborated with a CNS colleague from the Veterans' Administration to conduct a small study to assess the impact of this treatment. Promising results spurred her on to seek funding from the American Heart Association and conduct a study that confirmed that aerobic arm exercises can delay the onset of leg pain that makes walking even short distances difficult for many people with peripheral arterial disease (PAD). This resulted in a series of progressively larger studies that have supported the use of this intervention, thus enriching the lives of these patients and often eliminating the need for drastic surgery. All of this stemmed from a creative nurse who changed the question from "How can we take better care of post-op patients?" to "What can we do to prevent the need for surgery in the first place?"

Source: Treat-Jacobson *et al*. (2019).

Von Oech (1990, p. 6) has observed that "Nothing is more dangerous than an idea when it's the only one you have." He offers several creative exercises to help people learn to think differently, which is the first step in finding new solutions. A few simple ones are:

- Coming up with 10 uses for a common item (e.g., picnic table or dinner tray).
- Solving jigsaw puzzles and seeing subtle patterns.
- Making up analogies (How is nursing like the Mall of America? What does an oriental rug have in common with psychotherapy?).

- Looking for the second right answer to a problem: not *the* answer or *the* result, but forcing yourself to come up with a second possibility, however nonsensical.
- Reading jokes or riddles that can make us laugh or shake our heads in disbelief: "What do John the Baptist and Winnie the Pooh have in common?" (answer at the end of the chapter).

A Framework for Safe, Reliable, Effective Patient Care

Over a period of 15 years, leaders within the Institute for Healthcare Improvement and Safe and Reliable Healthcare developed a framework for action to improve the quality and safety of health care and describe leaders' responsibilities in achieving this goal in the *Framework for Safe, Reliable, Effective Care* (Frankel *et al.*, 2017, p. 9). Anchored by two foundational domains of culture and the learning system, the framework includes nine interrelated components, with patients and families at the core, and leaders as the agents of change. Figure 16.1 includes the framework with descriptive detail of the components.

Culture is "the product of individual and group values, attitudes, competencies, and behaviors that form a strong foundation on which to build a learning system. A learning system is characterized by its ability to self-reflect and identify strengths and defects, both in real time and in periodic review intervals" (Frankel *et al.*, 2017, p. 9). Leaders are responsible for guiding the creation of the culture,

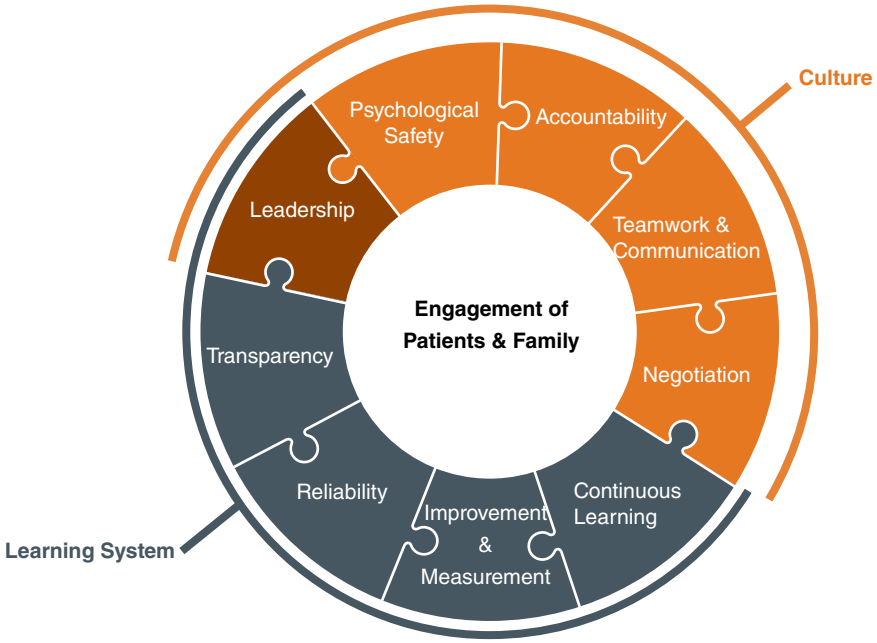

Figure 16.1 Framework for Safe, Reliable, and Effective Care. Source: Frankel, A., Haraden, C., Federico, F., and Lenoci-Edwards, J. (2017) *A Framework for Safe, Reliable, and Effective Care*. Cambridge, MA: Institute for Healthcare Improvement. http://www.ihi.org/resources/Pages/IHIWhitePapers/Framework-Safe-Reliable-Effective-Care.aspx. Reprinted with permission from the Institute for Healthcare Improvement.

as well as ensuring that the structures, systems, and processes are in place to support the delivery of safe, effective care; continuously assess performance; address deficits; and promote healthy behaviors. Patients and families are at the center of the model, reinforcing their centrality as the focus and active partners.

The framework reinforces the idea that leaders at *all* levels are to be active participants in influencing their followers to develop the behaviors and employ the processes and technologies that yield continuous ongoing improvement. Thus, senior leaders are to develop broad strategic goals and initiatives, middle-level managers are to implement these within their areas of responsibility, and clinical leaders are to engage their staff in delivering safe, quality care at the front lines. Essentially all leaders have four main responsibilities, regardless of their titles:

- *Guarding the learning system*: Fully engaging in the work of self-reflection that leads to transparency; understanding and applying improvement science, reliability science, and continuous learning; and inspiring that work throughout the organization.
- *Creating psychological safety*: Making sure that anyone in the organization, including patients and families, can comfortably voice concerns, suggestions, and ideas for change; speaking up and modeling a curiosity for new ideas.
- *Fostering trust*: Creating an environment of non-negotiable respect, ensuring that people feel their opinions are valued, and any negative or abusive behavior is swiftly addressed.
- *Ensuring value alignment*: Applying organizational values to every decision made, whether in service of safety, effectiveness, patient-centeredness, timeliness, efficiency, or equity.

The Role of Nurses in Quality and Safety

"Of all the members of the health care team, nurses. . . play a critically important role in ensuring patient safety by monitoring patients for clinical deterioration, detecting errors and near misses, understanding care processes and weaknesses inherent in some systems, and performing countless other tasks to ensure patients receive high-quality care" (Agency for Healthcare Research and Quality [AHRQ], 2019). The Institute of Medicine's landmark report on the future of nursing (2011, p. 225) noted: "Leadership from nurses is needed at every level and across all settings.. . . Nurses must understand that their leadership is as important to providing quality care as is their technical ability to deliver care at the bedside in a safe and effective manner."

According to the World Health Organization (WHO, 2020, p.14):

> nurses are critical to deliver on the promise of "leaving no one behind" and the global effort to achieve the Sustainable Development Goals (SDGs). They make a central contribution to national and global targets related to a range of health priorities, including universal health coverage, mental health and noncommunicable diseases, emergency preparedness and response, patient safety, and the delivery of integrated, people-centred care. No global health agenda can be realized without concerted and sustained efforts to maximize the contributions of the nursing workforce and their roles within interprofessional health teams.

Thus, the 72nd World Health Assembly designated 2020 as the International Year of the Nurse and the Midwife, both to honor the 200th anniversary of the birth of Florence Nightingale, and to

recognize the daily contributions of nurses and midwives to the safety, health, and well-being of populations across the globe.

A robust body of research over the years has quantified the impact of nurses and the care environment on patient outcomes across the globe (Aiken *et al*., 2012, 2017; Copanitsanou, Fotos, and Brokalaki, 2017). In 2019, Lake and colleagues analyzed data from a comprehensive data set of 17 articles covering 2,677 hospitals, 141 nursing units, 165,024 nurses, and 1,368,420 patients, in 22 countries. Their findings: better work environments were associated with lower odds of poor safety or quality ratings and negative patient outcomes, and higher odds of patient satisfaction.

To put a very real perspective on how clinical nurses are leaders, promoting quality and safety on a daily basis, AARP (2020) profiled 10 nurses who were on the front lines in the COVID-19 pandemic. Robin Krinsky had this to say:

> My duties used to be logical and organized—nothing unusual, certainly nothing catastrophic. Now it's hectic. I describe it as organized chaos. I don't know what I am going to walk into. Everything is ominous. I just want to make sure my patients are breathing. This is the new normal.
>
> The worst part of my day is this: Every day, we find out how many patients are coronavirus-positive, those who died, those on ventilators. We find out how many nurses are virus-positive, or who are quarantined because they are symptomatic. Every day, those numbers rise. I have not been tested for the virus. We don't have enough tests in New York for all health-care personnel.
>
> I don't care about the consequences. I will not stop doing what I love to do. Nurses are leaders. We are a special breed. During disasters—and the coronavirus is the ultimate disaster—we don't walk away. But I am scared every day.

The ANA provides resources to help nurses at all levels ensure safe, quality care to patients, families, and communities. The Code of Ethics for Nurses specifies in Provision 3: "The nurse promotes, advocates for, and protects the rights, health and safety of the patient" (2015, p. 9); and in Provision 6: "The nurse, through individual and collective effort, establishes, maintains, and improves the ethical environment of the work setting and conditions of employment that are conducive to safe, quality health care" (2015, p. 23). ANA also hosts conferences and online courses and publishes many guidance documents to help nurses ensure safe practice and supportive work environments. Topics include safe nurse staffing; violence, incivility, and bullying; disaster preparedness; the Nursing Scope and Standards of Practice; and care coordination.

The International Council of Nurses (ICN, 2020) is a federation of more than 130 national nursing organizations representing more than 20 million nurses worldwide. Working collaboratively across borders, the ICN promotes quality and safety worldwide through endorsements and joint statements, publications, conferences, advocacy, commissions, and engagement with the WHO on key policy issues.

Nursing Leadership in Policy Formation

One particular application of nursing leadership occurs in the creation and promotion of policies related to health and health care. Anderson (2015, p. 6) defines policy as a "relatively stable, purposive course of action or inaction followed by an actor or set of actors in dealing with a problem or matter of concern." While many nurses think that policy work is outside their area of responsibility, in

actuality nurses operate within policies every day, such as organizational policies on documentation, evidence-based practices that govern the practice of nursing, visiting policies, or infection control policies. And it is vitally important for nurses to be actively engaged in helping develop policies so that they are useful, understandable, relevant to the particular situation or problem, and actionable.

In addition, broad organizational and governmental policies also need nursing input if they are to achieve the same goals of usefulness, relevance, and action. Nurses bring a particular viewpoint, what has been called "the nursing lens" (Disch, 2020). Nurses view situations holistically; consider the impact of the problem or treatment on the person, family, or community; employ exquisite skills of communication; and can connect with people during particularly stressful periods, helping them do their very best work. Nurses are quick to make accurate assessments and know which of many possible approaches will likely be most effective. Nurses also anticipate unintended consequences and can steer a decision-making body toward a better option. One such example occurred when a health system board, in deciding how to roll out the electronic health record (EHR) to its clinicians, initially considered training all of the nurses first so that the "bugs" could be worked out and the physicians would not be inconvenienced. A board member who was a nurse pointed out several unintended consequences with the plan: (a) the errors that could arise from nurses having to enter physician notes and orders into the EHR; (b) the inefficiencies to the nurses' workload; (c) the likely communication breakdowns; and (d) possible friction between nurses and physicians. After hearing the possible scenarios of what could likely happen, the board changed its plan and decided that all clinicians would learn together how to use the EHR.

Given the number of significant societal challenges compromising the nation's health, nurses are particularly attuned to, and actually responsible for, taking action to address the larger system issues, whether they be one's work setting, social determinants of health within communities, or societal inequities wherever they occur. The ANA Code of Ethics (2015, p. 1) expressly states in Provision 8 that "the nurse collaborates with other health professionals and the public to protect human rights, promote health diplomacy, and reduce health disparities." Jane Barnsteiner (personal communication) has noted that "we [nurses] are just as responsible for providing safe, quality care to our patients and their families as we are for fixing underlying broken health care systems."

Representative Lauren Underwood (Mason *et al*., 2021, p. xix) offers a powerful example of an individual who became a nurse out of personal contact with nurses when she was a young girl and who now has a passion for making "quality health care more affordable for American families." In January 2019, she was sworn into office as the first woman and first person of color from her community. She asserts that "Whether serving as health care providers, community leaders or even policy makers, nurses across this country are in a position to boldly lead."

The Role of the Nurse Executive in Patient Safety

Although there is support for nurses leading the quality journey, Disch and colleagues (2011) found that the specific role of the chief nursing officer (CNO) in promoting quality and safety in organizations was unclear, and that physician leaders and others in the organization were often unaware of the CNO's participation in and impact on quality and safety initiatives. The authors visited eight medical centers across the country, conducting interviews with senior leaders, physicians, and staff to examine the role of leaders in promoting quality and safety, with particular emphasis on the role of the CNO. They found that in every organization the CNO was an active and respected member of the senior leadership team, but in no organization did they have a seat on the governance board.

Table 16.3 Action Steps for Chief Nursing Officers to Use in Leading Organizational Change

Secure senior leadership support
Identify a leader and organization-wide team to lead the effort
Conduct an assessment of the current status of the organization's performance
Survey nurses, other health care providers, and employees about their perceptions and experiences
Schedule educational sessions to cover the philosophy and concepts, as well as key action steps
Engage patients and families in discussions about their perceptions of the culture and organization's performance in the area
Examine and update organizational documents to reinforce the desired change(s)
Establish ongoing feedback loops for communication as to progress and necessary revisions
Evaluate the progress of the initiative and revise the plan as warranted

Many CNOs were well integrated into the agenda, either giving a routine update or being consulted on a topic. One board chair noted that the "board absolutely listens to the CNO—we are extremely aware of the involvement of nursing in the health care environment."

Barnsteiner and Disch (2018) examined the role of the CNO in a particular aspect of quality and safety, ensuring person- and family-centered care (PFCC). Given nurses' holistic perspective and clinical background, well-established networks, and profound understanding of systems, they concluded that the CNO is eminently qualified to provide leadership in moving systems toward any organizational goal, including embracing PFCC. Their nine action steps can serve as a roadmap for leading any organizational change (see Table 16.3).

The primary nursing organization for nursing leaders, the American Organization for Nursing Leadership (formerly the American Organization of Nurse Executives, AONE, 2019, p. 1) asserted that "the role of the nurse executive in patient safety is to help lead best practices and establish the right culture across multiple disciplines within the organization." To this end, AONE published *The Role of the Nurse Executive in Patient Safety*, which outlines four guiding principles nurse executives should follow to lead safety initiatives:

- Lead cultural change.
- Provide shared leadership.
- Build external partnerships.
- Develop leadership competencies.

The document also outlines key components related to each of the guiding principles, along with recommended strategies for action. Some examples of these are identify a validated culture of safety survey instrument; create an audit/monitoring plan; report progress to the board, executive leadership team, and throughout the organization; leverage the voice of the bedside nurse and continue to enhance competencies; ensure that all health care providers understand contemporary safety science, including human factors, error reporting, fair and just cultures, and high-reliability organizations. A number of these topics are covered in greater detail in Chapter 8.

As to nurses actually serving as members of boards, Prybil (2016) found a significant disparity between the percentages of nurses and physicians. In analyzing findings from eight studies that had examined the presence of nurse and physician leaders on boards over the previous 10 years, he found that the percentage of nurses ranged each year from 2% to 6%, while that of physicians ranged from

14% to 26%. His recommendation? "It is my belief that board deliberations are enriched significantly by the presence and contributions of highly qualified nurse leaders, and it is my hope that their presence around boardroom tables will increase markedly in the coming years" (p. 303). Sundean *et al.* (2019, p. 346) concurred, noting nursing's relevant health care expertise, knowledge, and perspectives, enabling nurses to provide "salient input to contribute to board discussions and policymaking . . . and to improve health care governance decision making leading to improved health care outcomes." They proposed that content on governance be covered in nursing school curricula.

Developing a Capacity for Leadership

In the draft revision of the American Association of Colleges of Nursing's Baccalaureate Essentials (2020, p. 6), Domain 10 speaks to person, professional, and leadership development. Competency in this area encompasses three foci:

- Development of the nurse as an individual, resilient, agile, and capable of adapting to ambiguity and change.
- Development of the nurse as a professional, responsible and accountable for lifelong learning and ongoing self-reflection.
- Development of the nurse as a leader, proficient in asserting control, influence, and power in professional and personal contexts.

From an international standpoint, the Nursing Now campaign is a global effort to improve health by raising the status and profile of nursing (Nursing Now, 2020). It espouses that "Nurses are at the heart of most health teams, playing a crucial role in health promotion, disease prevention and treatment. As the health professionals who are closest to the community, they have a particular role in developing new models of community-based care and supporting local efforts to promote health and prevent disease." One priority effort is to ensure that the concept and principles of nurse as leader be woven throughout the entire curriculum, and not just be a stand-alone course just before graduation.

Explicitly including leadership in beginning nursing educational curricula is an important step in the evolution of professional nursing. Many nursing students and some practicing nurses have commented that "I'm not a leader" or "I don't want to become a [nurse manager/administrator/chief nurse executive/any formal leadership role]. I just want to take care of my patients." However, it has become increasingly evident that *all* nurses must develop some level of leadership competency to function effectively as a nurse in today's health care environment. Nurses must act as leaders, whether in formal or informal roles, and step forward in identifying threats to quality and patient safety and in proposing solutions to make health care safe for all. Leading or working with and through others to improve patient care also includes the responsibility of identifying and working to mitigate system and environmental factors that prevent the delivery of safe patient care. Nurses at all levels must pursue the joint goals of delivering safe, quality patient/family care while working to improve the systems within which that care is delivered. Phillips *et al.* (2016) offer a set of teaching strategies to help registered nurse (RN)/Bachelor of Nursing (BSN) students apply systems thinking in fostering leadership in quality and safety. The story of Helen Krutke and Laurie Zander in Textbox 16.5 highlights how two relatively new staff nurses accepted this challenge.

Nursing students also have opportunities for exerting leadership, not from a formal position of authority but from knowledge of their patients, families, and communities. Textbox 16.6 describes two situation in which nursing students exerted leadership in different situations.

Textbox 16.5 Clinical Case #3: Nursing Innovation in Patient Care: Ambulatory Front-Line Nurses Ask a Clinical Question and Lead Change That Results in a New Practice Recommendation

Contributed by
Helen Krutke BSN, RN and Laurie Zander BSN, RN-BC
Advocate Aurora Health

"Leadership is the art of motivating a group of people to act towards achieving a common goal" (Ward, 2020). Front-line nurses can effectively lead and impact practice changes with a strong shared governance model. Shared governance is an empowering process designed to achieve organizational goals by promoting shared decision-making and accountability (Johnson *et al*., 2012).

For this project, front-line nurses asked the question: "In the ambulatory setting, what is the most reliable and valid method for pediatric temperature taking for children with injury, illness, or well child exam by age group?" Nursing staff had realized that there was no standard for taking rectal temperatures with children, generating complaints from staff and parents about the value of the practice.

A diverse team was formed of front-line nurses, nursing leadership, a nurse scientist, and a librarian. The Iowa Model was used to frame the process, which included a review of the literature and a current state survey of nursing practice, evidence critiqued, and practice gaps identified.

Practice change recommendations were developed and included that a distinction be made between the need for a core body temperature (rectal) and a screening temperature. The recommendations clearly outlined the most appropriate temperature route based on age and whether the visit was a well child exam, injury, or illness visit. These recommendations were consistent with those from the Society of Pediatric Nurses and the American Academy of Pediatrics. It was thought that these evidence-based practice recommendations could result in parent, patient, and nurse satisfaction.

Key leadership and clinicians were engaged to support these recommendations. Shared Governance Councils, Pediatric Nursing Council, primary care providers, the Children's Physician Council, and the Nursing Policy and Procedures Committee were identified as stakeholders. Formal presentations, active listening, being open to feedback, and modifying work were paramount to implementation.

Upon approval, dissemination began. Various methods and tools were used to reach nurses, physicians, and leaders to support practice change. The RNs presented a poster at the *Annual Nursing Science Conference* 2019, gave a podium presentation at the *Building Bridges to Research Based Nursing Practice Conferenc*e 2021, and explored potential collaboration with the Society of Pediatric Nurses to update practice recommendations.

As impactful as the practice change recommendations were, the skills taught to nurses by "doing" were even more important. Engaged front-line nurses, supported by leadership and a nurse scientist, acquired the knowledge to collaborate, encourage, and support individuals to be active participants in evidence-based practice. This creates an empowered, engaged, and skilled nursing workforce. While the work initially seemed daunting, working through one step at a time gave nurses confidence in the entire process. As one administrator noted, an unintended outcome is that this project produced "a loud, confident voice for patients and fellow nurses." It starts with one nurse leading positive change and can result in the growth of emerging nurse leaders.

