

Nursing Times

Leadership Skills for Nurses



SPECIAL SUPPLEMENT

INTRODUCTION

A dynamic profession needs confident leaders at all levels

As nursing gains increasing influence in all aspects of healthcare provision, it is vital that practitioners develop leadership skills at an early stage in their careers

Leadership is a key skill for nurses at all levels. While this may be stating the obvious for those whose position gives them direct managerial responsibility, even the most recently qualified practitioners need the confidence and skills to be able to offer leadership to students and other colleagues such as healthcare assistants.

A range of policies and initiatives mean the nursing profession has a growing influence on all aspects of healthcare delivery. Practitioners need to be able to exert this influence clearly and confidently. Already the introduction of nursing metrics is bringing nursing care firmly into the boardroom.

Well collated and presented metrics make it impossible for trust directors to ignore the contribution that good nursing care makes to both patient outcomes and cost-efficiency. In the coming economic squeeze on healthcare, metrics will be crucial in defending nursing jobs. However, nurse directors and senior nurse managers will need the ability to stand their ground in the face of competing interests.

The Prime Minister's Commission is likely to extend the profession's influence over healthcare in the UK. It has called for nurses to take "centre stage" in health leadership and policy making, while retaining traditional caring skills "rooted in compassion".

While leadership skills can develop organically, if they are to be applied effectively they need to be focused. It is impractical to expect the NHS to fund leadership training for all its nurses, but the skills can be refined through personal reflection and following the advice of experienced leaders. This supplement brings together a range of recent articles published in *Nursing Times* to help nurses become confident leaders.

The selection of articles also demonstrates how the magazine has changed its emphasis over the past year, making it more policy focused and relevant to senior nurses. Articles in the extended and redeveloped Practice section of *Nursing Times* bring together essential information to help nurses to develop and extend their practice or progress in their career. They also explain the nursing implications of key healthcare policy and initiatives. We hope you enjoy this supplement and find it useful in developing your leadership skills or those of your colleagues.

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Editor, *Nursing Times*



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What leadership styles should senior nurses develop?

In order to be effective in their roles, senior nurses need to adopt a range of leadership characteristics and behaviours

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Frankel, A. What leadership styles should senior nurses develop? *Nursing Times*; 104: 35, 23-24.

Senior nurses are likely to engage in a range of leadership activities in their daily routine. Some will naturally adopt an effective leadership style, while others may find the concept of leadership or seeing themselves as leaders difficult to understand. Effective leadership is critical in delivering high-quality care, ensuring patient safety and facilitating positive staff development.

This article outlines the characteristics of an effective leader, the political context and various leadership activities for senior nurses. It also discusses mentorship, different leadership models and the process of professional socialisation.

INTRODUCTION

For the purposes of this article, senior nurses are defined as practitioners with additional post-qualification education, skills and experience who work in the nursing team as a day-to-day, hands-on, visible presence.

Leadership can be defined as a multifaceted process of identifying a goal or target, motivating other people to act, and providing support and motivation to achieve mutually negotiated goals (Porter-O'Grady, 2003). In the daily life of a senior nurse, this could refer to coordinating the day/night shift and the team of nurses and support staff on duty under the direction of that nurse. The successful operation of the shift, staff morale and managing difficult or challenging situations depends largely on the senior nurse's leadership skills.

It is important to appreciate that leadership roles are different from management functions. In Stephen Covey's (1999) book *The Seven Habits of Highly Effective People*, he quoted Peter Drucker as saying: 'Management is doing things right;

leadership is doing the right things. Management is efficiency in climbing the ladder of success; leadership is about determining whether the ladder is leaning against the right wall.' This suggests that management is about tasks, whereas leadership is about perception, judgement, skill and philosophy. We could infer from this that it is much more difficult to be an effective leader than an effective manager.

CHARACTERISTICS OF AN EFFECTIVE LEADER

Leaders are often described as being visionary, equipped with strategies, a plan and desire to direct their teams and services to a future goal (Mahoney, 2001). Effective leaders are required to use problem-solving processes, maintain group effectiveness and develop group identification. They should also be dynamic, passionate, have a motivational influence on other people, be solution-focused and seek to inspire others.

Senior nurses must apply these characteristics to their work in order to win the respect and trust of team members and lead the development of clinical practice. By demonstrating an effective leadership style, these nurses will be in a powerful position to influence the successful development of other staff, ensuring that professional standards are maintained and enabling the growth of competent practitioners. In a study by Bondas (2006), leaders who were described as driving forces were admired. They were regarded as a source for inspiration and role models for future nurse leaders.

Leadership for senior nurses is primarily about the following: making decisions; delegating appropriately; resolving conflict; and acting with integrity. The role also involves nurturing others and being aware of how people in the team are feeling by being emotionally in tune with staff.

The above functions are the core elements necessary to connect leadership with the effective development of other team members. This is largely achieved by working

alongside them in a mentoring and coaching role. A good and successful leader will seek to develop other staff through their leadership. Saarikoski and Leino-Kilpi (2002) found the one-to-one supervisory relationship was the most important element in clinical instruction. Research also suggests that mentorship facilitates learning opportunities, helping to supervise and assess staff in the practice setting. Terminology frequently used to describe a mentor includes: teacher; supporter; coach; facilitator; assessor; role model; and supervisor (Hughes, 2004; Chow and Suen, 2001).

In my organisation we often refer to the phrase 'don't just tell me - show me', to illustrate the need for instructions to be supported by clear leadership and supervision. It is recommended that staff are first shown how to perform a task and then supported to complete it. A culture based on continual learning through support and best-practice methods will empower and motivate staff. Dynamic clinical leaders and supportive clinical environments are essential in the development and achievement of best practice models.

Key factors described as effective in nurturing transformational clinical leaders are: provision and access to effective role models; mechanisms for mentoring and clinical supervision; provision of career pathways; intentional succession planning; organisations that value clinical competence; and promotion of centres of excellence (Borbasi and Gaston, 2002).

POLITICAL CONTEXT

Nurse leaders need to be able to respond to an ever-changing healthcare environment, including organisational expectations and changes to local and national policy. I do not know of any clinician or manager who would dispute that nursing roles are changing. These roles have become more specialist, autonomous, accountable and focused on outcome, with both positive and negative consequences for the profession. Consumers

and purchasers of healthcare services have greater expectations of higher standards, particularly in relation to nursing care.

Nurse leaders must demonstrate resilience in responding to change and supporting others to embrace this in a positive way. Effective leaders should be capable of reframing the thinking of those whom they are leading, enabling them to see that changes are not only imperative but achievable.

Senior nurses need to find ways of becoming involved in organisational decision-making on issues impacting on clinical care such as: developing policy; workforce planning; departmental business planning; and clinical and corporate governance. Sorensen et al (2008) advocate that senior nurses must develop constructive processes through which they become accepted as equal team members. They also need to design workplace systems that underpin good patient outcomes, evaluate nursing expertise and represent nursing interests in corporate decision-making forums.

LEADERSHIP ACTIVITIES OF SENIOR NURSES

Senior nurses should be able to develop other staff by enabling them to apply theory to practice and encouraging them to test new skills in a safe and supportive environment. This, again, is an example of where leadership activities combine with developmental ones to create competent practitioners through practice-based learning.

These nurses should adopt a supportive leadership style with mentorship, coaching and supervision as core values. Constable and Russell (1986) showed that high levels of support from supervisors reduced emotional exhaustion and buffered negative effects of the job environment. Consequently, it would be particularly beneficial for supervisors to provide emotional support to nurses and give them adequate feedback about performance to increase self-esteem (Bakker et al, 2000). Senior nurses should also apply leadership skills in encouraging staff to use critical reflection to facilitate new understanding.

In the ward environment, there can be tensions between professional disciplines. Resolving these and building effective relationships between multidisciplinary team members is a test of senior nurses' leadership abilities. With nurses becoming more autonomous decision-makers, this must inevitably lead to revising the relationship between professional roles.

Senior nurses also have a leadership role in facilitating their organisation's staff support

and development programme, which should aim to reduce stress, burnout, sickness and absenteeism among colleagues. Supervisors have a significant influence on employees' personal and professional outcomes. Bakker et al (2000) reported that senior nurses can buffer the effects of a demanding work environment on staff nurses by thoughtfully maintaining a leadership style that supports staff needs.

A successful leader will see each person as an individual, recognising their unique set of needs, as not everyone will perform at the same level or respond in the same way to environmental stressors or workplace pressure. Leaders need to support staff in ways in which individuals recognise as being useful.

In the same way, staff will be motivated by different factors. Leaders must focus on the needs of individual staff and use motivational strategies appropriate to each person and situation. They must seek to inspire demotivated staff and maintain the motivation of those who are already motivated. Leadership seeks to produce necessary changes in demotivated staff by developing a vision of the future and inspiring staff to attain this. Leadership is the driving force of the work environment and directly affects staff motivation and morale. West-Burnham (1997) argued that leaders should seek to improve on current practice, and use their influence to achieve this. This includes working within the team to develop goals and a feeling of shared ownership to achieve excellence in clinical practice.

MENTORSHIP

Different people are motivated in different ways, so leaders must use strategies that individuals find motivating to empower them and highlight the importance of the nursing role. One method of achieving this is through structured mentorship. I believe that mentorship should foster ongoing role development and be based on the acquisition and mastery of new skills.

Senior nurses should take time every shift (5–30 minutes) to be involved in some form of mentoring activity, which should then be recorded in staff members' 'learning log'. The learning log is a simple, task-specific recording method used as documented evidence that mentorship has been given on a particular area of work activity. The staff member participates in the completion of their log, which briefly records:

- The nature of the activity being coached;
- Strengths and weaknesses in performing the activity;

- Coaching intervention;
- Future goals.

It is important that staff members do not feel micromanaged. Learning logs must be viewed as a mentorship tool, rather than a management one. The log is merely used to remind and refresh the mentor and staff member about what has been achieved between the last formal clinical supervision session and the next. The learning log will be used for reflection purposes to form the basis of a more comprehensive supervision discussion.

Leaders, in their capacity as mentors, must ensure that more junior staff have the freedom to seek information, through an open exchange of opinions and ideas. Staff should also be given the opportunity to show initiative, thus promoting confidence in decision-making and underpinning knowledge and competence in their own skills. The goal of mentorship should be to create a stable and supportive environment which encourages professional growth through effective role modelling. Murray and Main (2005) argued that the notion of role modelling is seen as a traditional expectation of less experienced nurses learning from more experienced ones.

LEADERSHIP MODELS

There are a number of useful models to help to guide senior nurses in leading other staff. The two most common are transformational and transactional models (Bass, 1985; Burns, 1978).

The effects of transactional leadership are short-lived, episodic and task based, with the transactional leader only intervening with negative feedback when something goes wrong. This form of leadership would have a place where there is a specific short-term directed project or piece of work to be completed.

In a ward, it is more desirable to identify a leadership model that offers longevity in the relationship between senior nurses and junior colleagues. The transformational model is more complex but has a more positive effect on communication and teambuilding than the transactional model (Thyer, 2003). Transformational leadership shapes and alters the goals and values of other staff to achieve a collective purpose to benefit the nursing profession and the employing organisation. Bass (1985) found that transformational leadership factors were more highly correlated with perceived group effectiveness and job satisfaction, and contributed more to individual performance

practice changing practice

and motivation, than transactional leaders.

Adair (2002) proposed a different model. This is the three-circle model of strategic leadership, with the circles being the needs of the task, the individual and the team (Fig 1).

Adair believes that knowledge or expertise alone is not enough to lead; however, without it, leadership is impossible. Leaders should be aware of both group and individual needs, and should harmonise them to support common goals.

Each of the three needs in the model interacts with the others. One must always be seen in relation to the other two (Adair, 2003). This is a democratic model of leadership, in which there is consideration for the opinions of those who have to carry out the task. Individuals and groups are involved in decision-making processes concerning their work. The valuing of people, their knowledge, experience and skills is central to this model.

Leadership models are a useful tool for senior nurses and help to put the function of leadership activity into perspective. These nurses should not be concerned about using various models and developing an eclectic strategy. The models should be used as a framework on which to build an effective leadership style which suits the individual leader and those whom they are leading.

PROFESSIONAL SOCIALISATION

Supervised learning in clinical practice fosters emotional intelligence, responsibility, motivation and a deeper understanding of patient relationships and nurses' identity and role (Allan et al, 2008).

For care standards to improve, attention must be paid to improving post-registration education and practice development. This should include clarifying role expectation and developing a professional identity. Professional socialisation is a learning process that takes place in a work environment, of which junior nurses are an integral part. Effective leaders will generate opportunities which create potential for professional self-development for junior staff. It is during this socialisation period that junior nurses develop opinions, attitudes and beliefs about their role which form the basis of professional growth. The role-modelling behaviour of senior nurses during this process is critical in transmitting appropriate professional values from one generation of nurses to the next.

The role of senior nurses is dynamic and multifaceted. Nurse leaders in practice settings have unique opportunities to

influence and even create the environment in which professional practice can flourish. Marriner-Tomey (1993) suggested that, in this highly influential role, nurse leaders have a major responsibility to change behaviour to provide an environment that supports the preparation of competent and expert nurses. It is part of nurse leaders' role to serve as a model in providing effective socialisation experiences that impart the appropriate values, beliefs, behaviours and skills to staff.

BETTER OUTCOMES FOR PATIENT CARE

Ultimately, a goal of any healthcare organisation should be to influence the quality of patient care through good nursing leadership. Good leaders should encourage junior staff to gain a better understanding of patients and their needs and values. Overall, these strategies will lead to increased patient satisfaction, more effective nurse-patient relationships and quicker recovery times.

Empowered nurses are eager to implement evidence-based practice. They are highly motivated, well informed and committed to organisational goals, and thus deliver patient care with greater effectiveness (Kuokkanen and Leino-Kilpi, 2000).

Good leadership could produce better

patient outcomes by promoting greater nursing expertise through increased staff ability and competence. Aiken et al (2001) argued the hospital practice environment has a significant effect on patient outcomes. Junior nurses should be encouraged to seek maximum rather than minimum standards, and be expected to achieve and maintain high-quality benchmarks.

CONCLUSION

This article has highlighted senior nurses' essential leadership role in developing skilled and competent staff. Leadership behaviour has a great impact on staff. Senior nurses must acknowledge the importance of their role, recognising that junior staff rely on their leadership in developing their own professional skills.

These nurses must use their leadership behaviour to positively influence organisational outcomes and need to appreciate the inter-relationship between developing nursing practice, improving quality of care and optimising patient outcomes. Healthcare organisations need nurse leaders who can develop nursing care, are an advocate for the nursing profession and have a positive effect on healthcare through leadership.

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Effective team leadership: techniques that nurses can use to improve teamworking

Exploring how implementing a three-point strategy in team meetings enables members to reflect on their team's effectiveness and build on this

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ABSTRACT Nash, S., Govier, I. (2009) *Effective team leadership: techniques that nurses can use to improve teamworking. Nursing Times*; 105: 19, 22–24. This is the second article in a two-part series on leadership. The first examined transformational approaches to effective leadership in healthcare settings. This article describes the strategies that nurses can use to ensure healthcare teams are effective: team reflection; ensuring all members participate; and establishing ground rules.

BACKGROUND

Lord Darzi (2008) said: 'Leadership is not just about individuals, but teams.'

Govier and Nash (2009) discussed the principles that underpin transformational and effective leadership in healthcare settings. This article builds on this by focusing on the importance of team development and offers some practical exercises that leaders and teams can do to consider their effectiveness.

Teams that work well together and have higher levels of participation are more effective in delivering high-quality health care, plus their members have better well-being and lower stress levels (Borrill et al, 2002).

The Health and Safety Executive (2008) identified that nursing has a high prevalence of self-reported work-related stress.

Ball and Pike (2006) reported that nurses' levels of psychological well-being fell during

the period between two RCN surveys in 2000 and 2005.

