

CE ONLINE

Leadership & Communication in the Perioperative Setting: The Impact on Patient Safety

(An Online Continuing Education Activity)



A Continuing Education Activity

Sponsored By

Pfiedler
ENTERPRISES

Sponsored By

ETHICON
PART OF THE *Johnson & Johnson* FAMILY OF COMPANIES

Welcome to

Leadership & Communication in the Perioperative Setting: The Impact on Patient Safety

(An Online Continuing Education Activity)

CONTINUING EDUCATION INSTRUCTIONS

This educational activity is being offered online and may be completed at any time.

Steps for Successful Course Completion

To earn continuing education credit, the participant must complete the following steps:

1. Read the overview and objectives to ensure consistency with your own learning needs and objectives. At the end of the activity, you will be assessed on the attainment of each objective.
2. Review the content of the activity, paying particular attention to those areas that reflect the objectives.
3. Complete the Test Questions. Missed questions will offer the opportunity to re-read the question and answer choices. You may also revisit relevant content.
4. For additional information on an issue or topic, consult the references.
5. To receive credit for this activity complete the evaluation and registration form.
6. A certificate of completion will be available for you to print at the conclusion.

Pfiedler Enterprises will maintain a record of your continuing education credits and provide verification, if necessary, for 7 years. Requests for certificates must be submitted in writing by the learner.

If you have any questions, please call: 720-748-6144.

CONTACT INFORMATION:



© 2013

All rights reserved

Pfiedler Enterprises, 2101 S. Blackhawk Street, Suite 220, Aurora, Colorado 80014
www.pfiedlerenterprises.com Phone: 720-748-6144 Fax: 720-748-6196

Leadership & Communication in the Perioperative Setting: The Impact on Patient Safety

(An Online Continuing Education Activity)

OVERVIEW

The perioperative setting is a unique practice environment. Provision of safe and effective care in all areas of a surgical services suite requires a complex organizational structure, utilizing a diverse skill mix from numerous personnel. In addition, within this complex setting, various members of the surgical team may have conflicting goals and objectives. Because this environment is so complex and may also be intense at times, effective leadership and communication skills are crucial in order to bring these diverse workers together to provide safe care and achieve positive patient outcomes, which include prevention of surgical site infections, medication errors, wrong-site surgery, and other preventable complications related to surgical intervention. This continuing education activity will provide a review of leadership styles and communication skills in the perioperative setting and their impact on patient safety. It will define leadership and then differentiate leadership versus management. Various leadership styles, as well as the principles of leadership will be reviewed. The qualities of an effective clinical leader will be outlined. An overview of the communication process will be presented, including the impact of poor communication and problems with communication in the perioperative setting. The standards and guidelines published by various agencies, organizations, and professional associations designed to assist perioperative leaders with effective communication in order to develop a patient safety culture will be outlined. Finally, the relevant research on leadership and communication and their impact on the work environment in regards to patient safety will be reviewed.

OBJECTIVES

Upon completion of this continuing nursing education activity, the participant should be able to:

1. Define leadership.
2. Differentiate leadership and management.
3. Distinguish various leadership styles and qualities.
4. Discuss the key aspects of the communication process in the perioperative practice setting.
5. Identify national guidelines related to improving communication and patient safety in the perioperative practice setting.
6. Describe the impact of leadership and communication on patient safety as outlined in the literature.

INTENDED AUDIENCE

This continuing education activity is intended for perioperative registered nurses and surgical technologists who are interested in learning more about leadership styles and communication skills and their impact on patient safety in the perioperative practice environment.

CREDIT/CREDIT INFORMATION

State Board Approval for Nurses

Pfiedler Enterprises is a provider approved by the California Board of Registered Nursing, Provider Number CEP14944, for **2.0 contact hour(s)**.

Obtaining full credit for this offering depends upon completion, regardless of circumstances, from beginning to end. Licensees must provide their license numbers for record keeping purposes.