Textbox 16.6 Clinical Case #4: Leadership from Nursing Students

Nicole Dailey was an undergraduate when she first became intrigued by policy and the impact that nurses and, in her case, nursing students could have. As a senior Bachelor in Student Nursing (BSN) student, she applied for and was selected to intern with State Senator John J. Marty of Minnesota. She was subsequently appointed to the Roseville Human Rights, Inclusion and Engagement Commission shortly before graduating from the BSN program, and then rose to become vice chair of the commission after one year. She won a full scholarship to Mitchell Hamline Law School, where she continues making a difference as she is now editor of the school's *Journal of Public Policy*.

Hannah Calmus McCallum and Katrina Cuffey shared a passion for calling attention to and reducing the negative effects of climate change on global health. After attending an Earth Day Celebration in April 2016, they led the "green ribbon effort" to have graduating students wear green ribbons to indicate their support for a commitment to action on climate change. In addition, students were given a pledge to remind them of this commitment: "I pledge, as a health professional, to take action on climate change by promoting sustainable healthcare, clean energy, and other efforts to protect the environment in order to improve the health of the communities I serve and the Earth we inhabit." In addition to the pledge, the card contained action steps that people could pursue. According to Hannah Calmus (2016):

> The substantial number of ribbons worn that day proves a couple of key points. One is that nurses understand that climate change is a threat to health and want to be involved. Two, students and professionals alike are capable of taking a stand and making a difference. . . . This commencement display is simply one example of how nurses and students are starting to embrace this calling. By coming together as current and future health professionals, we will have the means to foster a larger impact than any one of us alone. As awareness of climate change is raised further, let us be a source of hope and guidance for all who rely on and trust in us. This is our duty, our purpose, and our privilege. This is why we are nurses.

There are commonalities among the stories of what these students and nurses did to provide leadership in improving care in very distinct situations. First, each individual was passionate about a particular issue. As was emphasized earlier in the chapter, no one can be "the leader" in every situation. Examine situations that are occurring in your setting or problems that are jeopardizing patient care and focus on something about which you feel strongly—and maybe have an idea as to what could be done better. Second, they all read extensively about the issue, reviewed the literature and organizational policies to see what was known, and sought input from experts. They also were able to engage others who shared their interests. Then, they followed certain steps that work well in creating needed change (Disch, 2019, p. 350), some of which were used in these examples, though not all will be needed in every situation:

- Pull together a diverse group of stakeholders to discuss the issue and pool ideas. Think more broadly than just those in the immediate area. For example, if the concern is about managing a chronic illness, consider the input of home health nurses and social workers.
- Identify leaders of the project who can reflect different perspectives if the project is broad in scope (e.g., nurses and therapists, or, as in the case of the opening vignette, a charge nurse and a member of the security staff).
- Keep the focus on what is best for the patient, family, or community, as well as support for those providing care.

- Compile data to reflect the extent of the issue, the impact, any information on previous attempts at resolution, and experiences from other organizations that have had success in the same area.
- Identify champions within the group who can speak to key constituents. Who else is affected by the problem or the proposed solution? Think broadly about who these people might be.
- Obtain administrative support. Depending on the scope of the issue, this may be senior management or a nursing practice council, or a clinical leadership team, e.g., the oncology program or neonatology.
- When approaching a person whose support is critical to the acceptance of the policy, send the person with the greatest influence on that individual to garner support.
- Anticipate the need to speak more than once with some people, particularly if they are wary of the change. Elicit their perspectives, concerns, worst fears, and ideas for solutions. Listen carefully.
- Identify a timeline, desired outcome(s), and a process for keeping people informed along the way.

Programs for doctoral nursing practice (DNP) students offer rich opportunities for students to engage in meaningful quality improvement projects as they learn leadership skills, if the programs are rigorously set up and faculty are knowledgeable themselves on the Quality and Safety Education for Nurses (QSEN) competencies and their application. One example of work done by a DNP student at the University of Minnesota School of Nursing is presented in Textbox 16.7. As you read this case, you will see how Andrea followed many of the steps listed above.

Textbox 16.7 Clinical Case #5: Integration of Leadership Principles in Executing a Doctorate in Nursing Practice (DNP) Project to Improve the Quality and Safety of Health Care for Pregnant Women

The purpose of Andrea Jordan's DNP project was to reduce the risk of health harm from inorganic mercury by (a) increasing detection of inorganic mercury exposures in at-risk pregnant women; and (b) eliminating the source of inorganic mercury exposure in those with detectable levels of this toxin in their urine. She knew that women of childbearing age in Minnesota, especially those of East African, Latina, and Hmong ethnicity, are at increased risk of inorganic mercury exposure through the use of skin-lightening products. Pregnant women are more likely to use these products in combating pregnancy-related skin changes. Despite the clear harm inorganic mercury exposure poses to people, there were currently no guidelines for screening at-risk populations.

To accomplish her work, she engaged several partners: the Minnesota Department of Health's (MDH) lead epidemiologist for the state's biomonitoring program; the chief operating officer of Minnesota's largest federally qualified health center (FQHC); the FQHC's certified nurse midwives; laboratory staff at MDH and the FQHC; and local public health and hazardous material management personnel at the Minnesota Pollution Control Agency. Andrea was instrumental in leading the development and implementation of a protocol to educate clinicians and patients about mercury exposure and to set up a process for pregnant women to be tested for inorganic mercury at their initial prenatal visit with a midwife. After 250 patients were screened, the data were presented to the Minnesota Environmental Health Tracking and Biomonitoring Advisory Panel and the US Centers for Disease Control and Prevention. Andrea's efforts contributed to the important evidence both agencies are using to guide the clinical incorporation of protocols similar to the one she helped implement. Also, for the future, she has established strong collegial relationships that can be drawn upon in further work.

It is important to emphasize that leadership is not a static concept, and that one person cannot be a leader in every situation, for all time; mindful leaders know when to step back for others to lead from their expertise. Barbara Nichols has served as a leader and trailblazer within nursing and health care for more than 50 years in a variety of roles: charge nurse, staff nurse educator, first Black President of the Wisconsin Nurses Association, President of the American Nurses Association, and former CEO of CGFNS International, among other leadership roles. In Textbox 16.8, Nichols reflects on how leadership has evolved—and what is essential today.

Textbox 16.8 Reflections from Barbara Nichols, PhD, RN, FAAN, a Nursing Leader with 40 Years' Experience

I have spent my professional life in two arenas: professional associations, and public and private institutions locally, nationally, and globally. My leadership experiences have been inextricably linked to these journeys. I have learned that leadership is vital to achieving collective goals with passion, perspective, and purpose. Thus, my thoughts on what makes an effective leader and what constitutes leadership success draw from these personal experiences.

I have learned that leadership effectiveness requires that you challenge your own assumptions, beliefs, values, and perceptions. This is a foundational notion because how you think ultimately guides your decisions and actions. Although valuable, I contend that leadership is more than informational and educational learning through training workshops and conferences that emphasize the development of behavioral skills to exert positional influence over others to achieve goals. On the other hand, Peter Drucker's ideology that knowledge has power when coupled with Senge's notion that effective leaders must manage relationships advance dynamic and fluid leadership success. Effective leadership demands the ability to develop new and better ways of dealing with the challenges being faced. My view precisely.

Leadership, according to Argyris (1993), is managing knowledge through people. Leadership effectiveness is the ability to address challenges and opportunities by developing new understanding that is not adequately addressed by the past. As the literature implies, effective leadership must focus on what we can create rather than what problem can be solved.

As a Black female nurse who has held leadership positions, yes, race matters and so does gender. I have had to deal with race in overt, covert, subtle, and symbolic ways. I have found that race influences perceptions, beliefs, and actions; but more and more it arrives in unconscious and aversive ways. The difficulty as a Black leader is that you are never quite sure if the response you evoke is because of race or gender. Our pathway to leadership success is cluttered with obstacles of racism, sexism, marginalization, trench warfare, and low expectations. Nevertheless, I have learned that you hold the position and must lead. I have learned that achievement knows no color.

I have learned four important elements from my leadership journey that began over 40 years ago:

1) Leadership is a lifelong journey on a road that is not clearly marked.
2) Relationships are primary; build and maintain relationships; all else is derivative.
3) Be clear about your own values, make time for self-reflection and self-examination.
4) Acknowledge contributions of others.

I conclude with a quote from Maya Angelou: "I do my best because I'm counting on me."

Levels of Leadership Preparation

As with all the six QSEN competencies, leadership competency can be developed through engaging in a series of progressive activities and techniques. At the *introductory* level, learners can try these activities:

- Select 3 experienced staff nurses to interview on the following questions: What is your definition of leadership? When did you first recognize that you were a leader? What advice would you give to other nurses about being effective in creating change?
- Partner a student nurse with a practicing leader involved in some aspect of operational quality and safety in health care to examine the leader's role. What aspects in their background helped prepare them for this role? What is the most satisfying? What is the most frustrating? What one piece of advice for promoting successful change would they give?
- Access the website of your State Board of Nursing. What is the background of the members of the Council? Of the Chair? Is your state a member of the Nurse Licensure Compact? What is the Compact? What are pros and cons to a state being a member? Cite two references to support your position.

As the learner gains confidence, these *intermediate* activities can be helpful:

- Attend a Quality/Safety Committee meeting with a member of the nursing staff and analyze the formal and informal leadership roles displayed by members. Did the meeting seem to produce results? Why or why not?
- Read the *AACN Standards for Establishing and Maintaining Healthy Work Environments* (AACN, 2016). Which of the six standards is particularly meaningful to you? Can you identify one strategy that your organization could adopt to strengthen its performance?
- Take the leadership assessment quiz from Mindtools at https://www.mindtools.com/pages/article/newLDR_50.htm and identify your strengths and areas for growth in leading others.

Finally, at the *advanced* level, the learner can accept greater responsibility for pulling together diverse groups to tackle complex quality and safety issues that span boundaries:

- Identify a patient care issue that concerns you. Reflect on who are the key people who need to be involved, and develop approaches for engaging each individual or group:
  - Who are the people who will want to work with you on this project because they see the same need for change, and can become partners and allies?
  - Who are the organizational leaders, or sponsors, who have the power to give approval, launch a work group, and help with resources?
  - Who are advocates or champions who will come on board early?
  - Who will oppose the change? Perhaps out of feeling threatened or disagreeing with the plan or disliking change in general.
  - Who is going to be affected, even remotely, if the change is adopted?
  - Who are the healthy skeptics, those who pose questions and can help identify potential weaknesses in the plan?
  - Who needs to be kept updated on the progress of the work?
- Identify an issue in your community that is broadly affecting health, e.g., homelessness, racial inequity, violence. Gather data profiling the extent of the problem, and what initiatives have been

launched to address it. How successful have they been? Which individuals or groups have this issue as a priority for action? Are there city or community meetings on the topic? Select one to attend and assess how compelling is the case that leaders are making for change. What do you think could help?

- Review *Twenty-Five Things Nurses and Patients Should Question* at https://www.choosingwisely.org/wp-content/uploads/2015/02/AANursing-Choosing-Wisely-List.pdf. Pick one item that interests you. What policies, if any, are in place in your institution regarding this topic? Are they congruent with the recommendations?

Seeking Help

Leaders at all stages of development can benefit from others' perspectives in recognizing problems, defining the extent of their impact, engaging others in helping achieve goals, and improving fundamental systems. As noted at the beginning of the chapter, leaders today who believe that they are individually responsible for, and actually able to independently fix, today's complex problems are not going to succeed. Indeed, successful leaders today need to draw on collective intelligence, to engage others enthusiastically in co-creating a "new normal." This does not necessarily mean agreement, but rather ensuring that all perspectives are heard, even those of dissenters who can provide crucial insights. Presented here are a number of strategies to consider when seeking new viewpoints:

- Identify an individual in the organization who is highly regarded and has been effective in leading change. Ask to meet with her or him and gain their perspective on strategies that work.
- Talk with colleagues from other organizations (or students from other schools or disciplines). Find out what is working in their environments and how are they handling certain problems.
- "Invite an adversary to lunch" (Disch, 2014, p.7). Identify someone with whom you strongly disagree about some issue and seek to understand their point of view. Maybe invite her or him to coffee. Ask them: Why do they feel the way they do? What experiences led them to a particular point of view? What do they think is a good outcome or goal? Ask yourself: What is it about this person that evokes such a strong reaction from me? Are there areas of their behavior that remind me of myself?
- Become active within your own organization, whether it be a school or college or health care setting. Find out what is going on in quality and safety, what opportunities are available, what is occurring in the larger environment.
- Subscribe to one or two professional journals, perhaps not even in nursing, to find out what are new trends and practices affecting your areas of interest.
- Participate in relevant organizations and become exposed to leaders within your particular interest area. Attend National Student Nurse Association meetings or local specialty chapter meetings such as those associated with the American Association of Critical-Care Nurses or the Emergency Nurses Association.
- Attend regional or national conferences on topics of interest to you. Introduce yourself to other attendees and see how they are handling particular issues.
- Participate in reverse mentoring. Identify someone younger than you who is skilled in a particular area, e.g., information technology, social media contacts, Excel spreadsheets, and ask if she or he would be willing to work with you to gain specific skills or abilities.

Angela Barron McBride is an acknowledged leader and mentor to thousands over the course of her career. Her book, *The Growth and Development of Nurse Leaders* (2020), offers a number of insights into being a leader, including some that are not usually seen in leadership texts, such as knowing what you know and don't know, the shadow side: neediness and failure, and telling others what to do. In Textbox 16.9, she reflects on the changes she has witnessed over the years in the concept of mentoring.

Textbox 16.9 Rethinking Mentoring: Reflections from Angela Barron McBride, PhD, RN, FAAN, Distinguished Professor and University Dean Emerita, Indiana University School of Nursing

As a newly minted RN in 1962, I thought I was "done," ready to take care of patients and their families. I knew that I had to demonstrate that my college degree didn't mean I lacked the requisite clinical skills, but I had worked as a nurse's aide all through high school doing my share of routine caregiving, and now I had the necessary book learning to handle a range of situations. It's not that I was cocky, but I felt "prepared." I thought so much about the need to "prove my worth" that I didn't think much about all of the mentoring I would need throughout a career.

No one talked much about mentoring when I entered the profession. The onus was on demonstrating your abilities, not on your development. If someone helped you to succeed, you attributed it to their being nice rather than to help that was your due as an investment in the future of the profession. Then the Women's Movement happened, bringing with it much consciousness raising to our profession and to me personally. This was the heyday of asking "Is nursing a profession with its own body of knowledge?" and the development of graduate programs, nursing research, and nursing theory. At the same time, more women were expecting to be asked "What do you want to do next?" and wanting to realize their own leadership abilities.

If ours was a practice profession preparing tomorrow's health care leaders, then there was so much to learn after becoming an RN about negotiating with others, program development, grant writing, speaking in public, conducting research, strategic planning, resource development, policy-making, and serving on boards. In the ferment of this period, we began to rethink many things. The old notion of "Jump through these hoops to prove yourself" had to be replaced by a more welcoming approach. Now that women had many career options, the profession needed to be more welcoming. This meant that mentoring needed to be construed as an obligation that all who are more seasoned assume toward the fledgling, because a field that embraces the brand new is more likely to retain them (including men) over their professional lifetime. And those who have a full career are more likely to become health care leaders.

Over my lifetime, there has been a paradigm shift in the concept of mentoring. I now see it as an umbrella concept that can take many forms over a career—advising, counseling, supporting, critiquing, socializing, challenging, coaching, sponsoring. Mentoring generally refers to helping someone achieve their best in a specific context. The undergraduate has a clinical preceptor who provides tips on how to organize work given the rhythms of a particular unit; the doctoral student has a dissertation advisor who helps with writing the first article for publication; the supervisor seizes on the "teachable moment" to help the struggling manager deal with a colleague's racist remarks; a consultant assists the new nurse executive or CEO in thinking more expansively about future growth. Mentoring can be formal and over time or informal and short term. It can be time limited and/or open ended; in person and/or using an array of communication strategies; it can occur early in a career and around all career transitions. The emphasis isn't on one mentor per person, but on each nurse developing their mentoring

network. Mentoring is not only an obligation that mentor and protégé assume, but one that workplaces and the profession have to encourage.

An expanded view of mentoring serves a generative function. When the workplace and the profession seek to maximize the development of individuals over time, there is less likelihood that those benefiting from such advantages will settle into smugness and stop growing. Those who have benefited from mentoring are more likely to mentor others, "paying forward" the investment made in them. And that vision is what the Women's Movement sought to achieve. And that farsightedness is what I think nursing leadership seeks to embody in the twenty-first century.

Summary

Being a leader can be a tremendously rewarding experience, particularly if everyone involved agrees on the goal, supports each other, and feels pride in what has been accomplished. However, in today's challenging environment, leaders can also feel as though they are taking people on a journey on which nobody wants to go. And yet change is essential if key goals are to be achieved: quality and safety for patients and families; equity and fairness for our communities; and healthy work environments for all caregivers and staff. Being a nurse today requires a commitment to being the best clinician possible, as well as being a leader in working with and through others to improve the systems that ensure safe, quality care for all.

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Resources

Books to Stimulate Creativity

Gelb, M.J. (1998) *How to Think Like Leonardo da Vinci: Seven Steps to Genius Every Day*. New York: Random House.
Von Oech, R. (2011) *A Whack on the Side of the Head: How You Can Be More Creative*. New York: Warner Books.

Videos on Being a Leader

Best Leadership Video Ever!!: https://www.youtube.com/watch?v=NjMBuTfDZKk
A Funny Lesson on Leadership: The First Follower: https://www.youtube.com/watch?v=V74AxCqOTvg

Foundational Leadership Documents

Goodwin, D.K. (2018) *Leadership in Turbulent Times*. New York: Simon & Schuster.
Moss, M.P., and Phillips, J.M. (2021) *Health Equity and Nursing*. New York: Springer.
NCHL [National Center for Healthcare Leadership] Health Leadership Competency Model™ 3.0. https://www.nchl.org/research/#NCHL_Health_Leadership_Competency_Model_30.
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Answers to Ambiguity Challenges

1) There was the father, his son, and his son's son. This equals two fathers and two sons for a total of three.
2) They were two of a set of triplets.
3) BSAINXLEATNTEARS
   Remove six letters to leave B A N A N A

Appendix A

Prelicensure Competencies

Table A.1 Patient-Centered Care

Knowledge	Skills	Attitudes
Integrate understanding of multiple dimensions of patient-centered care: • patient/family/community preferences, values • coordination and integration of care • information, communication, and education • physical comfort and emotional support • involvement of family and friends • transition and continuity	Elicit patient values, preferences, and expressed needs as part of clinical interview, implementation of care plan, and evaluation of care Communicate patient values, preferences, and expressed needs to other members of health care team Provide patient-centered care with sensitivity and respect for the diversity of human experience	Value seeing health care situations "through patients' eyes" Respect and encourage individual expression of patient values, preferences, and expressed needs Value the patient's expertise with own health and symptoms Seek learning opportunities with patients who represent all aspects of human diversity Recognize personally held attitudes about working with patients from different ethnic, cultural, and social backgrounds Willingly support patient-centered care for individuals and groups whose values differ from own
Describe how diverse cultural, ethnic, and social backgrounds function as sources of patient, family, and community values Demonstrate comprehensive understanding of the concepts of pain and suffering, including physiologic models of pain and comfort	Assess presence and extent of pain and suffering Assess levels of physical and emotional comfort Elicit expectations of patient and family for relief of pain, discomfort, or suffering Initiate effective treatments to relieve pain and suffering in light of patient values, preferences, and expressed needs	Recognize personally held values and beliefs about the management of pain or suffering Appreciate the role of the nurse in relief of all types and sources of pain or suffering Recognize that patient expectations influence outcomes in management of pain or suffering

(*Continued*)

Quality and Safety in Nursing: A Competency Approach to Improving Outcomes, Third Edition.
Edited by Gwen Sherwood and Jane Barnsteiner.

