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**The nexus of nursing leadership and a culture of safer patient care**

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**Aims and objectives.** To explore the connection between nursing leadership and enhanced patient safety.

**Background.** Critical reports from the Institute of Medicine in 1999 and Francis QC report of 2013 indicate that healthcare organisations, inclusive of nursing leadership, were remiss or inconsistent in fostering a culture of safety. The factors required to foster organisational safety culture include supportive leadership, effective communication, an orientation program and ongoing training, appropriate staffing, open communication regarding errors, compliance to policy and procedure, and environmental safety and security. As nurses have the highest patient interaction, and leadership is discernible at all levels of nursing, nurse leaders are the nexus to influencing organisational culture toward safer practices.

**Design.** The position of this paper is to explore the need to form a nexus between safety culture and leadership for the provision of safe care.

**Conclusions.** Safety is crucial in healthcare for patient safety and patient outcomes. A culture of safety has been exposed as a major influence on patient safety practices, heavily influenced by leadership behaviours. The relationship between leadership and safety plays a pivotal role in creating positive safety outcomes for patient care. A safe culture is one nurtured by effective leadership.

**Relevance to practice** Patient safety is the responsibility of all healthcare workers, from the highest executive to the bedside nurse, thus effective leadership throughout all levels is essential in engaging staff to provide high quality care for the best possible patient outcomes.

**What does this paper contribute to the wider global clinical community?**

- Leadership engagement enhances patient safety through positive safety culture
- Leadership education is important for the support of emerging nurse leaders
- Adopting an organisation wide blame free philosophy breaks down barriers to a safety culture

**Keywords:** leadership, healthcare, safety culture, patient safety

## **INTRODUCTION**

Patient safety culture is reflected in the beliefs, attitudes, perceptions, values and patterns of behaviour of an organisation and its employees toward safety (Bowie, 2010; Muls et al., 2015). As recently evidenced in such investigations as the Mid Staffordshire Trust inquiry (Francis, 2013), healthcare environments have been acknowledged as high-risk and a lack of a safety culture has major effects on patient outcomes. Alternatively, a positive safety culture in healthcare is evidenced by visibility of leaders and credible support for patient safety initiatives (Agnew, Flin & Reid, 2012; Castel, Ginsburg, Zaheer & Tamim, 2015). Avoidance of adverse events, requires a system wide approach as it is recognised that errors are the result of failures related to "...management decisions and organisational processes" (Auer, Schwendimann & Koch, 2014, p. 23; Kaufman & McCaughan, 2013). To

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overcome system faults, setting patient safety as an organisational priority assists in fostering a culture of safety (Auer et al., 2014). A strong safety culture will use failings to adapt work practices aiming to improve and enhance patient care, thus increasing positive outcomes (Bowie, 2010). Development of a safety culture relies upon engagement at all levels, communication between executive and unit levels, and trust in organisational leaders and management (Ammouri, Tailakh, Muliira, Geethakrishnan & Al Kindi, 2014; Auer et al., 2014).

Safety culture has only recently been emphasised within healthcare, after having been prominent in safety critical industries such as aviation and the military for many years. A positive safety culture does not just happen, it requires the input and alignment of quality and organisational properties. These properties have been identified as: teamwork, evidence-based practice, communication, ongoing education, a just culture, leadership, and patient-centred care (Reid & Dennison, 2011; Sammer, Lykens, Singh, Mains & Lackan, 2010). A culture of patient safety within an organisation requires support from all parties, especially organisational leaders. The Mid Staffordshire public inquiry exposed a lack of basic patient care, and a negative organisational culture fostered by a focus on systems statistics and reports rather than patient experiences and outcomes (Francis, 2013). A positive safety culture, on the other hand, provides a platform on which to base patient-centred care with safe care delivery, shared values, zero-tolerance for substandard care, empowerment of front-line staff, recognition of staff for their contributions, and professional responsibility described as foundations for patient-centred care (Francis, 2013; Muls et al., 2015).

Patient safety has been on the global healthcare agenda since the Institute of Medicine (IOM) released its report "To Err is Human" where medical errors were highlighted as taking more lives than motor vehicle accidents, breast cancer and AIDS (Kohn, Corrigan & Donaldson, 2000). This sparked several initiatives from the World Health Organisation (WHO) such as the perioperative Surgical Safety Checklist and the introduction of Hand

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Hygiene programs to globally improve patient safety (WHO, 2009). A major systemic influence on patient care, and thus patient safety, is nursing leadership (Agnew, Flin & Reid, 2012; Auer, et al., 2014; Cummings et al., 2010; Dignam et al., 2011; O'Connor & Carlson, 2016; Vaismoradi, Bondas, Salsali, Jasper, & Turunen, 2012). As nurses have the highest patient interaction, nurse leaders are in the best position to influence organisational culture toward safer practices (Hendricks, Cope & Baum, 2015; Vaismoradi et al., 2012).