Team effectiveness and the ability to reflect are two of the least valued qualities when teams have completed a 360-degree feedback team performance inventory (Aston Organisation Development, 2009).

Given the evidence that teams that are effective can improve members' well-being as well as quality of care, it is important to consider how teams can increase their effectiveness.

AIM

This article aims to introduce some simple techniques to enable team leaders and members to reflect on their team's effectiveness and to build on this with some development activities.

This does not negate the fact that, at times, teams may wish to use external help and other resources to support this process.

These techniques can be used both following team-development programmes as a way to embed and revisit development, and to identify development needs.

Given that such programmes may be seen as a luxury, the techniques outlined below can be used in routine team meetings. The act of using the techniques focuses the team on the issues and has a development effect in itself.

The issues and simple techniques described are:

- Team reflection;
- Ensuring all team members participate;
- Establishing ways of working/ground rules.

TEAM REFLECTION

It is difficult to build time for reflection.

The frequent cry is: 'Don't just stand there – do something.' However, evidence suggests

PRACTICE POINTS

- Evidence shows that nurses' psychological well-being has decreased over recent years.
- Team effectiveness is directly linked to members' well-being and quality of care.
- Nurses can use a three-point strategy to improve their team's effectiveness, which involves team reflection, ensuring that all members participate and establishing ground rules.
- Being part of an action learning team will enable nurses to maximise team effectiveness.

we would do well to cry: 'Don't just do something – stand there, reflect and then take action.'

West (1996) argued that team members' ability to reflect on their task objectives, processes and team culture is the best predictor of their team's effectiveness. The preference to lean towards action rather than reflection is observed in many groups.

Four facilitated groups taking part in the RCN Nutrition Now campaign were recently asked to

reflect on how they were working as a team and the next steps they needed to take with their projects.

Each team immediately focused on the action to be taken. When the facilitator asked what their reflections were about teamworking, they either said they had not discussed it or that they were working well.

After another prompt from the facilitator about communication, there was a pause, then team members suggested there were perhaps issues with communication. This led to further reflections and discussions about their effectiveness and actions on how they would communicate between sessions.

When reflecting, teams need to consider how they rate themselves in terms of effectiveness. Are members working well together? What is the communication like in the team, especially about the task being carried out, the methods and processes used to get the work/task done? Does the team review its objectives?

Adopting a discipline of asking the following questions will help teams to reflect:

- What is working well?
- What is not working well?
- What can be done about it?

The model often used in the more formal clinical supervision groups is Gibbs' (1988) model of reflection (Fig 1). Performed well, this provides a framework to explore issues, near misses and critical incidents, working towards an avoidance culture instead of a blame culture.

For the purposes of this article, the three questions just highlighted are all that are needed initially for teams to experiment together – the key is in getting started.

We gravitate naturally towards 'what is not working well' in discussions. There is a place for this to get it off our chests. However, the difference between this 'whinge session' and a structured, reflective session is the learning and action that follows.

This process of challenge, in a supportive environment, is the foundation of action learning. Lord Darzi (2008) said: 'Throughout my career, in all the clinical teams I have worked in, my colleagues and I have challenged one another to improve the way we provide care for patients.'

Action learning is about reflection and experiential learning. It is a balance of support and challenge. The benefits of this activity are:

- Service improvement by reflecting, questioning and finding better ways of doing things;
- Individual development – growth in personal awareness and interpersonal skills;
- Learning from successes and failures;
- Improving change-management skills;
- An opportunity for reflection, supervision, ensuring momentum in taking action and support in a safe environment.

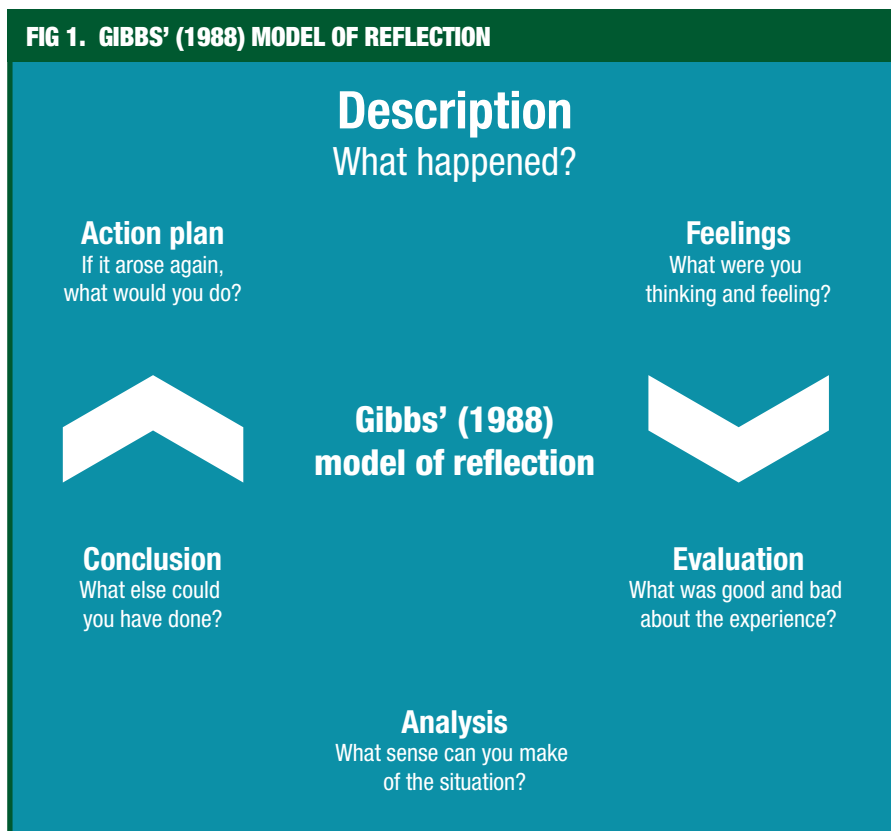
Action learning is usually done in sets of 6–10 people who meet every six weeks and carry out a form of group coaching/clinical supervision.

These principles can be applied to teams so the discipline of action learning becomes the normal way of working – challenging, supporting and coaching in order to improve the way in which we provide care to our patients.

In the high-profile cases of poor patient care that appear in the press, was the challenge element missing in the team responsible? Whether the challenge concerns lack of resources, priorities or poor practice – are we asking the right questions?

The ability to reflect, learn from reflection and take action on what needs changing is

FIG 1. GIBBS' (1988) MODEL OF REFLECTION



an important part of team effectiveness. Another important element is the participation of all members.

ENSURING ALL MEMBERS PARTICIPATE

The essentials of a good meeting are:

- Having the right people participating;
- Having clarity of purpose for the meeting;
- That it is evident how the meeting contributes to high-quality service provision (RCN and NHS Institute for Innovation and Improvement, 2007).

This is an art in itself. The next steps are to ensure that all team members participate in the discussions.

The theory of personality type covers the different ways in which people take in information and make decisions, and where they focus their attention and get energised. These differences can lead to misunderstandings and miscommunication.

It is not necessary to know our personality 'type' to ensure team meetings are effective, as the theory of personality is taken into account in current guidelines and good practice. However, having the team do a Myers-Briggs

Type Indicator (www.MyersBriggs.com) or similar exercise will stimulate discussion around ways to improve teamworking.

How often do meetings appear to be dominated by the few? This may be because those who focus their attention externally and become energised by interacting with others (extraversion) will naturally think out loud while they are discussing something. Those who focus on their internal world of ideas and experiences and energise by reflecting on their thoughts, memories and feelings (introversion) need time to think things through before commenting.

To facilitate this and to help those who think things through while talking, it is necessary to prepare in advance for the meeting. Of course this is good practice, but often meetings are run without agendas, or agenda items appear as a list of subjects with no clarity about the decision that needs to be made.

Nash (2006) argued that effective meetings need the following:

- An agenda and papers sent out in advance so the introverts can think about the information as can the extraverts, whose tendency is to do-think-do;

Practice in depth

TABLE 1. VALUES AND ASSOCIATED BEHAVIOURS

| Value (the why) | Behaviours (the how) |
|--|---|
| Respect: 'How can we show respect to you?' | Listening to me |
| | Not interrupting |
| | Not trivialising what I say or what I am concerned about |
| | Not using mobile phone or email or other interruptions when I am talking to you/we have a meeting |
| | Ensuring participation |

● Kline (1999) suggested that agenda items are phrased as a question, so that each team member can think about what is needed from them. For example, how can we ensure patients get adequate nutrition at mealtimes?

● Round robins are also useful as everyone has equal air time, that is, each person has one minute to talk about an agenda item – this ensures that everyone has input and prevents someone dominating the time or others remaining quiet (Nash, 2006).

So, now the team is in place, it has the right people and clarity of purpose, and all members are participating. Do we articulate what we expect of each other?

ESTABLISHING GROUND RULES

One element of team effectiveness is about establishing an understanding of the ways of working, in both the processes and behaviours expected as well as team tasks.

It is natural to focus on tasks, as they appear more tangible. However, it is the misunderstandings around perceived values and behaviours that can cause team conflict and stress. It is important to try to articulate what each team member means by their own values.

When exploring ways of working or setting ground rules, the discussion usually takes the form of listing various words on a flip chart, such as confidentiality, honesty and respect.

Misunderstanding and miscommunication result from our different interpretations of these ground rules. A simple but effective way of discussing these values and behaviours that make up ways of working is the how/why technique. This simple exercise could form part of the team's reflection time.

Each team member says what is important to them when working together.

If they mention a value such as respect, other team members are encouraged to ask 'How?' until the behaviours are identified. If the person mentions a behaviour such as 'Listening to me', then the question 'Why?' is asked until the value (in this case respect) is identified. An example is outlined in Table 1.

Ground rules and ways of working are meant to be reiterated and reinforced. Establishing these is not meant to be an exercise that is done once at the team's inception; they should be revisited, not only if there is a problem, when clearly this must be challenged, but also as part of the team's reflective activity.

PUTTING IT INTO PRACTICE

So what would a team meeting be like if we tried the interventions and techniques set out above? This need take only about 10 minutes, which can be at the start, end or as an agenda item during a meeting.

The following is an example of putting this into practice:

- The team leader or chair of the meeting says that the team will be asked to think about an issue, for example how the team communicates. This may be listed as an agenda item for people to come prepared;
- The agenda item is written as three questions – for example on communication:
 - What is working well in the way we communicate?
 - What does not work well in the way we communicate?
 - What can we do to improve communication?
- There is then a round robin. Each member is given a specific time to answer the questions – 30 seconds to a minute is long enough. There are no discussions or interruptions at this stage;
- When all members have been able to contribute, the team identifies one action on which they agree that they can try between now and when the team meets again;
- If the action agreed is a specific behaviour, such as not interrupting when others are speaking, by using the how/why technique and asking why, the team will arrive at a value such as respect. The value and behaviour can be added to the ways of working/ground rules.

At the next meeting, there is a discussion about whether the action agreed had been taken, what the learning was and what, if any,

the follow-up actions are. In this way the team shows that it takes action and learns together – an action learning team.

CONCLUSION

Taking time to reflect, ensuring that all team members participate and establishing ways of working do not need to be time-consuming or onerous.

Like anything worth doing, it needs practice – the more it is done, the easier it becomes and will start to be second nature. Evidence shows that taking time to do this improves team effectiveness. Since this has a direct correlation with team member well-being and quality of care, the question is not can we afford to do it but rather can we afford not to do it? ●

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Using life coaching techniques to enhance leadership skills in nursing

A life coach helped a team of primary care nurses to improve teamworking and manage stress

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ABSTRACT Williamson, C. Using life coaching techniques to enhance leadership skills in nursing. *Nursing Times*; 105: 8, 20-23.

This article describes a recent initiative, which used life-coaching to develop strong leadership skills and empower individual team members and the team as a whole. A three-stage process was used to enable a team of nurses in a GP practice to improve working relationships, leadership skills and stress management.

Life coaching aims to help people to enhance work performance and career opportunities and to achieve more in life. According to Martin (2007): 'Your coach cannot do the work for you but can, and should, suggest where you direct your focus to gain optimum benefit from what you are doing.'

The NHS has identified that this kind of work – that is, enhancing leadership and management – is very much needed. The NHS Institute for Innovation and Improvement's (2006) leadership qualities framework contains detailed descriptions of qualities and levels of attainment specifically tailored to the NHS' needs and environment.

Earlier this year, an advanced nurse practitioner (ANP) approached me to ask about team-building. The term can induce dread at the thought of outdoor activities or other similar pursuits. However, my work as a life coach focuses on building a communication structure to make a team work, from management to co-worker level and beyond to outside the team.

The ANP outlined the situation as follows: 'Since the advent of QoF [the quality and outcomes framework] in general practice, [there has been] more and more pressure on practice nurses to achieve targets for the GPs to earn money.'

'I work with a team of three practice nurses and two HCAs, in a very busy surgery with a

practice population of 12,500 patients. There are four partners with four salaried GPs.

'More and more I was noticing the nursing team having negative attitudes, moaning, feeding off each others' negativity and I felt it was starting to spiral out of control.

'The team had great difficulties in time management, difficulties saying no and we rarely had time to communicate.

'The biggest problem was changes in working practice. For example, a new ECG machine was to be used and it took so much longer than [was] acceptable before the nurses were able to perform an ECG without there being some problem.'

The ANP had frequently discussed her concerns within the GP practice but decided to take the initiative and sought out a supportive pharmaceutical representative, who agreed to jointly fund any work carried out to help the team develop.

WORKING WITH THE ANP

At my first meeting with the ANP, she raised further issues to address: 'At the time I was working well out of my comfort zone as a newly qualified nurse practitioner. I had much less time to deal with management problems and I was very conscious when I was asked for advice/help that I was not able to give the time I should. Also, at times, I felt irritated that it was not acknowledged that I had my own stresses and work commitments that couldn't wait either.'

'In the past, the nursing teams I'd led all worked as a team and people supported each other. In this team, they all had different problems and never seemed to think about how anyone else felt, or how busy other people in the practice were. I feel it's part of my responsibility to try to make the nursing team as effective and efficient as possible – it was obvious to all the practice team how stressed a few members of the team were.'

After a lengthy discussion about work, stress, management and how to move forward, we agreed a programme to cover all dysfunctional aspects of the team and enable it to move forward in a positive way (Table 1).

INDIVIDUAL COACHING

The aims of the individual coaching sessions with the ANP were to help her develop:

Self-belief – this focuses on preparing people to stand up for what they believe in, on the understanding that they focus on achieving the best outcomes for the team and service; **Self-awareness** – to be effective leaders, staff need a strong sense of self-worth so they can handle pressure and stress more effectively; **Self-management** – without this ability, it can be difficult to implement effectively what has been learnt;

Personal integrity – this can help with the decision-making process. The ANP demonstrated this when she was persistent in applying for funding;

The ability to enable others – this can be empowering for others and actively helps them to take responsibility and thus develop their own self-esteem and confidence.

Reflecting on these one-to-one sessions, the ANP said they 'made me realise my own values and why I get more irritated by certain characteristics of the team members. It wasn't my fault that we were not working well as a team; each individual team member needed to own their responsibilities.'

Zwell (2000) argued: 'One key function for many managers is developing the leadership ability of their subordinates.' If they are to develop others, managers need a strong sense of identity, their core competencies and what they need to improve.

The individual sessions helped the ANP to focus on herself, recognise her strengths, know her limitations and begin to build and shape the right team around her.

Owen (2005) summarised this as follows: 'By having the self-confidence and self-awareness to know their own weaknesses, they [the leader] can build the right leadership team to help them and they can then be open about learning.'