Companion website: www.wiley.com/go/qualityandsafetyinnursing3e

Table A.1 (Continued)

Knowledge	Skills	Attitudes
Examine how the safety, quality, and cost effectiveness of health care can be improved through the active involvement of patients and families Examine common barriers to active involvement of patients in their own health care processes Describe strategies to empower patients or families in all aspects of the health care process	Remove barriers to presence of families and other designated surrogates based on patient preferences Assess level of patient's decisional conflict and provide access to resources Engage patients or designated surrogates in active partnerships that promote health, safety and well-being, and self-care management	Value active partnership with patients or designated surrogates in planning, implementation, and evaluation of care Respect patient preferences for degree of active engagement in care process Respect patient's right to access to personal health records
Explore ethical and legal implications of patient-centered care Describe the limits and boundaries of therapeutic patient-centered care	Recognize the boundaries of therapeutic relationships Facilitate informed patient consent for care	Acknowledge the tension that may exist between patient rights and the organizational responsibility for professional, ethical care Appreciate shared decision-making with empowered patients and families, even when conflicts occur
Discuss principles of effective communication Describe basic principles of consensus building and conflict resolution	Assess own level of communication skill in encounters with patients and families Participate in building consensus or resolving conflict in the context of patient care	Value continuous improvement of own communication and conflict resolution skills
Examine nursing roles in assuring coordination, integration, and continuity of care	Communicate care provided and needed at each transition in care	

Definition: Recognize the patient or designee as the source of control and full partner in providing compassionate and coordinated care based on respect for patient's preferences, values, and needs.

Table A.2 Teamwork and Collaboration

Knowledge	Skills	Attitudes
Describe own strengths, limitations, and values in functioning as a member of a team	Demonstrate awareness of own strengths and limitations as a team member Initiate plan for self-development as a team member Act with integrity, consistency, and respect for differing views	Acknowledge own potential to contribute to effective team functioning Appreciate importance of intra- and interprofessional collaboration
Describe scopes of practice and roles of health care team members Describe strategies for identifying and managing overlaps in team member roles and accountabilities Recognize contributions of other individuals and groups in helping patient/family achieve health goals	Function competently within own scope of practice as a member of the health care team Assume role of team member or leader based on the situation Initiate requests for help when appropriate to situation Clarify roles and accountabilities under conditions of potential overlap in team member functioning Integrate the contributions of others who play a role in helping patient/family achieve health goals	Value the perspectives and expertise of all health team members Respect the centrality of the patient/family as core members of any health care team Respect the unique attributes that members bring to a team, including variations in professional orientations and accountabilities
Analyze differences in communication style preferences among patients and families, nurses, and other members of the health team Describe impact of own communication style on others Discuss effective strategies for communicating and resolving conflict	Communicate with team members, adapting own style of communicating to needs of the team and situation Demonstrate commitment to team goals Solicit input from other team members to improve individual, as well as team, performance Initiate actions to resolve conflict	Value teamwork and the relationships upon which it is based Value different styles of communication used by patients, families, and health care providers Contribute to resolution of conflict and disagreement
Describe examples of the impact of team functioning on safety and quality of care	Follow communication practices that minimize risks associated with handoffs among providers and across transitions in care	Appreciate the risks associated with handoffs among providers and across transitions in care
Explain how authority gradients influence teamwork and patient safety	Assert own position/perspective in discussions about patient care Choose communication styles that diminish the risks associated with authority gradients among team members	
Identify system barriers and facilitators of effective team functioning Examine strategies for improving systems to support team functioning	Participate in designing systems that support effective teamwork	Value the influence of system solutions in achieving effective team functioning

Definition: Function effectively within nursing and interprofessional teams, fostering open communication, mutual respect, and shared decision-making to achieve quality patient care.

Table A.3 Evidence-Based Practice (EBP)

Knowledge	Skills	Attitudes
Demonstrate knowledge of basic scientific methods and processes	Participate effectively in appropriate data collection and other research activities	Appreciate strengths and weaknesses of scientific bases for practice
Describe EBP to include the components of research evidence, clinical expertise, and patient/family values	Adhere to Institutional Review Board (IRB) guidelines Base individualized care plan on patient values, clinical expertise, and evidence	Value the need for ethical conduct of research and quality improvement Value the concept of EBP as integral to determining best clinical practice
Differentiate clinical opinion from research and evidence summaries	Read original research and evidence reports related to area of practice	Appreciate the importance of regularly reading relevant professional journals
Describe reliable sources for locating evidence reports and clinical practice guidelines	Locate evidence reports related to clinical practice topics and guidelines	
Explain the role of evidence in determining best clinical practice Describe how the strength and relevance of available evidence influences the choice of interventions in provision of patient-centered care	Participate in structuring the work environment to facilitate integration of new evidence into standards of practice Question rationale for routine approaches to care that result in less than desired outcomes or adverse events	Value the need for continuous improvement in clinical practice based on new knowledge
Discriminate between valid and invalid reasons for modifying evidence-based clinical practice based on clinical expertise or patient/family preferences	Consult with clinical experts before deciding to deviate from evidence-based protocols	Acknowledge own limitations in knowledge and clinical expertise before determining when to deviate from evidence-based best practices

Definition: Integrates best current evidence with clinical expertise and patient/family preferences and values for delivery of optimal health care.

Table A.4 Quality Improvement.

Knowledge	Skills	Attitudes
Describe strategies for learning about the outcomes of care in the setting in which one is engaged in clinical practice	Seek information about outcomes of care for populations served in care setting Seek information about quality improvement projects in the care setting	Appreciate that continuous quality improvement is an essential part of the daily work of all health professionals
Recognize that nursing and other health professions students are parts of systems of care and care processes that affect outcomes for patients and families Give examples of the tension between professional autonomy and system functioning	Use tools (such as flow charts, cause–effect diagrams) to make processes of care explicit Participate in a root cause analysis of a sentinel event	Value own and others' contributions to outcomes of care in local care settings
Explain the importance of variation and measurement in assessing quality of care	Use quality measures to understand performance Use tools (such as control charts and run charts) that are helpful for understanding variation Identify gaps between local and best practice	Appreciate how unwanted variation affects care Value measurement and its role in good patient care
Describe approaches for changing processes of care	Design a small test of change in daily work (using an experiential learning method such as Plan–Do–Study–Act) Practice aligning the aims, measures, and changes involved in improving care Use measures to evaluate the effect of change	Value local change (in individual practice or team practice on a unit) and its role in creating joy in work Appreciate the value of what individuals and teams can to do to improve care

Definition: Use data to monitor the outcomes of care processes and use improvement methods to design and test changes to continuously improve the quality and safety of health care systems.

Table A.5 Safety.

Knowledge	Skills	Attitudes
Examine human factors and other basic safety design principles as well as commonly used unsafe practices (such as workarounds and dangerous abbreviations) Describe the benefits and limitations of selected safety-enhancing technologies (such as barcodes, computer provider order entry, medication pumps, and automatic alerts/alarms)	Demonstrate effective use of technology and standardized practices that support safety and quality Demonstrate effective use of strategies to reduce risk of harm to self or others Use appropriate strategies to reduce reliance on memory (such as forcing functions, checklists)	Value the contributions of standardization/reliability to safety Appreciate the cognitive and physical limits of human performance
Discuss effective strategies to reduce reliance on memory		
Delineate general categories of errors and hazards in care Describe factors that create a culture of safety (such as open communication strategies and organizational error reporting systems)	Communicate observations or concerns related to hazards and errors to patients, families, and the health care team Use organizational error reporting systems for near miss and error reporting	Value own role in preventing errors
Describe processes used in understanding causes of error and allocation of responsibility and accountability (such as root cause analysis and failure mode effects analysis)	Participate appropriately in analyzing errors and designing system improvements Engage in root cause analysis rather than blaming when errors or near misses occur	Value vigilance and monitoring (even of own performance of care activities) by patients, families, and other members of the health care team
Discuss potential and actual impact of national patient safety resources, initiatives, and regulations	Use national patient safety resources for own professional development and to focus attention on safety in care settings	Value relationship between national safety campaigns and implementation in local practices and practice settings

Definition: Minimizes risk of harm to patients and providers through both system effectiveness and individual performance.

Table A.6 Informatics.

Knowledge	Skills	Attitudes
Explain why information and technology skills are essential for safe patient care	Seek education about how information is managed in care settings before providing care Apply technology and information management tools to support safe processes of care	Appreciate the necessity for all health professionals to seek lifelong, continuous learning of information technology skills
Identify essential information that must be available in a common database to support patient care Contrast benefits and limitations of different communication technologies and their impact on safety and quality	Navigate the electronic health record Document and plan patient care in an electronic health record Employ communication technologies to coordinate care for patients	Value technologies that support clinical decision-making, error prevention, and care coordination Protect confidentiality of protected health information in electronic health records
Describe examples of how technology and information management are related to the quality and safety of patient care Recognize the time, effort, and skill required for computers, databases, and other technologies to become reliable and effective tools for patient care	Respond appropriately to clinical decision-making supports and alerts Use information management tools to monitor outcomes of care processes Use high-quality electronic sources of health care information	Value nurses' involvement in design, selection, implementation, and evaluation of information technologies to support patient care

Source of all tables: "Quality and Safety Education for Nurses," by L. Cronenwett *et al*., 2007, *Nursing Outlook*, *55*(3), pp. 122–131. Reprinted with permission from Elsevier Ltd.
Definition: Use information and technology to communicate, manage knowledge, mitigate error, and support decision-making.

CHAPTER 19

Becoming a Leader: A Little Voice in a Big Arena

Christopher Johns

Introduction

A common trigger for reflection is conflict. It makes practitioners feel uncomfortable because of the negative emotions it often evokes and the lack of skill in dealing positively with it.

The struggle with conflict is illustrated in Sally's narrative 'A little voice in a big arena' written to fulfil the conflict management assignment five months into the MSc Leadership in healthcare degree.[1] Her writing reflects how she is just getting to grips with reflective practice, becoming a leader and narrative expression.

As with all reflective narratives, move into dialogue with it to draw your own insights and consider how it might inform your own practice. Indeed, use Sally's narrative as a trigger for your own reflection.

A Little Voice in a Big Arena

I work as a deputy ward manager within an elective orthopaedic unit. It is an ever-demanding job! Policies and protocols, targets, deadlines, and budgets are the everyday reality. Against this background, front line staff, like myself, struggle to provide patient-centred service in a system that seems intent on constraining rather than enabling effective practice and leadership. I work alongside my Ward Manager. My role is often one of confusion and difficulty. I am viewed as a leader but not completely let off my reins. When those reins are sometimes dropped, I find I'm pulled back with the understanding I wasn't ready to go it alone!

With new government initiatives being continually developed, there is increasing pressure placed on the organisation to meet targets and deadlines and deliver a cost-effective healthcare, contributing to a rapidly changing environment. The pressures placed on the NHS today are filtering down to ward level where the cracks are beginning to show and ward leadership is becoming an uphill struggle**.** Cope (2001, p. 1) notes – 'Within organisations we see managers struggling to come to terms with new demands on their managerial and leadership style. We have shifted from a position where control is managed by virtue of a formal badge of office (manager, patient, director etc.) to one where we have to lead people through the use of more intangible and flexible forms of leadership'.

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I wish Cope was correct. The formal badge still rules OK! Yet more people are talking about leadership, but I suspect it is a leadership to drive forward change rather than the transformational style advocated by Burns (1978, p. 28) who expresses transforming leadership as 'being committed, having vision of what could be accomplished and empowering others with this vision so that all would accomplish more with less. The leader meshes with followers on deeply held values'. Klakovich (1994, p. 42) shares this view – 'for some time, nurses have been pressured to *do more with less*, that is, to maintain high productivity without sacrificing quality'. Leaders have to balance the reality of maintaining the quality of care on a reduced budget with reduced resources. *Do more with less* – the klaxon call at the factory gate. Because of the pressures being placed on the health service and each department managing their own resources, issues of conflict inevitably arise. Barriers are erected, protocols and policies are barraged around, and common courtesy becomes a thing of the past.

Taylor and Singer (1983) suggest that companies' capacity could grow as long as the people involved can survive the stress through tension. They discuss that without a certain amount of tension within the working environment, barriers for change would not be broken down. However, tension can cause upset and barriers to be extended, not broken down; then, staff can become demotivated, demoralised, and unsatisfied. Can I hold this tension creatively? I support others, but who supports me?

The situation involved the placement of a patient on the ward arising from pressure within the organisation. Since the government introduced the traffic light system for bed management, 'red alert' has become an everyday event in my hospital. Working within an elective ward environment, we have a rapid turnaround of patients and, on some occasions, are left with an empty bed. We often assist the organisation by accepting non-orthopaedic elective admissions and minor trauma admissions to assist with the tight bed management of the hospital. We have strict guidelines on what we expect due to our rapid pace of work, the experience of our team and the infection risk to our elective patients.

On the occasion in question, the bed manager approached me regarding a man who had been admitted to the accident and emergency department with severe head injuries. He had been brutally assaulted and the police were treating it as attempted murder. His condition was unstable and he required a nurse to special him. As the assailant had not been caught, he was deemed at risk and needed a police guard.

I was surprised at the bed manager's request to place this gentleman (whom I shall call George) within our ward environment. I judged the environment was inappropriate and staffing already tight and no room for movement to create a nurse special. The ward was busy and there were several acute post-operative patients being monitored; and there was also a very real issue due to the open ward environment of risk to the patients and staff. I expressed my concern and stated my case in a 'professional manner' to the bed manager, who accepted the situation and the admission was refused. Even as I use the words 'professional manner', I realise I am uncertain what I mean. It feels like defensive learnt behaviour I retreat behind. Enough to just note it.

Two hours later, I receive another phone call from the bed manager. In an uptight and forthright manner he states, 'there is nowhere to place George and that pressure is now being placed on me to have George moved from accident and emergency. It has been discussed with the hospital manager and hospital administrator and George will be admitted to your ward!'

The wind is taken from my sails. I take a deep breath and restate my case detailing the ward policy and stating the ward would be unsafe in the event of George's admission. My 'professional manner' disintegrates into outrage, outrage that discussions have been held without my input and decisions made without one of the managers entering the ward to see the environment, the workload and the staffing levels. No respect for myself and my staff, no reasoning or compromise, just a dictatorial command.

An assembly of senior management appear on the ward; the bed manager, the hospital manager and the hospital administrator. They inform me that George will be brought to the

ward shortly and they are providing a nurse from another area to special George for the shift. I felt overpowered by the situation. I questioned why the situation had been handled in this way and why had there been no discussion with myself and my team over the appropriateness of this patient's placement. My questions were not directly answered. The hospital administrator stated that ward staffing had not been adversely affected as they would provide cover for the next twelve hours, and the situation would be reviewed in the morning. I foresaw that further resistance would be futile. I expressed my unhappiness with the situation. My lament fell on deaf ears. The managers left the ward and George arrived with his nurse and police guard. My shoulders felt heavy.

An hour later, now late evening, the chief executive of the hospital appeared on the ward. She explained the difficulty in finding an appropriate placement for George and acknowledged the issues I had raised. She thanked me for the cooperation of my staff and myself and asked to be made aware of any problems.

I had been bruised by the situation, but the chief executive had eased the swelling. Because she went out of her way visit to the ward and acknowledge a difficult situation, I did not feel so alone. It may have just been clever words, but it bolstered my resolve to make the best of the situation.

Drawing Insight

The situation I experienced touches on issues of conflict manipulation, 'focusing on getting away from what we don't want rather than creating what we do want' (Senge 1990, p. 157). The hospital managers saw that George's admission to the accident and emergency department had caused disruption and once George's condition had been stabilised their priority was to move him to a more isolated environment. George was a problem that needed to be fixed! I perceived the need to provide George with a more secure environment but had real concerns that the area of elective orthopaedics was inappropriate and that little would be gained from this transfer except to enable the organisation to tick off a problem that disturbed their 'smooth running' (Friedson 1970).

Using ethical mapping (Johns 2013) I reviewed the situation from different perspectives.[2] From my perspective, I had the right to be involved in the decision concerning bed use on the ward. Ward staffing was stretched, and the ward environment was not suitable for the patient's care. From the bed manager's perspective, representing the organisation, the bed was needed. In considering ethical principles, I felt my autonomy had been disregarded. I was also anxious about 'doing harm' to the other ward patients, but I sense this was an emotional rather than rational response. I was responding to my bruised ego! The ethical claim of the managers was a utility claim of needing a bed so the organisation could run smoothly. I was simply a thorn in their side.

Johns (1999, p. 289) writes – 'Ethical mapping helps the practitioner see different and often contradictory perspectives of any situation and to examine the factors that determine which perspectives prevails'. It quickly became apparent that the only gain of George being admitted to the ward was the organisation managing to place their problem patient. I feel that George would have received better short-term gain from being placed within a more secure environment. The high dependency nursing environment that was required for George was unacceptable and inappropriate within a busy ward.

Abiding by the Nursing and Midwifery scope of professional practice, I need to have competence and confidence with the care I provide to patients. 'Acknowledge any limitations in your knowledge and competence and decline any duties or responsibilities unless able to perform them in a safe and skilled manner'. Perhaps this is my 'professional manner'?

As the Deputy Manager, I failed *in my duty* to act as an advocate for the nursing team; to express our limitations and knowledge to care for such a highly dependant patient. I felt overpowered by the

organisation, having been told what I was to do, like a naughty school girl rebelling against her teacher. This transactional manner left me feeling angry and frustrated. The managers involved were working from a negative short-term vision and not considering all the components involved within their decision. Cope (2001) discussed this as map conflict – conflict occurring when two people viewed the same situation from different perspectives. Map conflict can lead to a tense situation, lines of communication can break down, leading to little or no resolution.

In guided reflection, I was challenged – 'Are you always fighting a losing battle that leaves you demoralised? Have you considered the idea of yielding versus failure?' Maybe seeing the bigger picture, I might have seen that and yielded. But I wanted to make the point. I didn't want to yield! I wanted to resist the autocracy that managers can always do what they want to do, to run roughshod over everyone. I wanted my voice heard, even if it was a rebellious, angry, childish voice! But I see the point of yielding.

I do not respond well to conflict. Thomas and Kilmann (1974) note five modes of managing conflict; avoidance, accommodation, compromise, competitive, and collaboration. Of these, I consider the collaborative mode as being the most congruent with being a transformational leader who is both assertive and cooperative with colleagues. However, my normal hat is accommodating the views of others who I perceived as more powerful than myself. But not this time! This time I was competitive, although not by choice. It was an emotional response like a hurt child railing at injustice! Cavanagh (1991) discussed that the competitive style of conflict management usually occurs when a person follows their own gain to the detriment of others. This can lead to frustration, anger, and arguments, creating damage to relationships and not viewing the situation as a whole but with tunnel vision. Some theorists believed that conflict has a positive effect on ourselves and the organisation. For example Deutsch (1971) (cited by Cavanagh 1991) suggested conflict could be highly enjoyable as you gain experience of your own capabilities. Competition is a power game with winners and losers and where the interests of the more powerful usually prevail as in this experience. The opportunity to solve the problem becomes reduced and only concludes because one party intimidates or shouts the loudest.

I also have to question how assertive I am. Applying the assertiveness action ladder, I can see I slip on rungs 7–10.[3] Rung 7 is about communication skills. Rung 8 is concerned with staying in adult-mode. Yet faced with managers speaking at me like critical parents, I slipped into child mode. The hurt child railing against maternal domination! In child-mode, I was unable to play the power game (rung 9). Transactional Analysis (TA) (Stewart and Joines 1987) helps me position myself in a relationship with the managers. Within TA, the ideal pattern of communication is 'adult-adult' based on rationality and responsibility. However, I can see that as I became anxious, I flipped into child mode in response to my managers' parental stance. Our lines of communication became crossed and communication brokedown. This is evident in the way my manager becomes parental when anxious for whatever reason. In response, I observe, how staff are compliant like children. When I have stood up for myself and refuse to shift into child mode, it leads to stress between us. Usually, just to move on, I tend to yield.

Although parent-child situations can at times be comforting, this situation became one of the critical response to a rebellious non-conforming child. Taylor and Singer (1983, p. 71) touched on this view when they discussed a bureaucratic organisation; they expressed a feature of such an organisation 'is that people should obey rules and should know their place'. However, they went on to say, 'contacts with staff in other departments are limited and these people are often seen as competitors for resources or even enemies who do not understand the difficulties and needs'.

Although I do not feel that staff are always viewed as competitors, and I do not believe this was the case in this situation. I *do* feel I was viewed as not understanding the organisation's needs as a whole, which went on to incite the parent like attitude of the hospital administrator. If I had been approached in a collaborative way, then I feel certain a compromise would have been reached. I was trying to maintain 'professional' or adult approach, but the response was parental.

Once George had been placed on the ward, my focus was on the staff as I felt I had let them down and allowed the ward to be placed in an unacceptable position. I saw myself as the parent, comforting and nurturing the staff around me, ensuring the staff remained focused on George and his needs and not the negative energy felt towards the situation that had occurred.

