Development of Skills, Behavior, and Leadership for Charge Nurse Positions

Contact Hours: 2.0

First Published: May 31, 2012
Course Expires: August 31, 2017

Acknowledgments

RN.com *acknowledges the valuable contributions of…*

Kim Maryniak, RNC-NIC, BN, MSN has over 22 years staff nurse and charge nurse experience with medical/surgical, psychiatry, pediatrics, and neonatal intensive care. She has been an educator, instructor, and nursing director. Her instructor experience includes med/surg nursing, mental health, and physical assessment. Kim graduated with a nursing diploma from Foothills Hospital School of Nursing in Calgary, Alberta in 1989. She achieved her Bachelor in Nursing through Athabasca University, Alberta in 2000, and her Master of Science in Nursing through University of Phoenix in 2005. Kim is certified in Neonatal Intensive Care Nursing and is currently pursuing her PhD in Nursing. She is active in the National Association of Neonatal Nurses and American Nurses Association. Kim's previous roles in professional development included nursing peer review and advancement, teaching, and use of simulation. Her current role as clinical director provides oversight of travel and per diem nurses, including education, quality, and process improvement.

Disclaimer

RN.com strives to keep its content fair and unbiased.
The authors, planning committee, and reviewers have no conflicts of interest in relation to this course. Conflict of Interest is defined as circumstances a conflict of interest that an individual may have, which could possibly affect Education content about products or services of a commercial interest with which he/she has a financial relationship.

There is no commercial support being used for this course. Participants are advised that the accredited status of RN.com does not imply endorsement by the provider or ANCC of any commercial products mentioned in this course.

There is no "off label" usage of drugs or products discussed in this course.

You may find that both generic and trade names are used in courses produced by RN.com. The use of trade names does not indicate any preference of one trade named agent or company over another. Trade names are provided to enhance recognition of agents described in the course.

Note: All dosages given are for adults unless otherwise stated. The information on medications contained in this course is not meant to be prescriptive or all-encompassing. You are encouraged to consult with physicians and pharmacists about all medication issues for your patients.

Purpose

The purpose of this course is to focus on development of the skills, behaviors, and principles of leadership that apply to the role of charge nurse.

Learning Objectives

After successful completion of this course, you will be able to:

1. Identify at least two strategies to promote the image of nursing.
2. Describe at least two factors to improve the work environment.
3. Name the five rights of delegation.
4. Verbalize how the American Nurses Association's Principles of Staffing and Code of Ethics apply to patient care.
5. List the four key factors for a culture of safety.
6. Discuss the role of the charge nurse in promoting patient and family-centered care.
7. Identify at least two approaches to build trust and effective communications.

Introduction

"Front line" nurse leaders are essential in assessing, planning, and implementing quality patient care. Titles of these leaders can include "charge nurse," "team leader," "resource coordinator," "assistant manager," and a variety of others. These leaders consistently make decisions, mentor, prioritize staffing needs, participate with patient care, and influence budget and disciplinary determination. Effective leadership is fundamental to staff retention, satisfaction, and improved patient outcomes (Flynn, Prufeta, & Minghillo-Lapari, 2010).

For the purpose of this course, the term charge nurse will be used.

The Image of Nursing

The Image of Nursing

As a nurse leader, one question to ask yourself is, "*How can I model a positive image of nursing and hold others to a higher standard?*" Each of us is responsible for nursing's image, from how we treat patients and colleagues, to what we tell relatives, friends, neighbors, and community members about our profession. The American Nurses Association (ANA) states in the Code of Ethics (2010a): "*The profession of nursing, as represented by associations and their members, is responsible for articulating nursing values, for maintaining the integrity of the profession and its practice, and for shaping social policy.*" This is also reinforced with the Florence Nightingale pledge that is recited by each of us, "*I will do all in my power to maintain and elevate the standard of my profession.*" (ANA, 2012)

Improving the Image of Nursing

The single most important action nurses can take to improve the image of nursing is to model how we want to be perceived, which includes:

- **Respect for others**: support one another, celebrate successes, and accept differences
- **Dress for success**: dressing professionally will allow you to be taken more serious, and allow the patients to identify you as a nurse
- **Accountability**: hold ourselves accountable, as well as those around us
- **Effective communications**: be aware of verbal and non-verbal behavior in interactions
- **Understand the business of healthcare**: take the opportunities available to you to learn the different aspects of healthcare.
- **Use evidence-based practice (EBP**): by incorporating evidence-based practice, nurses align the profession of nursing with other professions and experts who advocate EBP as a vital method for improving healthcare.

To promote the image of nursing, you need to be able to communicate effectively, negotiate, project a positive attitude, and be receptive to others' ideas. Nurses have consistently been identified as a trustworthy profession by survey.