The certificate of course completion issued at the conclusion of this course must be retained in the participant's records for at least four (4) years as proof of attendance.

IACET Credit for Allied Health Professionals

Pfiedler Enterprises has been accredited as an Authorized Provider by the International Association for Continuing Education and Training (IACET), 1760 Old Meadow Road, Suite 500, McLean, VA 22102.

CEU STATEMENT

As an IACET Authorized Provider, Pfiedler Enterprises offers CEUs for its programs that qualify under ANSI/ IACET Standard. Pfiedler Enterprises is authorized by IACET to offer **0.2 CEUs (2.0 contact hours)** for this program.

RELEASE AND EXPIRATION DATE

This continuing education activity was planned and provided in accordance with accreditation criteria. This material was originally produced in July 2013 and can no longer be used after July 2015 without being updated; therefore, this continuing education activity expires in July 2015.

DISCLAIMER

Accredited status as a provider refers only to continuing nursing education activities and does not imply endorsement of any products.

SUPPORT

Grant funds for the development of this activity were provided by **Ethicon**.

AUTHORS/PLANNING COMMITTEE/REVIEWER

Rose Moss, RN, MN, CNOR
Nurse Consultant

Elizabeth, CO

Elizabeth Deroian, RN, BA
Program Manager
Pfiedler Enterprises

Aurora, CO

Julia A. Kneeder, RN, MS, EdD
Program Manager/Reviewer
Pfiedler Enterprises

Aurora, CO

Judith I. Pfister, RN, BSN, MBA
Program Manager/Planner
Pfiedler Enterprises

Aurora, CO

DISCLOSURE OF RELATIONSHIPS WITH COMMERCIAL ENTITIES FOR THOSE IN A POSITION TO CONTROL CONTENT FOR THIS ACTIVITY

Pfiedler Enterprises has a policy in place for identifying and resolving conflicts of interest for individuals who control content for an educational activity. Information listed below is provided to the learner, so that a determination can be made if identified external interests or influences pose a potential bias of content, recommendations or conclusions. The intent is full disclosure of those in a position to control content, with a goal of objectivity, balance and scientific rigor in the activity.

Disclosure includes relevant financial relationships with commercial interests related to the subject matter that may be presented in this educational activity. **“Relevant financial relationships”** are those in any amount, occurring within the past 12 months that create a conflict of interest. A **“commercial interest”** is any entity producing, marketing, reselling, or distributing health care goods or services consumed by, or used on, patients.

Activity Planning Committee/Authors/Reviewers:

Rose Moss, RN, MN, CNOR
No conflict of interest

Elizabeth Deroian, RN, BA
No conflict of interest

Julia A. Kneeder, RN, MS, EdD
Co-owner of company that receives grant funds from commercial entities

Judith I. Pfister, RN, BSN, MBA
Co-owner of company that receives grant funds from commercial entities

PRIVACY AND CONFIDENTIALITY POLICY

Pfiedler Enterprises is committed to protecting your privacy and following industry best practices and regulations regarding continuing education. The information we collect is never shared for commercial purposes with any other organization. Our privacy and confidentiality policy is covered at our website, www.pfiedlerenterprises.com, and is effective on March 27, 2008.

To directly access more information on our Privacy and Confidentiality Policy, type the following URL address into your browser: <http://www.pfiedlerenterprises.com/privacy-policy>

In addition to this privacy statement, this Website is compliant with the guidelines for internet-based continuing education programs.

The privacy policy of this website is strictly enforced.