## **METHODS**

An integrative review of research literature was undertaken to develop an understanding of leadership in healthcare and its influence on patient safety and safety culture. Inclusion and exclusion criteria were determined to provide consistency and rigor to the literature review. Articles were included if they were written in English; full text; peer reviewed research published between 2010 and 2016. The articles including content on both leadership and patient safety. Papers were excluded if they were not published in English and did not meet the inclusion criteria.

The initial search of the databases identified 905 articles, of which 298 articles met inclusion criteria based on their titles. A review of the keywords in these 298 articles led to elimination of a further 194 articles, leaving 104 articles for initial review. Fifty-four were discarded following review of their abstracts. The initial selection of articles yielded 50 articles for inclusion and following review, a further 10 articles were excluded as there was no discussion or findings correlating leadership to patient safety or safety culture, leaving 30 for inclusion.

Themes developed during the review of the literature based on the influences on safety culture in healthcare. These themes have been labelled 'leadership and employee engagement and empowerment', 'barriers to a safety culture', and 'leadership styles and patient outcomes'. Before discussion of these themes, a description of leadership styles prominent in nursing is warranted.

## Leadership styles

Leadership theories have been studied and developed throughout history starting with the Great Man Theory of the 1800's to the Army Leadership model of 2007 (Ledlow & Coppola, 2014). These theories have seen many styles of leadership emerge, although not all leadership styles suit all situations. Styles of leadership explain how leaders engage with others. Leadership may be categorised under two main style types: relational and task-oriented (Cummings, 2012; Cummings et al., 2010). The leadership styles prominent in healthcare literature are transformational and transactional leadership. In depth discussion on leadership theories and styles is beyond the scope of this paper, however a short description is warranted.

Transformational leadership theory was developed in the 1970's by Burns (Burns, 1978) and has recently been explored throughout nursing literature. Transformational leadership is a relational leadership style adopted by magnet hospitals (Brewer et al., 2016) to lead charge in developing and maintaining standards of excellence in patient safety and patient outcomes. This style of leadership is associated with positive patient outcomes resulting from a blameless safety culture (Lievens & Vlerick, 2013; McFadden, Stock & Gowan, 2014; Merrill, 2015). A blameless safety culture, or a just culture, is a non-punitive environment where inadvertent actions are used as a stepping stone to improve practice, but where reckless behaviour will not be tolerated (Jarrett, 2017).

The characteristics of a transformational leader include the ability to engage, motivate, inspire and empower followers to aim above and beyond their own boundaries to achieve a shared vision or organisational goal. Leaders are visible; they set clear expectations and promote open multidisciplinary communication; and they see errors as an opportunity for improvement (McFadden et al., 2014; Merrill, 2015; O'Connor & Carlson, 2016). Transformational leaders invoke change and demonstrate emotional intelligence, consult with their followers before making decisions, and share the load (Cope & Murray,

2017; Doody & Doody, 2012; Giltinane, 2013). This style of leadership fosters a safety culture within an organisation through the development of trust and a just, blame-free environment (Merrill, 2015; Vogelsmeier et al., 2010). Transformational leaders value their followers opinions, respect their experience affirm their nurse colleagues ideas and involve them in decision-making (Sherman, 2012). In large organisations, there may be pockets of excellence in units or areas where the leaders have an exceptional following, however, this may not be represented across an organisation. Similarities exist in transactional leaders described to follow.

Transactional leadership, a task-oriented leadership style, uses rewards to motivate followers to achieve goals (Ledlow & Coppola, 2014). This in turn can have a positive influence on follower's satisfaction levels. This leadership style is very effective when decisions need to be made with haste, such as during medical crises, however may have negative effects on patient outcomes as it may reinforce task-based behaviours in nurses which lies in contrast to holistic nursing care (Cope & Murray, 2017; Giltinane, 2013). Both transformational and transactional styles of leadership use forms of motivation to engage staff or followers.