Did You Know?

One random survey of licensed nurses was conducted at one hospital. The survey asked nurses throughout the organization to name three characteristics that expressed what professionalism was to them (Bryan-Brown & Dracup, 2003). The results were:

Professional Characteristics	Personal Characteristics
Knowledge (78)	Respect for others (51)
Competence (53)	Integrity (35)
Appearance (48)	Positive attitude (28)
Teamwork (27)	Compassion (18)

Improving the Workplace Environment

The image of nursing and the workplace environment in healthcare are closely related. Work and care environments must be safe, healing, and humane. The environment must also be respectful of the rights, responsibilities, needs, and contributions of patients, their families, nurses, and all healthcare professionals. There are six key factors to a successful workplace environment:

1. Skilled communication
2. Authentic leadership
3. Meaningful recognition
4. Appropriate staffing
5. Effective decision making
6. True collaboration

(American Association of Critical-Care Nurses [AACN], 2005)

Skilled Communication

Charge nurses must be as proficient in communication skills as they are in clinical skills. There needs to be a focus on finding solutions and achieving desirable outcomes, while protecting and advancing collaborative relationships among colleagues. All relevant perspectives should be invited and heard. Consensus should be built with good will and mutual respect. There also needs to be congruence between words and actions (AACN, 2005).

Authentic Leadership

Some nurse leaders assume that job security is of principal importance to employees. Among workers, however, it ranks far below the desire for respect, a high standard of ethics, contributions, and trusting and honest communications between employees and management.

Nurse leaders must be proficient communicators, team builders, driving forces for positive change, committed to service, results-oriented, and role models for shared practice (AACN, 2005).

Characteristics of Transformational Leadership

Characteristics of a transformational leader include:

Individualized Consideration

Characteristics include:

- Empathy and support
- Keeps communication open and encourages challenges
- Respects and celebrates the individual contribution

Intellectual Stimulation

Characteristics include:

- Challenges assumptions
- Takes risks and solicits ideas
- Encourages creativity

Inspirational Motivation

Characteristics include:

- Challenges with high standards
- Communicates optimism about future goals
- Provides meaning for the task at hand

Role and Identification Model

Characteristics include:

- Provides design of vision and purpose, values and norms that gives meaning to the work
- Plants pride and feelings of mission
- Enhances performance capabilities
- Provides personal example

(Luzinski, 2011)

Meaningful Recognition

A fundamental human need is recognition of the value and meaningfulness of one's contribution to an organization's work. This is also essential to developing at a personal and professional level. Individuals who are not recognized may feel invisible, undervalued, unmotivated, and disrespected. Nurses must be recognized and must appreciate others for the value each brings to the work of the organization (AACN, 2005). Charge nurses can have a significant impact on providing meaningful recognition.

Appropriate Staffing

Staffing is a multifaceted process with the goal of matching the needs of patients throughout their illness with the skills and competencies of available nurses. Inappropriate staffing is one of the most detrimental risks to patient safety as well as the welfare of nurses. Because the condition and acuity of patients is dynamic with continuous fluctuations, flexibility of nurse staffing that goes beyond fixed nurse-to-patient ratios is imperative (AACN, 2005). Charge nurses not only make decisions for the day-to-day staffing assignments, but can contribute to development of appropriate acuity-based staffing tools.

Effective Decision Making

Nurses are valued and dedicated partners in making policy, guiding and assessing clinical care, and leading organizational operations.

As advocates for patients, families, and the nursing profession, nurses are involved in making patient care decisions. "*As the single constant professional presence with hospitalized patients, nurses uniquely gather, filter, interpret, and transform data from patients and the system into the meaningful information required to diagnose, treat, and deliver care to a patient. This data management role of nurses is a vital link in the decision making activities of the entire health care team*" (AACN, 2005, p.4).

True Collaboration

Effective charge nurses support true collaborations as a continuing process that is consistently in development, and contributes to a shared culture. Common goals can be achieved by respecting each individual's voice and authority, incorporating differences, resolving opposing interests, and protecting the contributions of all involved to achieve optimal outcomes (AACN, 2005).

"*True collaboration is a process, not an event. It must be ongoing and build overtime, eventually resulting in a work culture where joint communication and decision making between nurses and other disciplines and among nurses themselves becomes the norm*" (AACN, 2005, p.20).

Delegation

Delegation

Delegation is the process where responsibility and authority for performing a task is transferred to another person who accepts that authority and responsibility. Although the delegator is also accountable for the task, the delegate is also accountable to the delegator for the responsibility assumed (ANA, 2005).

Charge nurses not only delegate themselves, but assist their team members in making delegation decisions.