CONTACT INFORMATION

If site users have any questions or suggestions regarding our privacy policy, please contact us at:

Phone: 720-748-6144

Email: tonia@pfiedlerenterprises.com

Postal Address: 2101 S. Blackhawk Street, Suite 220
Aurora, Colorado 80014

Website URL: <http://www.pfiedlerenterprises.com>

INTRODUCTION

Leading a department or organization is not an easy task; however, effective leadership is critical to the success of the department and organization.¹ Effective leaders can create a working environment that promotes staff satisfaction and productivity, thereby contributing to the overall success of the department; conversely, ineffective leadership can result in a loss of staff morale and productivity and ultimately have a negative impact on departmental and organization outcomes. Today, with the ongoing advances in technology and health care in general, the definition of success in the perioperative practice setting often includes the provision of safe and effective patient care and achieving optimal outcomes. To realize these successes, this work environment requires strong, consistent, knowledgeable leaders who are visible, inspire others, and can motivate the multidisciplinary team. A key component of effective leadership at all levels is effective communication.

LEADERSHIP

Overview

Much has been written about leadership and many theories have been formulated about what describes a good leader and what attributes enable some people to lead while others cannot.² What is known about leadership is that it³:

- Does not merely result from the individual traits of leaders;
- Must also involve interpersonal transactions and empathy between the leader and those who follow;
- Is not automatic; and
- Is a significant component of an organization's culture and consequently impacts what occurs in successful organizations.

But what exactly is leadership? Leadership is as much an art as it is a skill; it seems to be one of those qualities that is difficult to describe, but you know it when you see it.⁴ Webster defines leadership as the "the quality of character and personality giving a person the ability to gain the confidence of and lead others".⁵ Other definitions of leadership and nursing leadership include⁶:

- An interpersonal process for influencing the actions of an individual or group toward accomplishing goals in a given situation;
- Setting the pace and direction for change;
- Facilitating innovative practice; and
- A vehicle through which health policy and nursing practice can be influenced and shaped.

Since leadership may often be associated with one person, four aspects of leadership stand out in this regard⁷:

- To lead involves influencing others;
- Where there are leaders there are followers; followership is an interpersonal process of participating by following;
- Leaders seem to come to the forefront when there is a crisis or other special problems; in other words, they often become more visible when an innovative response or solution is needed; and
- Leaders are people who have a clear idea of what they want to achieve and why.

Thus, leaders are people who are able to think and act creatively in non-routine situations and who set out to influence the actions, beliefs, and feelings of others; in this regard, being a “leader” is personal. However, leadership may also be linked to the role of manager, which can create some confusion because not all managers are leaders and not all leaders are managers.

Leadership versus Management

Leadership and management are two distinctive and complementary systems of action: as noted, the term “lead” involves influencing the performance or actions of an individual or group toward accomplishing a goal, or to guide; the term “manage” means to direct or control the use of, to exert control over, to make submissive, and to succeed in accomplishing one’s purpose.⁸

Leaders are focused on change and get things done by setting a direction, developing a vision of the future, and defining strategies for producing the changes needed to accomplish the vision. This requires motivating and inspiring, keeping the staff moving in the right direction, and assisting in removing obstacles to achieving the vision. In contrast, managers promote stability through planning, budgeting, organizing, staffing, controlling, and problem-solving. Both effective leaders and managers are needed for success in today’s increasingly complex health care organizations.

It is important to understand the distinction between leadership and management, especially when trying to measure the effectiveness or responsibilities related to these positions. There are many commonalities between leadership and management, including involvement with establishing direction, aligning resources, and motivating people, but there are distinct differences as well.⁹ Managers are more focused on frontline activities, maintaining order and productivity, and problem-solving. Leaders are more goal-directed and visionary; they develop the vision and the strategic plan to achieve the vision. Table 1 provides a comparison of management and leadership differences; Table 2 differentiates managerial and leadership duties.