BELBIN ROLES ASSESSMENT

Belbin (1996) published a management book based on a study of successful and unsuccessful teams competing in business

TABLE 1. INTERVENTIONS AND OUTCOMES

| Level of intervention | Areas to be covered | Desired outcomes |
|--|--|---|
| Individual coaching with ANP | <ul style="list-style-type: none"> ● Leadership style and qualities ● Who is in control? How to take an assertive stance ● Where do you give away your power? | The aim of these sessions was to give the ANP time out from her busy workload to evaluate how she was doing, what was going well and what was not working. This also gave her the opportunity to think more about herself rather than just focus on her team |
| Belbin (1996) team roles assessment | All six staff in the team completed an online Belbin team roles assessment | <ul style="list-style-type: none"> ● To develop a greater understanding of an individual's role within a team ● To help identify where conflict may arise and understand how to adapt our behaviour ● To help an individual understand why they may respond in a particular way during times of stress |
| Three two-hour group sessions with all six members present | <ul style="list-style-type: none"> ● Assertiveness ● Taking responsibility ● Understanding how a person's stress affects the team ● How to look after each other ● Take greater control of your life rather than outside influences impacting on it | These group sessions were a way of raising awareness of many different issues at both a personal and team level. It allowed team members to share information about themselves in a non-threatening manner, which creates a greater level of support and ownership |

games at Henley Management College. He described a team role as 'a tendency to behave, contribute and interrelate with others in a particular way'. With this in mind, I felt a Belbin assessment would be an ideal way for the team to start to examine:

- The roles they bring to the workplace;
- How these fit in with the team;
- The contribution of roles to the team.

There are nine team roles in total and the questionnaire helps to identify individuals' preferred roles, their manageable roles and their least preferred roles. These nine roles are:

Plant – creative, imaginative and unorthodox;

Resource investigator – an excellent communicator, recognises opportunities and is extrovert;

Coordinator – a strong sense of objectives, promotes decision-making, delegates well;

Shaper – challenging, driving and dynamic, thrives on pressure and an effective delegator;

Teamworker – cooperative, supportive and diplomatic, averts friction and listens well;

Implementer – disciplined, efficient, organised and reliable;

Completer finisher – conscientious, pays attention to detail and delivers results;

Specialist – has rare skills or knowledge, and is dedicated, professional and single-minded;

Monitor evaluator – discerning, objective, questioning and sees all options.

Once staff understand their preferred roles, it can help to explain why they relate well to

some people and have conflicts with others.

It also helps to explain some of the less favourable traits, since for every role there is a set of strengths, allowable weaknesses and non-allowable weaknesses.

This gives staff a new vocabulary with which to talk to others about their behaviour and how it impacts on others. Typically, a complete Belbin programme includes not only self-perception but also team members' perceptions of each other. In this case study the process was limited to self-perception only, but nonetheless brought out some strong underlying issues.

The ANP said: 'It was very interesting that the frustration I had with certain members of staff, who were not acting and following up on new initiatives as I expected, was brought to a head when Catherine had us all working on the types of personalities we were.

'I found out that I look at things from 'the wider picture' and these particular team members looked at things using 'detail'. This was extremely helpful in me understanding them more. Now I will be able to help prevent problems occurring when we set up new initiatives by giving them more detail than I previously felt that they needed.'

It is important for managers/leaders to understand the behavioural characteristics of their staff so that when conflicts do arise they can be discussed on a professional level rather than a personal one.

GROUP SESSIONS

The aims of the three group sessions were to:

- Raise awareness;
- Understand behaviour;
- Empower staff.

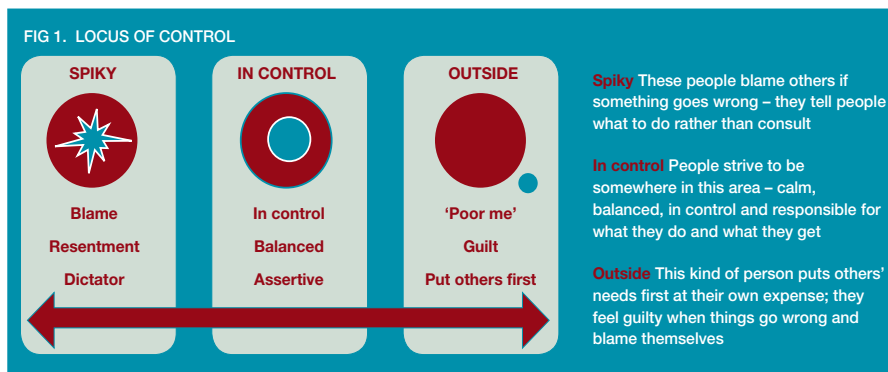
Before starting the group sessions one team member (an HCA) said: 'I hoped the sessions would teach us something about us as individuals and as a group.' From a managerial point of view, the ANP had hoped the sessions would help the group to understand that other team members also had stresses to deal with and that this stress has an impact on the team. She also hoped that 'the team would look at themselves more and stop blaming 'the system' for their stress and realise we are actually quite lucky where we work'.

All six team members were asked to contribute and share issues that arose for them in the sessions – if they felt comfortable to do so. All agreed to maintain confidentiality and professionalism throughout the sessions, respect each others' point of view and bear in mind that the sessions may bring up personal issues that people may want to keep private.

RAISING AWARENESS

A life coach's role is to help people see things as they really are. Downey (1999) quoted Tim Galloway's definition of coaching as: 'To establish a firmer connection with an inner authority that can guide vision and urge excellence and discriminate wisdom

practice changing practice



EMPOWERING STAFF

The following quotes all illustrate how much team members learnt about themselves:

'We became more open with each other; we understood each others' difficulties, setbacks, expectations and problems. We also realised the importance of needing to meet together more often' (HCA);

'I am working on noticing when I take on too much or when I am unrealistic in what I can achieve in a certain time and how this causes me stress. I am learning to say no. I found these sessions extremely valuable and well facilitated' (practice nurse);

'I thought the sessions were very well structured. However, if the issues that were raised are not addressed then nothing will have been gained at a practice level' (HCA);

'I feel much more confident in leading the team of nurses and, in future, know how to get the best results out of each individual team member as I understand much better how they tick' (ANP).

However, one HCA pointed out: 'At a practice level, little is likely to change until more time is given by management to the concerns and expectations of the staff.'

This last comment is certainly true and the evidence from this initiative helped the ANP to secure more management time to fulfil her role. After this process, the ANP said: 'I hope the GPs will notice the nurses are much happier in their work and are working much better as a team. Nurse clinics will be better run and the nurses will be taking more responsibility and following through what they have done.'

Reward and recognition are both essential at work. As Zwell (2000) said: 'If employees significantly impact on the organisation and are not rewarded for that impact, expect them to go to other organisations where they will feel more appreciated.'

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without being subject to an 'inner bully'. This is an interesting quote – as people begin to know themselves and make changes, some guilt may need to be addressed.

The results of the Belbin assessment helped all team members to see themselves in a new light and allowed them to appreciate each others' strengths and weaknesses.

For example, many of the team emerged as strong teamworkers, in that they are cooperative and can avert friction. However, this can also mean they are indecisive (an allowable weakness) and, if left unchecked, this can lead them to avoid situations that may entail pressure (a non-allowable weakness). This is helpful for the ANP as it helped to explain why individual team members were reluctant to make decisions.

Another example is the monitor-evaluators in the team. Their contribution is to be discerning and objective but this can lead them to be uninspiring and sceptical (allowable weaknesses) and, if left unchecked, this can lead to them being cynical and pessimistic (non-allowable).

Every role is important and it is essential that each person's strengths and contributions are recognised.

A practice nurse commented: 'I hope that as a result of the team-building sessions, we will value and acknowledge each other more and each member's contribution to the practice.'

Another way of raising awareness is to look at the 'locus of control', which is considered an important aspect of personality. The concept was developed in the 1950s and refers to the extent to which people believe they can control events that affect them.

Understanding this concept can help people to become aware of:

- When they give away power to others;
- When they are passive;
- When they put others' needs first at their own expense;
- When they assume someone else's power;
- When they become dictators;

- When they blame others for a mistake they made.

The model in Fig 1 helped the team to identify when they were most likely to fall into passive behaviour and when they would rebel and become more aggressive. We also found stress levels had a significant influence on people's behaviour and responses to others. Helping people to understand how their behaviour undergoes subtle changes as they become more stressed can help them to make positive choices to stay in control.

One of the HCAs found this process very useful, saying: 'Personally I need to look at the bigger picture, take stock of where I am and what I want from my job.'

UNDERSTANDING BEHAVIOUR

Stress has a major impact on people, affecting them on every level – mentally, physically and emotionally. All members of the group said they wanted help and advice on how to deal with stress levels. Stress is a very personal issue – what helps one person will not always help another so it is important for staff to understand their own response to stress and determine what will help them.

One of the highlights for the ANP in the group sessions was noticing that her staff felt they acted in positive ways. However, team members were able to point out to each other during the sessions that they were not always assertive or calm and could actually be aggressive or short with people.

One way to tackle this is for staff to consider stress levels as they rise and then go back and determine the trigger factors and their response. Knowing trigger points in certain situations can help people to manage their reactions and responses more appropriately.

A practice nurse said: 'I learnt that, to do as good a job as I can without getting too stressed, I need clarity, the opportunity to discuss issues, time and support.'

Examining transformational approaches to effective leadership in healthcare settings

This article outlines the three core 'constants' that can be used to develop effective leadership as nurses deliver care in an increasingly challenging environment

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INTRODUCTION

Healthcare services are constantly adapting to trends and policy, with healthcare professionals, especially nurses, having to lead, organise and deliver care in an increasingly challenging and changing environment.

Traditional values about care are being challenged and often come into conflict with the business environment that appears to dominate healthcare management (Shaw, 2007). This challenging and changing environment is not unique to health care; it is considered to be universal and appears to be increasing in intensity and complexity.

Vaill (1996) described this often frenetic and unpredictable environment as 'permanent white water' – an environment that frequently puts people in the position of doing things they have little experience of or have never done before. He also argued that, although good management skills are still essential for day-to-day operations, navigating permanent

PRACTICE POINTS

- Leadership exists at all levels of an organisation, especially as people share in a vision that moves them towards achieving the goal of providing safe and quality health care.
- Recognising the value of proactive choice when faced with difficult decisions about healthcare organisation and delivery is critical when leading, responding and adapting to change.
- The core values and principles that underpin nursing and the act of caring provide an internal compass that facilitates authentic and transformational healthcare leadership.

white water successfully must begin with effective leadership.

Kotter (1996) suggested that management is concerned mainly with order and consistency, while leadership is centred on change and movement. Management focuses on controlling complex processes, whereas leadership is about challenging existing ways of doing things and setting new directions in organisations.

It could be argued that management is about 'doing things right' and leadership is about 'doing the right things'. Covey (2006) supported this view, asserting that yesterday's methods do not work in the permanent white-water world, where managers traditionally manage within the system and focus on doing things according to the rules.

Like Vaill, Covey agreed that, while the managerial role is essential and performs a vital function, leadership must come first to make managing more effective. If management is efficiency in climbing the ladder, then it is leadership that determines whether the ladder is leaning against the right wall. The story in Box 1 may help to illustrate this point of view.

To help individuals, teams and organisations to navigate the permanent white-water

environment safely, Covey (2006) suggested that there are three constants that provide stability in times of great uncertainty. These are change, choice and principles.

This article considers each of these three constants, focusing mainly on the principles that underpin transformational and effective leadership in healthcare settings.

THE CONSTANTS Change

When it comes to responding and adapting to change, Yoder-Wise (2006) stated there are two choices. We can either 'get organised' or 'go with the flow'.

In a permanent white-water environment, going with the flow is fraught with uncertainty and danger, whereas organising ourselves allows us to achieve greater stability and safety.

Covey (2006) argued that, in a constantly changing environment, when times are difficult and uncertain, there is a need to develop a solid, unwavering core. He asserted that, when we adopt changeless and timeless principles – such as trust, fairness, service, courage, humility, integrity, human dignity, contribution, growth and empowerment – as core values, we anchor and enable ourselves to adapt and respond to forces of change.

George (2007) also recognised the constancy of change, and challenged people to discover their 'true north' to enable them not only to cope with change but also to navigate successfully the permanent white water that often accompanies change.

In the same way in which a compass points towards a magnetic field, our true north is the internal compass that guides us successfully through life. It represents, at the deepest levels, who we are as human beings. It is based on what is most important to us, our most cherished values, our passions and motivations, and the sources of satisfaction in our lives.

When we follow our internal compass as

nurses, clinical leadership will be authentic and transformational. We will also be more likely to reflect the core values that underpin nursing and the act of caring. This ensures we choose the 'care of people' as our main concern, treating them as individuals, respecting their dignity and providing them with high standards of practice at all times (NMC, 2008).

Alimo-Metcalfe and Alban-Metcalfe (2005) suggested the one thing that characterises organisational life is that change is inevitable. They also maintained that in organisations that constantly drive for improved efficiency and results, greater pressures are placed on their employees.

So, in organisations such as the NHS and large professional groups such as nurses, these pressures can often lead to increased stress and lower performance. This can be potentially harmful in terms of providing safe and effective patient care.

Acknowledging these pressures and the associated risks is especially important in light of Lord Darzi's (2008) report. This heralds a significant change for the NHS in England, mainly because it has made quality of care a central organising principle alongside access, volume and cost of healthcare services.

The RCN is being proactive in asserting nursing's key role in contributing to the quality-of-care agenda. It has recently published a report (RCN, 2009) that outlines a series of recommended actions (for England only) to achieve this. These are designed to gain recognition and acknowledgement of the value and impact of the ward sister/charge nurse role for high-quality care, and put in place the necessary measures to strengthen and support this role for care quality.

Other home countries, such as Wales, have also introduced initiatives that place more emphasis on the ward sister/charge nurse role to lead and manage changing environments and so directly influence and enhance patient care (Welsh Assembly Government, 2008). There is also evidence that links the impact of this role to standards of patient care. For example, the Hay Group (2006) showed that effective ward management has a significant impact on resource use as well as on performance indicators such as: patient satisfaction; absenteeism rates; amount and nature of complaints; number of drug errors and levels of severity; and staff turnover rates. Reaffirming ward sisters' and charge nurses'

key clinical leadership role and ensuring they have the capacity, time, resources and authority to coordinate and deliver patient care, is a top priority.

Leading, responding and adapting to change is everyone's business. Although ward sisters/charge nurses play a key role in leading health care in acute settings, it should also be recognised that leadership support and development must occur at all levels and settings of healthcare organisations. A major challenge is how we 'take the bedside to the boardroom'. Executive nurses in particular are challenged with balancing the leadership of business with the leadership of caring. These senior nurse leaders will recognise more than others that failure to deliver the fundamental components of care can bring down an NHS board faster than either financial or performance failures (Machell et al, 2009).

Choice

A unique ability that sets us apart as human beings is that of self-awareness and the ability to choose how we respond to stimulus. While conditioning can have a strong impact on our lives, we are not ultimately determined by it. Covey (2004) suggested that between what happens to us and our response is a space, and within this space is the ability to choose our response – 'response-ability'. He quoted the account of the eminent Austrian psychiatrist Viktor Frankl, who was incarcerated in a Nazi death camp in the Second World War. Frankl, like so many others, endured unimaginable experiences and hardships and was one of the few who survived.

Frankl (2004) said: 'We who lived in concentration camps can remember the men and women who walked through the huts comforting others, giving away their last piece of bread. They may have been few in number, but they offer sufficient proof that everything can be taken from a man but one thing: the last of human freedoms, to choose one's attitude in any given set of circumstances – to choose one's own way.'

During his time in the death camp, Frankl realised that he alone had the ability to determine his response to the horror of his situation. He exercised the only freedom he had in the environment by imagining himself teaching students after his release. He became an inspiration to others around him and realised that within the middle of the stimulus-response model, humans have the

freedom to choose. Although Frankl's understanding was realised in an inhumane environment, we too can learn lessons that can be applied in far more favourable situations that, nevertheless, present challenges.