Dunham and Klafehn (1990) expressed the dilemma leaders can feel trying to show alliance to two separate groups who expect them to take two different forms of action. Although I had a feeling of guilt for not 'fixing' the situation, I feel that the staff around me showed me allegiance. They were disappointed but didn't take the view that my action should have been any different. However, my self-esteem took a big knock. I became accountable for the situation that had developed, trying to ensure no harm was to come to George and aiming to provide a good quality of care. I had an inner fear regarding the situation and the way my position had been viewed. I felt anxious and unconfident in my abilities; I had become a shell of the Deputy Ward Manager who had started her shift. I was trying to save face with my staff and function as if the situation had never arisen. Dickson (1982, p. 147) writes – 'Anxiety is our biggest enemy it holds us back, makes us doubt our worth and ability, makes us worry about losing approval'.

I found myself within a coat of armour, protecting myself from possible further conflict from the ward staff. I was afraid of criticism for accepting George's admission from my colleagues. Instead of being impulsive and strong, I became concerned I had placed us in an unacceptable position and the ward was at risk. All healthcare workers live out the daily tension of balancing what is therapeutic against what is safe. Perhaps practitioners err on the side of safety for fear of criticism if the people in their care come to some harm.

Reflecting on the conflict surrounding George's admission and the chief executive's involvement has opened my eyes to the leadership styles involved. The hospital administrator approached the situation with a transactional manner showing a dictatorial attitude oozing negative vision. This clashed with my emerging transformational leadership style, in which I felt I had approached the situation. By visiting the ward late in the evening and not on an official timetable, the chief executive approached the situation (me?) using a connective leadership style. She expressed her understanding of my concerns and the needs of the organisation. She offered her support and acknowledged my dedication to my role, she expressed thanks to myself and my team for assisting in George's admission. She showed me warmth and empathy throughout our conversation. This created an uplift of my confidence and my self-esteem, maintaining and cultivating my caring attitude. She bridged the gap between the organisational leaders and myself.

When I expressed this sentiment in guided reflection, it was suggested that the CEO's action was like *putting a band-aid over a raw wound*. I hadn't seen that perspective because I was in hurt-child mode and needed comforting. It put doubt in my mind as to whether the CEO was indeed responding as a connective leader. Perhaps she is just a clever politician! I must reflect more deeply on that! Dickson (1982, p. 159) expressed – 'As women develop more familiarity with the skills, they learn how to be more reflective in situations instead of reacting only to the other person. Thinking and consequently acting with more clarity improves self confidence at a deep and fundamental level instead of muddling along, feeling generally burdened with worries and concerns, they learn to decide on priorities and to sort out who and what really does matter in their lives'.

I found myself in the big muddy puddle that exists within big organisations created by power plays, different agendas, breakdown in communication, and unresolved conflict. The puddle gives off a bad atmosphere and creates a negative working environment.

Given a similar situation, I feel confident of my ability to stay in adult mode, enabling me to control rather than lose control. Being on the front foot offers me a vision of leadership behaviour. Johns (2016, pp. 26–27) devised the 'front foot thinking scale' consisting of 27 attributes of being on the front foot in contrast with being on the back foot (Table 19.1). Applying the scale to my experience gives me feedback of where my strengths and weaknesses may lie. It is insightful and empowering, sowing seeds for becoming more on the front foot. My

TABLE 19.1

Front Foot Thinking

Front foot thinking												Back foot thinking
		10	9	8	7	6	5	4	3	2	1	
1	Views self as a leader	X	X	X	X	X	X	X	X	X	X	Views self as follower
2	Uses initiative/proactive	X	X	X	X	X	X	X	X	X	X	Waits for others to command/reactive
3	Takes responsibility	X	X	X	X	X	X	X	X	X	X	Shirks responsibility
4	Assertive/confident	X	X	X	X	X	X	X	X	X	X	Non-assertive/hesitant
5	Mindful of being on the 'front foot'	X	X	X	X	X	X	X	X	X	X	Not aware of being on the front foot
6	Strong sense of purpose	X	X	X	X	X	X	X	X	X	X	Weak sense of purpose
7	Takes initiative	X	X	X	X	X	X	X	X	X	X	Lets things slide
8	Alert/Is prepared	X	X	X	X	X	X	X	X	X	X	Not alert/Unprepared
9	Visible to others	X	X	X	X	X	X	X	X	X	X	Keeps head down
10	Recognises one's own value	X	X	X	X	X	X	X	X	X	X	Need to be valued by others
11	Focuses on strengths	X	X	X	X	X	X	X	X	X	X	Focuses on weaknesses
12	Sees the whole picture	X	X	X	X	X	X	X	X	X	X	Sees the small picture
13	Crosses hierarchical lines	X	X	X	X	X	X	X	X	X	X	Hierarchical bound
14	Voice is heard	X	X	X	X	X	X	X	X	X	X	Voice subdued
15	Expands autonomy	X	X	X	X	X	X	X	X	X	X	Constrained autonomy
16	Foresight	X	X	X	X	X	X	X	X	X	X	Hindsight
17	Thinks outside the box/Creative	X	X	X	X	X	X	X	X	X	X	Thinks inside the box/ Conforming
18	Dynamic sense of relationship	X	X	X	X	X	X	X	X	X	X	Confined by normal relationships
19	Poised	X	X	X	X	X	X	X	X	X	X	Anxious
20	'being in place' (as a leader)	X	X	X	X	X	X	X	X	X	X	'Put in my place' (by the organization)
21	Decisive	X	X	X	X	X	X	X	X	X	X	Prevaricates
22	Collaborative style of conflict management	X	X	X	X	X	X	X	X	X	X	Accommodating/avoiding style of conflict management
23	Bounces back (resilient)	X	X	X	X	X	X	X	X	X	X	Falls over (fragile)
24	Engaged	X	X	X	X	X	X	X	X	X	X	Detached
25	Yields	X	X	X	X	X	X	X	X	X	X	Fails
26	Takes risks/fearless	X	X	X	X	X	X	X	X	X	X	Plays safe/defensive
27	Enables others to grow	X	X	X	X	X	X	X	X	X	X	Stifles growth in others

average score across the 27 attributes is 6.4. My target is to achieve eight before the end of the programme! Sounds so simple and yet so powerful.

What other insights have I gained? Most significantly, to see the bigger picture and the significance of a shared vision (Senge 1990). I sense the rhetoric of caring the organisation espouses in their mission statement as hollow. The contradiction is vivid within this experience.

Reflection creates this space to stand back and see the bigger picture. By seeing the bigger picture can I see things for what they truly are. Becoming emotional, I lost sight and became anxious and defensive. The anxiety is the threat of losing a competition. Egos at dawn! The need to be in control! Then I either fight or flight. To flight is to accommodate the demand. To fight leaves me beaten up, for the managers are more powerful. Neither is a good way. I must hold collaborative intent and hold my ground and then yield if I must because Rome wasn't built in a day. In this way, I hold my poise and vision and my integrity and do not need so many band-aides! My little voice in a big arena becomes more powerful, yet powerful in a new transformational language. The leader inside me is unleashed. See if I get my promotion or whether I am now tarred.

My reflection reveals the way power or force works within the organisation. Notably, the organisational *force* to have its way – dependent on its position up the ladder of command with the threat of sanction if I resist, what French and Raven (1968) refer to as authoritative sources of power, or force. It is significant to distinguish between force and power; force is being used against someone to ensure control and power being used to create something positive through using facilitative sources of power to enable staff to grow.[4]

Within a transactional organisational culture, people are means towards reaching targets. The humanness factor lost in the machine is reflected in my metaphor of having only a 'little voice'. On the other hand, the transformational world seeks to create the best environment for patients and staff. One is a machine world, where people are a means to an end. The other is a world where humanness is valued. It is as stark as that.

However, the transactional culture does not and cannot be expected to shift easily. The system may not be malleable to change, even demanding subordination with the threat of sanction to ensure conformity. As such, being assertive and using voice may be problematic in a culture where it is safer to keep quiet and avoid trouble. It is an important appreciation because otherwise, the idealism of leadership would hurtle practitioners like myself against walls of shattered dreams.

I certainly felt the threat of sanction leaning heavily on me as these more powerful people imposed their hierarchical positions. I felt as if I was being brushed aside like an object. Yet my small hurt voice was heard along distant corridors, prompting the chief executive's band-aid response. Sharing this experience in class and listening to my peers' similar reflections make me realise this is the norm. It is a scenario played out daily across the healthcare arena, leaving wards managers like myself bruised and battered. The metaphor of 'band-aid' was very apposite. The Chief Executive, the nurturing parent, coming to heal her child's wounds. When I was acknowledged and valued, it was immensely surprising and healing. Perhaps, it should not be surprising. That only reflects the way I was perceived as a spanner in the works disrupting the system. At the moment I needed to be supported, I was made to feel more stressed.

Conflict situations surrounding bed management and appropriate placement of patients continue. I can better see them for what they are. I have a stronger vision as a leader of how I should manage conflict. I don't fear conflict anymore.

Commentary

Sally's narrative is not a hero's story. It is a confessional tale of struggle to be a leader against what she perceives as overwhelming odds. It paints a vivid picture of real-life governed by power interests.

Sally breaks the narrative into two. In the first part, she tells the story. The second part she titles *Reflection* in which she draws out and tells the reader the insights she has gained. Telling the story *shows* the reader what is significant, allowing the reader to draw out their own significance. It highlights the difference between show and tell as discussed in Chapter 7 in weaving the narrative.

Sally's emotional tension permeates through the narrative as she struggles to understand and resolve it in order to focus more rationally and face the barriers she feels constrain her emerging leadership. These barriers are embodied and reinforced through everyday relationships, as if the organisation is constantly reminding her of her place. Utilising the 'the front foot thinking' framework gave Sally a marker against which she could monitor her development of leadership. She found it offered her vision of leadership a practical structure to support her. Marker 20 is the idea of 'being in place' contrasted with 'being put in place' (Mayeroff 1971). Sally seeks to 'be in place' as a leader rather than 'put in her place' by the organisation. Being in place feels right. It is not contradictory. It is tune with one's vision of self, one's role and relationships with others. Being 'put in place' is a place where others want you to be to fit into their scheme of things. Seeking to become a leader or indeed any role working in transactional organisations, this tension will always be a focus for reflection. It is another way to view the reflective quest.

Notes

1. The MSc Leadership in healthcare degree is set out in Chapter 14.
2. See Figure 4.1.
3. See Table 4.3.
4. See Chapter 17 where the use of French and Raven's typology was fed into a guided reflection session.

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CHAPTER 20

The Learning Organization Exemplified by the Burford NDU Model

Christopher Johns

It is axiomatic that educational and practice organisations need to be compatible. It would be a stark contradiction to develop reflective practitioners within an educational curriculum only for them to experience a practice culture that constrained rather than enabled reflective practice. The benefit of reflective practise is so great that it would be insane for organisations not to invest heavily in further developing and supporting reflective practitioners. Indeed, excellent organisations are those that know how to tap people's commitment and capacity to learn at all levels of the organisation, whereby reflective practice is normal. This is achieved by becoming a *Learning Organization*.

The Learning Organisation

Senge (1990, p. 3) describes the Learning Organisation (LO) as:

> One where people continually expand their capacities to create the results they truly desire, where new and expansive patterns of thinking are nurtured, where collective aspiration is set free, and where people are continually learning how to learn together.

Senge identified five disciplines that collectively constitute the Learning Organisation. I have added the sixth dimension of leadership (Figure 20.1).

Vision

'The results they truly desire' reflects a vision. Vision consists of shared values that gives meaning and purpose to practice. Vision provides the background to practice. Against which all activity takes place. It is the motivational force necessary to realise it. From a reflective perspective, it sets up creative tension between itself as something desirable to work towards realising, and practitioners understanding of current reality gleaned through reflection.

Becoming a Reflective Practitioner, Sixth Edition. Edited by Christopher Johns.

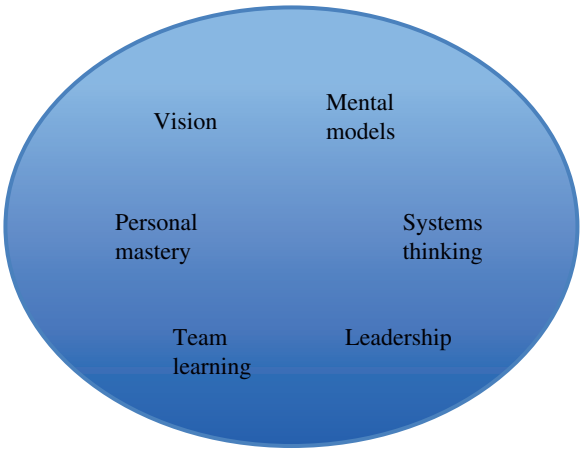

FIGURE 20.1 The six disciplines of the Learning Organisation.

Personal Mastery

Personal mastery is the essence of being a reflective practitioner who constantly works towards resolving creative tension in order to realise their vision of practice as a lived reality. This involves clarifying vision and seeing current reality more clearly.

Asa Senge (1990, p. 142) notes that – 'People with a high level of personal mastery live in a continual learning mode, they have a strong sense of purpose, they are deeply inquisitive thus are acutely aware of their ignorance, their incompetence and their growth areas. They are creative and deeply self-confident'.

Mental Models

The discipline of working with mental models starts with turning the mirror inward, learning to unearth their internal images and assumptions of the world, to bring them to the surface and hold them rigorously to scrutiny, and subsequently shifting them as necessary so they align with desirable practice. However, this may not be easy. As Senge (1990, p. 174) notes that – 'new insights fail to get put into practice because they conflict with deeply held internal images of how the world works, images that limit us to familiar ways of thinking and acting'.

Team Learning

Team learning brings practitioners to work collectively towards realising their vision of practice, creating a community of inquiry and learning. It takes reflective learning from an individual concern into a collective concern. This enables barriers that might block individual learning to be overcome by force of mass and organisational support. Yet, it is important to emphasise individual learning as a baseline for team learning. For, as Senge (1990, p. 140) notes – 'Organizations learn only through individuals who learn. Individual learning does not guarantee organizational learning. But without it no organizational learning occurs'.

Through team learning, mental models and systems thinking are aligned through dialogue. Senge (1990, p. 241) notes that – 'in dialogue, individuals gain insights that simply could not be achieved individually. A new kind of mind begins to come into being which is based on the development of a common meaning. . . people are no longer primarily in opposition, nor

can they said to be interacting, rather they are participating in this pool of common meaning, which is capable of constant development and change'.

However, as Isaacs (1993, p. 24/25) notes – 'Unfortunately, most forms of organizational conversation, particularly around tough, complex, or challenging issues lapse into debate (the root of which means "to beat down"). In debate one side wins and another loses; both parties maintain their certainties, and both suppress deeper inquiry'.

Debate reflects patterns of power relationships and rivalry, where people jostle for control typified by people lining up to get their point across and win the argument. Very little genuine listening takes. People partially listen to what they want to hear, seeking feedback to reinforce their position rather than be open to new possibilities through dialogue. Team learning requires a whole new approach to how people communicate – the idea of 'people are continually learning how to learn together'. It requires becoming aware of and breaking up old patterns based on authority to set free aspiration and expansive patterns of thinking.

Systems Thinking

Systems thinking is being aware of the pattern of underlying systems that governs how the organisation operates, and shifting these systems as necessary to enable the vision. Systems form a network that fuses together to work as a whole. As such, it is often difficult to focus on just one element of the system because they impact on each other.

Leadership

Leadership is the energy that drives the LO. *Creating and sustaining the LO is undoubtedly the most fundamental task of leadership,* and yet, within the NHS transactional culture, it is rarely achieved despite Governmental rhetoric as to its value as acknowledged with the NHS Forward Review[1] at a time of radical change.

The contemporary literature on leadership advocates a transformational or servant--leadership style of leadership, both of which are dialectically opposed to the prevailing transactional management prevalent in most public service organisations such as healthcare trusts.

The need for a transformational type leadership is advocated by the NHS Forward Review[2] at a time of radical change. Nicholson (2009) writes – 'Great clinical leadership is fundamental to this. Sustainable health systems are created when clinical leaders are empowered to bring about *transformational* change supported by managers who back good ideas, remove blockages to progress and provide support'. Nicholson should say 'supported by leaders' simply because managers are focused on tasks not relationships. As Wheatley (1999, p. 164) notes – 'Management is getting work done through others. The important thing was the work; the "others" were distractions that needed to be managed into conformity and predictability'.

Change the language simply because words hold meanings that reinforce certain behaviours.

Transformational leadership is concerned with creating and sustaining a dynamic and moral learning organisation to enable people to grow and realise their potential (Bass 1990). Yet, if organisations are primarily concerned with meeting strategic outcomes or targets, the moral landscape can quickly become obscured, the human factor lost in the machine (Johns 2016).

Servant-leadership emphasises leaders being 'of service' to enable others to accomplish what needs to be done through genuine collaborative relationships that invest in people to enable them to grow and fulfil their potential and 'creating community' to make sure that

other people's highest priority needs are being served and grow through community (Greenleaf 1977/2002; Johns 2016). Servant-leaders are reflective and mindful of self as a leader and the creative tension between leadership vision and the realities of working in a transactional organisation. They are visionary with foresight anticipating what is required based on a firm poised foot in everyday reality. It goes without saying that leaders have personal mastery and a firm grip of systems thinking and mental models.

Reflective Journal Entry

Last year I had a total knee replacement. I wrote in my journal:

> The ward manager dressed in her dark blue uniform sits in her office opposite the four-bedded bay where I am admitted for a total knee replacement. Throughout my three day stay I noted she did not once emerge and greet the patients. I find it had to imagine why not? Perhaps I impose my own values, that as a senior nurse I would always tour my ward at the beginning of a shift to say hello and sense what was happening alert to potential problems. I wonder have things changed so much that ward sisters renamed ward managers have no so little clinical input, stick as they are on their computers and administration tasks to fulfil.
>
> Shall I knock on their door and say something like 'just passing, thought I would say hello?' Or perhaps 'I have a pressure sore on each elbow- why is that? I notice your target on the notice board to reduce them. Let's talk about that. Hold her to account. Ask her why her care assistants respond so differently, some diligent, others as if they don't care. Of course I only see and interpret what I see. I do not see leadership, just a manager'.

I wonder, is this behaviour the new norm as organisations become increasingly corporate?

It will be difficult for organisations to become LOs because of their transactional nature reliant on a management ethos of command and control, with a focus on the outcome rather than process, meeting targets and ensuring its smooth running. It is an infrequent occurrence that norms or assumptions are challenged or that the required unlearning or relearning take place (Garside 1999). Leadership is sorely lacking, not helped by organisational blindness believing they actually have effective leadership. If you cannot recognise the problem, how can you fix it?

Yet, the implications of investing in genuine leadership would amount to a major culture shock. Establishing a vision of the LO is the foundation stone. To achieve this,

leadership must at one and the same time succeed in speaking the members' language whilst introducing them to a new language of the learning organisation, and motivating exploration of basic assumptions about reality by constructing tasks wherein members feel the limitations and self-contradictions inherent in their old language and practices. Torbet (1978) describes this as deliberate irony. He exposes the tension whereby – 'The rhetoric of collaboration alone will not promise shared purpose and self-direction among members. On the other hand, to attempt to develop shared purpose and self-direction through coercion is self-contradictory' (p. 113).

The Burford Nursing Development Unit (NDU): Caring in Practice Model

As newly appointed general manager of Burford Community hospital, I set about establishing a reflective practice culture. I was not yet aware of the Learning Organization as a concept. Only later did I stumble across Senge's book 'The fifth Discipline' published in 1993 and discover its resonance with a reflective culture.

My first task was to set out a vision of clinical practice.

Vision for Clinical Practice

I commenced by asking staff to tell me about the hospital's existing philosophy. It had been 'imported', based on the philosophy of the Loeb Center in New York (Hall 1964; Alfano 1971). This vision had now faded. It was no longer *alive*. Importing a vision is very passive. It denies practitioners the opportunity to explore and express their own values. Hence, they may feel they do not own it and consequently a lack of commitment towards it. As one practitioner put it, 'it was imposed on us but didn't make any difference anyway'.

My response was to facilitate constructing a collective vision. Practitioners (not just nurses) were invited to post their values on a notice board. After one month, I convened a series of meetings to explore these values. From these values, a draft vision was constructed and circulated. This was followed by another series of meetings to discuss and revise the vision statement until the collective agreement. It was included in our patient information package in a relatively jargon-free language to inform our patients and families (Table 20.1).

