

Management and leadership (mandl) reflection in nursing



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Description of the incident /near miss

The incident occurred in a care centre that provides nursing care and support for 20 young people with a physical disability (YPD) and 65 older people. The settlement consists of four individual units; two “ dementia”, one “ residential” and one “ YPD” providing care for people with many different conditions. Staff work allocated to individual units but is expected to help out in other than allocated units when necessary. One member of staff had a terrible attitude towards working/helping out in one of the dementia units and refused to do so when delegated to work there. This led to a challenging situation that could cause risks related to short staffing issues.

The analysis relates to the key elements of competence: Management and Leadership (M&L)

The situation was critical to me because it undermined safeguarding practice, affected teamwork concept and disorganised work causing workload difficulties. It was linked with factors that could affect safety and pose risks to clients (M&L 1. 13) and therefore as a leading member of staff I had to take action by organising work and co-ordinating duties by prioritising needs (M&L 1. 1).

According to the company regulations both dementia units should have daily minimum 5 care and 1 trained staff and 4 +1 in the other two on duty. When all staff present at work on the incident’s day had been checked; the “ residential unit” turned out to be overstaffed (5+1staff).

I have decided to take advantage of this opportunity and utilise available human resources in order to provide care for the clients in my unit (M&L 1. 5; 1. 6) and delegated a member from the “ over staffed” unit to help us.

It was obvious to me that I had to act non-judgementally to ensure equality and fairness towards all clients (M&L 1. 6) by allocating adequate number of staff for each unit.

The refusal to help in dementia unit was motivated by “ fear to work in an unknown environment”. However the members of staff on duty working in the unit that was short were experienced and well organised workers. The delegated member of staff who denied to help was explained that she could benefit from joining the experienced team and encouraged to learn more about dementia affected clients’ needs and how influence the clients outcomes (M&L 1. 3; 1. 15).

Feelings

Knowing the group of clients in dementia units from my own experience; their needs and limited abilities to act for themselves, I felt obligated to act for them. As a leading, trained staff I had the duty to ensure the patient’s right to be cared appropriately was met and the power to organise and co-ordinate work. It was a good opportunity to point out questionable behaviours that had potential advantages for the improvement of quality of care in the Home. Also the incident gave me the chance to show recognition to the experienced members of the team by asking to guide the new (in the unit) colleague.

Evaluation

The ability to re-organise work in one unit, so that we could attempt to manage to work in the short staffed unit without calling agency or bank staff was a positive aspect. Awareness of the workload and the “ routine” of work in the dementia units allowed me to think about what to do and how to do it. My main aim was to ensure “ our” clients were safe and looked after appropriately. As soon as I have noticed that one unit was “ overstaffed” I have decided to delegate one of their members to work with us. This might have been good in relation to co-ordinating work and the use of available resources but on the other hand it could have as well caused the incident. I planned the delegation effectively but the implications of the delegation of duties could have been explained first. Before co-ordinating and delegating I could have taken 5-10 minutes to explain to the delegated member of staff that she will work with an experienced team where support will be provided and that she could gain new experience and knowledge that she may well benefit from in the future.

Nevertheless, I simply presumed that the perception of the situation was the same for everyone. I did not consider the feelings or experiences of the member of staff that was meant to be transferred to our unit for her shift.

Once the situation was explained and an informal verbal warning was given to the “ non-cooperative carer” she changed her mind and came to work with us.

Analysis

Key system policies for Scottish Social Care (Quality Compliance Systems, 2014) include amongst others 'Safeguarding Arrangements' and their reports, for example State of care 2013/14 (Care Quality Commission, 2013/14), demonstrate that 'lack of staff' is one of the most common reasons for safety issues.

Reporting of Injuries Diseases and Dangerous Occurrences Regulations (RIDDOR) state what types of incidents/accidents have to be reported for further investigations (Health and Safety Executive, 2013). Although the described incident was classed as non RIDDOR reportable it had to be managed immediately in relation to Patient Safety and Quality Improvement Act of 2005 (The Agency for Healthcare Research and Quality, 2008)

Cartey and Clark (2010) claim that bearing in mind the patient's right to be cared appropriately in a safe environment by adequate number of qualified and or purposely trained staff is enshrined within the constitution needs to go along with an understanding that care workers face many challenging situations that can affect their performance and at the same time the patient's safety.

Care staff deliver the majority of hands-on nursing care but all too often they are perceived by superiors as "numbers" and therefore it can be difficult for them to feel motivated, maintain high morale and values and play a good role in a team. It is expected that they are responsible (the service user needs to feel secure in the knowledge that they will be responsibly looked after), supportive, compassionate, respectful towards each other and the service users, sensitive, understanding and having good people- skills.

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However for this to be achieved they need to be led by good examples (Bertucci, 2006).

The ideal example should according to Storey and Holti (2013) use a concept that is no exclusive to or within leadership. Therefore, mixing management styles e. g. autocratic - command and control based - to delegate duties effectively, organise and co-ordinate work with the ability to motivate and bring out the best in staff by communicating and sharing the mission and building partnerships within organisation (democratic) is critical (Schein, 2010).

Sims (2002) underlines the need for change in commitment to teams and teamwork where client centred and willing to focus on the customer needs attitude is seen as the key element. Teams are perceived as combined and unceasing efforts of everyone participating in care including not only healthcare givers and receivers but also planners (Walburg and Bevan, 2005).

Alas, teams that are cohesive, productive do not happen by accident. The Care Quality Commission (2013/14) reports show that appropriate use of available human resources is a longstanding concern that affects the quality of care in nursing causing many issues.

Therefore staff should be encouraged to work together even if they disagree or have different opinions in order to work out ways to resolve conflicts (Mickan, 2005).

Explaining the idea of working in “ the unknown” unit changed the attitude of the “ uncooperative carer”. The mixed approach might have been more time consuming compared to a straight commanding but proved to work well. The approach used on that day helped to identify the cause of the problem, avoid risks related to it and motivate the team which had a positive effect on personal development.

Should there be a just one style e. g. traditional management used, where the management is known to exercise power, fear and follow without question attitudes (Colins, 2001), the incident could have turned out from a near miss to a serious safety issue.

Berwick

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and Nolan

(2007)

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Conclusion

If the Manager would have paid more attention to developing and leading teams that work well together for the home as a whole prior to the incident, there would be no issue with working in other units and work could be co-ordinated and prioritised on the day of the incident in a different way.

However, the incident made me realise that without my initiative to seek help from other units “our” clients would be put at risk and treated unfairly. This gave me the strength to use all my powers to mitigate the risks related to staffing challenges and manage the problem as effectively as possible. I

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knew I had to be strict but at the same time I wanted to act in a sensitive manner to avoid over emotional response that could have caused unwanted effects. What I have learned was to use mixed styles approach in practice.

Action plan

If a similar situation arose in the future I would start the day with a flash meeting; explaining the risks and consequences of leaving a unit short of staff to the whole team (all units). I would allow some extra time to make sure we all understand our role as caregivers to be flexible and accommodating that enables us to deal with different types of patients with greater ease.

Then I would re-organise staff in units depending on the teams and needs of each unit; choose one inexperienced or new member of staff to work in the unit that would be short and explain that this is “ learning by doing” day and offer my personal support to that member of staff.