We can choose to be reactive to our environment. For example, if the weather is good we feel happy and if the weather is bad we will be unhappy. If people treat us well, we feel well; if they do not, we may feel bad and become defensive or even aggressive. We can, however, choose to be proactive and not let our situation determine how we feel. It is also liberating to know that even when we are faced with decisions that appear to be lacking in preferable choices, we can still choose our attitude.

Regarding choice, proactive leaders are driven by values that are independent of the weather or how others treat them. Mahatma Gandhi said: 'They cannot take away our self-respect if we do not give it to them.' Being proactive means assessing the situation and developing a positive response. Proactive leaders use their resourcefulness and initiative to find solutions rather than just reporting problems and waiting for other people to solve them. Such leaders are also more likely to view leadership as a choice, not a position; they will be nurses who are concerned with making things happen and making a positive difference to patient care.

Nurses sometimes find themselves disempowered and consider their choices are

BOX 1. LEADERSHIP AND MANAGEMENT

A group of workers and their managers are set a task of clearing a road through a dense jungle on a remote island to reach the coast, where an estuary provides a perfect site for a port.

The leaders organise the labour into efficient units and monitor the distribution and use of capital assets. Progress is excellent.

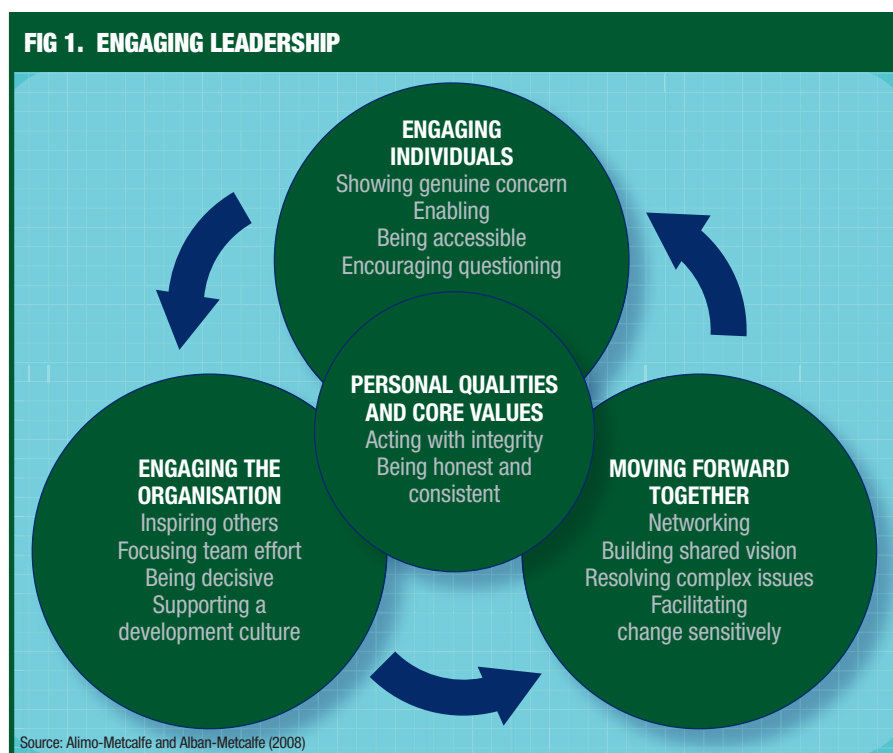
The managers continue to monitor and evaluate progress, making adjustments along the way to ensure that progress is maintained and efficiency increased wherever possible.

Then, one day amid all the hustle and bustle and activity, one person climbs up a nearby tree. The person surveys the scene from the top of the tree and shouts down to the assembled group below: 'Wrong direction!'

Source: Adapted from Covey (2004)

Practice in depth

KEYWORDS LEADERSHIP | CHANGE | CHOICE | PRINCIPLES



limited when faced with policies and directives calling for increased efficiency that appear to compromise quality of care. Once we decide to become more proactive, where we focus our efforts becomes more important. Our response to what happened to us will often affect us more than what actually happened, and we will choose to use difficult situations to build our character and develop the ability to better handle such situations in future.

Principles

Covey (2009) also subscribes to the view of connecting with our internal compass and discovering and following our 'true north'. He asserts boldly that principles govern growth and prosperity in both people and organisations, claiming that principles draw the highest and best from people because they reflect the whole person – body, mind, heart and spirit. Equally significant, these people then choose to influence and inspire others to find their voice through these principles.

Influencing and inspiring others are key components of transformational leadership. They not only allow us to increase leadership skills and abilities, but also help us to navigate the permanent white-water environment of health care. Through the power of transformational leadership, leaders and

followers raise one another to new heights of achievement and development. They are also able to sustain one another in a life-long effort to define and construct meaning in their work lives (Sashkin and Sashkin, 2003). This approach to leadership not only improves performance and productivity, but also makes a positive difference in the lives of organisation members. Transformational leaders achieve superior results because of their ability to motivate and transform people from dutiful followers into self-directed leaders who go beyond simply doing what is expected.

Bass and Riggio (2006) supported these benefits of transformational leadership, arguing that people who embrace the principles of such leadership have staff with higher levels of satisfaction, motivation and performance, as well as lower levels of stress and burnout. They also maintained that such teams are more innovative, collaborative and effective, which results in their organisations being able to respond more quickly and productively to change. In addition, these organisations possess effective, healthier and more humane cultures.

Alimo-Metcalfe and Alban-Metcalfe (2008) showed similar outcomes in their comprehensive research to investigate the impact of transformational (or engaging)

leadership on organisational performance in the NHS. They discovered that a culture of transformational or 'engaging' leadership significantly predicts increased levels of staff motivation, satisfaction and commitment. This combines with reduced stress and emotional exhaustion and increased general team effectiveness and productivity.

There are a number of transformational leadership models or frameworks that may prove helpful to nurses working in modern healthcare settings. One that has already been referred to, and is rapidly gaining recognition within the NHS and other sectors, is that of 'engaging leadership' (Alimo-Metcalfe and Alban-Metcalfe, 2008). The structure of this model is represented by four clusters of dimensions: 'engaging individuals'; 'engaging the organisation' (or team); 'moving forward together' (which relates to working with a range of internal and external stakeholders); and 'personal qualities and core values'. Fig 1 shows the various dimensions in each cluster.

The emphasis of engaging leadership is on serving and enabling others to display leadership themselves. It is not about being an extraordinary person, but rather a somewhat ordinary, vulnerable and humble – or at least a very open, accessible and transparent – person. This approach to leadership complements other viewpoints such as Collins (2001), who described highly successful, or 'level 5', leaders as people who channel their ego needs away from themselves and into the larger goal of building a great organisation. These leaders have a tremendous will to get things done, yet have a level of humility that sets them apart from others. They rarely talk about themselves, yet delight in talking about the organisation and the contribution of others.

Engaging leadership focuses on the critical importance of teamworking and emphasises the benefits of collaboration that create a culture where dialogue is open and new ways of thinking and doing are encouraged, listened to and truly appreciated. It stresses that leadership exists at all levels of an organisation, especially as people share in a vision that moves them towards achieving goals of providing safe and quality health care.

CONCLUSION

Effective and transformational leadership is pivotal to the success of healthcare organisations.

As nurses lead, respond and adapt to change,

they will recognise the value of proactive choice when faced with difficult decisions about healthcare organisation and delivery. ●

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The second article in this series examines how to lead effective teams.

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Practice changing practice

KEYWORDS QUALITY CARE INDICATORS | SPIDERGRAPHS | METRICS

Implementing quality care indicators and presenting results to engage frontline staff

This article describes the implementation of seven quality care indicators – or metrics – and the way data was presented to frontline staff

AUTHOR Suzanne Hinchliffe, CBE, RN, RM, DMS, MBA, is chief operating officer/ chief nurse at University Hospitals of Leicester NHS Trust and was previously director of nursing and governance/ deputy chief executive at St Helens and Knowsley Teaching Hospitals NHS Trust. **ABSTRACT** Hinchliffe, S. (2009) Implementing quality care indicators and presenting results to engage frontline staff. *Nursing Times*; 105: 25, 12–14. This article describes the development and implementation of seven nursing care indicators identified in a review of clinical records and assessment processes. The indicators were chosen because they were common to most trusts, had associated national guidance and/or emerged from patient complaints. Indicators were measured and presented using spidergraphs, which provided staff with data in a visual and understandable format.

INTRODUCTION

In an organisation as large as the NHS, the links between clinical practice and patient outcomes are often distant and rarely direct.

The use of basic performance indicators and targets that identify so-called ‘good’ and ‘bad’ hospitals has been criticised as being simplistic and unlikely to lead to clinical change and better outcomes.

NHS practitioners have not always been engaged by targets and other indicators used to manage and assess performance. In some cases, they were unaware of the targets being measured or what indicators contribute to performance ratings, which means that they are unlikely to use them to help improve the quality of their services.

In response to these issues, a suite of care indicators, or metrics, were developed. These evidence-based measures of care can be used to benchmark, monitor and improve clinical outcomes and patient experiences. They have

PRACTICE POINTS

- Indicators against which to measure nursing practice can be selected on the basis of national guidance or patient complaints.
- Indicators should be meaningful to practitioners and measure aspects of care over which nurses have an influence.
- Data collected on indicators should be presented in a way that enables staff to quickly and easily see how care provided in their ward or unit measures against best practice.
- Giving nurses ownership of care indicators can motivate them to improve their practice.

been subsequently supported by NHS North West, successfully piloted in a number of organisations and built upon from both an evidence base as discussed below and by different specialty mix.

THE INDICATORS

Following a review of all clinical records and assessment processes, the indicator topics were selected because they were common to most trusts, had associated national guidance and/or had emerged from patient complaints. Seven care indicators were chosen. These were:

- Falls assessment;
- Food and nutrition;
- Pressure area care;
- Pain management;
- Patient observations;
- Infection prevention and control;
- Medicine prescribing and administration.

The indicators are discussed in turn below, and the key issues to be considered in relation to each are listed.

Falls assessment

Falls are the most common patient safety incident reported to the National Patient Safety Agency’s (NPSA) National Reporting and Learning System (NRLS). In an average 800-bed acute trust, there will be around 24

falls every week, which equates to around 1,250 a year. Associated healthcare costs are estimated at a minimum of £92,000 per year for the average acute trust (Healy and Scobie, 2007).

Key issues:

- Patient safety and lifestyle;
- Reduced length of stay and cost;
- Falls reduction strategies.

Food and nutrition

Chronic poor nutrition leads to deficiencies in immune function, wound healing, organ function, mental state and growth.

The presence of disease can lead to inadequate nutrition by reducing digestion and absorption, altering metabolism and reducing appetite and therefore food intake.

Long-term enteral and parenteral nutrition are life-saving therapies for some patients but many who would benefit from this and other nutritional support are simply not receiving it (Kelly et al, 2001).

Effective nutritional management requires systematic patient assessment on admission, at scheduled intervals, in response to changes in a patient’s condition and before discharge. Dietary intake should be regarded as a vital sign and recorded as regularly as other vital signs, such as pulse and blood pressure.

Key issues:

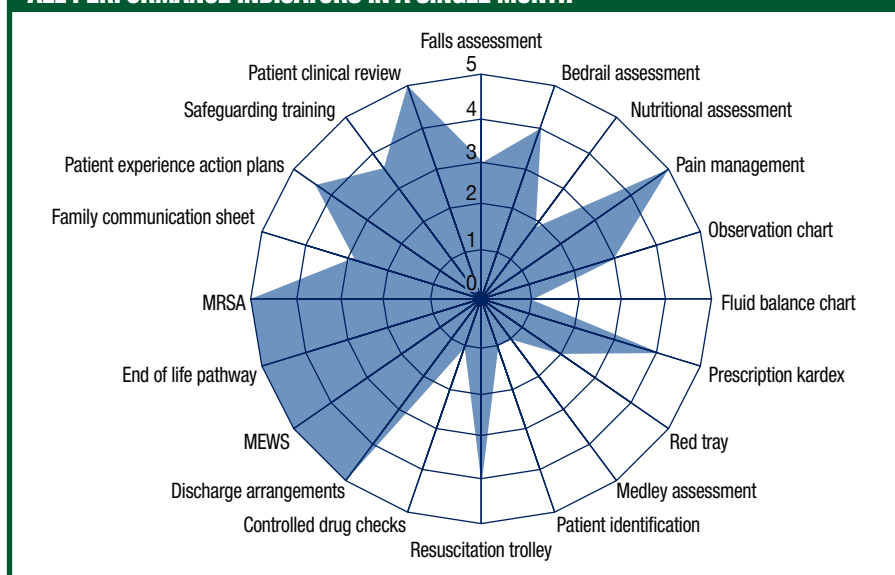
- Multidisciplinary team approach;
- Staff competency to implement care plans for effective nutritional management;
- Evaluation and care planning.

Pressure area care

The primary cause of pressure ulcers is unrelieved pressure to the skin, while secondary causes include exposure to cold or skin abrasion. Contributing factors include poor nutrition, weight loss and diabetes (Butcher, 2005).

These wounds have been estimated to cost the NHS £1.4bn–£2.1bn a year (Bennett et al,

FIG 1. AN EXAMPLE OF A SPIDERGRAPH ILLUSTRATING ACHIEVEMENT AGAINST ALL PERFORMANCE INDICATORS IN A SINGLE MONTH



2004) and this cost may be added to by litigation. These wounds are slow to heal and are associated with significant morbidity. Pressure ulcers affect quality of life and can contribute to cause of death.

Key issues:

- Decreased risk of infection;
- Decreased pain;
- Decrease in length of stay.

Pain management

Most inpatients will experience some degree of pain during their stay in hospital. In addition to the obvious discomfort for the patient, poor pain management can result in delayed wound healing, extended hospital stay and chronic pain syndromes (Bonnet and Marret, 2005).

Effective acute pain management requires systematic patient assessment on admission, at scheduled intervals, in response to new pain and before discharge. Pain intensity should be regarded as a vital sign and recorded as regularly as other vital signs, such as pulse and blood pressure.

Key issues:

- Excellent pain assessment;
- Enhanced patient satisfaction outcomes;
- Reduced length of stay.

Patient observations

The primary role of monitoring patient observations is to make clinicians aware of the deteriorating patient. The National

Confidential Enquiry into Patient Outcomes and Death has found the patients who did not survive had often shown signs of deterioration long before they died (Cullinane et al, 2005).

Abnormal physiological values are often charted without action in the hours preceding an in-hospital cardiopulmonary arrest and up to 24 hours before ward patients are admitted to intensive care.

The enquiry recommended that hospitals should pay more attention to physiological signs of decline, put in place 'track and trigger'

BACKGROUND

● Healthcare providers are increasingly required to demonstrate the effectiveness of their performance and to achieve centrally developed targets.

● Performance indicators and targets that identify 'good' and 'bad' hospitals have been criticised as simplistic.

● Targets do not always engage healthcare professionals in a way that motivates them to change clinical practice, and they are often unaware of what is being measured.

● Nursing metrics – indicators that measure performance on a range of aspects of care – are intended to generate meaningful information that will enable and motivate nurses to change their practice to improve patient outcomes.

systems for all patients and link these to a response team skilled in managing acute clinical problems.

Key issues:

- Failure to measure basic observations of vital signs;
- Lack of recognition of the importance of worsening vital signs;
- Delay in responding to deteriorating vital signs.

Infection prevention and control

Healthcare-associated infections have a high profile nationally and locally. Directives on reducing HCAI rates consistently guide healthcare providers towards developing cultures that embed infection prevention and control into all aspects of clinical care.

Key issues:

- Patient experience, including safety and comfort, and awareness of infection status;
- Early identification and management of known or suspected infections;
- Reducing transmission risk;
- Surveillance, analysis of potential acquisition and incident reporting;
- Promoting an organisational culture that recognises the significance of infection prevention and control and responds to the challenges with a focus on both a strategic and clinical aspects.

Medicine prescribing and administration

Medication errors tend to fall into three categories: prescribing; dispensing; and administering. All healthcare staff need to find ways to reduce the frequency of these errors.