Overall, it took four months to construct the vision. It opened a learning space for all practitioners to voice their views and think about their collective practice. It enabled practitioners to become active creators of their own practice and take responsibility for realising their beliefs in practice, to grasp their own destiny rather than have it imposed. The vision was now alive. It had drawn people in thinking about the hospital and its purpose.

The Three Cornerstones of a Valid Vision

Clearly, a vision cannot just say anything. In my experience, they were often written in vague rhetoric by someone years ago, pinned on office walls covered by layers of organisational memos or buried away in a policy file. The rhetoric is often grounded in caring clichés such as 'we believe in holistic care' that has no meaning for practitioners and clearly contradicted by even the most casual observation.

TABLE 20.1

Burford Vision for Clinical Practice (4th edition).

We believe that caring is grounded in the core therapeutic of easing suffering and enabling the growth of the other through his/her health-illness experience, whether toward recovery or death. The practitioner is mindful of being available to work with the person and the person's family in relationship, on the basis of empathic connection, compassion, and mutual understanding, where the person's life pattern and health needs are appreciated and effectively responded to.

Caring is seamless across healthcare settings and responds to and promotes both the local community's and society's expectations of effective service. In this respect, we accept a responsibility to develop a culture of reflective leadership and the learning organisation that continually strives to anticipate and develop the practice to ensure its efficacy and quality. By appropriate monitoring and sharing, we contribute to the development of the societal value of nursing and healthcare generally.

Our caring is enhanced when we work in a dialogical relationship with our (multi) professional colleagues on the basis of mutual respect and shared values within our respective roles. This means being free to share our feelings openly but appropriately, acknowledging that as persons, we can be stressed and have differences of opinion at times. This is the basis of the therapeutic team that is essential to reciprocate and support our caring to patients.

(March 2003, amended 2012, 2015)

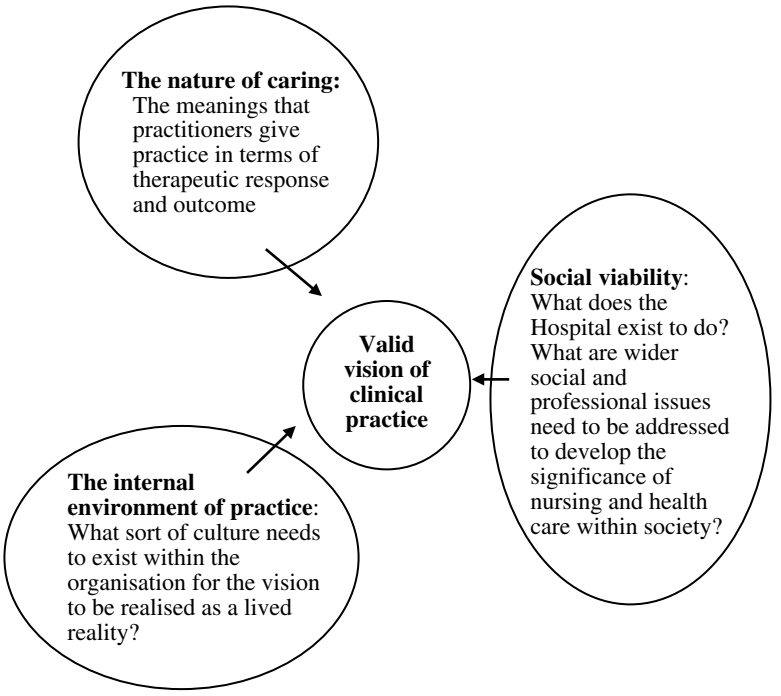

FIGURE 20.2 The three cornerstones of a valid vision.

A vision must be *valid* to give purpose to practice addressing what I term 'The three Cornerstones' (Figure 20.2).

The Nature of Caring

The Burford vision is person-centred grounded in an understanding of peoples' experience and working with them to assist them in meeting their needs and growing through their health-illness experience. The idea of growth stems from Mayeroff (1971, p. 1) who notes – 'To care for another person, in the most significant sense, is to help him grow and actualise himself. To actualise self is to fulfil one's human potential whatever that might mean for the person' (citing Maslow 1968). Hence, caring is more than just assisting people in returning to normal; and it is about enabling people to have healthier, more satisfying lives.

Newman (1994) notes how suffering/illness creates the opportunity to stand back and take stock of oneself. This can be difficult when people are locked into patterns of living.

A person-centred approach is a far cry from the medical model. Within the medical model, the ill person is reduced to the status of a patient with a set of symptoms that require investigation, diagnosis, and subsequent treatment. Little significance is attributed to emotional, psychological, spiritual, and social aspects of being ill or causes of illness. The nursing response is primarily to support the medical task.

I am sure many readers will remember being told not to sit on the bed and talk to the patient – there is *work* to be done! The implication being is that talking to patients is not work. The rise of technology and squeeze on resources has led to a culture whereby caring has been increasingly subordinated to unqualified staff. When the head is locked into the medical sphere, and the medical sphere is most valued within organisations, then practitioners can lose sight of the caring ideal. I know many readers will have experienced this state of affairs when visiting family or friends, or experienced their own heathcare. It is important to bring

this conflict to the surface because only then can nurses take action to resolve the contradiction to realise caring as a lived reality rather than as an ideal. Yet, in a world where the health agenda is dominated by productivity and a culture of 'more for less', times are hard for caring. Practitioners may switch off their caring self simply because it is too painful to witness suffering and the failure to ease suffering.

The Internal Environment of Practice

The internal environment of practice concerns the pattern of relationships between healthcare practitioners. The healthcare team develops and sustains collaborative and dialogical ways of working together based on shared purpose, respect, collective responsibility, and enabling leadership. This may not be easy due to traditional patterns of hierarchical and professional dominance that requires surfacing and shifting (Rowe 1996). Indeed this the situation at Burford hospital where some local GPs acted like feudal barons and where some staff still believed that matron should strictly control staff and work.

Social Utility

Social utility (Johnson 1974) concerns the role of the hospital in responding to and influencing societal expectations and wider professional issues such as research and teaching. It challenges practitioners to look beyond the immediate context of the practice setting towards the wider social and professional communities. For example, how does the local community view the most appropriate use of beds? Should a quota of beds be set aside for respite care? Should terminally ill patients take priority considering the nearest hospice is 16 miles away?

Vision, what vision?

Mandy writes – *'One of the workshops on the reflective practice course[3] was about being reflective in everyday practice, in which Chris provided an example of a philosophy that had been constructed through reflection. This was a sharp wake up call. I recalled that the department had it's own philosophy but if I was challenged as to it's contents I would have fail miserably. Once back in the department I eventually found the operational policy buried away in a filing cabinet. Included in its contents is the department's philosophy of care however it did not state who had devised it and when. I asked one of my colleagues who had worked in the department for many years as to the origin and author of the philosophy she looked at me blankly and said "I am sorry, I did not know we had one duck".*

In my next management supervision I raised this issue with my manager who also was ignorant of these facts but thought it might have been based upon the acute services philosophy. I compared the department's philosophy with one of the acute inpatient wards, only to discover that it was exactly the same. Johns (2013) draws attention to the difficulties caused by having an imported philosophy imposed on a practice: it denies articulation of the practitioner's own beliefs and values and is easily forgotten. What then is the point in having a generic philosophy devised by someone else, locked away in a filing cabinet? Non-whatsoever. Reflecting upon this, I established that the team believes that we provide a high standard of individualised care for patients within the department. However, we lack evidence to validate this. By not having a philosophy of care constructed on our collective beliefs and objectives of our practice, how do we know where we are going and the rational for the journey?

Creating a vision of practice is one thing. Realising it as a lived reality is quite another. There must be a collective determination to make it happen otherwise, the vision becomes meaningless and deeply frustrating.

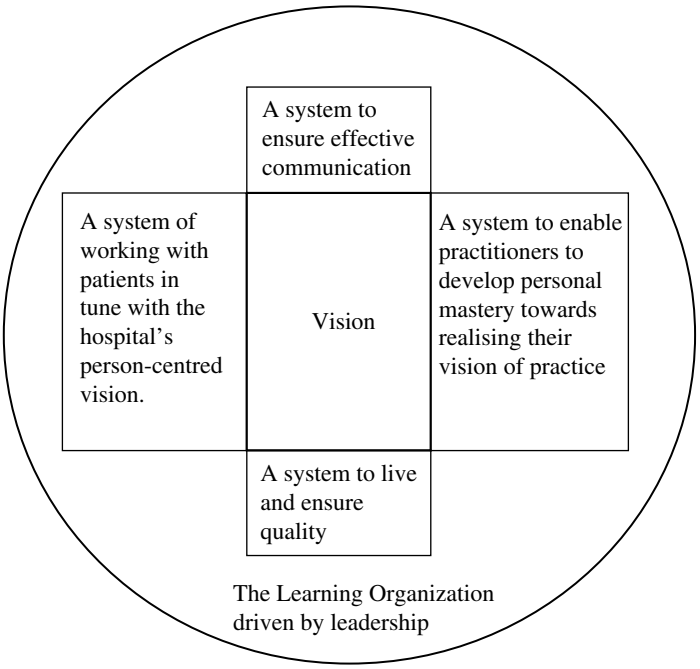

FIGURE 20.3 The Burford NDU: caring in practice model.

My response was to construct the 'Burford Nursing Development Unit: Caring in practice' model (Figure 20.3) comprising four *reflective* systems designed to enable practitioners to live and realise their collective vision as a lived reality against the background culture of the learning organisation.

The four systems are double feedback systems to enable practitioners to reflect on whether the systems are adequate towards enabling desirable practice. Hence, as with any *reflective* system, the systems are dynamic, under constant scrutiny for their efficacy.

A System of Working with Patients in Tune with the Hospital's Person-centred Vision

It was immediately apparent that the Roper et al. activities of a living model (1980) were redundant. This is a reductionist deficit model that views a patient as ten activities of living whereby practice is focused on identifying deficits within these activities and returning these activities to normal. An audit revealed the superficiality of assessment undertaken on the patient's admission. For example:

- Eating and drinking – 'likes a cup of tea in the morning'
- Expressing sexuality – 'likes to wear lipstick'
- Death and dying – blank

One problem with assessment schedules is the demand to fill them in. Hence, if an 'activity of living' box is not completed, it suggests the practitioner had not assessed adequately. The task becomes to complete the assessment sheet rather than to know the person.[4] The idea of 'activities of living' is easily understood from a functional perspective. As Pearson (1983, p. 53) noted – 'It speaks to nurses in a language which is familiar and related to nursing in this country and hence its greatest advantage then is its ability to convey meaning to clinical

nurses'. However, the 'activities of living' model had little congruence with the imposed Loeb Center philosophy.

It goes to reason that if practitioners develop their own vision, they have no need to interpret and apply an external model. They can tailor-make their own to fit. However, such liberty may be constrained by organisations imposing assessment conformity. Practitioners would need to assert their professional autonomy to choose the best tools for the job. Does a carpenter choose a spoon to chisel wood?

The Burford vision is grounded in person-centred practice. Hence knowing the person, understanding their needs, and working with the person towards meeting these needs is the central focus of this system. Hall (1964) challenges that nurses can only nurse what the person reveals of himself. As such, the practitioner's skill is to create the dialogical conditions whereby the person can reveal their experience, which Patterson and Zderad (1988, p. 23) described as a 'lived dialogue'. Only when the practitioner is in tune with the person can they appreciate and respond appropriately to the person's unfolding needs. Newman (1994, p. 13) writes:

> The task is not to try to change another person's pattern but to recognise it as information that depicts the whole and relate to it as it unfolds.

The Nine *Reflective* Cues

I constructed nine reflective cues to enable the practitioner to tune into the person from the perspective of the Burford vision and guide the practitioner's appreciation of the person's life pattern and needs (Table 20.2). The cues are constantly in play both assessing and evaluating what evolves forming the person's narrative.

Because the cues follow a natural line of inquiry, they are easy to apply except perhaps the cue 'how do I feel about this person?' The cue tunes the practitioner into her own feelings, thoughts, and how these might impact on the patient's experience.

With experience, these cues are internalised as a *natural* and intuitive reflective lens to tune into the unfolding clinical situation as a continuous process of assessment, response, and evaluation. The cues do not require direct answers. I emphasise this point because the practitioner who has embodied a reductionist systems approach, may miss the reflective point and view the cues as yet another set of boxes to complete. As Sutherland (1994, p. 68) noted – 'Although at first I did find myself going back to the Roper et al.'s headings to make sure that

TABLE 20.2

The Burford NDU Reflective Cues.

Core cue

What information do I need to appreciate the healthcare needs of this person?

The nine reflective cues

- Who is this person?
- What meaning does this health/ illness experience have for the person?
- How is this person feeling?
- How do I feel about this person?
- How has this event affected their usual life pattern and roles?
- How can I help this person?
- What is important for this person to make their stay in the hospice comfortable?
- What support does this person have in life?
- How does this person view the future for themselves and others?

I had not missed anything, omitting what was physically important, I did not need to do this for very long'.

Sutherland further noted the impact of the reflective cues in changing her mindset (1994, p. 68):

> Because the emphasis is centred on feelings and the total picture of that person's situation rather than on their ongoing physical needs, it forced me to move away from a need to find things out, fill things in and get things done as soon as possible in an orderly fashion. It forced me to start listening to what patients themselves were saying was important to them and then to plan care with them from this basis. It gradually became a welcome release for me.

There is something astonishing in Sutherland's words about the way she thought the Burford cues *forced* her to listen to the person, as if she hadn't really listened to the person before. As she suggests, the 'old model' became the task – hence the effort was to complete it rather than really listen to what the patient or family were saying. As Sutherland suggests, the key is listening and connecting; and then working with the person toward meeting their healthcare needs.

I use my experience working with Tony to illustrate the cues in action, the way they shape my perception and response within the clinical moment.

Tony

Susan (a staff nurse) asks me to help get Tony up for lunch. I have not met him before. I am informed that he is 53 years old, that he has primary lung cancer with liver metastases. He has been in the hospice for respite care 4 days.

I ask Susan 'Is there anything in particular I should be mindful of?'

'He's bit moody'.

'Why's that?'

'He's unhappy here and wants to go home. He finds it difficult to co-ordinate himself but doesn't want help'.

I knock on the closed door. No reply. I knock again and enter the room. The hand-drawn cards fixed to the bedroom wall immediately caught my attention.

'Hi Mr Birchall, I'm Chris. How are you this morning?'

He looks at me but doesn't answer. I sense his irritation. Susan's words come to mind. I gaze at the cards pinned to the wall – 'Who made these lovely cards?'

'My grand-daughter'.

'She has talent. Tell me about her?'

'Her name is Michelle. She is four years old'.

He becomes animated talking about her. She is very special to him, adding to his sadness and restlessness. I have opened the door to connect with Tony, talking about the thing that he cares most deeply for and grieves for its forthcoming loss. I reveal I have two young children. We talk about schooling and about his work – he had been a plumber. He knows he is not going to work anymore and accepts this. All the while, his anger simmers. Do I let him know I sense this? Such catharsis might prick the tension, and yet it might embarrass him. I take the risk 'You seem irritated being here?'

In doing so, I release my own anxiety. As if I have pressed a button, he pointedly says 'I want to be at home. Not that it's unpleasant in here but. . ..'

His words drift off. Patiently I wait.

He adds 'I want to be at home'.

'I sense that. . . so why are you here?'

'I had no choice because my daughter is away for the week and I need her support'.

He relaxes. He has expressed his irritation – a potent cocktail of anger at the hospice, at me, at himself, at cancer, at his daughter, that he is dying, grief of anticipatory loss, indeed at the world at large. He moves out of the shadow of his despair, more willing to engage with me.

He asks 'Tell me about yourself'.

I sense he needs to know me in order to accept my presence. I explain I work at the hospice to maintain my credibility as a palliative care teacher. He is intrigued. He stands and takes off his pyjamas. His nakedness was exposed. I hold him steady as he moves into and out of the shower. Slowly he dresses. I help him with his socks and shoes. I have been with him over an hour.

I ask 'Do you have any pain?'

'No'.

'That's good. . . I can see you need help with washing and dressing. Do you get this support at home ok?'

'My daughter helps me. We do have a nurse who comes in and monitors me so if things get any worse she's on hand to help'.

We go to lunch in the communal dining room. It is empty. We are late. Everybody else has gone. He invites me to join him for lunch. I stay with him until he has finished. There is something normalising about having a meal with someone. He tells me he was a keen cyclist. I tell him I am a morris dancer. By the time we finish, I am on his wavelength and sense his ease. I, too, am easier, having worked through my own anxiety. I sense the way feelings are reciprocated. It highlights for me the fundamental need to know people in order to respond appropriately to them on a level that is meaningful. We got there but it took an effort.

I imagine it must be difficult for him to deal with yet another nurse. I imagine he would rather have Susan help him, someone, he knows. He doesn't say that, at least not in words. Perhaps I could have said to him – 'I'll get Susan to help you', acknowledging his initial discomfort with me. But then, as Susan said, he's moody with everyone. Do patients have the right to choose their nurses in hospice? It is a profound question because I cannot impose my idea of relationships on patients. The very nature of suffering and facing dying must always make relationships precarious. In getting to know someone who is suffering, I trip along a fine edge of raw emotion.

Perhaps I could have simply connected superficially with him by helping him to wash, dress, escort him to lunch, administer, and monitor his pain medication and other symptom relief. But this was not the level of help he really needed. On a deeper level, I knew he was in crisis. I could read that, but that was my difficulty. I could not respond easily to the superficial caring issues outside that deeper context. Hence helping him wash and dress became difficult once I had touched his suffering. He also knew that and perhaps resisted me because he needed to protect himself from this intruding stranger. On the other hand, he might have preferred my superficial attention. I felt as if I had pushed his limits and challenged his control of the situation.

Later, I share this experience with Susan. She affirms my experience, acknowledging Tony's struggle in facing death. She feels I shouldn't worry unduly as Tony is 'difficult'. In other words, my experience is normal. Sensitivity flattened in order to cope with the stress of the day. The patient is the problem, not the inadequacy of the nurse.

Before I leave the hospice, I go and shake hands with Tony and thank him for accommodating me. He reciprocates my thanks for having the patience to stay with him. I sense he is lonely here without his daughter and granddaughter visiting. A week can seem a long time when time is running out and when such relationships are precious.

Applying the Reflective Cues

Who is This Person?

This cue guided me to see Tony as a person in the context of his world. His family and culture are brought into focus and scope of care. In acknowledging Tony as a person, I also

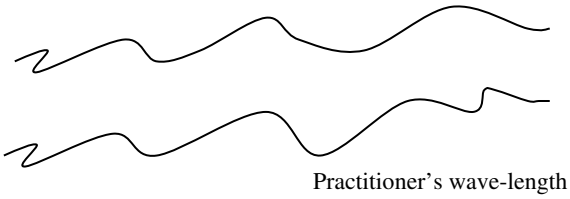

FIGURE 20.4a Tuning in and flowing with the patient's wavelength.

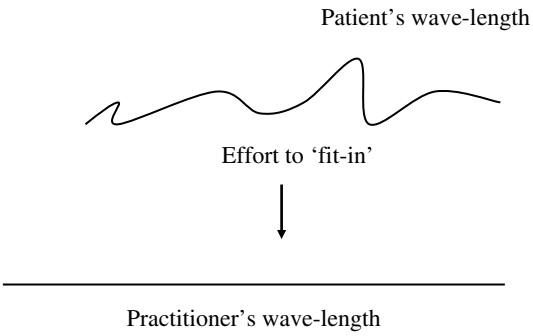

FIGURE 20.4b Forcing the patient's wavelength to 'fit-in'.

acknowledge myself as a person that sets the basis for a person-centred relationship. The most meaningful way to know a person is to get them to tell you their story. Immediately it reflects your concern and availability. To know Tony I must tune into his wavelength and flow with his story. Then I am to be available to work with him to sort out his diverse needs and find a healthier wavelength (Figure 20.4a). When people experience a crisis in their lives, their wave patterns become chaotic. Practitioners normally expect the patient to fit into the stereotyped 'good patient' mould – a symbolic straight line that flattens humanness (Figure 20.4b). The reward is to be accepted and cared for. Failure to 'fit-in' often leads to censure as characterised by the image of the 'unpopular patient'.[5] Such relationships lack harmony and feel flat.