Responsibility and Accountability

Although responsibility and accountability are often used interchangeably, they represent different concepts that go hand in hand. Responsibility signifies an obligation to accomplish a task; accountability is accepting ownership for the results or lack thereof. Responsibility can be transferred, but accountability is shared (ANA, 2005).

Authority

Along with responsibility, authority must also be transferred in delegation. Authority is the right to act. Therefore, by transferring authority, the delegator is empowering the delegate to accomplish the task. Too often this principle of delegation is ignored. Nurses retain authority, decreasing the ability of the delegate to accomplish the task, setting the individual up for failure, and minimizing effectiveness and productivity (ANA, 2005).

Differentiating Delegation from Assignment

Delegation is often confused with work allocation. Delegation involves transfer of responsibility and authority. With assignment or work allocation, no transfer of authority occurs, but is rather a bureaucratic function that reflects job descriptions and patient or organizational needs (ANA, 2005).

The Five Rights of Delegation

Right Task: Task is one that can be delegated for a specific patient.
Right Circumstances: Setting is appropriate and resources are available.
Right Person: Give the right task to the right delegate for the right patient.
Right Direction and Communication: Describe objectives, limits, and expectations.
Right Supervision: Monitor, evaluate, give feedback, and intervene if necessary.

Benefits to Delegation: Benefits to the Nurse

Nurses benefit from delegation, as more time can be devoted to those tasks that cannot be delegated, especially complex patient care or charge nurse responsibilities. Thus, patient care is enhanced, the nurse's job satisfaction increases, and retention is improved (ANA, 2005).

Benefits to Delegation: Benefits to the Delegate

The delegate also benefits from delegation, by gaining new skills and abilities that can assist with personal growth. In addition, delegation can bring support and trust, which creates self-esteem and confidence. Consequently, job satisfaction, motivation, a sense of pride and belonging are all increased. Individuals feel more appreciated and learn to value the roles and responsibilities of others, increasing cooperation and enhancing teamwork (ANA, 2005).

Benefits to Delegation: Benefits to the Organization

Improving teamwork decreases the amount of overtime and absences, increases productivity and efficacy, and helps everyone in achieving organizational goals. As delegation increases efficiency, the quality of care improves. As quality improves, patient satisfaction increases (ANA, 2005).

Barriers to Delegation: Personal Qualities

Poor communication and interpersonal skills can be barriers to delegation. In addition to good communication skills, respect, treating staff fairly, willingness to work with others, being open to suggestions, and providing feedback and acknowledgement for work well done is essential (ANA, 2005).

Barriers to Delegation: Fear of Competition or Criticism

This fear is unsubstantiated if the delegator has selected the right task and matched it with the right individual. In fact, the delegate's success in the task provides evidence of the delegator's leadership skills and ability to make appropriate decisions (ANA, 2005).

Barriers to Delegation: Fear of Liability

There are risks associated with delegation, but these risks can be minimized by following the steps of delegation. A related concern is fear of being blamed for the delegate's mistakes. If the delegator used discretion in selecting the task and delegate, then the responsibility for any mistakes made are solely those of the delegate (ANA, 2005).

Barriers to Delegation: Fear of Loss of Control

Fear is related to insecurity and inexperience in delegation. This is also a predominant concern in individuals who tend toward autocratic leadership styles and perfectionism. The key to retaining control is to clearly identify the task and expectations, monitor progress, and provide feedback (ANA, 2005).

Barriers to Delegation: Fear of Overburdening Others

Delegation is a voluntary, contractual agreement. The acceptance of a delegated task indicates the availability and willingness of the delegate to perform the task (ANA, 2005).

Barriers to Delegation: Fear of Decreased Personal Job Satisfaction

Because the type of tasks recommended to delegate are those that are familiar and routine, the delegator's job satisfaction should actually increase with the opportunity to explore new challenges and obtain other skills and abilities (ANA, 2005).

Side Note: Liability and Delegation

Fear of liability often keeps nurses from delegating. State nurse practice acts determine the legal parameters for practice, professional associations set practice standards, and organizational policy and job descriptions define delegation appropriate to the specific work setting.

As a charge nurse, familiarize yourself on where to find your state nurse practice act. For more information, also see the RN.com course *Professional Nursing Practice: An Update.*

Ineffective Delegation

When the steps to delegation are not followed or barriers remain, delegation is often ineffective. Inefficient delegation can result from unnecessary duplication, under-delegation, reverse delegation and over-delegation (ANA, 2005).

Unnecessary Duplication

To avoid unnecessary duplication, try to delegate associated tasks to as few people as possible. This allows the person to complete the assignment without spending time negotiating with others about which task should be done by which person. Also reporting is simplified for both the delegate and the delegator (ANA, 2005).