Medication errors are the second largest category of error after slips, trips and falls reported to the NPSA's NRLS. Approximately 5,000 medication safety incidents are reported to the NRLS every month.

Key issues:

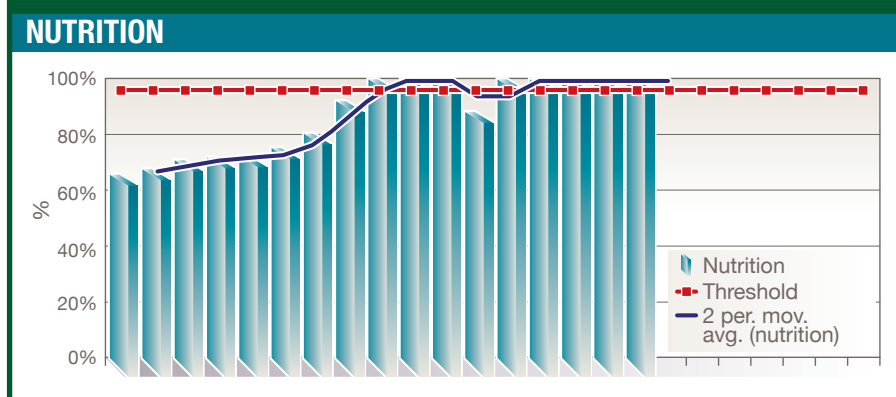
- Patient safety;
- Incident reporting;
- Open and fair culture.

Other categories are equally important and, as confidence grew, further indicators were introduced, often based around patient safety guidance – for example patient identification and controlled drug management. This resulted in a bank of over 20 indicators that complemented recommendations from national bodies, including the NPSA.

Practice changing practice

THIS ARTICLE HAS BEEN DOUBLE-BLIND PEER-REVIEWED

FIG 2. MONTHLY PERFORMANCE AGAINST A SINGLE INDICATOR OVER TIME



OUTCOMES

As the support and involvement of staff at all levels grew, so did confidence. This led to better compliance with the indicators. Further indicators could then be developed.

With the addition of support measures around indicators, for example supportive falls plans or campaigns to reduce HCAs, positive results emerged. These included over 90% compliance with risk assessments, a reduction in reported falls of 26%, and compliance with the monitoring and management of infection prevention and control hygiene measures which helped in the achievement of MRSA and *C. difficile* markers.

CONCLUSION

Our experience in developing, implementing and encouraging the ownership and adoption of indicators by practitioners has been a highly positive experience in fostering the drive to improve and maintain quality.

In particular, we feel the delivery of data in a purely visual, easily understandable form has been a key part of this success.

The recent publication of more than 200 new indicators – a key outcome of Lord Darzi's report *High Quality Care for All* – will make the dissemination of indicator data more vital than ever in our attempts to measure the quality and benchmark our work against our peers (Department of Health, 2008). ●

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COMMUNICATING PERFORMANCE DATA

Every month, trust boards are presented with trust-wide performance indicators as part of the drive to maintain performance and demonstrate care delivery standards.

It is vital that care indicators and the data generated by them are 'owned' and understood by staff at all levels, not only to raise awareness but also to help and support them to improve their own areas.

The recent National Nursing Research Unit report *State of the Art Metrics for Nursing* recognises that nurses 'must have responsibility for actions that lead to outcome in terms of legitimate authority, self-perception and sphere of practice'. It also states: 'There must be sufficient knowledge to inform remedial action' (Maben and Griffiths, 2008).

Frontline staff are genuinely interested in clinically governed care, but need governance-related data to be presented in a meaningful and comprehensible way. By holding up a mirror to wards and departments, we enabled them to see what was and was not working well and to identify support needed to make improvements.

Presenting data based on the care indicators as a list of numbers might not be the best way to communicate performance, and the gaps in performance to individual practitioners. We therefore decided to present the data in the form of spidergraphs – a visual reporting tool (Fig 1, p13). Also known as radar charts, these illustrate the gaps between current and desired performance with the aim of showing at a glance how each specialty/ward was performing against a range of care indicators. Bar charts showed performance against single indicators over time (Fig 2).

The categories are relevant to staff who, until recently, might not have received detailed monthly reports on patient falls, medication errors or nutrition assessment, for example.

We found clinical staff were genuinely interested in patient safety, experience and clinical outcomes. Where they saw how they were performing against the indicators, healthy learning and change began to take place.

In areas that were struggling to perform, the problem was frequently associated with leadership issues – for example the wrong staff mix, staff anxieties about caring for high-risk and high-dependency patients, capacity pressures or even having the right person in the wrong job.

Taking time to look at a simple spidergraph enabled us to find causes and solutions.

THE PROCESS

Each indicator chosen was complemented with the following:

- An evidence base;
- A list of patient, staff and organisational benefits from using care indicators;
- A range of criteria for measurement;
- Visual products for reports for individual wards (Figs 1 and 2 show dummy data);
- Visual products for corporate reporting.

Each indicator is measured on a monthly basis for 50% of patients in each ward area. Immediate feedback is given to ward staff, followed up by both a pictorial spidergraph and a historic look back to view progress.

Over time, the number of patients being monitored by indicators achieving high compliance may be reduced. The greater the compliance with each indicator criterion, the fuller the colour of the spidergraph.

Improving services through leadership development

A qualitative study found that a leadership development module was effective in helping health and social care staff to develop leadership skills

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ABSTRACT Janes, G. (2008) Improving services through leadership development. *Nursing Times*; 104: 13, 58-59.

BACKGROUND: The NHS is facing unprecedented reform. Effective leadership has been identified as crucial to the success of this modernisation,

AIM: To evaluate the perceived impact of a new module (Leadership With a Purpose - LWAP) from student, mentor/manager and service development perspectives.

METHOD: A descriptive, qualitative study was carried out using one-to-one semi-structured interviews and thematic analysis.

RESULTS: All participants reported a positive impact following LWAP attendance, with students and practice mentors/line managers identifying similar effects. Its usefulness during periods of transition was an unexpected finding. Further themes indicated wide-ranging effects on students' attitudes and skills. These included improved personal skills such as communication, assertiveness and self-awareness. Another key theme was students' improved ability to work with others. There was evidence of applying learning in practice, as participants implemented service improvements.

CONCLUSION: This study supports the limited research showing a positive impact. Its main contribution is the evidence it provides of the application of learning in practice in terms of service improvement following attendance. This is a major gap in the current body of knowledge.

This article is based on an evaluation study examining the impact on practice of a new leadership development module (Leadership with a Purpose - LWAP) for health and social care staff.

Fig 1 identifies some of the factors driving

today's unprecedented reform of the NHS and responses to this. Developing effective leadership at all levels of the service is crucial for successful modernisation (Department of Health, 2004; DH, 2000).

Recognition of this has resulted in a plethora of leadership development programmes. In a climate of enhanced educational accountability, robust evaluation, particularly on the impact of education in practice, is vital (Williams, 2003).

The LWAP module is one of a range of short introductory programmes available to health and social care staff in the UK, some of which have been evaluated (Janes and Wadding, 2004; Cooper, 2003; Edmonstone and Jeavons, 2000). However, major academic reviews concur in recognising the limited empirical evidence of the impact of leadership development programmes on practice (Hartley and Hinksman, 2003; Williams, 2003). It was therefore important this new, local module was evaluated.

AIM

This study aim of this study was to evaluate the perceived impact of the LWAP module in practice from student, mentor/manager and service development perspectives, in order to inform future provision.

A recognised model for the evaluation of training and development (Kirkpatrick, 1983) was used to demonstrate how this study adds value by enabling module

evaluation at a deeper level (level 3, that is, behavioural change and indirectly level 4, namely impact on the organisation) than is usually the case.

LITERATURE REVIEW

A systematic review of the literature was undertaken. Key search terms used were: evaluation; evaluation in practice; evaluation of education; leadership; and leadership development. Systematic filtering resulted in 38 papers, of which 14 concerned short, introductory programmes.

Much of the literature on leadership is descriptive and theoretically or practically weak (Hartley and Hinksman, 2003; Williams, 2003) or concerned with much longer, more intensive programmes.

However, critical review of these 14 studies indicates strikingly coherent findings from around the world. This amounts to a small but significant body of fairly robust evidence that introductory programmes have a positive impact on participants in three domains. These encompass: personal behaviour and attitudes; ability to work with others; and improving services.

Although no universal framework for leadership development evaluation has yet been agreed, these three domains would appear to comprise the core of any such structure. However, only a very small proportion of studies have addressed the impact of introductory programmes on

FIG 1. FACTORS INFLUENCING NHS CHANGE



service improvement behaviour in practice (Janes and Wadding, 2004; Krugman and Smith, 2003).

As identified earlier, the main purpose of contemporary leadership programmes is to develop staff who can modernise and improve services. Although there is evidence of their impact in this area, it is very limited, making it the most crucial area for further research.

METHOD

An action-orientated evaluation methodology was used, which combines the focus of process evaluation with the essence of action research. The benefit of this method lies in taking action in the real world (Lathlean, 1994). The study used a qualitative interpretive approach to data collection, which aims to capture and interpret the meaning of in-depth, narrative data on the lived experiences of individuals.

Population and setting

The research was undertaken in the North of England. The potential study population comprised a purposive, initial cohort sample of nine module participants from a range of disciplines and of both sexes, plus a chain referral sample of the practice mentor and line manager for each student. Inclusion and exclusion criteria were developed, based on the study's aims and resources available, to provide equal access in accordance with research governance (DH, 2005). All participants were female registered nurses and worked in one of two large acute NHS trusts.

Research governance and ethical issues

The study was approved by the relevant university research governance committee, NHS trust R&D departments and local research ethics committees. Being a member of university academic staff and module leader presented a potential ethical dilemma in the form of a dependent relationship between researcher and participants (DH, 2005). To minimise this, recruitment to the study began after the students received assessment results.

Data collection

This comprised the development and piloting of a semi-structured interview guide to ensure a degree of continuity and focus for the interviews. One-to-one tape-recorded interviews were then carried out with students, practice mentors and line managers to ensure a range of perspectives were captured. The practice mentors and line managers were identified by each student. Each interview was transcribed verbatim as

soon as possible and participants given the opportunity to verify their transcript.

Data analysis

A recognised framework (Burnard, 1991) guided the thematic analysis of each transcript and provided a transparent audit trail. Data analysis was undertaken independently by the researcher and a colleague who had no involvement in the project, before discussion to confirm the resulting themes. Participants were able to verify the final themes and research report.

RESULTS AND DISCUSSION Demographics

All participants were female – six nurses and one midwife. Of the seven interviews conducted, four were with students and three with people fulfilling the dual role of practice mentor/line manager for students (they will be referred to as mentors here). The mentor for student 1 did not participate. The students attended the module approximately nine months before interview and had been in their current roles from a few months to almost 20 years. Although not specifically asked about years of professional experience, it was apparent during interviews that all were very experienced practitioners.

Themes and sub-themes

Four broad themes emerged from the data. These were: the context of LWAP attendance; impact on the individual; impact on ability to work with others; and impact on service. Each theme comprised a number of sub-themes.

All participants reported a positive impact following module attendance. In contrast to some previous studies (for example, Krugman and Smith, 2003), mentors and students reported broadly the same impact with very few differences. Therefore, variations between groups are highlighted.

Theme 1: LWAP in context

The importance of contextual influences on impact in this study was not new. However, the usefulness of leadership development during a period of either personal or organisational transition was an unexpected finding and has not been identified previously in the literature. All participants were experiencing transition, either personal or organisational.

Similarly, transition was the motivating factor identified by all mentors for recommending the module. The mentor for student 4 said:

'I thought it would be good for her – there [are] a lot of issues within that department that we're wanting to look at and there is a need for a lot more change in there she knows clinically there isn't a problem – it's the leadership skills we're wanting to develop.'

Despite mentors' common reasons for recommending the module, there was wide variation in their expectations.

However, all mentors claimed students had gained from attendance and planned to continue recommending LWAP. This emphasis on transition is a feature of the current practice context and shows the impact of reform and modernisation policy on NHS staff (Wanless, 2004). Mentors in particular saw the module as a means of helping staff to cope with new roles and changing work practices, and to lead NHS transformation.

Theme 2: Impact on the individual

The findings demonstrated evidence of impact on individuals in terms of personal attitudes, skills and knowledge. This theme is broken down into three sub-themes.

● Sub-theme 1: Changed attitudes

Subtle but important changes in attitude were the most frequently cited differences by students and mentors alike. For example, a changed attitude to leadership was common:

'I'd have just normally said no-you do that-but because it's changed my thinking it doesn't always have to be that senior person's responsibility and that has changed me, you know, my way of thinking.' (Student 1)

This underpinned different attitudes to service improvement, resulting in students seeing this as part of their role, leading to increased confidence, motivation and passion for patient-centred care:

'I definitely think from doing the module it gave her a boost, it gave her something to work towards and it gave her the encouragement to really go and work towards making things happen rather than just thinking about it.' (Mentor for student 3)

Interviewees consistently identified increased confidence and self-esteem as a result of LWAP attendance. In addition, mentors highlighted the association between this and participants' increased risk-taking behaviour and willingness to learn from mistakes. This is an important finding as attitudinal change is the most difficult educational outcome to achieve (Ramsden, 1992). Increased confidence, self-esteem and risk-taking underpin self-belief, which is identified as central to leadership

practice changing practice

effectiveness in the NHS (DH, 2002).

● Sub-theme 2: Improved skills

All interviewees highlighted development of several key leadership skills after the module. These were: increased self-awareness; influencing skills including assertiveness and communication; and delegation. The following comments illustrate some of these changes:

'because I learned to look at myself I found it easier to implement the change and I do look at my work differently and I do plan things differently.' (Student 2)

'I have been more assertive and taken people to one side rather than just letting it go, which is a fault of mine, I am too passive. So the course made me recognise that and I'm dealing with it.' (Student 3)

The second example shows how enhanced assertiveness enabled effective accountability, which is another key leadership skill for NHS staff (DH, 2002). These support the findings of previous studies (Janes and Wadding, 2004; Cooper, 2003; Edmonstone and Jeavons, 2000).

● Sub-theme 3: Increased knowledge

LWAP students' increased knowledge was evident in three areas: leadership theory; tools and strategies; and the broader context of leadership practice. First, gaining an understanding of contemporary views on leadership appeared to have the most wide-ranging effect on participants, completely changing their approach to the topic and its relevance to them.

Students' lack of knowledge regarding contemporary leadership approaches was not surprising as this was the first programme most had experienced. However, this raises an important issue, as recent key health and social policy documents emphasise the importance of leaders adopting a transformational approach (DH, 2004; DH, 2000). This study's findings suggest that it is unwise to make assumptions about the understanding of this concept by key service staff.

Secondly, increased knowledge regarding practical tools and strategies for leaders also had an important personal impact on students. In particular, the circle of influence and win/win thinking and assertive communication were highlighted by students. Mentors generally took a broader view, identifying students' improved ability to adapt their behaviour to different people/situations and enhanced ability to implement change as key personal developments.

These findings support strong evidence from previous studies (Janes and Wadding,

2004; Cooper, 2003; Krugman and Smith, 2003; Tourangeau, 2003; Edmonstone and Jeavons, 2000).

Theme 3: Ability to work with others

● Sub-theme 1: Attitudinal changes

Enhanced recognition and appreciation of the contribution of others and ability to motivate them were frequently and consistently identified by students and their mentors/line managers alike, although there were slight differences. This reinforces the need to use other forms of data in addition to self-reporting to ensure the study is trustworthy. Valuing the contribution of others led to an increased willingness to ask for and accept support as this comment by student 3 illustrates:

'My attitudes have changed definitely in that I can rely on people-. I don't have to do it all myself. That's less stressful for me. I do leave time for the other things for me to do with the audit and the extra jobs that you do.'