Table 1 – Comparison of Management and Leadership in the Workplace¹⁰

Process	Management	Leadership
Vision Establishment	☐ Plans and budgets ☐ Develops process steps and sets timelines ☐ Displays impersonal attitude about the vision and goals	☐ Sets the direction and develops the vision ☐ Develops strategic plans to achieve the vision ☐ Displays very passionate attitude about the vision and goals
Human Development and Networking	☐ Organizes and staffs ☐ Maintains structure ☐ Delegates responsibility ☐ Delegates authority ☐ Implements the vision ☐ Establishes policy and procedures to implement the vision ☐ Displays low emotion ☐ Limits employee choices	☐ Aligns organization ☐ Communicates the vision, mission, and direction ☐ Influences creation of coalitions, teams, and partnerships that understand and accept the vision ☐ Displays driven, high emotion ☐ Increases choices
Vision Execution	☐ Controls processes ☐ Identifies problems ☐ Solves problems ☐ Monitors results ☐ Takes low-risk approach to problem-solving	☐ Motivates and inspires ☐ Energizes employees to overcome barriers to change ☐ Satisfies basic human needs ☐ Takes high-risk approach to problem-solving
Vision Outcome	☐ Manages vision order and predictability ☐ Consistently provides expected results to leadership and other stakeholders	☐ Promotes useful and dramatic changes, such as new products or approaches to improving labor relations

Table 2 – Managerial versus Leadership Duties¹¹

Managerial Duties	Leadership Duties
Focus on order	Focus on results
Develop policies and ensure compliance	Think strategically
Get things done cost effectively	Develop and communicate a shared vision
Effect compromises to solve problems	Create an agile and improving organization
Provide feedback to the workers	Create a sense of urgency
	Be an agent of change

Leadership Styles

There are many types of leadership styles. Studies indicate that the most successful leaders rely on several different leadership styles and may use various styles throughout the day, depending on the situation.¹² As discussed above, one key aspect of a leader is to motivate and inspire others. When a leader drives emotions in a positive direction toward enthusiasm, this effect is called resonance. Resonance results in productive, enthusiastic, high-performance individuals. Dissonance is the term for driving emotions negatively. Table 3 lists and compares six of the most common leadership styles. Each of these styles contains an element of emotional intelligence, which is vital to successful leadership.

Table 3 – Leadership Styles¹³

Style	How it Builds Resonance	Impact on Climate	When Appropriate
Visionary	Moves people toward shared dreams	Most strongly positive	When changes require a new vision, or when a clear direction is needed
Coaching	Connects what a person wants with the organization's goals	Highly positive	To help an employee improve performance by building long-term capabilities
Affiliative	Creates harmony by connecting people to each other	Positive	To heal rifts in a team, motivate during stressful times, or strengthen connections
Democratic	Values people's input and gets commitment through participation	Positive	To build buy-in or consensus, or to get valuable input from employees
Pacesetting	Meets challenging and exciting goals	Because too frequently poorly executed, often highly negative	To get high-quality results from a motivated and competent team
Commanding	Soothes fears by giving clear direction in an emergency	Because so often misused, highly negative	In a crisis, to kick-start a turnaround, or with problem employees

In addition to the leadership styles noted above, other styles include¹⁴:

Autocratic – This leadership style is considered the classic approach; it is the style in which the leader retains as much power and decision-making authority as possible. The followers are not consulted nor are they given the opportunity to give input; they are expected to obey orders without receiving explanations. Motivation is achieved through a structured set of rewards and punishments. This style may be appropriate in situations where the majority of the followers are novices or in crisis situations when there is no time for group decisions. The disadvantages of an autocratic leadership style are obvious: when members of a group feel that they have no input or are not supported, they are less likely to support the achievement of leadership goals.

Bureaucratic – The bureaucratic leader manages “by the book”, that is, everything must be done as outlined by the organizational policies and procedures. A bureaucratic leader enforces the rules. This leadership style is appropriate for work that involves serious safety risks.

Laissez-Faire – This leadership style is also known as the permissive or “hands-off” style. The laissez-faire leader gives followers as much freedom as possible and provides little or no direction; all authority or power is given to the followers. This style may be effective in mature, highly motivated work groups. There are many disadvantages to this leadership style, including that neither the task nor the follower is fostered and frustration by the lack of direction can create tension within the group.