Under-Delegation

Under-delegation occurs when the delegator fails to transfer full authority to the delegate, takes back responsibility for some of the task, or fails to direct and equip the delegate. As a result, the delegate is unable to complete the task, and the delegator must resume responsibility for its completion (ANA, 2005).

Reverse Delegation

Reverse delegation occurs when someone with a lower rank delegates to someone with more authority (ANA, 2005).

Over-Delegation

Over-delegation happens when the delegator loses control over a situation by providing the delegate with too much authority or too much responsibility. This places the delegator in a risky position, and increases the potential for liability (ANA, 2005).

Principles of Staffing

ANA Principles of Staffing

The ANA developed the *Principles for Nurse Staffing* to focus on the complexity of nurse staffing decisions, and recognize major factors for evaluating the safety and appropriate nurse staffing (ANA, 2010b).

Determination of staffing is one vital function of the charge nurse role. Familiarity with these principles can assist in making those sometimes difficult decisions.

Principles: Related to the Patient Care Unit

- Appropriate staffing levels for a patient care unit are based on analysis of individual and collective patient needs.
- The concept of nursing hours per patient day (NHPPD) is one that is seriously questioned.
- Unit functions needed to support delivery of quality patient care must also be taken into account when determining staffing levels

(ANA, 2010b)

Applying the Principles: Patient Care Unit Related

Critical factors considered for determining appropriate staffing:

- The number of patients.
- The acuity of the patients for whom care is being provided.
- The physical environment, including architecture, geography, and available technology.
- The level of preparation and experience of healthcare professionals providing care.
- An analysis of individual patient needs, including physical and psychosocial.
- Unit functions necessary, such as unit governance, quality measurement activities, development of critical pathways, and evaluation of practice outcomes.

(ANA, 2010b)

Principles: Related to Staff

- The specialized needs of various patient populations should determine the appropriate clinical competencies.
- Registered nurses must have support of nursing management and be represented at the operational and executive level.
- Experienced RNs should be readily available to provide clinical support to those RNs with less proficiency.

(ANA, 2010b)

Applying the Principles: Staff Related

Characteristics of nurses that should be taken into account when determining staffing levels:

- Experience with the population being cared for
- Experience level (i.e. novice to expert)
- Level of education and preparation, including certification
- Language capabilities
- Tenure on the unit
- Level of control of practice environment
- Involvement in quality initiatives and activities, such as nursing research
- Involvement in interdisciplinary and collaborative activities regarding patient needs
- Number and competencies of clinical and non-clinical support staff the RN must collaborate with, supervise, and teach

(ANA, 2010b)

Principles: Related to the Institution/Organization

- Institutional policy should reflect an environment that values registered nurses and other employees as assets and demonstrates a commitment to filling budgeted positions in a timely manner
- Documented competencies are required for nursing staff, including agency, supplemental, and traveling RNs, for those activities that they have been authorized to perform
- Organizational policies should acknowledge the complex needs of both patients and nursing staff.

(ANA, 2010b)

Applying the Principles: Institution/Organization Related

Institutions should have documented competencies for all nursing staff.

- When floating between units, there should be an efficient plan for cross-training to ensure competency.
- Individual opportunities must be provided to be involved in making the decisions that affect them.
- Reporting near misses and errors is encouraged to promote quality improvement.
- Policies should acknowledge patient and nursing staff needs, and provide:
    - Effective and efficient support services.
    - Access to timely, precise, applicable information that links clinical, administrative, and outcomes data.
    - Adequate orientation and preparation including nurse preceptors and nurse experts to ensure RN competency.
    - Training specific to technology used in providing patient care.
    - Time needed to collaborate with and supervise other staff.
    - Support in ethical decision-making.
    - Sufficient opportunity for care coordination and arranging for continuity of care and patient or family education.
    - Processes to facilitate transitions during work redesign, mergers, and other major changes in work life.
    - The right for staff to report unsafe conditions or inappropriate staffing without personal consequence.
    - A logical method for determining staffing levels and skill mix.

(ANA, 2010b)

Ethics

Ethics for Nurses

Ethics is an essential part of nursing. Nursing has a well-known history of concern for the welfare of the sick, injured, and vulnerable, and for social justice. "*This concern is embodied in the provision of nursing care to individuals and the community. Nursing encompasses the prevention of illness, the alleviation of suffering, and the protection, promotion, and restoration of health in the care of individuals, families, groups, and communities. Nurses act to change those aspects of social structures that distract from health and well being*" (ANA, 2010a, p.2).

It is an expectation of individuals who become nurses to adhere to the ideals and moral norms of the profession, and to embrace them as a duty of what it means to be a nurse. A code of ethics specifically describes the primary goals, values, and obligations of the profession (ANA, 2010a). Charge nurses apply ethics as well as provide support and guidance to others.