● Sub-theme 2: Skills development

In terms of enhanced collaborative working skills, the ability to develop and influence others was identified consistently by both groups. Some examples of developing others included encouraging colleagues to problem solve for themselves, plan their own work and develop areas of specialist interest, then share these skills with others. This commonly led to enhanced job satisfaction for colleagues. This finding supports previous work (Hill, 2003; Krugman and Smith, 2003). However, time constraints due to poor staffing levels were identified as a potential barrier, although this was not considered insurmountable.

Enhanced ability to influence others was also identified consistently by both groups and attributed to enhanced communication/empathy, which underpinned the development of more trusting relationships with colleagues. This is illustrated by student 2:

'the consultants, I think the management people find it hard to get [them] to change their mind on things, they're quite a powerful force and quite hard to win over but, if things are put to them in a way that they can view it more positively, we just chip away- small changes and I think it's them gaining confidence in us as people that can make changes.'

This is consistent with a number of other studies. The positive impact on students' ability to work more effectively with others is underpinned by the development of personal skills already discussed above.

Theme 4: Impact on service

● Sub-theme 1: Project characteristics

There was clear evidence of the application of learning in practice as illustrated by the service improvements participants implemented. Student projects had a number of common characteristics. These were: service user focus, multiple stakeholder involvement, unexpected spin-offs and the catalytic effect of module attendance.

Projects included the introduction of: telephone follow-up for orthopaedic patients; reducing the number of inappropriate referrals to a regional antenatal unit; a daily rest period for post-ICU surgical patients; and improving access for antenatal scanning. User-centred evaluation of projects was a module requirement, resulting in comments such as:

'The feedback we had from the patients is that they think it's excellent.' (Student 3)

The multi-stakeholder nature of student projects illustrates the complexity of modern health and social care as well as the application of enhanced collaborative working attitudes and skills by students. This also resulted in a balanced scorecard approach to evaluation. For one project, benefits for clients, administrative, sonography, medical and nursing staff were identified:

'It has had a huge impact and will in future on clinic times [and] consultant time so from the service point of view that's absolutely excellent.' (Mentor for student 2)

Following this success, although roll-out was desirable, the student was aware of the implications of this for other staff, demonstrating her increased knowledge of the broader context of practice.

Strong evidence emerged regarding the role of LWAP as a catalyst for service improvement. Student project ideas were not necessarily new but, in all cases, module attendance created the opportunity, motivation and commitment for implementation:

'She's probably thought about this for a long time and this has just given her that go-ahead to start it.' (Mentor for student 3)

The notion of LWAP as a driver for improvement was an unexpected finding and has not been noted by other authors. It provides a strong argument for the provision of formal programmes incorporating compulsory implementation of a service improvement project.

● Sub-themes 2 and 3: Factors affecting project success

Key contextual and policy drivers for service

improvement were highlighted as facilitating project success, particularly by the mentors. In addition, receiving support from immediate colleagues and managers and a positive organisational culture were strongly associated with effective project implementation by all participants. This finding further supports the literature on this subject.

One feature of this issue is the provision of leadership development as part of a trust-wide strategy, which is the case for LWAP and has been recommended in respect of another short, introductory programme (Cooper, 2003; Edmonstone and Jeavons, 2000).

Both groups of respondents consistently felt students' ability to apply the enhanced knowledge and personal skills gained from module attendance had an impact on the project's success.

Factors such as the multidisciplinary nature of practice and financial constraints were, not surprisingly, identified as barriers to project implementation by both groups of respondents, although these were not considered to be insurmountable. Students, but not mentors, identified cultural issues such as tradition and custom as inhibiting improvement.

The following comment provides one example summarising the wide-ranging impact that module attendance appears to have had on participants and, more importantly, on service delivery:

'At first I thought, it's such a short course, how valuable is that [service project] going to be? But it's demonstrated to me that that was an excellent way to look at it because it's increased [her] self-belief, it's had an impact on the team, it's had an impact on the service and will do in the future. It's just going to grow and grow and, from one module of introduction, I think what she's achieved is tremendous and it's only reflecting back now that I've probably realised just how far she's come.' (Mentor for student 2)

STUDY LIMITATIONS

One limitation of this study is that none of the students who failed to submit the module assignment participated. This may have been for a number of reasons including: they had a negative experience of the module; they did not value the academic credits attached to it; were too busy to take time out of practice to participate; or they assumed that the invitation had been sent in error. In addition, all participants were women.

CONCLUSION

In conclusion, a review of the literature revealed limited evidence of the impact of introductory leadership development programmes on participants and practice.

In addition, the absence of an agreed evaluation framework is apparent despite the fact that there has been massive investment in development opportunities for health and social care staff in recent years. The nebulous concept of leadership in health and social care practice requires a multi-faceted approach to evaluation. Despite some differences, the findings are strikingly similar to those of previous studies evaluating the impact of short leadership development programmes carried out in a number of countries.

This study's main contribution to the literature is its focus on the application of learning in practice through the implementation of service improvement projects. This enabled us to explore the impact of LWAP at level 3 (behavioural change) and indirectly at level 4 (impact on the organisation). This is a major gap in the current body of knowledge, which this study addresses by providing evidence of service improvement following module attendance.

While recognising the study's limitations, this research indicates that the LWAP leadership development programme is an effective organisational development strategy. The findings indicate that LWAP can simultaneously drive the modernisation of service delivery and empower the workforce to deliver this.

Thus, based on the study findings and the limited empirical research, the following structure for a universally applicable leadership development evaluation framework is proposed. This should explore programme impact in three domains: impact on the individual; ability to work with others; and service improvement. It should use a mixed methods approach, incorporating formal or informal 360-degree feedback from service users, colleagues and managers.

RECOMMENDATIONS

- Testing of the proposed evaluation structure incorporating three domains (impact on the individual; ability to work with others; and service improvement) on a larger sample and other leadership development programmes;
- Quantitative evaluation of the impact of LWAP service improvement projects on service costs, staffing levels, skill-mix and patient satisfaction;

- Evaluation of the service improvement impact of such programmes with no compulsory service improvement project;
- Evaluation of the impact of LWAP on non-nursing participants, for example allied health professionals, and administrative, technical and support staff;
- Evaluation of its impact on participants who did not complete the module.

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Practice changing practice

KEYWORDS PATIENT EXPERIENCE | COMPASSION | DIGNITY

Exploring how to ensure compassionate care in hospital to improve patient experience

The King's Fund Point of Care programme explores the barriers to providing compassionate care in hospital and how nurses can ensure such care

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This article is the first in a series by the King's Fund Point of Care programme looking at practical interventions to improve patients' experiences of care. It discusses what compassion means, what might prevent consistent compassionate care and what practical changes could ensure compassion.

INTRODUCTION

Care, compassion and respect have always been enshrined in the value statements of the health professions (NMC, 2009; 2008).

However, 'compassion' has recently gained a higher profile with policymakers. The NHS Constitution sets out certain NHS values including respect, dignity and compassion: '[The NHS] touches our lives at times of most basic human need, when care and compassion are what matter most' (Department of Health, 2009).

We wanted to look more closely at compassionate care – what it is, what prevents it and what enables staff, day in and day out, to be compassionate towards every patient in their care. To do this, we held a one-day workshop bringing together people who work in hospital (nurses, doctors, psychologists, chaplains, managers) and experts who have written on or researched the topic.

We have also published a short paper reviewing the literature on compassion and concepts related to it (Firth-Cozens, 2009). This article is based on the discussions at the workshop as well as the paper (see www.kingsfund.org.uk/pointofcare_compassion).

WHY DOES COMPASSIONATE CARE MATTER?

Healthcare staff want to be able to care for patients with humanity and decency and to give patients the same kind of care that they would want for themselves or their loved ones (Goodrich and Cornwell, 2008).

For many staff, such a desire may have been a motivating factor in their decision to enter the healthcare professions in the first place. Practitioners want to be able to show compassion to the patients under their care.

Compassionate care matters to patients. Anecdotally, it is the presence or absence of compassion that often marks the lasting and vivid memories patients and family members retain about the overall experience of care in hospital and other settings.

Improving patients' satisfaction about their experience of care is an outcome most patients and families agree has value in itself, and is emphasised in the goals in recent key policy documents (Department of Health, 2008).

Research evidence suggests that compassion affects the effectiveness of treatment. For example, patients treated by a compassionate caregiver tend to share more information about their symptoms and concerns, which in turn yields more accurate understanding and diagnoses (Epstein et al, 2005).

In addition, since anxiety and fear delay healing (Cole-King and Harding, 2001), and compassionate behaviour reduces patient anxiety (Gilbert and Procter, 2006), it seems likely that compassionate care can have positive effects on patients' rate of recovery and ability to heal.

THE ELEMENTS OF COMPASSION

Compassion, in simple terms, is 'a deep awareness of the suffering of another coupled with the wish to relieve it' (Chochinov, 2007).

Compassion requires that staff give something of themselves. When fatigue,

personal factors and organisational circumstances conspire to create workplace stress, it becomes more difficult for staff to feel and show compassion, creating a gap between their intentions and their capabilities.

Sometimes it is easier to identify when compassion is missing than when it is present. In the broadcast and print reports of failures in hospital care – such as, for example, the reports of the Healthcare Commission's (2009) and (2007) investigations into Mid Staffordshire and Maidstone and Tunbridge Wells NHS trusts – it is the apparent lack of compassion that fuels media outrage.

It is important to note that the focus on compassion should not reside merely at the 'sharpest ends' of care – that is, in emergency situations, or when a patient is known to be dying. Lack of compassion in mundane aspects of acute and everyday care also takes its toll on patients and staff. Indeed, it is the 'little things' that patients or carers often recall as having been either present or lacking in their experiences of care. For examples of these 'little things' go to www.kingsfund.org.uk/pointofcare_compassion. The elements of compassion, as defined in particular relation to health care, are described in Box 1.

ASSESSING COMPASSION

How do we assess how good we are at delivering compassionate care? The question is important, but it also presents an immediate, inherent challenge in an NHS reliant on quantified targets and measures.

If we accept that compassion is a felt experience, it follows that the closest we can come to measuring compassion is to ask patients whether or not they experienced it. Measures of compassion must rely to a large degree on patients' own subjective assessments of their experiences of care, which can be obtained in a variety of ways: interviews; questionnaires; frequent feedback mechanisms; and surveys.

BOX 1. THE ELEMENTS OF COMPASSION

- Compassion starts with good basic care and can be demonstrated in very practical ways – for example making sure that a patient’s feeding needs are addressed, that pain is managed and that the patient is helped to the toilet as needed. It can be equated with providing both dignity and respect.

- Compassion goes beyond essential care, however, to encompass ‘empathy, respect, a recognition of the uniqueness of another individual and the willingness to enter into a relationship in which not only the knowledge but the intuitions, strengths, and emotions of both the patient and the [caregiver] can be fully engaged’ (Lowenstein, 2008).

- As such, compassion involves ‘real dialogue’ – communication that is human to human rather than clinician to patient.

- The compassionate caregiver never stereotypes but appreciates difference, recognising the common humanity shared by both patient and caregiver.

- Compassion should not necessarily be seen as being sweet and nice. It includes honesty and may require courage.

- It is not a one-size-fits-all approach.

Compassion can mean very different things in different situations and to different people. In recognising the individuality of each patient, compassionate carers will also recognise how best to tailor their behaviour to show compassion based on an individual’s needs.

- In short, for healthcare professionals, compassion means seeing the person in the patient at all times and at all points of care.

There are other types of measure that might also be considered – measures of process and measures of structure. Since compassion can demonstrate itself in very practical ways, there are objective, practical measures that may indicate or point to its presence or absence (the ‘feeling for’ the patient) in the way care is delivered.

In this way, we can say that many of the physical indicators already assessed, while they might not measure compassion directly, do point towards it. The measures we have in mind are ones such as: how quickly staff respond to call bells; whether patients’ feeding needs are attended to; how well pain is managed; and how often and at what times of

day or night patients are moved from ward to ward. All of these have an impact on continuity of care and relationships between staff and patients.

These basic indicators of aspects of quality of care may tell us something about attitudes and behaviours that are important with respect to compassion. Poor performance in any of these dimensions may not be caused by a lack of compassion but rather might be taken as indications of environments in which patients are at risk of feeling uncared for, and therefore merit further investigation.

Structural measures that complete the more rounded attempt to measure compassion would be measures of risk in the physical environment or risk to staff capability to deliver compassionate care. Risk in the physical environment of care would need to be observed and audited. Risks to staff capability would be available from feedback in staff surveys to questions about the quality of leadership and support and teamworking. They would also be available in some of the human resource data such as: measures of staff turnover; vacancy rates; and the use of bank and agency staff in different locations.

WHAT STOPS COMPASSIONATE CARE FROM HAPPENING?

Why, when staff may have entered the healthcare profession with high ideals, abundant stores of compassion and a strong motivation to treat patients as they themselves would want to be treated, do lapses in compassionate care sometimes occur?

The main reason may involve the natural defences we develop in reaction to trauma. In care settings, staff experience regular, frequent or in some cases continuous exposure to human beings in varying states of pain and distress. Sometimes the defence takes the form of inappropriate joking; sometimes it manifests itself in numbing, a distancing reaction and withdrawal, as described by an acute care nurse in Box 2.

The key point is that under these conditions, practitioners must develop coping mechanisms – some more effective or appropriate than others.

Staff who do not find effective ways of coping may be more susceptible to stress and burnout. Self-reported stress of health service staff in general is considerably greater than that of the general working population (Wall et al, 1997).

Stress and depression is evidenced by high self-criticism (Brewin and Firth-Cozens, 1997), and a lack of compassion towards oneself is likely to work its way through to a lack of compassion towards patients (Gilbert, 2009).

Stress and burnout have their origins in different sources, some of them individual, some of them situational:

- Individual factors:

- Age and experience;

- Self-esteem levels;

- Personal resilience;

- Job satisfaction.

- Situational factors:

- Regular exposure to pain and distress;

- Conflicting information about what the organisation expects from staff or what is valued in the organisation;

- Poor feedback systems or lack of recognition or praise for individual acts of compassion and care;

- Lack of time and simultaneous pressure to meet targets.

Compassion, too, can become problematic for staff in settings where displays of emotion are treated as a failure to maintain an appropriate professional distance or authority. Though not necessarily unique to any one profession, this is particularly relevant to those in roles that place a high value on professional detachment. Such attitudes are more commonly associated with doctors but perhaps increasingly prevalent in nursing.

The role of education in teaching healthcare staff professional values and standards is also important. In medicine, the psychosocial aspects of caregiving have tended to command

BOX 2. AN ACUTE CARE NURSE’S VIEW

On staff coping with constant exposure to death and dying:

I went to work on an elderly ward where patients died daily and there was great pressure on beds. At first, I did all I could to make the lead-up to a death have some meaning and to feel something when one of them died. But, gradually, the number of deaths and the need to strip down beds and get another patient in as fast as you can got to me and I became numb to the patients; it became just about the rate of turnover, nothing else. (Firth-Cozens, 2009)

Practice changing practice

secondary status, and workshop participants felt this was increasingly common in nursing training. Training that emphasises professional detachment and positions compassion as 'soft and fluffy' may have a detrimental impact on interpersonal relationships between staff and patients – and to the quality of care delivered.

Even where the value of compassion is taught in the syllabus, there is a concern that, without systematic modelling and explicit endorsement and support for striving to be compassionate towards every patient, every time, it will be eroded and more difficult to practise.

ENABLING COMPASSION

When staff caring for patients feel under pressure and are subject to time constraints, it is often difficult to do just that one thing for the patient that makes the individual feel cared for. Enabling staff to feel and be compassionate towards patients in their care, at all times, requires action on multiple levels.

At an individual level, a powerful resource that healthcare professionals consistently cite is patients' stories.

In cases where professionals themselves, or their loved ones, become patients, the nature of their personal experience of care very often has a profound effect on how they carry out their clinical practice. Where first-hand experiences of care are not available, exercises in which staff are asked to role-play or write a narrative imagining themselves as patients can have a similar usefulness.

