Reflective Leadership: Integrating Quality and Safety Competencies to Fulfill Joy and Meaning in Work

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Nothing to disclose

Purpose and objectives:

To examine leadership strategies for integrating new safety and quality competencies in all of nursing: academia and clinical

To analyze the impact of quality safe nursing practice on the work environment for experiencing joy and meaning in work.
<table>
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<th>Challenges in Work Environment</th>
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<td>Personal values match organization values</td>
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<td>Ideal practice vs. constant process breakdowns with poor outcomes</td>
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<td>Good work vs challenges in the work environment.</td>
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<td>Derived from reflective, appreciative, and effective leadership</td>
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Interprofessional Teams

Roles & Responsibilities
(IOM Core Competencies, 2003; QSEN, 2007)

Safety

Evidence Based Practice
Teamwork
Informatics
Quality Improvement
Communication
Patient Centered Care
Values & Ethics
(IPEC, 2011)
Leadership to improve safety

- initiate improvements to the system,
- speak up about process breakdowns,
- communicate across disciplines,
- empower nurses to lead change
Reflective Leadership Transforms

- Influences intersection of self, others and systems
- Operates within Context of all that is going on
- Leads from sense of mission with mindful presence
- Context influences responses
Reflective Practice: Mindful Learning

Engaging in the moment through mindfulness

Learning from stories

Cycles of interpretation to consider assumptions, values and beliefs to clarify contradictions and make sense of practice

Analyze what happened in relation to self, others and the situated context
Reflective Practice: Transforming

**Reflection before action:** briefing to consider choices based on knowledge and previous experiences

**Reflection in action:** pause, huddle to clarify choices, context, uncertainty

**Reflection on action:** debrief what happened to apply lessons learned in future situations.
Julia has 5 years experience in the ED of a large teaching hospital since graduating with a BSN. She is eager to initiate changes in her work to integrate what she is learning from a staff development course on Teamwork to Improve Safety that incorporates the QSEN and IPEC competencies. While she is enthusiastic about changes to the unit, only a few other nurses have been attending the sessions so change has been slow and difficult. She is aware that several nurses brag about work-arounds to save time and most do not attend unit meetings when the Director discusses outcomes and ways to improve care in the unit.
Julia was on evening shift, short staffed due to the summer vacations so the waiting area was full even at 7 pm on Tuesday. Julia took report from Susan, a first year graduate. Susan reported on a 21 year old Hispanic female who had presented in the ED four hours earlier complaining of abdominal pain and accompanied by her mother. Susan had tried communicating with the patient using a few phrases from her college Spanish classes to assess the pain because no translator was available and the patient seemed to a lot of pain. It was storming, and the computer system was down due to a power outage. A hard copy chart was initiated with the name Maria Sepulveda.
The clerk had called the resident to see the patient. Susan was in another room so did not brief the resident before he saw the patient. The resident, fluent in Spanish, had grabbed the chart and began talking with the patient. Susan entered the room, the mother tried to interrupt but he ignored her and wrote an analgesic order on the chart; the order was sent to the pharmacy at shift change. After report, Julia checked the chart, noting she was not familiar with the analgesic and the protocol for a pregnancy test for women of childbearing age with abdominal pain. The resident had just rotated to the ED; there was friction between experienced nurses and the new residents about questioning orders.
Julia thought about how to question the resident about his order.
The pharmacist was now calling to question the dosage which is lower than usually ordered.
The patient had arrived in the ED at 3 pm, during the height of the storm. There had been a serious car crash that sent 4 patients to the ED about the same time. The crowded waiting area, the overworked triage nurse, and the short staff meant the patient, who spoke little English had waited for four hours to see the resident who had rushed in and out. Her mother who spoke no English had tried several times to seek help as her daughter’s pain worsened.
Julia recalled her class on teamwork and wants to clarify the resident’s order. As he approached the desk, she used SBAR to ask what analgesic dosage he intended to order for Maria Sepulveda, a 21 year old Hispanic female complaining of abdominal pain, possibly due to ectopic pregnancy. The pharmacist has called to check the dosage and they both want to discuss precautions for possible pregnancy. The resident looked surprised, stating the patient was not pregnant; she was 58 years old with abdominal trauma from a MVA. Both Julia and the resident re-checked the name on the chart. Maria Sepulveda had been mistaken for Marie Sepulvia, a 58 year old female patient with trauma from a MVA, whose chart was on the desk.
Reflective Prompts:

• What stands out to illustrate the QSEN and IPEC competencies?

• What are you concerned about? What else could it be?

• What assumptions are influencing decisions?

• What are examples of reflecting before action, in action, or after action that would improve care?

• How do nurses utilize unit standards of care, policies and other resources to assure delivery of right care?

• From Sherwood & Horton Deutsch, 2012
Reflective Leadership

Applies reflective thinking to make sense of practice

Values culture of safety within interprofessional practice

Inspires and empowers good work towards a healthy work environment.
References

- Annotated bibliography on www.qsen.org

