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Business, Leadership

RKOT 1 Organizational Systems and QualityLeadershipWestern Governor’s University Leadership Strategies Leadership is, first and foremost, a stance—an attitude. A leader faces the problem and says what we can do to address it. Leaders takeresponsibilityfor problems. (L 101: So You Want to Be a Leader inHealthCare) Two strategies a nurse might use as an informal leader on an interdisciplinary team are form a clearer picture of the real situation and start looking for ideas of how to solve the problem. L 101: So You Want to Be a Leader in Health Care) As a nurse on an interdisciplinary team you could start by gathering information regarding the situation to form a clearer picture. Often time’s members of the team only look at what is affecting their individual work flow. As a leader a nurse should put the patient at the center of the picture and investigate how the roles of the individual team members affect the patient as a whole. People often look only at how a situation will affect them and their workflow and do not look at the situation as a whole.

Instead of just complaining about a situation the can take a leadership role by gathering information from all members of the team and piecing this information together as to form a clearer picture of the situation. To become an effective leader the nurse must not only gather the information to form a clearer picture but also work with the team to look for and offer ideas to solve the problem. As a leader, a nurse would not just join in on the complaining.

Once the information is gathered and the problem is clearly identified; to be a true leader, the nurse would look for creative solutions possibly initiating

changes in workflow to alleviate the problem. A leader goes the extra step to implement change. Active Involvement Two ways a nurse can take an active, contributing role within the interdisciplinary team are identifying quality issues or concerns and ensuring there is open activecommunicationbetween members of the team as well as the patient.

As a nurse you should be a strong patient advocate. During interdisciplinary rounds you should bring up concerns that may affect patient care. If there is uncertainty regarding the scheduled treatments or procedures and timing of those interventions the nurse should advocate for the patient in order for the patient to receive the best possible care. Nurses must ensure patient safety by asking questions if they are no sure as to whether the right procedure or treatment is being ordered or carried out.

It is the nurse’s job, while overseeing the care of the patient, to report any unsafe or potentially unsafe acts in order to advocate for the patient and develop best practices. As an advocate for the patient you should also speak up if the patient has unmet needs such as inadequate pain control or if timing of procedures prevents patients from obtaining uninterrupted sleep. The nurse can also take an active role in the interdisciplinary team by ensuring there is open two way communication between members of the treatment team and also the patient.

Patients are generally more compliant with treatment plans when they have active participation in the development of the treatment plan. An example of open communication and team work make be the nurse coordinating with therapy in order to ensure the patient is medicated prior to undergoing

therapy in order to increase participation by the patient and therefore allowing the patient to become more engaged in their treatment secession. Teams work more efficiently when they have open communication.

The nurse can lead the team by ensuring that all members communicate and are on the same patient in regards to patient’s care plan andgoals. By ensuring the lines of communication or kept open and aligning workflow the ultimate winner is the patient due to better coordination of care. Cultureof Safety Psychological safety, active leadership, transparency and fairness are four characteristics used to create a culture of safety. (PS106 Introduction to the Culture of Safety) There are many ways that you can promote a culture on safety in your workplace.

When someone initially starts a position they are often assigned a buddy or preceptor. In order to create a culture of psychological safety people need to know they can speak up without being judged. One organization has taken steps to stand up todoctor’s if they are being derogatory to nurses or other staff. The nurses can actually call a code in which people stop their work follow and physically stand behind the nurse if she feels she is being spoken to in an inappropriate or unprofessional manner. Spirit on the spot is another example of creating anenvironmentof psychological safety.

By enabling anyone to report when someone is caught doing something right such as stopping to give directions to a visitor when someone appears lost it creates a positive environment to work. Active Leadership can be observed in organizations that have open forums in which leaders meet with front line staff and encourage questions regarding workflow or any ideas or

suggestions for improvement. Monthly leadership rounding is where leaders walk around on units and stop to speak with the staff asking how their day is going and if there is anything that their leader can do to make a difference in their work environment.

This is an excellent example of active leadership. These leaders come to the staff one on one and encourage open discussion. Transparency occurs when there is a system in which when errors are reported or near misses are reported action is taken to investigate the error or near miss and change is initiated that will decrease the likelihood of the error reoccurring. An example of transparency occurred within an organization by the change in national patient safety standards requiring two patient identifiers when working with a patient.

To create an environment of fairness an organization needs to act when errors are caused by system errors. Nurses often find system errors when procedures are changed or modified. People too often just thing of how the change will affect their own discipline and not how it will affect patient care or the system as a whole. The staff needs to know that if a change is implemented that creates errors instead of decreasing errors they will be able to speak up and a new course of action will be taken.

An example of culture of safety occurred when my hospital first implement EMR’s. The order sets were written where inpatient andobservationcould both be ordered on a patient at the time of admission. The utilization nurse felt comfortable addressing the issue with her leader and was encouraged to speak with not only her leader but also administration regarding the possible

conflict in orders. The nurse was rewarded for speaking up and the organization quickly worked to determine the best way to change the order sets in order to avoid the conflicting orders.

The organization then took steps to be transparent by admitting there was an error in the original order sets and doing educational seminars for the admit staff, physicians, nurses and coders regarding the conflict in orders. If there had not been a culture of safety and the nurse had not spoken up the error in orders may have continued for months resulting in incorrect or non payment for the facility and errors in co-pays for the patients. REFERENCES L 101: So You Want to Be a Leader in Health Care . (n. d.). Retrieved March 8, 2013, from Institute for Healthcare Improvement: http://app. hi. org/lms/lessonpageworkflow. aspx? CatalogGuid= 6cb1c614-884b-43ef-9abd-d90849f183d4&CourseGuid= c1164ba8-5af1-438b-8a1f-d409911a4948&LessonGuid= b9a441cc-d2af-4211-8ba8-5359c06a8cb6 PS106 Introduction to the Culture of Safety. (n. d.). Retrieved March 8, 2013, from Institute for Healthcare Improvement: http://app. ihi. org/lms/lessonpageworkflow. aspx? CatalogGuid= 6cb1c614-884b-43ef-9abd-d90849f183d4&CourseGuid= 789d9cbb-7dd3-4fe9-8df2-e0c63725b350&LessonGuid= 4b250d37-cf44-4561-b830-53ed5865c6b8