Providing practitioners with a forum for open and honest dialogue about their experiences of delivering care is similarly important. A safe and recrimination-free environment in which to discuss the everyday challenges, frustrations and pressures of the job – in which sharing stories and feelings about patients and their care is legitimised – is essential.

It helps to remind busy staff that every patient is individual and unique; it provides support to individuals; it encourages communication within the team; and it helps to improve team dynamics.

Good team relations make a difference not only to the quality of interactions among team members but also to the quality of care delivered to patients (see Box 3 for the markers of a good team). As such, enabling good teamworking is important.

Within teams, those in senior positions can

BOX 3. THE CHARACTERISTICS OF A GOOD TEAM

- Its task is defined and its objectives are clear
- It has reasonably clear boundaries and is not too large (ideally fewer than 10 people)
- Its members know who leads it and the leadership is good
- There is participation in decision-making by all members, good communication and frequent interaction between them
- It meets regularly to review its objectives, methods and effectiveness
- Its meetings are well conducted
- Its members trust each other and feel safe to speak their minds
- There is a shared commitment

enable compassion among staff by modelling compassionate behaviours – towards themselves, other staff and patients – often through relatively simple gestures, for example by encouraging a junior colleague to take a meal break or by taking one themselves.

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We also need to focus our attention on the formative stages of the professions, while nurses and doctors are learning their roles within a hospital. If modelling compassionate behaviour is crucial in the message it sends to all levels of staff, it is especially so when students are in hospital to observe and learn. Mentoring is particularly important in teaching settings and for practitioners at the start of their careers.

None of these suggestions will make much impact, however, if staff remain unaware of what is valued in the organisation or feel undervalued in their jobs. Providing regular feedback to staff on their performance and providing recognition when they deliver compassionate care can help alleviate stress and counter poor organisational morale.

Finally, acute care could learn a lesson from palliative care. With its primary emphasis on patients' experience, on their physical and psychological comfort and quality of life, the palliative care setting can serve as a model of how to better integrate a focus on compassion into care delivery. ●

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Developing a nursing education project in partnership: leadership in compassionate care

A project developed in partnership between an NHS board and a university has focused on promoting the importance of compassionate care in nursing practice

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ABSTRACT Adamson, E. et al (2009) Developing a project in partnership: leadership in compassionate care. *Nursing Times*; 105: 35, 23–26.

The prominence of the caring dimension has never had such a high profile in healthcare practice before.

As a result of this, the Leadership in Compassionate Care Project has evolved. A unique feature is the partnership between Edinburgh Napier University and NHS Lothian. Engaging with and helping qualified and student nurses to value and promote the delivery of compassionate care is a primary focus of the project.

This article outlines key policy drivers, the project's four main strands, and the aims, processes and perceived impact on practice.

BACKGROUND AND POLITICAL DRIVERS

Over the last decade, there has been an increasing emphasis on the caring dimension in healthcare policy, practice and research. This is particularly evident in policy documents emphasising the importance of person centred care (The Scottish Government, 2007; Scottish Executive, 2006a; 2006b; Department of Health, 2003).

It is apparent from these documents and a number of recent national projects that compassionate care is considered fundamental to nursing practice.

The importance and centrality of compassion in nursing has gained increasing prominence as a result of these many policy drivers. However, alongside this, an immense diversity of views has emerged on defining or conceptualising caring, which has tended to increase its elusiveness (Schantz, 2007). Basset (2002) suggested

that many authors believe that 'care is the central and unifying core in nursing' and argued that it was vital for nurses to understand this.

Nevertheless, it is evident from nursing literature that there are difficulties in defining both caring itself and the idea of compassionate care. Compassion has been called the prelude to caring, and caring has been described as the essence of nursing (Beauchamp and Childress, 2009). Care has also been described as "a human trait, an affect, a moral imperative, an interpersonal interaction, or as a series of therapeutic interventions" (Lavoie et al, 2006).

What does this tell us about delivering compassionate care in practice?

Leadership project

While research can be found on the subject of caring in general, less is available on the subject of compassionate nursing practice, and what nurses and student nurses understand this to be and how they take this into practice settings.

This was one of the main catalysts which led to the conception of the Leadership in Compassionate Care Project. In particular, there was a need to understand what compassionate care means both for patients and nurses, and how we could help students and registered nurses throughout NHS Lothian deliver such care.

A unique feature of this project was the strong partnership forged between Edinburgh Napier University and NHS Lothian.

It is apparent from recommendations in various policy documents that person centred care is expected to be a fundamental feature of nursing practice. It is imperative that patients' individual experience of care is the best that it can be, and meets their particular needs.

Attree (2001) found that aspects of care which patients valued in their relationships with nurses included open communication, kindness, concern, sensitivity and time spent with them. Patients rated dignity and privacy

highly, and being included in decision-making processes was also important.

Delivering holistic nursing care can be challenging as the many pressures in clinical settings continue to increase.

According to Goodman (2004), patients tend to judge the quality of technical aspects of care by healthcare professionals' interest and concern for their health and welfare. For patients, how care is delivered can be as important as the treatment itself.

It is evident from the literature that patients welcome compassionate care and it influences their perception of the quality of care provided (Henderson et al, 2007; Goodman, 2004; Attree, 2001; Lothian and Philip, 2001). Their experiences indicate that compassionate care cannot always be taken for granted (NHS Confederation, 2008).

Initially, the project team explored the meaning of compassionate care. A number of aims were identified and, from these, a project plan emerged. Fig 1 on p24 shows the links between the project's aims and strands and those who would benefit. The plan provided a useful guide for the team as the project evolved and also an effective tool for communicating aspects of the project.

Vital to the success of the project's development was the working partnership between the university and nursing staff.

Scott (2008) suggested that close partnerships between education and practice can cultivate a caring culture in healthcare. This was achieved on a number of levels in both organisations; NHS senior nurses and university lecturers participated in the project working group.

It was also considered vital that project development information reached all stakeholders, so routes of dissemination included roadshows, newsletters, email and face-to-face conversations.

As the project evolved, four strands emerged:

- Influencing nurse education by embedding the principles of compassionate care in the curriculum;

practice changing practice

- Supporting newly qualified nurses;
- Facilitating leadership skills development;
- Identifying beacon wards as centres of excellence in compassionate care.

PROJECT STRANDS Influencing nurse education

A priority was to influence education through embedding person centred, compassionate nursing practice in the nursing and midwifery programmes. This strand involved reviewing module descriptions and curriculum content to ensure the integration of person centred, compassionate care as a theme.

A questionnaire elicited students nurses' views of compassionate care in their programme. Their understanding of compassionate care was also explored. This information provided a baseline from which to build on and to ensure that compassionate care became a living theme through all teaching materials and learning activities.

Identifying beacon wards

The areas initially chosen to champion compassionate nursing practice were named beacon wards. Aspects of their good practice would be identified with the aim of sharing these with other clinical areas.

A list of desirable criteria for the beacon wards was developed. This focused on the following three key areas:

- Caring environment – initiatives demonstrating holistic and person centred care;
- Evidence of collaborative and effective team working – good ward communication, efficient team organisation and use of resources;
- Evidence of staff development – mentorship and preceptorship training and student evaluation.

All clinical areas in NHS Lothian interested in becoming part of the project were asked to present a portfolio to showcase their ward/clinical area. The project team provided support and guidance on portfolio development. The portfolio enabled staff to reflect on their 'caring practices' and highlighted many patient centred initiatives.

Eighteen portfolios were presented from a wide range of adult nursing specialties; six were shortlisted. Members of the project team, including the director of nursing and a senior academic from Edinburgh Napier University, visited the areas.

Following an in-depth selection process, four clinical areas were chosen for the initial programme of development work and awarded beacon status.

Aims of beacon wards

The project team identified a number of broad aims for the beacon wards:

- Develop an understanding of

compassionate care from the perspectives of patients, families and healthcare staff;

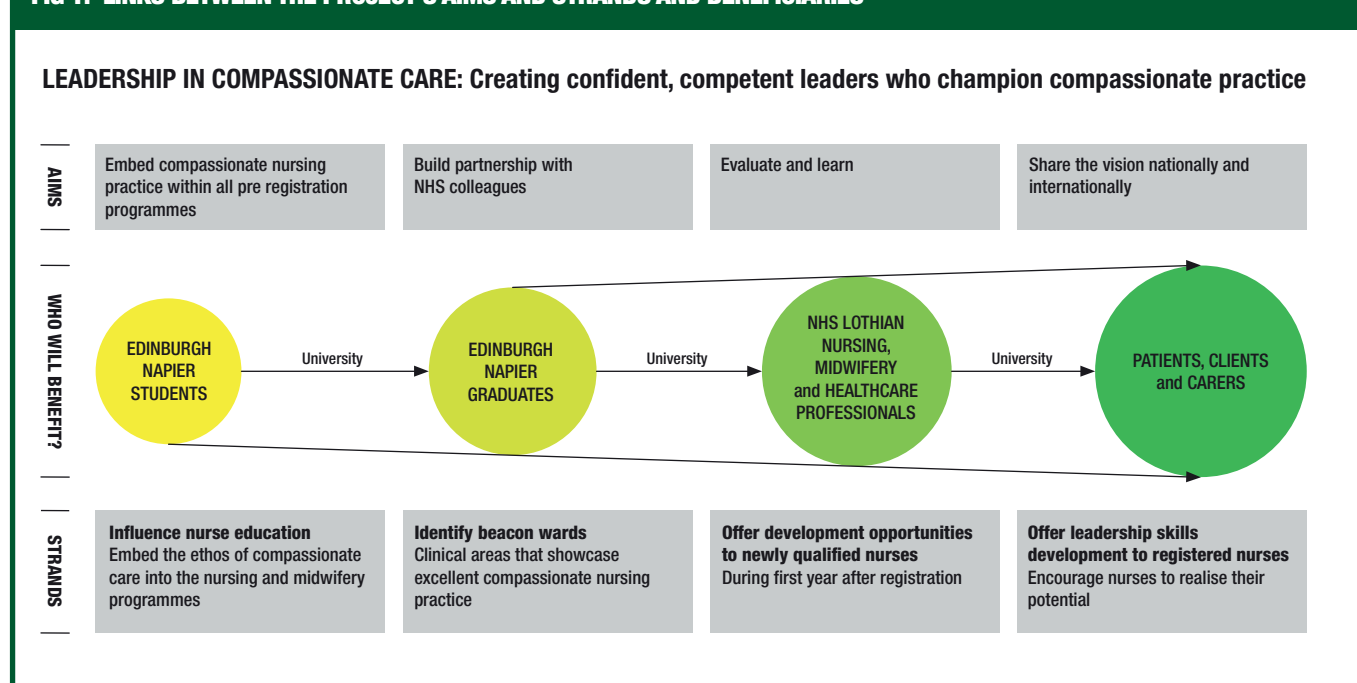
- Identify a 'working definition' of compassionate care;
- Develop key principles of compassionate nursing practice;
- Develop standards/best practice statements for compassionate care;
- Identify a practice development approach that would enable change and enhance compassionate nursing practice;
- Provide student nurses on placement in the beacon wards with exposure to compassionate care project developments;
- Ensure that all relevant experiences are studied, developed and shared so that best practice is rolled out across NHS Lothian;
- Feed back learning from work in the beacon wards into the nursing undergraduate programme.

Four senior nurses in compassionate care were appointed, one in each of the beacon wards. They helped staff to identify the structures and processes which enabled compassionate nursing practice to be consistently delivered.

Development opportunities for newly qualified nurses

Research by O'Brien-Pallas et al (2006) and Evans (2001) showed that many newly qualified nurses lack confidence and find their work environment challenging; this

FIG 1. LINKS BETWEEN THE PROJECT'S AIMS AND STRANDS AND BENEFICIARIES



affects their ability to provide compassionate care. It is evident that holistic nursing care requires commitment, confidence and competence to demonstrate a compassionate approach to care-giving.

The aim of this strand is to provide ongoing support for all newly qualified nurses working in NHS Lothian during their first year in practice. The DH (2008) linked confidence with the ability to care. In addition, Carter et al (2008) found the presence of a supportive peer culture is pivotal to creating and sustaining caring practices.

Our approach to supporting newly qualified nurses in practice involved a series of study days. Four took place in the first year and their content incorporated dynamic learning opportunities such as the use of role-modelling and drama. This drew on the findings of Harrison (2006), who suggested that incorporating artistic methods into nurse education can be an effective way of developing compassion.

Leadership skills development for registered nurses

This strand offers leadership development to nurses interested in taking forward a practice initiative focusing on compassionate care in their clinical area, such as protecting patient mealtimes. By adopting an inclusive approach, all members of the multidisciplinary team could be involved. McCormack and Garbett (2001) supported this, as they found that development initiatives were most effective when staff took ownership.

Facilitated action learning was planned to enable personal and professional development by providing the opportunity to reflect on practice issues and explore solutions. Study days were also organised to facilitate practice development skills that could then be used to help nurses to implement and evaluate their change in practice.

Table 1 sets out the aims, processes and the anticipated impact on practice.

CONCLUSION

The planning and development stages of the Leadership in Compassionate Care Project were vital to realising its vision and aims. This was ultimately based on a unique working partnership between education and practice.

The project continues to evolve and it is evident that awareness has been raised at different levels in educational and practice settings about the nature of compassionate care and delivering this in practice.

The impact of the various strands in terms of delivering the project vision and the potential this has to transform practice will continue to become apparent and be reported as it progresses.

Several national projects have recently emerged with a common aim of individualising patient experience. It is hoped the findings from the Leadership in Compassionate Care Project will have a positive impact on nursing practice nationally and internationally. ●

TABLE 1. AIMS, PROCESSES AND ANTICIPATED IMPACT ON PRACTICE

| Overarching aim | Principal processes | Impact on practice |
|---|--|---|
| Create confident, competent and compassionate leaders | <ul style="list-style-type: none"> ● Ensure that compassionate nursing practice is embedded in pre-registration nursing programmes ● Maintain the university and NHS partnership and, through this, ensure that compassionate care is promoted in both clinical practice and the university ● Ensure that learning and findings continually inform the evolving project ● Share the vision for compassionate nursing practice at every opportunity | <ul style="list-style-type: none"> ● Confident leaders who are able to champion compassionate nursing practice ● Registrars who are caring and competent ● Satisfied patients |
| Aims | Process | Impact on practice |
| Embed compassionate nursing practice in all pre-registration programmes | <ul style="list-style-type: none"> ● Encourage student centred learning ● Provide students with decision-making skills ● Review the personal development tutor role to enhance the personal and professional support offered to students ● Lecturers promote person centeredness and compassionate care in all interactions. Lecturers make caring practices explicit in all teaching sessions and reflective activities ● Set up supportive and nurturing relationships with all new university students throughout the programme ● Offer pastoral support for students through an independent adviser ● Build student/teacher relationships and supportive networks ● Offer mentor/buddy systems, where established students befriend new students and help them to settle into university | <p>Nurses and midwives who demonstrate delivery of care that:</p> <ul style="list-style-type: none"> ● Is person centred ● Is respectful and dignified ● Enhances patients' experience of healthcare |
| Build partnership with NHS colleagues | <ul style="list-style-type: none"> ● Seek agreement about the project vision ● Design joint working on sub-projects to influence and enhance the delivery of compassionate care ● Set up regular meetings to maintain effective communication between education and practice | <ul style="list-style-type: none"> ● A unified approach to care delivery ● The development of common goals and values in both practice and education |
| Evaluate and learn | <ul style="list-style-type: none"> ● Ongoing evaluation of the project through focus group discussions ● Feedback from students using satisfaction questionnaires ● Shared learning between key stakeholders | <ul style="list-style-type: none"> ● Gaps in delivery of compassionate care identified ● Measures taken to address these ● The meaning of compassionate care made more explicit |
| Share the vision nationally and internationally | <ul style="list-style-type: none"> ● Network between higher education institutes and practice areas locally, nationally and internationally (newsletter, website) ● The organisation of an international conference to share good practice ● Dissemination of project findings through publication | The establishment of good practice in compassionate nursing practice |

practice changing practice

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Compassion in nursing 1: defining, identifying and measuring this essential quality

An outline of what compassion is, how it is an integral part of care and relates to dignity, and how it might be measured in both qualified and student nurses

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ABSTRACT Davison, N., Williams, K. (2009) *Compassion in nursing 1: defining, identifying and measuring this essential quality*. *Nursing Times*; 105: 36, 16–18. The first in this two-part unit on compassion examines the concept of compassion, and how it can be identified and measured in practice. It also discusses the level of compassion expected in nursing.