Transactional and Transformational Leadership

A discussion of leadership styles would be incomplete without examining two major paradigms of leadership that provide a foundation for the study of leadership¹⁵:

- **Transactional Leadership** – This is considered the traditional form of leadership. Transactional leaders are those who set goals, communicate clear performance expectations, provide feedback to followers to keep them focused on the task, and create a motivating environment where best practice and quality service are the standard. Transactional leadership is aimed at maintaining the equilibrium; it is a foundation that helps to support transformational leadership.
- **Transformational Leadership** – This concept is described as the process in which one or more persons engage with others in a way that leaders and followers raise each other to a higher level of morality and motivation. By using this type of leadership, the integrity of an organization is both maintained and enhanced. Transformational leaders have been described as those who motivate others to do more than they initially intended and set challenging expectations for achievement of higher performance. Transformational leaders achieve better results by using one or more of the four “I”s, as follows:
 - **Idealized Influence** – The leadership attributes of serving as a role model and being respected, admired, and trusted.
 - **Inspirational Motivation** – The leadership behaviors that inspire and motivate, provide meaningful work, and communicate expectations clearly.

- Intellectual Stimulation – The leadership behavior that stimulates creativity, questions assumptions, and promotes new ways of responding to problems.
- Individualized Consideration – This is defined as the leadership behaviors that attend to the individual needs for achievement, and coach and mentor.

Leadership Principles

Principles of leadership are values translated into action.¹⁶ Some of the principles of effective leaders are outlined below¹⁷:

- Responsibility – Professional nurses who seek out growth and development opportunities actively look for challenging assignments; seeking increased responsibilities also means that one takes ownership of one's actions.
- Know Oneself and Seek Self-Improvement – One should evaluate oneself using leadership traits and characteristics and then determine one's strengths and weaknesses within each. A professional development plan should then be developed that capitalizes on one's strengths and allows one to improve on the identified weaknesses.
- Set the Example – A leader will set the standards for the followers by personal example; one's attitude, appearance, and personal examples are all watched by one's followers. Also, a good leader will show followers that he/she is willing to do the same things asked of the followers.
- Develop Your Followers – Leaders should give followers professional development opportunities; assigning tasks and delegating the appropriate authority to accomplish the tasks supports mutual confidence and respect between the leader and follower.
- Ensure the Job is Understood, Supervised, and Accomplished – This is a vital leadership principle; before the followers can perform, they must first know what is expected of them. Supervision is also essential; without it, one does not know if the assigned task is being accomplished appropriately.
- Know Your Followers and Look Out for Their Welfare – This is also a vital principle of effective leadership. A good leader should know his/her followers and how they respond in various situations. This knowledge will enable the leader to decide how to best handle each follower and when closer supervision is required.
- Keep Everyone Informed – A leader should inform the followers about the key issues in the unit in order to promote efficiency and morale. Informing everyone of the issues and giving the rationale as to why they are being asked to do something in a certain way make them feel part of the team. The key to informing the followers is to be certain that they have enough information to do the task effectively and to inspire their initiative, enthusiasm, and convictions.
- Make Sound and Timely Decisions – An effective leader must be able to evaluate situations quickly and make sound decisions based on this evaluation in order to implement solutions and resolve crises. Followers tend to lose confidence in a leader's ability if he/she is hesitant or reluctant to make a decision. Additionally, if

the decision made is the wrong one, the leader should not hesitate to reverse it; followers respect a leader who corrects his/her mistakes immediately instead of trying to bluff through a bad decision.

Leadership Qualities

In his book, *Where Have all the Leaders Gone?*, Lee Iacocca outlines the “nine C’s” of quality leaders¹⁸:

1. Curiosity;
2. Creativity;
3. Communication skills;
4. Character;
5. Courage;
6. Conviction;
7. Charisma;
8. Common sense; and
9. Competency.