### **Leadership and employee engagement and empowerment**

Engagement has been defined by Schaufeli, Matinez, Pinto, Salanova and Bakker (cited in Bargagloiotti, 2012, p. 1416) as a "...positive, fulfilling work-related state of mind". Nurses who are engaged have better patient and organisational outcomes and leadership engagement is influential in bedside nurse performance (Brady Germain & Cummings, 2010; Day, 2014). Nurse leaders who set clear guidelines, share their vision, and lead by example have greater employee engagement associated with increased performance from bedside nurses, which is important for safe and innovative practice (Brady Germain & Cummings, 2010). Senior nurse leaders may use recognition of good practice to motivate and empower bedside nurses to improve quality of care across the board (Haycock-Stuart & Kean, 2012).



Leadership engagement at the unit level has significant positive effects on the reporting of errors and adverse events as leaders who engage their staff create an open communication environment where there is no fear of repercussions for reporting errors (Castel et al., 2015).

Employee engagement by nurse leaders assists in developing trust in leaders'. Trust boosts safety culture, and visibility of leaders fosters trust. With the establishment of trust, organisational staff believe concerns will be heard and that the necessary patient safety changes will occur. Open communication channels developed through trust leads to a non-blame culture (Vogelsmeier et al., 2010). Studies suggest that organisations that have created a non-blame safety culture have better patient outcomes (O'Connor & Carlson, 2016). These outcomes occur when leaders create an environment where staff are encouraged to report errors, adverse events, near misses, and unsafe practices so system changes can be made (O'Connor & Carlson, 2016; Sammer et al., 2010). In a culture of safety staff are also enabled to seek help, without the threat of derision, but by knowing that they can voice their need for assistance to avoid possible harm (Squires et al., 2010).

Reports such as Francis (2013) revealed poor work environments that had negative impacts on patient outcomes. Such environments develop in the presence of dissatisfied nurses who may be suffering burnout or emotional exhaustion from ineffective leadership either at a unit level or throughout an organisation (Daly, Jackson, Mannix, Davidson & Hutchinson, 2014). With burnout, emotional exhaustion and dissatisfaction comes high attrition. This may be alleviated in part through leadership engagement of bedside nurses who realise the importance of their own clinical work and that of the quality agenda of the organisation, thus creating positive work environments (Daly et al., 2014).

Empowerment of staff through leadership engagement is a key variable in job satisfaction, organisational commitment and intention to stay (Cowden & Cummings, 2015). Intention to stay is an important consideration for healthcare organisations the world over with Australia predicting a nursing shortfall of approximately 109 000 within the next ten

years (Roche, Duffield, Dimitrelis & Frew, 2015). Through the creation of positive work environments, support for bedside nurses and active promotion of organisational goals and visions to encourage organisational commitment, transformational leaders play a direct role in nursing job satisfaction and intention to stay (Brewer et al., 2016; Roche et al., 2015).

Clinical nurse leaders are essential for ongoing quality of safe patient care (Hendricks et al., 2015). Organisations need to invest in leadership development as part of their succession planning. Globally there is a push for nurses to receive leadership education at undergraduate level, at entry level to the profession and through ongoing leadership programs within their work environments so as to grow and nurture leaders at all levels for succession planning (Sherman & Pross, 2010; Squires et al., 2010). Shared governance frameworks have placed patient safety as the responsibility of all health care workers and serve to empower staff to participate in organisational decision making to enhance patient outcomes (Kutney-Lee et al., 2016). These frameworks also promote leadership education and development programmes for all nursing levels, including new graduate nurses (Hendricks et al., 2015). Such programmes have been evaluated as being beneficial as nurses learn necessary leadership skills, gain awareness of the political and organisational needs that promote leader and organisational engagement, build self-awareness, and become empowered in their practice which has the flow on effect of empowering others. These enhanced skills empower nurses, especially the new graduate nurse, to autonomously make decisions at the bedside to maintain high levels of safe patient care (Hendricks et al., 2015). Fresh perspectives on quality care and safety challenges requires engaged leadership and engaged employees.

The employee engagement initiative of Leadership WalkRounds has been introduced in many hospitals worldwide. Leadership WalkRounds (WR) involve senior leaders and organisational executives engaging with bedside nurses to discuss patient safety concerns (Rotteau, Shojania & Webster, 2014; Sexton et al., 2014). The WalkRound provides visibility of organisational or senior clinical leaders creating opportunities for bedside staff to raise

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patient safety concerns to the executive level (Rotteau et al., 2014; Sexton et al., 2014). WRs have been documented as having a positive effect on patient safety outcomes with personal feedback to those bedside nurses raising concerns (Sexton et al., 2014). Alternatively, the WR can potentially provide a barrier to safety if competing goals are not recognised and mixed messages are sent. WalkRounds may expose a disparity in perceptions between bedside nurses and hospital or organisational leaders' opinions of the most critical issues to be considered regarding safety practices for positive patient outcomes and those perceptions of hospital or organisational leaders (Haycock-Stuart & Kean, 2012; Rotteau et al., 2014; Sexton et al., 2014). Hospital leaders may well steer conversations to issues of concern in their remit while missing or ignoring vital issues at the bedside.