INTRODUCTION

Compassionate care is a key product of healthcare providers and is expected by the public (Burdett Trust for Nursing, 2006). It is also a vital aspect of good nursing care (Johnson, 2008).

Using computers and doing administrative work are also part of modern nurses' daily routine, and it is claimed that these have distracted them from being compassionate (Black, 2008).

Alan Johnson, the health secretary until June 2009, also viewed compassion as important (Carvel, 2008). In June 2008, he trailed plans to develop quality indicators that would rate the performance of ward nursing teams, possibly including compassion (Carvel, 2008).

This was followed by Lord Darzi's NHS Next Stage Review, which formally announced that a set of national metrics would be developed (Department of Health, 2008).

In May 2009, the government published a set of over 200 quality indicators, with 53 on patient experience, covering dignity and respect and focusing on the person (The NHS Information Centre for Health and Social Care, 2009).

In addition, the NHS Constitution sets out certain NHS values, including respect, dignity and compassion (Cornwell and Goodrich, 2009; DH, 2009).

Nurses have long expressed concern that they do not have enough time to care for patients properly (*British Journal of Nursing*, 2004), and that tasks, routines and documentation take priority over holistic care (Pearcey, 2007).

The new metrics may cause dilemmas for nurses. Should nurses aim to provide high quality care – for which they have little enough time – or do they risk being distracted by addressing indicators which may measure superficial aspects of care?

LEARNING OBJECTIVES

- Describe the contribution that compassion makes to clinical practice.
- Identify the challenges involved in defining and measuring compassion.

Compassion and nursing

The link between compassion and nursing is not new. Schantz (2007) suggested that, at present, it is not encouraged in nursing practice where it may have become optional.

Society has witnessed an increase in the power of technology. This appears to be mirrored in nursing, where the technical and managerial aspects of care take priority over its delivery – possibly because the expansion of nurses' role has eroded the essence of nursing (Wright, 2004).

There needs to be debate within the profession about what exactly constitutes compassion. Consideration also needs to be given to the most appropriate method of measuring compassion, as well as how it can be identified in nursing applicants and developed in student nurses. Conditions that encourage compassion in nursing practice also need to be explored.

WHAT IS COMPASSION?

Compassion, or caring, can be viewed as "nursing's most precious asset" (Schantz, 2007), a fundamental element of nursing care (Dietze and Orb, 2000), and one of the strengths of the profession.

According to Torjuul et al (2007), it involves being close to patients and seeing their situation as more than a medical scenario and routine procedures.

The politician's notion of compassion, according to Alan Johnson, features smiles and empathetic care (Carvel, 2008). Is compassion more than the sum of these two behaviours?

One of the difficulties in considering issues such as compassion is that everyone – patients, nurses and politicians – will have their own personal, subjective definition. Personal definitions fit in with our own view of the world, but may have little in common with the views of others.

Schantz (2007) noted that there may be confusion over the exact definition of compassion because words such as caring, sympathy, empathy, compassionate care and compassion are used interchangeably.

The role played by empathy and sympathy in care provision is clarified by Dietze and Orb (2000), who argued: "Empathy and sympathy in or of themselves do not imply good therapy or care: they are simply part of the conditions required for appropriate therapeutic intervention."

Pearcey (2007) found that student nurses considered that it was doing the little things for patients that constituted a caring approach. She offered the perspective that nursing has a functional component or "doing" role, as well as a "being" role.

Ultimately, "compassion impels and empowers people to not only acknowledge, but also act" (Schantz, 2007). This involves focusing on another person's needs and channelling the emotion generated by their predicament into an active response.

There appear to be two elements involved in professional caring: instrumental caring, which includes the required skills and knowledge; and expressive caring, which involves the emotional aspects. Expressive caring changes nursing actions into caring (Woodward, 1997). This could help to explain why some nurses are technically competent, but do not seem outwardly compassionate.

However, Roach (2002) considered compassion – along with confidence, competence, conscience, commitment and comportment – as one of the six core elements of caring. If nurses claim to genuinely care for their patients, then without compassion, their caring may be incomplete and lacking.

IDENTIFYING AND MEASURING COMPASSION

Educators have the responsibility of identifying applicants to nurse education programmes who are compassionate or who have the potential to become compassionate nurses.

This is problematic because exactly what constitutes compassion is not clear, and trying to identify evidence of compassion in applicants is difficult. Evidence that an applicant has compassion can be sought from statements on caring made on an application form, or possibly provided by a referee.

Even having selected candidates who display the necessary qualities is no guarantee that, at the end of a pre-registration course,

they will still have these qualities. During educational programmes, students' values may be influenced by the informal curriculum (Johnson, 2008).

Teachers and mentors in both clinical and more formal educational environments may impart their own values and it is usually assumed that these influences will be negative, leading to "compassion fatigue" or burnout. This is thought to result from exposure to the realities of professional life, including trying to meet patients' needs while coping with the demands of the service and managers (Johnson, 2008).

Apart from the difficulties in attempting to recognise and develop compassion in applicants and students, there are difficulties and possibly dangers in measuring the compassion shown by nurses. The consequences of measuring compassion needs serious consideration before any attempt is made to rate or judge nurses because compassion is viewed as part of being a human (Proctor, 2000).

If a measurement tool indicates that a team of nurses lack compassion, this equates to saying they lack a fundamental human quality (Schantz, 2007), which could have significant negative consequences for individual team members.

WHAT LEVEL OF COMPASSION DOES THE PROFESSION EXPECT?

Student nurses are assessed on their ability to provide compassionate care in practice.

The NMC (2007) identified compassion, along with "care and communication" as an essential skills cluster that complements the proficiencies student nurses are required to achieve to register. The essential skills cluster states that student nurses need to provide competent and confidential care, treat patients like partners and in a dignified manner, and provide care without discrimination in a warm, sensitive and compassionate way.

It seems entirely appropriate for a caring-based discipline such as nursing to specify the fundamental elements needed for professional practice. The problem remains that, in the absence of clear, observable behaviours and traits that are agreed as reliable indicators of compassion, mentors will struggle to make judgements about what constitutes compassion in the next generation of nurses.

Mentors also face the difficulty common to all nurses of deciding what compassion really is and, consequently, their judgements about

the suitability of student nurses to join the register could be influenced by subjective views about compassion in practice.

Registered nurses are guided by the NMC's (2008) code of conduct, which demands that they respect the dignity of those receiving care. The concept of dignity, like compassion, is abstract and difficult to measure (Fenton and Mitchell, 2002).

Compassion is viewed as an integral part of dignity (RCN, 2008) and nurses' compassion plays a major role in providing dignified care to patients. Compassionate care enables patients to remain independent and retain their dignity (Dietze and Orb, 2000).

CONCLUSION

There is agreement in nursing literature and practice that the delivery of compassionate care is more than the competent execution of clinical skills; it involves a "doing role" and a "being role". Patients consider it is vital that they are "cared for" and "cared about" (National Nursing Research Unit, 2008).

Nurses themselves have to appreciate that clinical practice is changing and will continue to do so, and need to recognise that advanced clinical skills and compassionate care are not mutually exclusive; high tech does not have to mean low care.

This does not ignore the fact that there are and will continue to be tensions when attempting to truly care for patients with increasing use of technology, more acutely ill patients, fewer nurses and increased managerial functions for practitioners (Corbin, 2008). ●

Part 2 of this unit, to be published in next week's issue, looks at factors that influence compassion in clinical practice

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Compassion in nursing 2: factors that influence compassionate care in clinical practice

Exploring the professional, personal, cultural and educational factors that influence compassionate care, and how nurse educators can encourage it

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ABSTRACT Davison, N., Williams, K. (2009) *Compassion in nursing 2: factors that influence compassionate care in clinical practice. Nursing Times*; 105: 37, 18-19. This second in a two-part unit on compassion examines the factors that influence the use of this quality in daily clinical practice. Part 1 examined the concept of compassion and how to identify and measure it.

FACTORS THAT INFLUENCE COMPASSION

Caring for others is a fundamental part of nursing practice (Corbin, 2008).

It is difficult to imagine that nurses would not want to be compassionate to patients, but some factors interfere with good intentions and prevent them from being translated into actions.

Issues that may inhibit compassion in everyday nursing practice can be classified as professional, cultural and personal.

Professional factors

The availability and use of time can influence compassionate care. Pearcey (2007) studied third year student nurses' perceptions of clinical practice and, unsurprisingly, lack of time was seen to equate with lack of care.

There are suggestions that newly qualified graduate nurses acquire knowledge from textbooks, which ill equips them for clinical practice (Tweddell, 2007), limiting their ability to provide compassionate care. This criticism fails to acknowledge that, on pre-registration courses, half the education takes place in clinical practice.

Torjuul et al (2007) found experienced surgical nurses questioned the ability of newly qualified practitioners to be as compassionate as more experienced colleagues, but this view was based on their

lack of experience in challenging clinical situations. Tweddell (2007) suggested that compassion develops with experience. More experienced surgical nurses reported that being close to patients and relatives and witnessing their suffering allowed practitioners to see in a compassionate way (Torjuul et al, 2007).

Knowlden (1998) suggested that experience influences nurses' ability to be caring, as student nurses said they were often overwhelmed by the working environment. Therefore, it could be not the amount of clinical experience but the length of time it takes nurses to acclimatise which is important. Support mechanisms such as preceptorship and clinical supervision may have a role in facilitating compassionate care.

Wright (2004) argued that "personal, professional and healthcare agendas seem to draw us ever further away from the heart of nursing". He suggested that activities considered to be intellectually demanding, such as managerial and technical aspects of care, are perceived as more important than "hands-on" care. Managerial and technical functions are more likely to be carried out by more senior or experienced nurses, drawing them away from direct care, whereas newly qualified nurses will have comparatively fewer of these responsibilities.

Pearcey's (2007) study offers some support for Wright's views. Student nurses said that qualified nurses mainly cared for patients' medical needs, with the core element of nursing delegated to junior practitioners.

Many years ago, a "task-centred" approach to organising care was proposed as a possible defence mechanism against the anxiety that a more interpersonal style of working creates (Menzies, 1970). This may offer some insight into the behaviour of nurses who seek refuge in form filling and other activities not directly related to care.

Factors that inhibit compassionate care

LEARNING OBJECTIVES

- Describe factors that can influence the provision of compassionate care.
- Outline activities that student nurses could do to develop compassionate skills.

cannot be considered in isolation. As one student nurse explained: "A lot of the time, staff would probably like to spend more time 'caring' for patients, however with staffing levels as they are, nursing priorities are more to ensure that patients' medical needs are met first, then if

there is time the nurse can work on going beyond what is expected" (Pearcey, 2007). This indicates a belief that, at a basic level, nurses' role is to attend to medical needs, with additional care viewed as optional.

Caring for others may have a personal cost for nurses, and the effect of helping or wanting to help others who are traumatised or suffering can result in compassion fatigue (Absolon and Krueger, 2009).

Nurses need to be aware of strategies, both individual and organisational, that can limit the impact of working with suffering. A supportive and caring working environment (Stewart, 2009) and access to supervision are examples of organisational provision, with rest, diet, exercise, personal relationships and spiritual support as aspects that individuals can focus on (Absolon and Krueger, 2009).

Cultural factors

Exactly why society expects nurses to be compassionate is not clear, although this may be related to the profession's religious origins and because most care is usually provided by family or friends with whom we have emotional attachments (Woodward, 1997).

Patients assume that nurses will provide compassionate care. However, once this becomes the norm, there may be a danger that it will become devalued or hidden. Compassion is an individual and natural response to the suffering of a fellow human. Attempts by nurses to overtly display this quality could mean it becomes institutionalised, lacking any real feeling and ultimately worth less (Salvage, 2006).

Cultural changes can influence nursing, or

nursing may mirror cultural changes. The view of the profession as a calling or vocation is now somewhat outdated and likely to be associated with Nightingale's idea of service.

Today, the word "vocation" is frequently used to mean career, yet originally it meant calling, particularly to a religious way of life. As religious values have become more marginalised in society, so too caring may have moved to a more peripheral position in nursing culture (Woodward, 1997).

The decline in the original vocational nature of nursing might be related to the development of a scientific basis for healthcare (Salvage, 2004). This change may also be reflected by the vocabulary used in nursing, where compassion has been superseded by the use of words such as caring and empathy. Early nurse leaders viewed compassion as a fundamental quality of a nurse (Schantz, 2007).

Science and technology have both been linked to the decline in the caring nature of some nurses. There are concerns that some nurses apply their skills to machines and systems, rather than provide care for patients (Knowlden, 1998).

A great deal of nursing is practised in hospitals, which have their own culture. There have been substantial changes in hospitals over recent years and the resulting increase in pressures may have had a negative effect on the compassion shown by some nurses (Tweddell, 2007).

Personal factors

Koerner (2007) felt the personal philosophy of nurses forms the root of compassion, arguing that an ability to see how living beings are related and involved with each other is the foundation for compassionate care. She saw compassion for others as an active involvement, not a passive position, but cautioned that "compassion for others begins with kindness to oneself".

Personal beliefs are likely to have a considerable impact on the professional life of individual nurses, and it is worrying that some believe they should embrace and develop technical medical skills at the cost of caring (Castledine, 2004).

THE ROLE OF EDUCATION

Nurse educators may be in a position to take the lead in helping to ensure that student nurses are given opportunities to develop compassion in clinical practice.

If asked at interview, potential student nurses often say they have a concern for others and want to care for people.

Assuming these sentiments are truthful, nurse educators have a responsibility to nurture and develop these individuals, enabling them to become compassionate registered nurses. This might be achieved by exploring how students are assessed, both theoretically and clinically. The NMC clearly indicates that compassion is an attribute required of nurses, but it is left to educators to determine how and where it is developed and assessed.

It is possible that educators have focused on preparing highly skilled nurses, but have not allowed enough time to help them to develop fundamental caring skills. The increased focus on academic preparation for nurses may have resulted in the academic level of assignments taking centre stage. It is also easier to assess academic skills.

Designing assessments that measure ability to analyse the wholeness and complexities of practice presents challenges, and simply may not be academic enough in some eyes.

Mentors are in a good position to decide whether a student is compassionate in practice, but they are likely to need considerable support and guidance from nurse educators about how to detect the presence of compassion.

One solution could be to allow student nurses to appreciate the realities of receiving care by recording a journal or log of a patient's feeling and emotions – in effect, using the patient and her or his experience to identify compassion in nurses.

Mentor assessment of student nurses could be guided by Kralik et al's (1997) research, which explored patient perceptions of pre-operative care. In this study, patients categorised nurses as "engaged nurses" or "detached nurses", identifying the qualities of the former as friendly and warm, gentle, and compassionate and kind, all attributes essential to develop in student nurses.

CONCLUSION

It is vital that nurses, whether in practice, education or leadership positions, engage in the debate about defining and communicating the role of compassion in nursing.

Without involvement from frontline nurses facing the daily challenge of providing compassionate care, nursing may have a target-driven view of this concept placed on it. This will mean that nurses and educators will have to continue to tolerate "the current focus on achievement of competencies, and a 'tick box' approach to measuring performance" (Hunter, 2004). ●

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