Title:
Innovations in Leadership Development: Improving Organizational Safety Culture

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Session Title:
Reflective Practice: Innovations in Leadership Development Begins With Changing the Mindset to Transform Safety Culture

Slot:
G 14: Monday, 30 October 2017: 1:15 PM-2:30 PM
Scheduled Time:
1:55 PM

Keywords:
QSEN, reflective practice and safety culture

References:


Abstract Summary:
In this third session of the symposium we will use a case study approach to apply concepts of mindfulness and reflective practice introduced in the sessions 1 and 2. We will use a guided reflective process to identify truths in the case and rewrite to define best practices.

Learning Activity:

<p>| LEARNING OBJECTIVES | EXPANDED CONTENT OUTLINE |</p>
<table>
<thead>
<tr>
<th>Examine a case study using reflective practices to identify factors in patient safety.</th>
<th>patient safety culture characteristics; role of leadership; individual contributions to culture; QSEN competencies; developing a mindset for safety based on wisdom leadership</th>
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</thead>
<tbody>
<tr>
<td>Apply quality and safety competencies in case study analysis to determine ways to influence safety culture</td>
<td>application of QSEN competencies; participant discussion to rewrite the story to demonstrate quality safe care</td>
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**Abstract Text:**

The Quality and Safety Education for Nursing (QSEN) project defined six competencies with the required knowledge, skills and attitudes to improve quality and safety (Cronenwett et al, 2007). These competencies are hard-wired into accreditation standards for schools of nursing and are a growing expectation in clinical practice. Competency development alone will not transform organizational safety culture and improve patient care quality and safety. It is developing a transformed mindset that practices from a perspective of improvement, which is, working with quality and safety as a mindset, so that all actions are viewed from the perspective of safety risks and how care can be improved.

Reflection is the foundation for analyzing our work to make sense of the complexities of practice and deal with the contradictions of the ideal and reality; it is critical to develop awareness of the gaps between realities of practice and the ideal we strive for. In this third session of the symposium we will use a case study approach to apply concepts of mindfulness and reflective practice introduced in the sessions 1 and 2. We will use a guided reflective process to identify truths in the case and rewrite to define best practices.

Reflective practice is a positive change process that incorporates experiential learning by considering what one knows, believes and values within the contextual factors in any situation. As such, reflective practice helps nurses cope with the emotional labor of nursing in making sense of confusing and even contradictory work events and situations. Developing reflective practice is a habit of the mind to continually improve practice outcomes and expands one’s emotional intelligence.

We will explore why professionals fail to follow evidence based best practices and put patients at risk and consider how reflecting before action, in action, on action leads to improvement. Recognizing the connection between our actions with patients and the outcomes of the patient experience is an essential part of developing a safety culture. Safety culture is embedded in how workers at all levels live out organizational and system values and beliefs. Safety culture is a subset of the overall organizational culture and is deeply influenced by leadership models and how daily actions match stated values and beliefs. Nurses are a primary driver in developing safety culture because of their front-line presence with patients and families, their role in continuous assessment,
and their skills in clinical decision-making—all chief influences on a positive patient experience. The leadership role of every member of the organization is critical to ensuring that safety goals and culture enable the transformation to a high reliability organization (HRO). Effective organizations are learning organizations capable of responding to internal and external pressures in a dynamic environment and achieving best patient and worker outcomes.

Communication and culture are intertwined; culture is lived through communication across the organization. A positive safety culture demonstrates effective communication guided by mutual trust, shared perceptions of the importance of safety among all members and leadership, and confidence that error-preventing strategies will work. Safety culture acknowledges the complexity of system and human factors that influence safety through an interplay of leadership, policies, and front-line staff capable of transforming the patient experience to achieve best outcomes. Reflective practice turns an inward glance with the self-awareness to acknowledge the impact of our actions on others to develop emotional intelligences, synthesize knowledge and experience to expand vertical development, and reframe our future choices and actions to enable transformation—apply wisdom leadership. Achieving high reliability demands every one of us to practice from this intersection of dynamic caring leadership, commitment to lifelong learning so we see opportunity to learn in every experience, and mindful engagement in patient care delivery to see the individual in front of us. It means all of us working together to achieve a common goal—best patient outcomes each and every time.