A further opportunity for organisational leaders to engage with nursing staff is through the Chief Nursing Officer (CNO). CNOs are leaders within healthcare organisations and in the best position to be a nexus between bedside nurses and the organisation executive. Having a CNO within the organisational leadership team assists in the engagement of bedside nurses through leadership visibility and promotion of the quality and safety agenda, however, nurses are rarely represented on governing boards where decisions are made on policy and strategic priorities (Disch, Dreher, Davidson, Sinioris, & Wainio, 2011). As hospital boards are typically physician heavy, there is an imbalance in strategic priorities in that perceptions of safety and what constitutes an error may be different between nurses and physicians which may potentiate breakdowns in communication and mistrust in the leaders (Castel et al., 2015; Vogelsmeier et al., 2010). Healthcare organisations globally are promoting safety culture through accreditation schemes, in some cases redesigning work environments to support safety culture changes (Ammouri et al., 2014).

Many hospitals, primarily in the United States of America (USA), but also in Australia, Canada, Lebanon and Saudi Arabia have gained Magnet accreditation through the American Nurses Credentialing Center (ANCC) (ANCC, 2017). Magnet accreditation status is awarded to facilities who implement and maintain exemplary health care through the five

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forces of magnetism: transformational leadership; structural empowerment; exemplary professional practice; new knowledge, innovation and improvements; and empirical quality results (ANCC, 2017). This Magnet recognition framework promotes exemplary nursing care through a positive workplace culture. The framework provides a basis on which to build an enhanced setting that recruits and retains highly qualified staff, and through strong leadership maintains high staff satisfaction levels that have been proven to flow on to decreased patient mortality rates (Aiken et al., 2011; Moss, Mitchell & Casey, 2017). High quality work environments are the building blocks on which a culture of safety can be built, however, they cannot occur nor be sustained unless nurse leaders acknowledge their importance, and wholeheartedly endeavour to continue the work required to support them.

### **Barriers to a safety culture**

Safety culture is influenced by several factors both positive and negative. Blame has been recognised as a negative influence on patient safety and linked to under reporting of errors (Ammouri et al., 2014; Castel et al., 2015; Kaufman & McCaughan, 2013; O'Connor & Carlson, 2016; Vogelsmeier et al., 2010; Zaheer, Ginsburg, Chuang & Grace, 2015). While reporting systems are present in many organisations, a culture that does not foster safety initiatives, or not seen to be acting on reports, leads to distrust in the system by bedside nurses (Zaheer et al., 2015). Fears of recrimination through reporting voiced by bedside nurses include: disciplinary action, limited career advancement, and retaliation affecting livelihood (Castel et al., 2015; Kaufman & McCaughan, 2013). A culture of blame may also stem from a major disparity in perceptions between organisational leaders who "...declare patient safety as an organisational priority" (Vogelsmeier et al., 2010. p. 288) and bedside nurses who "...continue to report concerns about actual safety practices and priorities" yet nothing gets done (Vogelsmeier et al., 2010. p. 288).

Disempowerment of health professionals has been evident in healthcare in recent years due to relentless organisational change where the focus has strayed from the patient

(Dignam et al., 2011). This was evident in the Francis report (2013) where it was testified that bedside nurses in the Mid-Staffordshire NHS Foundation Trust were not engaged and not empowered to provide safe and appropriate care to patients as it was not seen as a priority from organisational leaders. Nurse leaders have also expressed frustration in being able to keep up-to-date with research and evidence-based practice to best support a safety environment and have requested more ongoing education concerning clinical care, conflict management but also specifically on leadership (Sherman, Schwarzkopf & Kiger, 2011).

Organisational changes have led to an increase in administrative duties for nurse leaders giving them less time to provide clinical leadership to bedside nurses (Brady Germain and Cummings, 2010; Dignam et al., 2011). These increased administrative tasks decrease leader visibility to bedside nurses and hampers channels for reporting safety concerns or errors. This may also lead to decreased patient safety initiatives from the bedside (Dignam et al., 2011).