Purpose of the Code of Ethics for Nurses

The Code of Ethics for Nurses provides a concise statement of the ethical obligations and duties of all individuals who enter the nursing profession. It is the profession's ethical standard that is non-negotiable, and is an illustration of nursing's own understanding of its commitment to society (ANA, 2010a).

Code of Ethics: Provision One

"*The nurse, in all professional relationships, practices with compassion and respect for the inherent dignity, worth, and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems*."

- 1.1 Respect for human dignity
- 1.2 Relationships to patients
- 1.3 Nature of health problems
- 1.4 The right to self determination
- 1.5 Relationships with colleagues and others

(ANA, 2010a, p.2-5)

Code of Ethics: Provision Two

"*The nurse's primary commitment is to the patient, whether an individual, family, group, or community.*"

- 2.1 Primacy of the patient's interests
- 2.2 Conflict of interest for nurses
- 2.3 Collaboration
- 2.4 Professional boundaries

(ANA, 2010a, p.5-6)

Code of Ethics: Provision Three

"*The nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient.*"

- 3.1 Privacy
- 3.2 Confidentiality
- 3.3 Protection of participants in research
- 3.4 Standards and review mechanisms
- 3.5 Acting on questionable practice
- 3.6 Addressing impaired practice

(ANA, 2010a, p.6-8)

Code of Ethics: Provision Four

"*The nurse is responsible and accountable for individual nursing practice and determines the appropriate delegation of tasks, consistent with the nurse's obligation to provide optimum patient care.*"

- 4.1 Acceptance of accountability and responsibility
- 4.2 Accountability for nursing judgment
- 4.3 Responsibility for nursing judgment and action
- 4.4 Delegation of nursing activities

(ANA, 2010a, p.8-9)

Code of Ethics: Provision Five

"*The nurse owes the same duties to self as to others, including the responsibility to preserve integrity and safety, to maintain competence, and to continue personal and professional growth.*"

- 5.1 Moral self-respect
- 5.2 Professional growth and maintenance of competence
- 5.3 Wholeness of character
- 5.4 Preservation of integrity

(ANA, 2010a, p.9-11)

Code of Ethics: Provision Six

"The *nurse participates in establishing, maintaining, and improving healthcare environments and conditions of employment conducive to the provision of quality healthcare and consistent with the values of the profession through individual and collective action.*"

- 6.1 Influence of the environment on moral virtues and values
- 6.2 Influence of the environment on ethical obligations
- 6.3 Responsibility for the healthcare environment

(ANA, 2010a, p.11-12)

Code of Ethics: Provision Seven

"*The nurse participates in the advancement of the profession through contributions to practice, education, administration, and knowledge development.*"

- 7.1 Advancing the profession through active involvement in nursing and in healthcare policy
- 7.2 Advancing the profession by developing, maintaining, and implementing professional standards in clinical, administrative, and educational practice
- 7.3 Advancing the profession through knowledge development, dissemination, and application to practice

(ANA, 2010a, p.12)

Code of Ethics: Provision Eight

"*The nurse collaborates with other health professionals and the public in promoting community, national, and international efforts to meet health needs.*"

- 8.1 Health needs and concerns
- 8.2 Responsibilities to the public

(ANA, 2010a, p.12-13)

Code of Ethics: Provision Nine

"*The profession of nursing, as represented by associations and their members, is responsible for articulating nursing values, for maintaining the integrity of the profession and its practice, and for shaping social policy.*"

- 9.1 Assertion of values
- 9.2 The profession carries out its collective responsibility through professional associations
- 9.3 Intra-professional integrity
- 9.4 Social reform

(ANA, 2010a, p. 13)

For more information, see the RN.com course *Professional Nursing Practice: An Update.*

Safety Culture

Promoting a Culture of Safety

Many nurses are familiar with the Institute of Medicine's (IOM) report in 1999, *To Err is Human*. Statistics in this report include that as many as 98,000 Americans die each year of largely preventable medical errors. Medical errors cost from $17 million to $29 million yearly, and account for up to 2.4 million additional hospital days (IOM, 1999).

Upholding a safe environment demonstrates a level of compassion and attention for patient welfare that is as important as any other aspect of healthcare.

Considerations of Safety

Safety problems can be traced to errors and accidents, and many nurses have become accustomed to view those errors and accidents as aberrant developments. Shifting this view is the first step in developing a safety culture. Many errors arise from system failures, and the errors are actually a consequence rather than a cause of the problem.

Minimizing Future Errors

The challenge when any error occurs is learning from it and how to improve design systems to minimize future errors and accidents. Minimization is the objective, as no one can anticipate everything that can go wrong in a process as complex as healthcare (Spath, 2011).