The key to tuning into Tony is to attentively listen (Smith and Liehr 1999) and be empathetic to Tony's experience beneath the surface signs and assumptions that might lead me to assume what it means. It means being prepared to self-disclose as appropriate, challenging the professional barriers that practitioners may prefer to hide behind (Derlaga and Berg 2014). Yet Within the human-human relationship he needed to know me. It challenges the practitioner adopting a 'bedside manner'. Jourard (1971) observed the way the nurse dons a bedside manner when she dons her uniform, and that the uniform encourages stereotypical behaviour that diminishes the individual. He notes (p. 180) – 'it is acquired as a means of coping with the anxieties engendered by repeated encounters with suffering, demanding patients'.

Unfortunately, such a manner becomes rigid over time. The patient will recognise this, limiting their willingness to tell their story. It is a controlling behaviour designed to reduce the possibility that the patient will behave in ways that are likely to threaten the professional person.[6]

What Meaning Does This Health Event Have for the Person?

Having gained an appreciation of who Tony is, I then tune into the particular health issues that bring Tony into care, to enable him to make sense of his bewildering experience. Newman (1999) describes this as a *rhythm of relating*, acknowledging that the patient's rhythm may be in turmoil due to the illness experience. As Newman (1999, p. 227) notes – 'Nurses should

develop a tolerance for ambiguity and uncertainty and "hang in there" with clients until a new rhythm emerges more compatible with health'.

How is This Person Feeling?

Tony revealed a cocktail of distressing emotions that bubbled to the surface. I tripped along with this cue cautiously, not wanting to intrude inappropriately into his private world but mindful of opening a space whereby he could express these emotions safely and discharge as appropriate. Until these emotions were released, it was impossible to talk through his experience in any meaningful way.

How Do I Feel About This Person?

Initially, I did not feel comfortable with Tony. His anger lay thick on the surface despite his compliance. I was mindful of my emotional response and endeavoured to be open to his experience rather than defend myself to manage my anxiety. It reveals the essential attribute of poise in being available to Tony.[7]

How has This Event Affected Their Usual Life Pattern and Roles?

Serious illness can prompt a radical reassessment of lifestyle and what people consider significant within their lives. Disruption of normal patterns can have detrimental consequences if not carefully managed – hence knowing his normal lifestyle is useful, so I do not disrupt it unnecessarily or disturb his control over events.

How Can I Help This Person?

My intention was to help ease Tony's suffering. To do this, I needed to understand his suffering as best I can. He did not reveal himself to me easily, so to help him, I first had to create the conditions where he could reveal himself. Of course, I needed time to do this, and fortunately, I had it. As the narrative reveals, his suffering expressed itself as multifaceted anger. Acknowledging his anger was the first step to easing it using communication skills such as catharsis, catalytic, and confrontation within our dialogue.[8]

In the fast pace of clinical practice, such time might be at a premium, creating a dilemma for the practitioner in prioritising time for such work.

What is Important for This Person to Make Their Stay in the Hospice Comfortable?

Tony did not want to be at the hospice but felt obliged to because of his social circumstances. The cue raises issues of comfort and control, especially those 'little things' that make a significant difference to the person's comfort and perception of being cared for (MacLeod 1994). For Tony, I suspected that being understood made his stay more comfortable, enabling him to flow more easily in this potentially hostile environment. Talking about his granddaughter was clearly significant.

Perhaps I could have challenged Susan's analysis and labelling of Tony as 'difficult'. Labelling is such a perverse act and disrupts any therapeutic potential. It highlights how easily practitioners label people as 'difficult' as a way of dealing with the anxiety these people arouse within them. I recognise my failure to confront Susan reflects a deeper need to avoid conflict, reflecting how practitioners also conform to a social norm of the harmonious team.[9] Mindful of creating a caring environment where people are comfortable reflects and communicates a deep sensitivity to the person as befits any claim to person-centred care.

What Support Does This Person Have in Life?

I tentatively queried his support at home. I did not meet his daughter, so I did not gain her perspective. However, the hospice is geared up to the social and psychological aspects of care. My role is to collaborate with others if aspects of supporting Tony emerge through our conversation. From a pragmatic perspective, support is vital to mobilise and develop with a view to eventual discharge, especially where the person requires support in the community with the risk and associated impact and cost of the person blocking the bed.[10]

How Does This Person View the Future?

Tony knew his condition was terminal. His anticipatory loss rippled through our whole encounter. Tony's imminent death is present between us even if we do not overtly mention it. Perhaps I could have explicitly used this cue as knowing him would have made this an easier topic to broach. Other, more specialist practitioners would also broach this cue with him. As such, I was mindful of not overstepping my role at that moment.

A System to Ensure Effective Communication

Communication is vital to ensure continuity and consistency of care between practitioners and across practice settings. It can be formal and informal. Formal communication occurs through writing notes and reports, through shift reports, ward rounds, and various care meetings that may include patients and families. Verbal communication is through language. Non-verbal communication is through writing, signs and gestures, body posture, and intonation that convey positive and negative power messages.

Informal verbal communication takes place in the way practitioners relate to each other and with patients and families throughout the day; corridor conversations, passing remarks, the sluice room conference, coffee chat, and the suchlike.

Narrative Notes

I wrote in Tony's notes – *Tony's anger is an expression of his suffering and loss at being in the hospice. It is understandable although difficult to respond to*. I feel he needs to have control of being in the hospice. *After helping him wash and dress we lunched together and shared many common interests that helped to lift his despair at least for the moment. He acknowledges he needs to be here as difficult as that is for him. In particular he misses his granddaughter*.

I deliberately referred to Tony's *suffering* to orientate staff to that word central to WHO definition of palliative care and by doing so confront the predominant symptom management attitude that prevailed at the hospice.

Tony's notes were part of the nursing process that since the late 1970s has dominated the approach to thinking and writing about patient care. Essentially the nursing process is a linear problem-solving approach that structures thinking through four stages:

• Goal setting	An interpretation of assessment in terms of identifying specific actual or potential problems/patient needs and goals to be achieved in responding to the problem/need.
• Planning	Establishing the response to solve the problem/need.
• Intervention	Carrying out the planned care.
• Evaluation	Determining whether the set goal has been met, including re-defining the problem or goal as necessary in light of consequences.

In theory, a practitioner should be able to pick up the care plan and continue the patient's care as a seamless dynamic activity, amending it as necessary to reflect the unfolding situation. The nursing process was intended to promote a culture of individualised and negotiated care (De la Cuesta 1983). However, the opposite tended to happen when it was accommodated to fit within the existing dominant medical model culture, resulting in a minimal or lip-service response to the ideology of individualised care (Latimer 1995). The patient became a set of problems or needs diagnosed by the nurse. The nursing diagnosis movement (NANDA) was a natural development from the nursing process within the USA, yet is a process fraught with difficulty because it imposes abstract meanings on 'nursing' concepts in the futile effort to ensure consistency of diagnosis. In this respect, this movement mirrors medicine's approach to diagnosis. Practitioners might find some common understanding of what a grade 4 glioma is, but can practitioners find common meaning in using the word suffering, spirituality or agitation?

In an observational study of the impact of primary nursing on the culture of a community hospital (Johns 1989), one practitioner commented – 'much of it is just nursing, you don't have to write that down'. This comment reflects the stereotypical pattern recognition and common sense knowing that this practitioner and her colleagues possessed, and their struggle to write down what was so obvious to them. As another practitioner commented – 'patients we know well don't need care planning'. I asked one staff nurse on her return from holiday if she had read her patients' care plans. She commented – 'I haven't had time because it's so busy', again suggesting that care plans were unnecessary. The human within the machine becomes a contradiction. As Wilber (1998) puts it, systems are the language of 'it' and a stark colourless landscape of labels.

My retrospective audit of nursing notes at Burford revealed the nursing process had no value either as a comprehensive record of care or enabling the continuity of care.

In response, I developed the idea of *narrative notes* as a more meaningful response to using the reflective cues commencing with an initial story around the first reflective cue 'who is this person?' that sets the scene for recording the patient's dynamic journey towards meeting health needs. Assessment, planning, intervention, and evaluation become a seamless and continuous process.

Bedside Handover

At Burford, we moved from an office-based shift report to a bedside report to involve patients in dialogue concerning their treatment and care. Shift reports in closed rooms must be questioned from a patient-centred perspective (Ward 1988). A considerable literature emerged in the 1990s' that explored patent participation in decision making (Ashworth et al. 1992; Biley 1992; Jewell 1994; Trnobanski 1994; Waterworth and Luker 1990). Working with and negotiating decision-making is congruent with the hospital's vision.

However, some staff may resist the bedside handover because:

- fear of breaching patient confidentiality by disclosing information in public areas;
- some patients would not be able to participate;

- some patients would not want to be involved;
- uncomfortable for practitioners used to a more traditional approach of talking about patients behind closed doors.

From a person-centred perspective, a bedside report is an act of care. Not to involve patients would be a contradiction that reduces them to objects of care rather than active participants in their own healthcare. It may take more time and may create some risk of public disclosure, but it did lead to greater trust that more than offsets any bureaucratic concern of risk. Unfortunately, organisations wary of litigation tend to lean heavily towards risk management even when risk is managed.[11] Where patients decline or are unable to participate, the report is continued in the office. Practitioners noted how the bedside report enabled them to make better sense of patient information having seen and spoken with the patient beforehand. Patient notes are stored at the bedside for both patient and practitioner availability. The idea of patient held records is well known in community settings, reflecting the philosophy of working with the patient in terms of their care. This practice challenges practitioners to be mindful of what they write, knowing that it might be read by the patient or the patient's family.

The shift report group enter his room and say hello. Tony declines being involved in his bedside handover. We then proceed to the office to dialogue about his care. Susan says Chris has been with Tony this morning. I give a verbal account of what I have written in the notes adding the bit about his 'cocktail of emotions' and his granddaughter's cards pinned on the wall. Other staff comment that Tony's irritation has been difficult for them to penentrate but they can understand why he responds like that. I suggest it is us who has the problem not Tony. They agree. I can feel a shift in attitude towards him. As defences drop so compassion rises. One of the group says 'that has been insightful'.

De-briefing

Often events happen that are particularly disturbing. Reflective de-briefing is an opportunity for staff to de-brief as a group when necessary in recognition of the emotional impact of caring for some patients and issues of misunderstanding. Indeed, it can be part of the reflective handover, although at other times, it needs more time.

De-briefing has a number of obvious benefits:

- It acknowledges that sometimes, for whatever reasons, practice can be tough;
- It is okay to be distressed, angry; cutting across a culture where practitioners have hidden their feelings in the (misguided) belief that 'good nurses cope' or not to burden their colleagues.
- Where practitioners can be legitimately heard and valued as persons with human needs and human frailties.
- Constructing the therapeutic team by bringing staff together to create a new culture of mutual support in their caring quest; bringing vision into clear view.
- Confronting inappropriate attitudes, behaviours, assumptions, and defence mechanisms that disrupt therapeutic ways of working with patients and colleagues.
- Promoting the morale, self-esteem, and motivation of colleagues, with organisational consequences of retaining staff, enhancing quality of care, and reducing staff sickness.
- De-fusing toxic stuff and not taking it home with you!
- Realising the learning organisation.

Summary

A system to enable staff to grow and realise their potential is set out in Chapter 21. A system to live and ensure quality is set out in Chapter 22. Leadership is explored in Chapter 21.

Notes

1. *https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf*
2. *https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf*
3. See Chapter 14 for detail of this programme
4. The robotic attitude of nurses and their paucity of assessment is vividly illuminated in 'people are not numbers to crunch' (Chapter 11) through our experience with nurse fantastic.
5. For example see Johnson and Webb (1995), Kelly and May (1982).
6. The bedside manner is very evident in the behavious of the various nurses in the narrative 'People aren't numbers to crunch' (Chapter 12).
7. See 'The being available template' as a reflective framework (Table 5.1).
8. Catalytic, catharsis and confrontation are all communication skills within Six-Category Intervention Analysis – see Table 16.1.
9. See also Hank's conflict chapter.
10. Delays in discharging patients out of hospital after treatment could be costing the NHS in England £900m a year, an independent review noted. Labour peer Lord Carter's report found nearly one in 10 beds was taken by someone medically fit to be released. http://www.bbc.co.uk/news/health-35481849 (accessed 16 March 2016).
11. Chapter 20 sets out a standard of care on confidentiality during beside handover.

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1

Clinical Leadership Explored

David Stanley

Find people who share your values, and you'll conquer the world together.
John Ratzenberger, author of *We've Got It Made in America*

Introduction

Jesse Jackson, the American political and civil rights leader, has said: 'Change isn't about processes or structure. It is about courageous people who are prepared to act.' This book is about people in the health service who are courageously driven by their values and prepared to act on them. These people may apply courage: suggesting the best available evidence in the face of luddite behaviour; care when time is pressing; clinical competence; commitment; compassion or any of the foundational and traditional values evident and relevant in modern health care. For me, these are **clinical leaders**: women and men, across the spectrum of the health service, who explore the boundaries of their practice and who press for continual improvements in quality care, increased innovation and productive changes in practice. They are leaders because they put their values (about care, compassion, competence, commitment, courage, etc.) into action. Others see these values in practice and follow, because they hold, aspire to or believe in the same values and beliefs.

While nursing leadership and healthcare leadership are terms that have been evident in the nursing and health industry literature for many decades, clinical leadership is a relatively new term. However, what do we know about the concept of clinical leadership and what does the term mean? This chapter sets out to explore definitions of clinical leadership, the attributes of effective clinical leaders, and attributes less likely to be associated with clinical leadership. It will also consider who clinical leaders might be, and will outline the implications for health organisations when understanding and recognising clinical leaders. It suggests that if an organisation – or indeed the health service as a whole – is to adapt and develop, there is an urgent need to identify who the clinical leaders are and to understand how they see themselves or are recognised by others (Mountford and Webb 2009; Jeon 2011; Storey and Holti 2013a; Bender 2016).

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Clinical Leadership: What Do We Know?

Attempts to define clinical leadership, like insights into the concept, are relatively new (Stanley and Stanley 2017). There were early contributions from Peach (1995) and Lett (2002), both from an Australian perspective, and US authors Dean-Barr (1998), McCormack and Hopkins (1995), and Rocchiccioli and Tilbury (1998) added to the dialogue. Berwick (1994) and Wyatt (1995) from a medical perspective, Forest et al. (2013) from a dentistry perspective and Schneider (1999) from a pharmacological standpoint have also added to the discussion. Most recently and also from a medical perspective, Stanton et al. (2010), Swanwick and McKimm (2017), and Storey and Holti (2013a) have offered a summary of what clinical leadership may mean. However, and in spite of this growing body of literature, a clear definition remains elusive (Mannix et al. 2013; Jeon et al. 2014). Fortunately, more literature is evident each year that addresses Malby's (1997) suggestion that there has been limited agreement on a definition of clinical leadership.

Harper (1995) offered one of the earliest definitions, suggesting that a clinical leader possesses clinical expertise in a specialist practice area and uses interpersonal skills to enable nurses and other healthcare providers to deliver quality patient care. McCormack and Hopkins (1995), Cook (2001b), and Lett (2002) support Harper's view, suggesting that clinical leadership can be described as the work of clinicians who practise at an expert level and who have or hold a leadership position.

Rocchiccioli and Tilbury (1998), writing from a nursing perspective, also cite excellence in clinical practice, but add that it also involves an environment where staff are empowered and where there is a vision for the future. Lett (2002) and Swanwick and McKimm (2017) suggest that a clinical leader is a clinical expert who leads their followers to better healthcare by providing a vision to those followers and so empowering them. Expert practice and a positive impact on quality patient care again feature, but each also links clinical leadership with vision, and this is at odds with the research results that support this book (Stanley 2006a, b, 2008, 2011, 2014; Stanley et al. 2012, 2014, 2015; Stanley and Stanley 2019). These publications suggest that clinical leadership and vision are seldom directly linked. Instead, clinical leaders are more likely to be followed because they match their values and beliefs with their actions in clinical practice; a perspective elaborated on in Chapter 4. This perspective aligns clinical leadership with approaches to leadership driven or based on a values-based leadership style; James et al. (2021).

Stanton et al. (2010, p. 5) offer the view that anyone who is in a clinical role and who exercises leadership is a clinical leader, before suggesting that a clinical leader's role is to 'empower clinicians to have the confidence and capability to continually improve health care on both the small and the large scale'. The UK Department of Health's (2007) definition *(and I feel it is still one of the best)* is that the role of a clinical leader is:

> To motivate, to inspire, to promote the values of the NHS, to empower and create a consistent focus on the needs of patients being served. Leadership is necessary not just to maintain high standards of care, but to transform services to achieve even higher levels of excellence.
>
> (DoH 2007, p. 49)

Bender (2016) recently attempted to develop a theoretical understanding of clinical nurse leader practice and suggested that the core attributes of clinical nurse leaders rest on links to clinical practice, effective communication, effective interprofessional relationships, team working and supporting other staff.

Clark (2008) and Cook (2001a) suggest that clinical leaders are in non-hierarchical positions, with Cook adding that clinical nurse leaders are directly involved in providing clinical care that continually improves care through influencing others, with Cook and Holt (2000) supporting this perspective. Clinical nurse leaders also have a relationship with quality patient care and are able to influence others, implying perhaps that they may not need to be in positions of power or those that are hierarchically significant to lead in the clinical arena. The research that supports this book bolsters such views. These authors also imply that clinical leaders must be good communicators, and that they need effective team-building skills and respect for others.

The *McKinsey Quarterly* definition of clinical leadership; another that I particularly like (cited in Stanton et al. 2010) is that:

> Clinical leadership is putting the clinician at the heart of shaping and running clinical services, so as to deliver excellent outcomes for patients and population, not as a one-off task or project, but as a core part of clinicians' professional identity.

In addition, the literature points to a number of key elements in the recognition of clinical leadership (Stavrianopoulos 2012; Chavez and Yoder 2014; Stanley and Stanley 2017):

- **Clinical expertise** (Berwick 1994; Harper 1995; Rocchiccioli and Tilbury 1998; Schneider 1999; Lett 2002; Stanley 2006a, b, 2008, 2011, 2014; Stanton et al. 2010; Swanwick and McKimm 2017; Stanley et al. 2012, 2014, 2015; Won 2015; Bender 2016; Stanley and Stanley 2019).
- **Effective communication and interpersonal skills** (Harper 1995; Cook and Holt 2000; Cook 2001b; Stanley 2006a, b, 2008, 2011, 2014; Swanwick and McKimm 2017; Stanley et al. 2012, 2014, 2015; Jeon et al. 2014; Won 2015; Bender 2016).
- **Empowerment and respect for others** (Rocchiccioli and Tilbury 1998; Cook and Holt 2000; Lett 2002; Stanley 2006a, b, 2008, 2011, 2014; Stanton et al. 2010; Stanley et al. 2012, 2014, 2015; Bender 2016; Boamah 2018; Stanley and Stanley 2019).
- **Team working or team building** (Rocchiccioli and Tilbury 1998; Cook and Holt 2000; Lett 2002; Stanley 2006a, b, 2008, 2011, 2014; Stanton et al. 2010; Stanley et al. 2012, 2014, 2015; Bender 2016).
- **Driving change, making care better and providing quality care** (Berwick 1994; Harper 1995; Schneider 1999; Cook 2001b; Lett 2002; Stanley 2006a, b, 2008, 2011, 2014; Ferguson et al. 2007; Clark 2008; Stanton et al. 2010; Swanwick and McKimm 2017; Stanley et al. 2012, 2014; Byers 2015; Demeh and Rosengren 2015; Stanley et al. 2015; Stanley and Stanley 2019).
- **Vision** (Rocchiccioli and Tilbury 1998; Cook and Holt 2000; Lett 2002; Clark 2008; Swanwick and McKimm 2017).

However, it is my contention that there is much more to understanding clinical leadership than these definitions and views.

Reflection Point

Look around the area where you work. Who would you identify as a clinical leader? Why would you select this person or people? How does your choice of clinical leader fit with the definitions already offered in this chapter?

Attributes *Less* Likely to Be Seen in Clinical Leaders

Clinical Leaders Are Not Seen as Controlling

Being viewed as 'controlling' was consistently seen as less likely to be associated with the qualities of a clinical leader, a view supported by Coventry and Russell (2021), who explored the clinical leadership attributes of clinical nurse educators. Table 1.1 indicates emphatically that in the six research studies that support this book, being 'controlling' was always the attribute identified as least likely to be linked to clinical leadership (for more on these see Chapter 4). Moreover, the percentages are remarkably similar across a range of professional disciplines, cementing a disassociation between being controlling and clinical leadership. In the sixth study with rural and remote area nurses' clinical leaders who 'did not listen, gave poor feedback, were not focused on staff, did not connect or engage with the team or were dishonest, aggressive or inflexible,' were seen as poor clinical leader (Stanley and Stanley 2019, p. 6).