While no single set of requirements exists for a leader, nor is there any one leader who exhibits all the characteristics, some of the salient traits or characteristics demonstrated by effective leaders include¹⁹:

- A life-long learner;
- A risk-taker;
- Acceptance of interpersonal stress;
- Dependable;
- Empathetic;
- Energetic;
- Functional expertise;
- Innovative;
- Intelligent;
- Persistent;
- Self-confident;
- Tolerant; and
- Visionary.

The Impact of Today's Health care Climate on Leadership

In the dynamic perioperative practice setting, with ongoing technological advancements and various initiatives to improve patient safety, it becomes evident that the leadership qualities noted above are particularly relevant for perioperative leaders. Both the health care climate and settings are vastly different today than those of decades past. Some of the factors that shape the current health care setting, as well as management choices and leadership qualities, include²⁰:

- Reduced lengths of hospital stays;
- Less invasive procedures;
- An increased shift to outpatient care settings;
- Aftercare of patients taking place in home settings, ie, shifting care to family or other caregivers;
- Payment models – Reimbursement is subject to increased review;
- Staff shortage – This contributes to more stress related to providing services, scheduling staff, and assigning staff to meet patient care demands;
- Worker model – This is changing from an institutional to a mobility model, which results in less loyalty to the workplace, only to the work;
- Pace of technology increases demand for knowledge, change, and adaptation often more quickly than the worker can cope;
- Accountability by managers for work performed by temporary workers – This increases stress through responsibility for workers that are not well known; and
- Managers are taken away from the clinical area to address systems issues, resulting in increasing independence of the staff; managers are forced to be more reactive and less proactive because they are removed from the practice area more often.

In this changing face of health care, the nurse must function as a leader using knowledge and skills to make decisions that affect patient care on a daily basis. The nurse is accountable for those decisions and actions and for the subsequent outcomes. The importance of leadership is demonstrated by the large amount of current research on the topic. Five research-based practices for exemplary leadership are²¹:

1. *Model the Way* – Good leaders earn respect and trust by modeling trustworthiness, honest communication, sharing information, and giving and receiving feedback. A good leader must model a high level of emotional intelligence.
2. *Inspire a Shared Vision* – A good leader sees a vision and then works backwards from there to develop steps through which the staff can become involved to grow the vision. The leader must be open and forthright with communication as the team works to achieve the final goal.
3. *Challenge the Process* – A good leader accepts and seeks out challenges, adopting innovation early on. The clinical leader challenges practice issues and uses research to support change or assure evidence-based practice for current practices.

-
4. *Enable Others to Act* – A strong clinical leader encourages staff autonomy and control over making changes or developing practice. Collaboration and shared governance support the staff while demonstrating positive leadership characteristics.
 5. *Encourage the Heart* – By celebrating accomplishments and growth through recognition, the staff become more aware of their significance in the daily activities of patient care and patient outcomes. Good leaders take time to learn the goals, values, and insecurities of the staff in order to provide support and rewards for positive performance.

Another important factor in effective leadership is the impact of emotions in the workplace. Patients exhibit positive well-being from the “peaceful invested presence of another”.²² Furthermore, research demonstrates that emotions are interdependent and all members of a team share the emotions of any one member of the team. As a result, leaders must have an understanding of their own personal situations and emotions, the impact they have on others. To enhance one’s emotional intelligence and ability, a leader should understand the following skill sets²³:

- *Self-awareness* – Able to read one’s own emotional state; awareness that negative moods can be transmitted to staff or translated into relationships with staff.
- *Self-management* – Compensate for a negative mood so it is not transferred to staff; adjust behavior as necessary to promote a positive atmosphere among staff.
- *Social Awareness* – Ability to assess the emotions and moods of others, expressing a sense of caring and compassion through actions and communication.
- *Relationship Management* – Establish bonds with the staff to support positive relationships and avoid potential conflicts; enthusiasm, caring, and supportive feelings are generated throughout the team from the leader.
- *Adult to Adult* – The change is from an adult-child relationship model to one of adult-adult; leaders who use horizontal communication and interactions that include staff as part of the decision-making process support positive outcomes.