Characteristics of a Safety Culture

Trust must be present amongst team members, in a manner that is helpful and supportive of one another. Individuals must have friendly, open relationships emphasizing credibility and attentiveness. The work environment should be resilient and focus on creativity and goal achievement of employees (Spath, 2011).

Key Components of a Safety Culture

There are four key components that contribute to an overall culture of safety. These include:

1. A reporting culture
2. A just culture
3. A flexible culture
4. A learning culture

(Spath, 2011)

A Reporting Culture

A reporting culture involves a climate in which people are prepared to report errors and near misses. In addition, this type of culture is only effective when an organization appropriately handles the information reported. If there is an environment of blame and punishment, then the culture will not be maintained (Spath, 2011).

A Just Culture

An environment that includes a “just” culture features an atmosphere of trust in which people are encouraged to provide, and may even be rewarded, for providing essential safety related information. An important component of this type of culture is a clear understanding of the difference between acceptable and unacceptable behavior (Spath, 2011).

A Flexible Culture

Flexibility is vital, particularly the ability to adapt in the face of high pace operations or potential threats. In many cases it involves shifting control to expert resources on the spot and then reverting back once the emergency has passed (Spath, 2011).

A Learning Culture

A culture of learning is characterized by the willingness and ability to draw the right conclusions from the safety information system. Individuals in an organization must also have the will to implement major changes when their need is indicated (Spath, 2011).

Side Note: Three Manageable Behaviors

To Err is Human … You make a mistake, admit the mistake, help put measures in place to prevent the error from happening again, and move on.

To Drift is Human … You take a short cut because you are busy or you decide not to follow a policy so the procedure goes faster and there is an undesirable outcome. This is addressed, reviewed, and followed up on and you move on.

The Reckless Act … You willingly put a patient at risk knowing there will be an undesirable outcome. A strong disciplinary or punitive response should be anticipated.

(Marx, 2007)

Encouraging a Culture of Safety

Charge nurses can encourage a culture of safety by ensuring staff have the needed tools and resources to improve patient safety. With new changes and technologies, charge nurses can provide positive reinforcement for improvements towards the safety of both patients and nurses.

In addition, participation in unit-specific safety practices that are evidence-based is another responsibility of nurses. To be effective, all staff needs to be aware of their role in the patient safety process, and how they can best promote and maintain a patient safety culture (Spath, 2011).

Patient and Family-Centered Care

Expectations of Patients and Families

According to the Institute for Healthcare Improvement (2008), patients and families expect:

- To be listened to, taken seriously, and respected as a care partner.
- To always be told the truth.
- To have information communicated to all members of the care team.
- To have coordination among all members of the healthcare team.
- To be supported emotionally and physically.
- To receive high quality, safe care.

An Emphasis on Collaboration

With patient and family-centered care (PFCC), the emphasis is on collaborating with patients and families of all ages, at all levels of care, and in all healthcare settings. There is an acknowledgment that families, (however they are defined by the patient), are essential to patients' health and well being, and are allies for quality and safety within the health care system.

Core Concepts of PFCC

There are four core concepts of PFCC:

1. Dignity and respect
2. Information sharing
3. Participation
4. Collaboration

(Institute for Family Centered Care, 2008)

Dignity and Respect

Dignity and respect is achieved when healthcare practitioners listen to and honor patient and family perspectives and choices. Patient and family knowledge, values, beliefs, and cultural background are incorporated into the planning and delivery of care.

Information Sharing

Healthcare practitioners communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete, and accurate information in order to effectively participate in care and decision making.

Participation

Participation occurs when patients and families are encouraged and supported in participating in care and decision making at the level they choose.

Collaboration

Patients, families, healthcare practitioners, and hospital leaders should collaborate in policy and program development, implementation, and evaluation; in healthcare facility design; and in professional education, as well as in the delivery of care (Institute for Family Centered Care, 2008).

Key Approaches

Some key approaches that occur with PFCC include:

- Care is based on continuous healing relationships (collaboration)
- Care is customized according to patient needs and values
- Patient is the source of control
- Needs are anticipated
- Transparency is necessary
- Knowledge is shared and information flows freely

Promoting PFCC

PFCC is a model of caring and requires a paradigm shift for many nurses. It can be difficult for some to demonstrate transparency and transfer the locus of control to the patient and family. Charge nurses provide valuable support in educating and upholding standards of PFCC.