Clinical Leaders Are Not Seen as Visionary

'Being visionary' was also poorly associated with clinical leadership. As with Cook's (2001a) study, having a vision or articulating a vision appeared to be unrelated and unrecognisable as a dominant feature of the qualities and characteristics for which clinical leaders were recognised.

Table 1.1 'Being controlling': The characteristic least commonly associated with clinical leaders.

	Study 1	Study 2	Study 3	Study 4	Study 5	Study 6
	Nurses	Paramedics	Residential care staff	Volunteer ambulance officers	Allied health professionals	Rural and remote area nurses
Percentage of respondents who identified *controlling* as the attribute least likely to be linked to clinical leadership	78%	84%	80%	84%	83%	Being controlling was mentioned by 32 of the 56 (57%) participants as an attribute least likely to be associated with a clinical leader

In Study 1 the term 'visionary' was identified by 72.3% of respondents as affiliated with clinical leadership, although even with this percentage it was ranked 27th on a list of 42 words to describe the qualities and characteristics most associated with clinical leadership. In each of the six studies, being visionary or having a vision failed to be rated highly in terms of a percentage factor, or as an attribute of clinical leadership. Table 1.2 offers data from all six studies to support this view. Interestingly, the percentages seemed to drop as the studies progressed in time (from 72% with nurses in 2005 to 34.2% with allied health professionals in 2015). The sixth study was based on interviews and did not gather percentage responses, although it was rarely discussed by participants.

These results question the significance of 'vision' or 'being visionary' as a quality or characteristic sought or seen in clinical leaders. In each of the studies, respondents were invited to list their own attributes of clinical leaders and, as such, many additional attributes were offered. However, very few related to 'vision', 'being visionary' or 'being forward thinking' (Stanley 2006a, b, 2008, 2011, 2014; Stanley et al. 2012, 2014, 2015; Stanley and Stanley 2019). The lack of characteristics centred around clinical leaders being visionary was borne out by the results of the interviews or free-text comments, where 'vision' was hardly mentioned as an attribute looked for in clinical leaders, and rarely described as the motivation behind being a clinical leader. One person in the sixth study said, 'Sometimes as leader you might have a vision' (Stanley and Stanley 2019), but this was the closest comment and one of only two that even mentioned vision in the context of clinical leadership in this study. Some respondents discussed goals or objective setting, but these were commonly focused on work tasks or professional development aspirations and only loosely related to vision.

This may be because respondents were drawn to or identify with clinical leaders who can lead them through the 'here and now' issues of busy and chaotic clinical work – who can cope with the demands of each day as it comes, rather than postulate and pontificate about how things could or should be. Clinical leaders were seen and selected if they had their values on show and stood on a solid foundation of care and compassion that governed and drove their practice standards. Clinical leadership is therefore defined in action, as clinical leaders mobilise their values and beliefs to guide and direct what they do when faced with challenges and critical problems in the clinical area (Clark 2008;

Table 1.2 'Being visionary' as associated with clinical leadership.

	Study 1	**Study 2**	**Study 3**	**Study 4**	**Study 5**	**Study 6**
	Nurses	**Paramedics**	**Residential care staff**	**Volunteer ambulance officers**	**Allied health professionals**	**Rural and remote area nurses**
Percentage of respondents who identified *visionary* as an attribute likely to be linked to clinical leadership	72% Ranking 27th out of 42 attributes	51% Ranking 37th out of 54 attributes	20% Ranking 33rd out of 54 attributes	40.9% Ranking 38th out of 54 attributes	34.2% Ranking 36th out of 54 attributes	Being visionary was mentioned by only 2 of the 56 (3.5%) participants as an attribute of a clinical leader

Stanley 2006a, b, 2008, 2011, 2014; Edmondstone 2009; Stanley et al. 2012; Forest et al. 2013; Stanley et al. 2014; Scully 2014; McLellan 2015; Stanley et al. 2015; Stanley and Stanley 2019).

Clinical Leaders Are Not Seen as 'Shapers'

Cook (2001a) saw clinical leaders as 'creative', identifying the typology of 'shapers' to describe them (see later in this chapter). In each of the six research studies that influence this book, creativity was rarely identified as a defining characteristic of a clinical leader. As indicated in Table 1.3, being 'creative/innovative' or 'artistic' was seldom ranked highly on the clinical leader attribute list.

Artistic was ranked second only to 'controlling' as the characteristic least associated with clinical leadership in the first study among nurses and was continually ranked near the end of the order in all the other studies. Higher percentages of respondents did still consider being 'creative/innovative' a feature of clinical leadership. However, this failed to be as strongly associated with clinical leadership as other attributes, and in interviews with clinical leaders or in other data sources, creativity and innovation were seldom expressed as an attribute worthy of note (Stanley 2006a, b, 2008, 2011, 2014; Stanley et al. 2012, 2014, 2015; Stanley and Stanley 2019).

I have struggled with this aspect of the results since my initial publications. Rolfe (2006), who wrote a commentary on the 2006 article (Stanley 2006b), was likewise unsure of the validity of the results, given that creativity was ranked so low. However, this feature of the results has been confirmed again and again with each subsequent study (see Table 1.3). I am sure that some clinical leaders are creative and that being creative is a substantial skill

Table 1.3 'Creative/innovative' and 'artistic' as associated with clinical leadership.

	Study 1	Study 2	Study 3	Study 4	Study 5	Study 6
	Nurses	Paramedics	Residential care staff	Volunteer ambulance officers	Allied health professionals	Rural and remote area nurses
Percentage of respondents who identified *creative/innovative* as an attribute likely to be linked to clinical leadership	76.5% Ranking 25th out of 42 attributes	51% Ranking 32nd out of 54 attributes	60% Ranking 27th out of 54 attributes	59.0% Ranking 27th out of 54 attributes	56% Ranking 22nd out of 54 attributes	Being innovative was identified by only 3 of the 56 (5.3%) participants in this study.
Percentage of respondents who identified *artistic* as an attribute likely to be linked to clinical leadership	13% Ranking 41st out of 42 attributes	24% Ranking 50th out of 54 attributes	0% Ranking 54th out of 54 attributes	42.5% Ranking 48th out of 54 attributes	8.5% Ranking 50th out of 54 attributes	This was not identified by any of the participants in this study.

for clinical leaders to employ, but I am now sure that being creative is not something that others look for in their clinical leaders. Creativity does remain a key attribute that clinical leaders should aspire to, and it is of particular relevance if clinical leaders are to influence innovation or change or to find new ways to bring their values into practice. Chapter 9 elaborates on the issue of creativity and identifies a number of strategies that clinical leaders can employ to bolster their creative capacity.

Attributes *More* Likely to Be Seen in Clinical Leaders

While the previous section has focused on the attributes less likely to be recognised in clinical leaders (control, vision and creativity), this section addresses the attributes that the six research studies, and others, have identified as being directly linked to clinical leaders.

Cook attempted to identify the attributes of effective clinical leaders by focusing not on nurses at the 'hierarchical apex of the organisation . . . but on those nurses that directly deliver nursing care' (2001a, p. 33). His study focused on nurses who were not deemed to be in conventional nursing leadership positions but who displayed many of the attributes of highly effective leaders. Following his data analysis, he produced a table that set out the clinical leaders' attributes – described as 'typologies' – with associated constraining and facilitating factors related to each attribute.

Cook (2001a) recognised clinical leaders or 'discoverers', who had a desire to improve the care they provided, and 'valuers', who valued both themselves and those around them and were able to empathise with their colleagues and patients. 'Enablers' encouraged others to see what needed to be done and assisted them to do it; 'shapers' possessed the 'creativity' to generate new ways of working and were able to help others make decisions; and 'modifiers' supported and helped others with the process of change. Cook indicates that his 'research identified aspects of leadership that are unique to clinical nursing' (2001a, p. 36), but suggested that further research was required to identify these with confidence.

Many clinical leadership attributes were identified in the six research studies (Table 1.4), although 10 were most prominent. Many are also interrelated and interdependent, so it would be unusual if a clinical leader who was considered clinically competent and clinically knowledgeable was not also seen as a role model in their clinical area. However, each of these attributes has been singled out and will be explored separately as a way of establishing a complete map of a clinical leader's attributes.

Clinical Competence/Clinical Knowledge

One of the key elements of clinical leadership relates to the clinical leader's ability to remain credible and competent in the provision of clinical care. High numbers of participants in all six studies, as well as information from Jonas et al. (2017), Mannix et al. (2013), McDonnell et al. (2015), Won (2015), Bender (2016), Stanley and Stanley (2017), and Coventry and Russell (2021) supported this perspective. Clinical leadership appears to be firmly embedded in the domain of clinical activity. Clinical competence was clearly linked to clinical experience and the confidence that others saw in the clinical leader's ability. It meant being able to show or to do – as well as to know or to teach others about – clinical

Table 1.4 Attributes most likely to be associated with clinical leadership.

	Study 1	Study 2	Study 3	Study 4	Study 5	Study 6
Attributes	**Nurses**	**Paramedics**	**Residential care staff**	**Volunteer ambulance officers**	**Allied health professionals**	**Nurses in rural and remote areas**
Clinical competence	95.2%	96.2%	100%	90.1%	83.7%	98.2%
Approachable	97.3%	96.2%	100%	90.1%	83.1%	83.9%
Empowered, motivated/ motivator	94.1%	86.5%	80%	77.0%	72.6%	64.2%
Supportive	94.1%	91.3%	100%	77.0%	75.2%	64.2%
Inspires confidence	93.0%	85.6%	40%	85.2%	52.1%	53.5%
Has integrity/is honest	87.2%	93.3%	100%	78.6%	83.1%	53.5%
Role model for others	Not covered in this study	93.3%	80%	88.5%	79.8%	78.5%
An effective communicator	Not covered in this study	89.4%	100%	86.8%	88.3%	82.1%
Visible in practice	85.6%	85.6%	100%	65.6%	55.0%	78.5%
Copes well with change	90.9%	79.8%	100%	73.7%	76.9%	33.9%

issues. Interestingly, being an 'expert' in their clinical field was not specifically mentioned, although this was a central feature of the characteristics identified by Cook (2001a) and by Berwick (1994), Stanton et al. (2010), and Schneider (1999) in relation to clinical leadership from a medical, pharmacological and nursing perspective, respectively.

Clinical leaders were identified as clinically competent – that is, as credible in their clinical field and working in a 'hands-on' capacity (Stanley 2006a, b, 2008, 2011, 2014; Stanley et al. 2012, 2014, 2015; Stanley and Stanley 2019) – and were therefore recognisable because they possessed a set of knowledge that was specific to their clinical field. In the sixth clinical leadership study with rural and remote area nurses. the main attribute sought from effective clinical leaders was that of 'good clinical skills' (Stanley and Stanley 2019). While this knowledge base may extend into a broad range of topics or areas, clinical leaders were often identified because they knew, and could do well, the 'stuff' central to their clinical area and practice.

One nurse said, 'You've got to be knowledgeable, but you've also got to have knowledge that's applicable to the area that you work in.' Others said that 'being good clinically' was important, and another added that clinical leaders needed to be 'knowledgeable in their area of practice.' Effective clinical leadership rested on sound clinical knowledge that

extended into having knowledge not just about clinical issues, but knowing how teams worked, how individuals worked and about relationships between people. One study respondent said that it was about being 'aware of people's limitations . . . aware of who works well together, who needs a lot of support and who doesn't. Who needs time effectively on their own and who doesn't and who needs continual prompting and back up.'

Approachability

Approachability was rated very highly as a clinical leader attribute, a view also supported by Coventry and Russell (2021) in their exploration of clinical leadership with clinical nurse educators. This was exemplified by an allied health professional who described a clinical leader as one who is 'supportive, fair, reasonable, willing to change, understanding and approachable'. In the study with rural and remote area nurses, clinical leaders were sought who were 'approachable, valued respect for others, were trustworthy, calm, caring and compassionate', all attributes described or identified in the previous studies (Stanley and Stanley 2019). Ineffective clinical leaders were described as being 'basically dictators', while effective clinical leaders had a more relaxed approach and saw staff as 'equal in their own right'. Poor clinical leaders were described as being 'bossy, they try to control things, they make changes without talking to people and they don't listen', while many respondents reacted well when a clinical leader 'valued' them, or made 'staff feel they were there for them', or when clinical leaders were 'approachable, friendly and understanding'. These views were supported by Cook (2001a), Clark (2008), Edmondstone (2009), Mannix et al. (2013), Won (2015), and Bender (2016).

Empowered/Motivator or Motivated

Clinical leaders and front-line professionals were identified because they were confident, a view supported by Van Dyk et al. (2016), or because of their enthusiasm and their ability to make others feel confident. Clinical leaders were motivated and able to motivate others because they showed

> belief in what you're doing . . . because I know people who are higher, you know a higher level than me are not necessarily good leaders . . . they're not . . . they don't necessarily have any belief in what they're doing.

Clinical leadership was seen to be about empowering people to perform better, deal with quality care (Jonas et al. 2017) and sow the seeds to let others take the lead. One participant in the rural and remote area study said a clinical leader is 'approachable, very organized, know the ward, inside out have very good clinical skills and they are good enough to stand up to management and tell them no' (Stanley and Stanley 2018).

Supportive

Being supportive was linked to being approachable, with a high number of respondents suggesting that effective clinical leaders needed to support others in their team. This view

was again evident in the results of Coventry and Russell (2021) study and was also identified as important by Mannix et al. (2013) and Bender (2016), who saw support as a central role of building and sustaining effective teams. In the study with rural and remote area nurses, one said,

> It's about the way they treat the patients and family members, the way they stay positive with all staff, they are fair with all staff, congratulating the team for a job well done, providing positive feedback (Stanley and Stanley 2018).

Inspires Confidence

Linked to being motivational, inspiring confidence was suggested by a large number of respondents as central to the attributes of clinical leaders. This view was significant in areas of rural and remote practice where staff were more isolated and needed to be more self-reliant (Stanley and Stanley 2019). In support of this view, an allied health professional suggested that a clinical leader is one whom 'others view as the best example of excellent performance and that motivates others to grow and succeed' (Stanley et al. 2015). Coventry and Russell (2021) suggested that inspiring confidence was linked to role modelling and implementing change.

Integrity/Honesty

Being honest and having integrity are linked to attributes of approachability and being supportive. Being seen as honest was consistently rated highly as a clinical leader attribute (Coventry and Russell 2021). Edmondstone (2009) added that clinical leaders needed to enjoy the trust and respect of their colleagues to be successful. One allied health professional described an ideal clinical leader by saying 'they should not be a bully and have clear understanding of people's roles and responsibilities', they should have 'integrity, be honest and be transparent' (Stanley et al. 2015). Rural and remote area nurses also looked for clinical leaders who were 'open and honest' (Stanley and Stanley 2019).

Role Model

In addition to clinical competence and clinical knowledge, clinical leaders were also identifiable because – unlike managers and, to a lesser extent, leaders – in general – respondents viewed them as role models (Watson 2008; Coventry and Russell 2021). Clinical leaders had their standards of practice on show and others indicated that it was the ability of a health professional to care effectively for their patients or clients that made them stand out as a clinical leader. One respondent indicated that being a good clinical leader meant 'being a good role model, making sure that your practice is evidence-based, that you pick up on poor standards of care and you pick up on problems and identify them'. Another added, 'a good manager may not lead by example, whereas a good clinical leader would'. Clinical leaders were seen as 'someone you would look up to', 'people that have been inspirational or people you've thought, "oh that's what I really want to be like"'. These views were supported by Cook (2001a), Watson (2008), Mannix et al. (2013), Bender (2016), and Coventry and Russell (2021).

Effective Communicator

High numbers of study respondents and information from Cook (2001a), Clark (2008), Edmondstone (2009), Jonas et al. (2017), Mannix et al. (2013), and Bender (2016) indicate that a central attribute of clinical leadership is effective communication. This meant that clinical leaders needed to be 'extremely good at explaining things at the right level that you understand', as one study respondent said. Clinical leaders were also respected if they listened and effective communication was fundamental if clinical leaders – who were not managers or titled leaders – were to influence their colleagues. One respondent indicated that 'the ward manager has got the title and therefore they manage and are seen to be leaders because of the title, but there are other people that lead by virtue of their opinion'.

Visible in Practice

Although this was less evident than some of the other attributes, in order to be approachable, supportive and an effective role model, clinical leaders needed to be visible, available and present. The maxim, **'you can't be what you can't see'** applies here. One respondent indicated:

> If you want information, or if you want the best way to do something on the ward at that moment you're not going to get, or you don't have time to go looking for matron or phoning the nurse consultant, who's maybe in the middle of a clinic and can't come up until . . .
>
> *Because they're not around?*
>
> . . . because they're not around. I want somebody right there on the ward.
>
> *So, is being a clinical leader about being visible and present?*
>
> I think it does help to have leadership on the ward, that is visible . . . I think you need clinical leaders on the ward where they can be utilised and their knowledge shared and lead from the front.

Another respondent supported this view: 'to lead it is very, very difficult, very time-consuming and exhausting and I think you have to . . . give of yourself, and that's why you have to be visible'. Clark (2008) agrees and adds that visibility means that clinical leaders were present in the clinical area: not just that they were there, but that they were engaged and involved. When another respondent said of a colleague that she was 'an ideal clinical leader' because 'she is very visible', it captured all the characteristics and attributes discussed here. Visibility implied clinical competence, clinical knowledge, effective communication, support, empowerment and motivation, being open and approachable and acting as a role model. Not being visible, or being unable to be involved in patient/client care activity, was seen by some respondents to place the person in a difficult position, or one that weakened their clinical leadership potential or clinical credibility.

Copes Well with Change

Finally, clinical leaders were also identified as being able to cope well with change, a view supported by Mannix et al. (2013) and also evident in Coventry and Russell's (2021) study, with clinical nurse educators being seen as change agents who were the go-to people if something needed to be changed or implemented (Coventry and Russell 2021). Dealing well with change is recognised as a key attribute in the modern health service and is one that is valued in clinical leaders.

Other Attributes

Over the years I have shared my views on clinical nurse leadership attributes and found considerable support for the characteristics I offered. However, I have always been keen to explore further attributes. After many discussions to solicit further views and based on my own and others' research, the following attributes are also worthy of consideration:

- courage
- ability to make decisions
- ability to offer direction
- sense of humour
- persistence and determination
- dynamism/energy
- calm under pressure
- positivity
- empathy
- compassion (critical for the application of compassionate leadership) (West 2021)
- change facilitation
- passion

These additional characteristics enhance an understanding of clinical leadership and can be seen to add a further perspective to the characteristics and attributes required to grasp what makes an effective clinical leader.

Values: The Glue that Binds

Values can be described as deeply held views that act as guiding principles for individuals and organisations (Pendleton and King 2002; Clark 2008; Gentile 2010). When they are stated and made explicit – or even if they are inferred from observable behaviour, then followed – they form the basis of trust in any relationship; and if values are stated or shown and not followed, then trust can be harmed. Values also relate to where individuals or organisations stand on a range of issues and point towards actions or statements that reflect what is important to that person or organisation. In the study with rural and remote area nurses one participant said,

> my view is that it's about people putting their values and beliefs into action. . . if my mother gets sick that's the nurse I want to have look after my mother, because she puts into practice what I think is the important values of nursing. That's what I think clinical leadership is all about (P50) (Stanley and Stanley 2019).

Antrobus and Kitson (1999, p. 750) identified 'understanding self and having a clear understanding of values, purpose and personal meaning' as part of the skills repertoire that they identified for effective nurse leaders. Cook (2001a) also saw clinical nurse leaders as 'valuers' who empathised with others and who tried to gauge their own and others' feelings. However, in the data from the research for this book, clinical leaders described themselves as being driven by their values and 'passion' for high-quality patient care. Coventry and Russell (2021) found in their study with clinical nurse educators that clinical leaders were seen as sharing their values, encouraging a positive culture and being guided by concern and compassion most of the time. Ultimately, holding and demonstrating values and beliefs emerged as a strong attribute of clinically focused leaders, with clinical leaders being identified if they were seen to demonstrate their values or had their values on show. Therefore, they were followed not because they had control, or for their vision and creativity (although they may have had these attributes), but because their values and beliefs were the driving force behind their ability to engage in critical problems and face the challenges of clinical care.