The various leadership styles and the essential vocabulary and skill sets discussed above are interdependent and function in a collaborative manner to promote an exceptional leader.

THE COMMUNICATION PROCESS

Overview

As discussed above, communication skills are needed to be an effective leader. Furthermore, in the complex perioperative environment, effective communication is a key factor in promoting efficiency and patient safety.

Understanding the communication process can assist in preventing misunderstandings and improve the sending of important messages. Based on a theoretical model, communication is an interactive process between two or more persons and consists of several elements. The sender encodes a message using verbal and nonverbal behaviors, the message is sent, and the receiver must then decode the message. The receiver becomes the sender and must encode and send a response back to the sender who now becomes the receiver.²⁴ In order to assure successful communication, a message must be verified by some type of feedback. Knowing that a message was communicated accurately is very important, especially in a critical patient-centered situation.

This basic process of communication between sender and receiver is intended to both convey information and exchange thoughts or feelings.²⁵ Both the internal and external climate of communication also have considerable influence over the message being sent, and impact how the message might be received. The internal climate is composed of the sender's and receiver's feelings, biases, values, basic temperament, and the stress level. The temperature, personal space needs, timing, and the general surroundings where the communication occurs characterize the external environment. In addition, there are other external influences that can be potential barriers to effective communication, such as a person's status; power and authority issues; and gender, especially when communication occurs between a predominantly male medical profession and a predominantly female nursing professional. Despite these considerations that influence the ability to communicate effectively, it is important to remember that communication is first and foremost an interactive process and that the message being sent is never more important than the people engaged in the process.

In addition to being aware of the communication process, there are also certain skill sets that relate to effective communication. These interpersonal communication skills can be grouped into the following five key categories²⁶:

- *Listening Skills* – Active or conscious skills required to truly listen and understand, plus effectively respond to what a person is saying.
- *Assertion Skills* – Verbal and nonverbal behaviors that allow a person to maintain respect, satisfy needs, and defend rights without dominating, abusing, or controlling others.
- *Conflict Resolution Skills* – Abilities that allow a person to deal with conflict, while preserving or promoting closer relationships when the conflict is resolved.
- *Collaborative Problem-Solving Skills* – A means of resolving conflicts and solving problems effectively.

-
- *Skill Selection* – Guidelines that enable a person to choose what communication skills to use in any given situation, including the use of appropriate humor.

Teamwork and Communication

Teamwork is another key concept related to communication and ultimately the provision of safe patient care. Teamwork is the interaction or relationship of two or more health professionals who work interdependently to provide care for patients; teamwork means that the members of the team²⁷:

- Are mutually dependent;
- See themselves as working collaboratively for patient-centered care;
- Benefit from working collaboratively to provide patient care;
- Share information that may lead to shared decision-making; and
- Know when teamwork should be used to optimize patient-centered care.

With teamwork as a desired outcome, a culture of effective communication is imperative; many medical errors have been attributed to interpersonal interactions, with the lack of or failed communication being cited as the most common cause.²⁸ In order to achieve a collaborative, high-performance team that achieves optimal patient outcomes as the end in mind, one must have an understanding of how and where communication breakdowns occur among team members.

Problems with Communication in the Perioperative Practice Setting

In the perioperative practice environment, there are several complicated communication relationships including nurse-nurse, nurse-physician, and nurse-patient. This communication is critical to the patient and to the operations within a surgical environment. Communication failures account for over 60% of root causes of sentinel events annually, and have done so since 1995 according to the Joint Commission.²⁹ Because clinical communication is so complex, there are several ways in which it could fail, such as³⁰:

- *System Failure* – Where the process is not in place to support effective communication;
- *Message Failure* – When the information is not transmitted even though the system exists; and
- *Reception Failure* – In which the information that was transmitted accurately and using the proper tools was misinterpreted or it arrived too late.