PFCC Strategies

Some strategies for promoting PFCC:

- Involve patients and families in all aspects of the planning, delivery, and evaluation of health care services.
- Recognize families as important members of the healthcare team. Encourage and support families in care planning and decision-making.
- Support patients in involving their families in their healthcare experiences with ways that they choose.
- Welcome family members at all times regardless of rounds, change of shift, or other events on the unit.
- Encourage and support family members to be present during procedures and treatments, if this is the preference of the patient.
- Provide information to patients and families in ways that are helpful, empowering, and nurturing to the patient in care-giving and decision-making.
- Provide easy and accessible opportunities for patients and families to ask questions of staff.
- Provide care that respects patients' values, preferences, and expressed needs.
- Coordinate and integrate the care for the patient (coordinate services such as tests, consultations, or procedures).
- Provide timely, tailored, and expert care in managing the physical comfort of the patient.
- Provide emotional support in relieving fear or anxiety that accompany an injury or illness, including fear of pain, disability or disfigurement, loneliness, financial impact, or the effect of illness on the family.

(Institute for Family Centered Care, 2008)

Communications and Trust

Communications and Trust

In any given shift, the nurse in charge must communicate with many individuals with differing personalities, communication styles, and disciplines. Building trust with others and developing effective communications is a valuable part of this role.

The Crucial Conversation

A conversation that is identified as crucial occurs when there is a difference in opinions, one where the stakes are high, and emotions are strong. A crucial conversation can be avoided or faced and either handled poorly or well.

Reasons that this dialogue is handled poorly include biological responses ("fight or flight"), the conversations happen without warning and require improvisation, or there is self-defeating behavior that causes someone to say or do the wrong thing (Patterson, Grenny, McMillan & Switzler, 2002).

Successful Conversation

When it is identified that a conversation is crucial, the goal of dialogue is to allow free flow of information between those involved. This can only be effective if it feels safe for all parties to discuss information. If someone feels threatened, the content of the dialogue will not be understood.

Some questions a person can ask his or herself to return to effect communication include:

a) "*What do I actually want from myself?*"
b) "*What is it I really want from others?*"
c) "*What do I want from the relationship?*"
d) "*How would I behave if I want these results?*"

(Patterson, Grenny, McMillan & Switzler, 2002)

Observing Responses

During a conversation, it can be identified when safety is at risk or another person feels threatened by assessing behavior and responses. Behavioral signs can indicate when a conversation is turning crucial, such as flushing, sweating, tightening of muscles, raising voice, not speaking at all, or other body language indications (Patterson, Grenny, McMillan & Switzler, 2002).

Silence or Violence

When individuals do not feel safe, they will resort to either silence or violence. With silence, the person purposefully withholds information, which can include leaving the conversation, changing the subject, using sarcasm, or shifting the focus to others. This can restrict the information flow needed in the dialogue. With violence, the person tries to force others to accept their view, which may include coercion, interrupting others, stereotyping or name-calling, or belittling. In communications, it is important to identify these behaviors with all involved, including oneself (Patterson, Grenny, McMillan & Switzler, 2002).

A Safe Conversation

Techniques to make a conversation safe begin with respect for all involved. There should be mutual purpose in which the individuals are working towards a common goal. This doesn't mean that each person should agree with one another, but that a difference in perspectives does not mean that there cannot be a mutual understanding and respect for one another as individuals.

Some techniques include apologizing when a person has made a mistake, confirming respect for others, and clarifying the purpose (Patterson, Grenny, McMillan & Switzler, 2002).

Pay Attention to Your Stories

If a conversation turns crucial for a participant, a common response is to unintentionally create an internal story. This is a defense mechanism, and it must be recognized to have effective dialogue.

Some stories include:

a) "*It's not my fault*", where we are the victim.
b) "*It's all your fault*", where the other person is the villain.
c) "*There's nothing I can do*", where we are helpless.

It is important to stop and recognize these stories as inaccuracies, not as the truth (Patterson, Grenny, McMillan & Switzler, 2002).

Understanding Others

Many times it is difficult to understand what others are trying to say in a conversation. That can be where we invent stories in our minds, and when we try to clarify we may say something that will actually put others on the defense.

If you have a sentence with "you" in it, such as "*What do you mean?*" this can make the other person feel defensive. Instead, try reflecting on yourself, to show that you are the one that needs clarification. A helpful sentence starts with, "*Help me understand why…*" This shows that you are the one that needs assistance, which can help maintain safety.

Speaking Persuasively

Speaking honestly and with respect includes confidence, humility, and skill. A helpful acronym is "STATE", which involves:

- **S**hare your facts; focus on facts rather than emotions
- **T**ell your story; allows others to understand our point of view and intent
- **A**sk for others' paths; includes others in the conversation, and their points of view
- **T**alk tentatively; this gives others a chance to hear your perspective without violence
- **E**ncourage testing; gives others an opportunity to disagree

(Patterson, Grenny, McMillan & Switzler, 2002)

Effective Listening

Two acronyms can assist with effective communication and listening; AMPP and ABC.