Inadequate or inappropriate leadership education has also been recognised as a barrier to nurse's acceptance of leadership roles (Enterkin, Robb & McLaren, 2013; Grindel, 2016). Recruitment to nurse leader positions is, and has been difficult, due to inadequate succession planning or preparation and development of bedside nurses through leadership education (Enterkin et al., 2013; Grindel, 2016). In some instances, this is due to the leader role taking on increased management and administrative responsibilities and the bedside nurses being aware of same (Enterkin et al., 2013). Effective organisational leadership communications organisational goals and visions (Enterkin et al., 2013). When this is not happening, engagement and recruitment of bedside nurses to leadership roles is further hampered. Engaging bedside nurses, creating awareness of leadership roles, offering leadership education or supporting staff who enrol in leadership courses, recognising clinical expertise and supporting new nursing graduates will improve recruitment into leadership education programmes and to consider leadership roles (Grindel, 2016).

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Bedside nurses have been reported as believing that the quality of patient care is dependent on the individual nurse delivering the care, whereas, nurse leaders believe leadership impacts the quality of care by driving the quality agenda through policy development and leadership from the executive perspective (Haycock-Stuart & Kean, 2012).

### **Leadership styles and Patient outcomes**

Nurse leadership may have both positive and negative impacts on the work environment, depending upon the leadership style and attitudes of the leader. A leader need not be a manager, a person of power, or someone in the organisational hierarchy, although leaders in these areas will be highly influential on organisational culture (Daly, Jackson, Mannix, Davidson & Hutchinson, 2014).

Care settings having strong leadership, with satisfactory staffing levels, multidisciplinary collaboration, and empowerment to contribute to policy development, have decreased incidence of adverse events such as medication errors, healthcare acquired infections, complaints related to care, and falls (Wong & Giallondardo, 2013). Patient safety is also concomitant to the nursing work environment and the influence of leadership on the workings of this care setting (Squires et al., 2010). Poor leadership behaviours, such as those of the laissez-faire leader: no leadership, or ineffective leadership impact absenteeism, stress, emotional exhaustion, and intention to leave (Cope & Murray, 2017; Merrill, 2015). These factors have a significant effect on the quality of care provided by bedside nurses and on patient safety (Squires et al., 2010).

Creating safe care environments requires nurse leaders to “listen and learn” (Squires et al., 2010, p. 916) and involve employees in decision making, to develop trust among bedside nurses, and to look to errors as an opening for learning and an opportunity to improve practice (Merrill, 2015; O’Connor & Carlson, 2016). Leaders and nurses need to take responsibility to seek leadership education and participation for their own professional growth and to develop their own confidence and competence in leadership. Further,

followers of leaders should reflect on their influence on the support of their leader.

Encouragement and support, rather than criticism and passive-aggressive commentary can diminish a leader's effectiveness. Hospital acquired harm decreases as ward safety culture increases, with leadership behaviour having a direct influence on patient outcomes (O'Connor and Carlson, 2016).

## **CONCLUSION**

Patient safety is the responsibility of all healthcare workers, from the highest executive to the bedside nurse, thus effective leadership is the nexus to engagement of staff to provide high quality care. Creating a just, blame-free workplace safety culture through effective leadership and the recognition and fostering of up and coming leader's only serves to strengthen the team for the best possible patient outcomes. The positive wellbeing of our patients relies on a culture of safety as the patient safety practices at the bedside are heavily influential on patient outcomes. Whether directly or indirectly, those with the most influence on a patient's outcome is the nurse at the bedside. With effective leadership, these bedside nurses can be empowered to go above and beyond their self-imposed boundaries to meet a vision shared by their leader without fear of recrimination. A leader is looked upon for clear guidance toward a common goal, this and more is provided by the effectual leader.

Leadership styles that have claimed credence in today's healthcare literature are those of transformational and transactional leaders. These leaders can engage their staff to bring about the necessary changes that make their nursing units stand out from the crowd with increased levels of excellence in patient care. Unfortunately, several barriers to the creation of a safety culture exist that has resulted in poor patient care worldwide. The safety of our patients relies on a culture of safety. A safe culture is one nurtured by effective leadership and leadership styles used by organisational and nurse leaders are the nexus to enhanced patient safety outcomes.

**Relevance to practice** Leaders may not necessarily be in formal senior positions but may be anyone who is influential in patient care. Patient safety is the responsibility of all healthcare workers, from the highest executive to the bedside nurse. Patient experiences are influenced not only by the nurse at the bedside but the overall workings of the organisation thus effective leadership throughout all levels, especially from clinical nurses at the bedside, is essential in engaging staff to provide high quality care for the best possible patient outcomes.

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