Being creative and having a vision remain central to the successful application of transformational leadership (Frankel 2008; Marriner-Tomey 2009), although they appeared not to be features for which clinical leaders are recognised (Stanley 2006a, b, 2008, 2011, 2014; Stanley et al. 2012; Scully 2014; Stanley et al. 2014; McLellan 2015; Stanley et al. 2015; Coventry and Russell 2021). There is a view that values are inextricable from vision, although Pendleton and King (2002) declare that it may be even more important to know where you stand (a values-centred position) rather than where you are going (pertaining to vision). This implies that values are rooted in understanding an individual's and organisation's principles, while vision is about being able to drive through or respond to changes in the future.

Clinical leaders are identifiable because of where they stand and how they behave when dealing with patients and colleagues. When facing challenges in the clinical arena, they are recognisable because they display their principles about the quality of care and they deal

with patients in a 'hands-on' fashion, living out their values in the actions of clinical care. They stand apart from novice clinicians, poor decision makers, staff who are 'hidebound', managers who are tied up with other functions and those who are less visible in the clinical environment. They may be experts in their clinical field, but they are recognised not necessarily because of their expert practice, but because when faced with challenges and critical problems their actions are directed, and their leadership is defined by the values and beliefs that they hold about care, healthcare and respect for others.

Who Are the Clinical Leaders?

In the past, leadership studies were very much focused on leadership at the high end of the organisational hierarchy, shining a light on the academic, political and management domains (Antrobus and Kitson 1999). The proliferation of these studies and literature has to some extent overshadowed leadership by others, at other levels of the health service, although this trend has slowed and been redressed in recent years. Indeed, as a nurse practitioner in the late 1990s, it was the lack of appropriate literature or studies about clinical-level leadership that spurred me on to my own research journey in the topic of clinical leadership. It is now clear that leadership is everyone's business (Ogawa and Bossert 1995; Cook 2001a; Higgins et al. 2014; Jonas et al. 2017;). Because clinical-level leaders are central to the provision of healthcare, they have found themselves more and more the focus of leadership studies and the recipients of leadership education. Burns (2001) supports these views and believes that in a chaotic healthcare environment, front-line leaders are not only required at all levels, they may understand the environment's complexities even more than executive leaders removed from direct operations.

The success and appeal of television programmes like *Undercover Boss* support this view, and demonstrate the value of understanding the workplace from a front-line staff perspective, what Mintzberg (1983) calls the 'operating core' of a healthcare organisation. However, clinical leadership has historically been less valued than senior management and, as such, health service management has dominated the leadership debate in health to the detriment of clinical, bedside or front-line leadership. Clark (2008, p. 30) suggests that organisations should be tapping into 'the leadership skills and potential of all front line staff to deliver high-quality, safe and effective care to patients and service users'.

Indeed, when I began my clinical leadership research journey as a student at Nottingham University, doctors and nurse consultants were identified as the clinical leaders. Allied health professionals were not even considered in the mix, and to a large extent leadership training or education was the domain of those in identified hierarchical management positions. Coventry and Russell (2021) sought to explore if clinical nurse educators were seen as clinical leaders. They found that they were, and indeed had much in common with the attributes and characteristics identified in the clinical leader studies that underpin this text.

The six studies that support this book confirmed that clinical leaders exist in vast quantities and at all levels within all clinical areas. The 188 questionnaire respondents in the initial study nominated 326 people as clinical leaders, and in the 4 clinical areas of the focused interviews, the 42 nurses interviewed nominated 130 people as clinical leaders, most of whom (although not all) were middle-level nurses or lower. Clark (2008, p. 30) also suggested that

'some nurses may not think of themselves as leaders because they equate leadership with authority or with specific job titles rather than as a way of thinking or behaving'. Coventry and Russell (2021) found that in spite of the informal nature of the clinical nurse educators' role, clinical nurse educators encouraged, promoted, supported and engaged in advancing the nursing profession and promoting excellence in nursing care. As the study results show, health professionals see clearly that their clinical colleagues are leaders – and rightly so.

The initial study and the four that followed demonstrated that clinical leaders were to be seen at all levels, with nominations offered for doctors, other health professionals, area managers, directors of nursing, clinical nurses, registered nurses and even healthcare assistants; although again, mid-level health professionals who were focused on clinical activities received the most recognition as clinical leaders. No direction was given on the questionnaires about whom to nominate and only 8.8% of all nominations in the initial study were for medical staff – a figure that might stun Stanton et al. (2010) or Swanwick and McKimm (2017), or others who write about the pivotal place of medical professionals as clinical leaders.

Medical professionals may be clinical leaders, but it is equally the case that any health professional, at any level, who has the attributes identified in this chapter and who is followed because they have their values and beliefs on show and match these to their actions, may be seen as a clinical leader.

From a nursing perspective, the mid-level registered nurse was the candidate most likely to be viewed as a clinical leader by their colleagues, both senior and junior. The results (Stanley 2006a, b) also showed that differences exist between specialist units and general wards; in the latter, lower-level registered nurses followed mid-level registered nurses in being commonly nominated as clinical leaders. In specialist clinical units, as well as mid-level registered nurses, more senior registered nurses or clinically based specialist nurses were common candidates for selection. Moreover, significantly fewer clinical leaders were identified in non-specialist clinical areas. It was worryingly noted that clinical areas that commonly took new graduates and neophyte practitioners into their first experiences of healthcare had fewer clinical leaders in place to support them. However, the attributes that identified clinical leaders were the same, regardless of the clinical area in which they worked.

There was little support for managers to be seen as clinical leaders. If a manager had an element of 'control' built into their role, or if they had minimal clinical engagement, they were seldom identified as a clinical leader. This view was supported in the results of Coventry and Russell's (2021) study with clinical nurse educators.

This is not a new point, and publications for some time have drawn attention to the tension between clinical leadership responsibilities and management functions (Rafferty 1993; Christian and Norman 1998; Antrobus and Kitson 1999; Stanley 2000; Firth 2002; McCormack and Garbett 2003; Thyer 2003; Stanley 2006c). The main focus of the conflict was between the clinician's desire to remain clinically focused and the need to be able to maintain the management and resource capabilities of their clinical area. For many allied health professionals, this was a common feature of their clinical leadership/management dichotomy. A research transcription extract demonstrates this point:

> The main one I think is really the issue from the [organisation's] point of view . . . the [organisations] want to implement schemes or whatever which I don't feel are in the best interests of the patients or staff . . . for example the [organisations] are trying to

> have [middle-level nurses] carry a hospital bleep, now I disagree with that because I feel my role should be ward-based, clinically based and I don't want to see my role as managing the hospital.

This highlights the observation that clinical leaders are selected because they have their values on show. As such, when health professionals are promoted away from the clinical area or lose direct client contact, many face a crisis of conscience as they struggle to remain rooted to their core professional values while being directed and drawn into areas of management and administration that are often either removed from or in conflict with their values and beliefs about patient/client care (Stanley 2006c). Even if this is not the case and a crisis of conscience is avoided, others may recognise the 'controlling' elements in their role, and this may diminish their identification or effectiveness as a clinical leader.

Clinical leaders, therefore, are not identified because of their position, job title, role in the health service or badge. They can be in any clinical area and involved in any aspect of patient care or clinical service. They are rarely found in offices, removed from clinical contact or interaction with clients or patients, and they are generally experienced health professionals focused on their desire or 'passion' for developing a high standard of care and best-quality service.

Clinical leaders are recognised for having their values and beliefs sit behind their actions and interventions. They are not recognised for their vision or creativity (although some are creative and visionary). They are found across the spectrum of health organisations, often at the highest level for clinical interaction, but not commonly at the highest management level in a ward or unit team, and they are seen in all clinical environments.

Clinical Leader Stories: 1 Leading by Example

While I was a second-year physio student, I was fortunate enough to work alongside someone who I believe was the epitome of clinical leadership in healthcare. When I reflect on the type of physio I want to be I always think about my interactions with this instructor. This physio clinical supervisor was professional, approachable and open. She was an effective communicator and clinically competent. I observed many physios gravitating to her on the ward as she was so knowledgeable and always happy to help. She empowered other physios to engage professionally with other members of the healthcare team and actively sought out students to practice or observe clinical skills and practices that were uncommon on the ward. I really appreciated this encouragement, as I was new to the ward environment and lacked the confidence to really engage with senior staff members or seek out learning opportunities on my own. I feel this was an extremely positive experience for me as it has increased my awareness of the difference you can make to a student's transition to practice by empowering them and encouraging them to speak up. I feel she offered a good example of Congruent Leadership and Transformational Leadership. The physio clinical supervisor's values were evident in their practice and the clinical leadership displayed by her has inspired me to want to lead others by setting a positive example myself. I know that in the future I'll be a positive role model by putting what I learnt into action and leading by the example that was shown to me. ***Lisa: Physiotherapy Student.***

Reflection Point

Do you need to have a title or hierarchical role to be an effective clinical leader? Why might this matter? Discuss this with a senior colleague. What are their views on this question?

Clinical Leadership Defined

The definition offered in this book is that:

> **clinical leaders are clinical experts in their field and are followed because they match their actions with their values and beliefs about quality patient care.**

In addition, it is suggested that the attributes of effective clinical leaders are those of clinical competence, clinical knowledge and effective communication, and that they are empowered motivators, role models, visible in practice, supportive, have integrity, are inspirational, cope well with change and are open and approachable.

It is suggested that clinical leaders can be found in all areas of care and that they are seldom managers or even the most senior health professional. Instead, clinical leaders are identified in large numbers and represent the clinician who is visible in practice with their values and beliefs about care on display (Coventry and Russell 2021).

Reflection Point

When in your career have you undertaken leadership training? Was it at an undergraduate or postgraduate level? Or has your employer, recognising the value of having clinical-level leaders who understand the value of leadership instruction, sent you on or supported you to undertake further training? Speak with your clinical colleagues. What leadership instruction have they received?

Why Clinical Leadership Now?

Why should we consider clinical leadership at this time and in this context? When I was a student nurse in the 1980s, no one mentioned 'leadership', let alone 'clinical leadership'. Indeed, I recall a strong element of subservience running as an undercurrent through the profile of our nursing curriculum and within our training, suggesting that doctors were nurses' leaders and their betters, and that we did not need to make decisions or think too much. I can recall, too, the beginnings of a quiet rebellion as nurses abandoned their nurses' cap and moved to competency-based assessment, university-based education, new roles, new dress codes and new titles. Yet the subservience was evident, nonetheless.

So why has clinical leadership become an issue for current and future health professional students and practitioners?

A New Agenda

Leadership development is being seen as central to the development and modification of the health agenda (Stanton et al. 2010; Mannix et al. 2013; Phillips and Byrne 2013; Rose 2015; Townsend et al. 2015; West et al. 2015; Bender 2016; Swanwick and McKimm 2017; West 2021). The UK Department of Health said as long ago as 1999 that it required staff who can establish direction and purpose, inspire, motivate and empower teams around common goals, in order to help produce improvements in quality, clinical practice and service (DoH 1999), and nothing has changed to modify this requirement. Similar calls to action are evident in other parts of the world where leadership development is seen as central to the development of the healthcare agenda. Leadership is needed at all levels (DoH WA 2004) and it is suggested that clinical leadership needs to be increased, that clinical networks for change need to be initiated and that growing change management and leadership skills are essential for all health professionals (DoH WA 2004; Martin and Learmouth 2012; Storey and Holti 2013b; Scully 2014; Byers 2015; McLellan 2015; Rose 2015; West et al. 2015; West 2021).

Changing Care Contexts

It is recognised that the context of healthcare is changing. Care provision is no longer (and has really never been) solely in the domain of the acute hospital. Therefore, as new healthcare environments are developed, new ways of working with new roles and staff mean that new approaches to care and greater innovation are required. The development of nurse practitioners, for example, and wider skill sets for allied health professionals and paramedics offer examples of how the healthcare environment is developing. Patients can now be treated and cared for in a range of clinical areas (and indeed, remotely via telehealth) and environments by experienced and skilled health professionals, who can deliver and prescribe care and implement clinical decisions based on their critical thinking.

Change Equates to More Leadership

There is also a recognition that the health service needs more staff with greater leadership (as opposed to management) skills and insights (Stanton et al. 2010; Byers 2015; McLellan 2015; Swanwick and McKimm 2017). This is partly in response to the realisation that the more change there is, the greater is the need for leaders (Kotter 1990). It is also an acknowledgement that until quite recently there has been under-investment in leadership training and leadership development and even a lack of discussion about clinical leadership within healthcare (Rafferty 1993; Hurst 1997; Lett 2002; Stanley 2008; Martin and Learmouth 2012; Storey and Holti 2013a; Scully 2014; Byers 2015; McLellan 2015; Rose 2015; West et al. 2015; West 2021). I would suggest that the core reason for a surge in leadership, and clinical leadership in particular, is the realisation that change, innovation, the development of quality care and the links between values and care, compassion and quality are all based on effective leadership (West 2021). While management is essential,

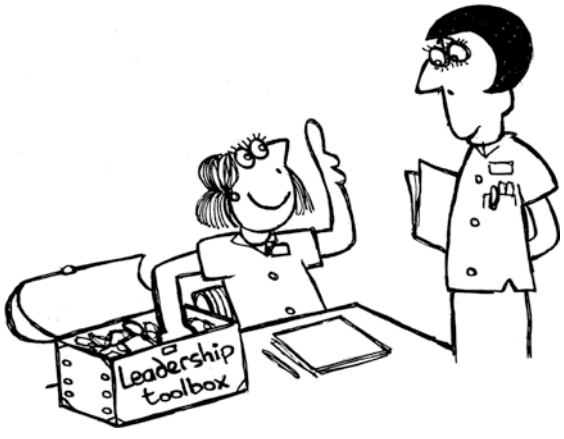
the development of grassroots, front-line leaders opens up genuine opportunities for a positive impact on innovation, creativity and change (James et al. 2020).

More Emphasis on Quality

As Francis (2013) shows, there is a pressing need to do better, often with limited resources (Storey and Holti 2013a; Scully 2014; McLellan 2015; Byers 2015; Rose 2015; West et al. 2015; West 2021). The drive to improve quality and support the integration of quality improvement sits at the heart of a need to generate more effective clinical leadership. In the UK, initiatives such as the 'Payment by Results' scheme mean that care providers are rewarded for the volume of work they do and are assessed against an ever-stricter quality reporting mechanism (Stanton et al. 2010). An emphasis on quality supported by the adoption of clinical governance strategies also places more pressure on clinicians to continuously improve the quality of care.

Clinicians are best placed to address quality initiatives, change and innovation in clinical practice. Linking all of these is the realisation that if care is to improve and develop, then change and innovation in practice are required. It is often the clinician, working with clients, other colleagues, relatives and patients, who is best placed to identify inefficiencies, bottlenecks and problems, and who can identify the most appropriate solutions for these issues. Clinicians are indeed the 'operational core' of the health service (Mintzberg 1983).

Therefore, if the health service is to grow, support innovation and initiate change, it needs leaders with skills and talents to take their ideas and projects forward. As well, if the health service is to retain a focus on the core values that underpin the provision of quality health care then an exploration of values-based leadership approaches is vital (James et al. 2020; West 2021). In the clinical arena, it is clinical leaders who are in an ideal position to fulfil this role and who are ideally situated to support other clinicians to develop the health service. Clinical leaders, however, need the skills, attributes, tools and techniques to initiate and manage change effectively and the personal will and abilities to recognise themselves as 'change agents' and as a force for positive growth in the health service.



Case Study 1.1 Vivian Bullwinkel

Vivian Bullwinkel is rightly regarded as a clinical leader. Read about her and consider how holding on to her values during her struggle in difficult conditions was central to her survival and shaped her ensuring career as a health professional leader.

Vivian was born in 1915 and began her education in Broken Hill, New South Wales before training as a nurse and midwife in 1934. At the outbreak of World War II she travelled to Melbourne with a view to join the war effort. Enlisting took time, and while she waited for an opportunity to contribute she worked as a nurse at the Jessie MacPherson Hospital in Melbourne.

In May 1941, Vivian volunteered for the Australian Army Nursing Service (AANS) and was posted to Singapore, the bastion of the British Empire in the Far East. She served at the 2/13th Australian General Hospital, and with other Australian nurses she cared for wounded Allied soldiers, often under difficult conditions as the war reached closer. By early February 1942, the Japanese army was on the brink of taking Singapore. Vivian boarded the SS *Vyner Brooke* with 65 other nurses fleeing the Japanese advance, but the ship was struck by Japanese aircraft a few days later and sank. A large number of passengers, including Vivian and many of the nurses, made it to shore on the island of Banka (now part of Indonesia). The nurses surrendered to the occupying Japanese army; however, the following day they were ordered to walk out to sea, where they were machine gunned. Vivian was shot and injured, but survived by feigning death until the Japanese had moved off. Twenty-one nurses were murdered.

Following the massacre, Vivian dragged herself back to the beach, the sole survivor of the atrocity. In the jungle just off the shore she discovered a wounded British soldier and for several weeks they both hid in the jungle, scavenging food and managing their wounds as best they could. However, their deteriorating condition forced them to surrender. The British soldier died shortly afterwards. Vivian and other Australian nurses spent a further three and a half years in captivity, being starved, tortured, refused medical care or treatment, and moved from one jungle camp to another. Death was a constant threat, but Vivian's determination to survive and willingness to offer others compassion and companionship saw her survive to be released at the war's end.

Following World War II, 'Sister Bullwinkel' served with the Australian army in Japan in 1946 and 1947 before resigning from the military at the rank of captain. In 1955 she joined the Citizen Military Forces and served until 1970, reaching the rank of lieutenant colonel. In addition, she spent 16 years as matron and 7 years as Director of Nursing at Melbourne's Fairfield Hospital. She retired in 1977, married Colonel F.W. Statham and moved to Perth, Western Australia, where she died in 2000.

Vivian was awarded the Royal Red Cross Medal in 1947 for services to the veteran and ex-prisoner of war communities, to nursing, to the Red Cross Society and to the wider community. She was appointed a Member of the Order of the British Empire (MBE) in 1973, was awarded the Order of Australia (AO) in 1993, and was also a recipient of the Florence Nightingale Medal.

In 1993 she returned to Banka Island to unveil a shrine to the nurses who were murdered there. She survived multiple difficulties and challenges during her years of

(Continued)

captivity, and if persistence and determination are invincible, Vivian Bullwinkel is surely the personification of this tenet.

Challenge: Can you recognise any of the attributes of a clinical leader in Vivian's story? How might these attributes have contributed to her survival as a Japanese prisoner and her ongoing career success?

Summary

- Change and quality in the health service are not all about processes and structure; they are also about courageous people who are prepared to act.
- The main attributes of clinical leaders are approachability; empowerment and motivation; being visible in practice; clinically competent and clinically knowledgeable; having values and beliefs on show; having effective communication skills; coping well with change; having integrity; and is supportive, inspires confidence and is a positive clinical role model.
- Clinical leaders are not identified because of their position, job title, role in the health service or badge.
- Clinical leaders can be found in any clinical area and are involved in any aspect of patient care or clinical service.
- Clinical leaders are generally experienced, clinically focused health professionals driven by their desire or 'passion' for developing a high standard of care/service.
- Clinical leaders are the people at the 'coal face' (operating core) and are in the best position to identify change initiatives and to drive change or quality in clinical practice.
- Six research projects that explored who clinical leaders are, why clinical leaders are seen as such and what the experiences of clinical leaders are sit at the heart of this book and the theory presented here.
- Clinical leadership and the clinical leader's time has come. There is a new agenda in the health service focusing on innovation, change, a drive for quality and leaders who use values-based leadership approaches. Care practices and the context of care provision are changing. There is a recognition that greater change needs stronger leadership and that leaders can come from any stratum of the health industry. Indeed, effective change, quality improvements and innovation may be more successful if they are initiated and developed by clinicians who are empowered to lead and apply their values about compassion, care, competence, communication, and other values held within healthcare.

Mind Press-Ups

Exercise 1.1

If you can, approach a person who you feel is a clinical leader. Explain to them that you see them as a clinical leader and ask them how they feel. Were they shocked, surprised, delighted? How did they respond to your announcement?

Exercise 1.2

What are your experiences of leadership development from your undergraduate or formative healthcare education? Do you feel well prepared and instructed in leadership theories and techniques? Ask some colleagues how they learnt about leadership and what they understand leadership to be.

Exercise 1.3

Draw a 'mind map' with the word 'leadership' in the centre. You could start the map here and build or add to it as you progress through the book or over the trajectory of your studies.

Exercise 1.4

Who are your leaders? Who might you direct an alien or stranger to if they asked you to take them to your leader? Would these be the same people if you were asked to take them to your 'clinical leader'?

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