- **A**sk others to tell their stories
- **M**irror others to confirm their feelings
- **P**araphrase to acknowledge others and indicate you are trying to understand
- **P**rime when you cannot get further; by stating what you think another person is stating, it will either be acknowledged or disagreed with, which can then further discussion

- **A**gree; use this when you truly agree with something the other person states
- **B**uild; build on where you are in the conversation
- **C**ompare; with differing views, comparison can create insight

(Patterson, Grenny, McMillan & Switzler, 2002)

Building Trust

Trust is an essential component in effective relationships. Trust needs to start within oneself, which includes four components of integrity, intent, capabilities, and results.

- **Integrity**: This can be increased by standing for something, being open, and making and keeping commitments to ourselves.
- **Intent:** It is important to inspect and redefine your motives, state your intent, and choose abundance (meaning that there is enough to go around).
- **Capabilities:** This can be enhanced by keeping yourself relevant (skills, knowledge, and strengths), running with your strengths, and knowing where you are going.
- **Results:** Expect to win (to avoid self-defeating behavior), take responsibility for results, and finish strong.

(Covey, 2006)

Effective Leadership

Thirteen essential behaviors have been identified of high trust leaders:

1. Talk straight
2. Demonstrate respect
3. Create transparency
4. Right wrongs
5. Show loyalty
6. Deliver results
7. Get better
8. Confront reality
9. Clarify expectations
10. Practice accountability
11. Listen first
12. Keep commitments
13. Extend trust

(Covey, 2006)

Communications and Trust

Building trusting relationships and effective communications starts with self-reflection. This involves not only what we see within ourselves, but also an awareness of how we are perceived by others. It can be difficult to view ourselves from the perspectives of others, but it gives valuable insight into what we as individuals need to work on to establish healthy relationships.

Conclusion

Nurse leaders are essential in providing and influencing the quality of patient care, promoting the profession of nursing, affecting the work environment, participating as an agent for change, and upholding evidence-based practice. The skills and knowledge required for these roles is expansive and can be intense to be effective. Commitment of individuals in charge nurse roles has a significant impact on all of those around them, as they are vital to the provision of healthcare.

References

American Association of Critical-Care Nurses. (2005). AACN *Standards for Establishing and Sustaining Healthy Work Environments: A Journey to Excellence.* Retrieved April 2012 from http://www.aacn.org/WD/HWE/Docs/HWEStandards.pdf

American Nurses Association. (2010a). *Code of Ethics for Nurses with Interpretive Statements*. Washington, DC: American Nurses Publishing.

American Nurses Association. (2010b). *Principles for Nurse Staffing*. Washington, DC: American Nurses Publishing.

American Nurses Association. (2005). Principles *for Delegation*. Washington, DC: American Nurses Publishing.

American Nurses Association. (2012). *Florence Nightingale Pledge*. Retrieved April 2012 from http://nursingworld.org/FunctionalMenuCategories/AboutANA/WhereWeComeFrom/FlorenceNightingalePledge.aspx

Bryan-Brown, C. & Dracup, K., (2003). *Professionalism*. *American Journal of Critical Care, 12*(5), 394.

Covey, S.M.R. (2006). The *Speed of Trust: The One Thing That Changes Everything.* New York, NY: Free Press.

Institute for Family Centered Care. (2008). Advancing *the Practice of Patient and Family Centered Care: How to Get Started.* Retrieved April, 2012 from http://www.familycenteredcare.org.

Institute for HealthCare Improvement (IHI). (2008). Patient-*Centered Care*. Retrieved April, 2012, from http://www.ihi.org/ihi

Institute of Medicine. (1999). To *Err is Human: Building a Safer Health System*. Retrieved April 2012 from http://www.iom.edu/Reports/1999/To-Err-is-Human-Building-A-Safer-Health-System.aspx

Flynn, J., Prufeta, P., & Minghillo-Lapari, L. (2010). Cultivating Quality: An Evidence-Based Approach to Taking Charge. *American Journal of Nursing, 110*(9), 58-63.

Luzinski, C. (2011). Transformational Leadership. *Journal of Nursing Administration, 41*(12), 501-2.

References

Marx, D. (2007). Patient *Safety and the "Just Culture".* Retrieved April, 2012 from http://www.health.ny.gov/professionals/patients/patient_safety/conference/2007/docs/patient_safety_and_the_just_culture.pdf

Patterson, K., Grenny, J., McMillan, R., & Switzler, A. (2002). Crucial *Conversations: Tools for Talking When Stakes are High.* New York, NY: McGraw Hill.

Spath, P. (2011). Error *Reduction in Health Care: A Systems Approach to Improving Patient Safety*, (2nd ed). San Francisco, CA: Jossey-Bass.