It is important to remember that the failure to communicate in an accurate and timely manner, that is, communication failure, is a significant contributor to medical errors.

The Impact of Poor Communication³¹

There are various consequences that may occur when health care professionals do not communicate well. For example, information can be overlooked or forgotten, not conveyed, or misdirected; instructions can also be delayed or misinterpreted. Other effects of poor communication include:

- Inappropriate orders may be implemented – An example of this may include administering the wrong dose of medication or administering medication at the wrong time.
- Ambiguous telephone orders may be given and accepted – Because the names of several medications sound alike, as well as the issues of poor connections, language accents, or background noise, telephone orders are often opportunities for either misinterpretation or confusion. If an ambiguous order is taken and not verified, errors related to wrong treatments or medications could occur.
- A change in status may be overlooked or go undocumented – Such changes include the onset of depression, a rise in body temperature, or an increase in heart rate. If unaware of such changes, the care delivered by a health care provider could potentially cause harm.
- Critical details may be overlooked or go undocumented – Examples here include patient allergies, blood type, or correct surgical site. Again, if unaware of these details, a health care provider could potentially cause a patient harm.

Because of the increasing recognition that poor communication is linked to so many types of medical errors, greater attention is being given to this aspect of care in order to improve communication within the health care setting. A summary of the related research and various professional initiatives to improve communication and patient safety is presented below.

- *Silence Kills*. Vital Smarts and the American Association of Critical-Care Nurses (AACN) co-sponsored a research study related to communication in health care organizations. The study suggests that nearly three in four medical errors are caused by mistakes in interpersonal communication. The study further explores the specific concerns that people have difficulty communicating that may contribute to avoidable errors and chronic problems in health care.³²

In this study, seven crucial conversations that those involved in health care fail to have are identified as leading to errors and other problems. The results of the study as they relate to these conversations are discussed.³³

1. *Broken Rules*: 84% of physicians and 62% of nurses and other clinical care providers see others taking shortcuts that could be dangerous to patients. The focus was on about 10%, indicating that they felt comfortable with 90% of their colleagues' abilities.
2. *Mistakes*: 92% of physicians and 65% of nurses and other clinical care providers work with people who have difficulty following directions. Poor clinical judgment was seen when making assessments, doing triage, suggesting treatment, or getting help by 88% of physicians and 48% of nurses.

3. *Lack of Support*: 53% of nurses noted that 10% of their colleagues are impatient, refuse to answer questions, or are reluctant to help; 83% have a team member who complains when asked to help; 76% say that over half of their colleagues give emotional support when needed, and 64% say over half give help when needed.
4. *Incompetence*: 81% of physicians and 53% of nurses demonstrate concern over competency of some nurse or other provider that they work with; 68% of physicians and 34% of nurses have concerns about the competency of at least one physician with whom they work.
5. *Poor Teamwork*: 88% of nurses have one or more team member who is part of a clique or gossips and divides the team; 55% have a team member who tries to look good at others' expense.
6. *Disrespect*: 77% of nurses work with some nurses who are rude, insulting, or condescending; 33% work with some who are verbally abusive and yell, shout, swear, or name call.
7. *Micromanagement*: 52% of nurses work with someone who abuses authority by pulling rank, bullying, threatening, or forcing their point of view on them.

The study focused on three of the seven items in more detail: incompetence, poor teamwork, and disrespect. Discussion of these items demonstrated that while there are significant concerns in these areas, very few nurses felt comfortable addressing the problem and felt it was even more difficult to approach a physician with concerns. Also in the study, physicians identified that they are as unlikely to confront nurses and other care providers as they are to confront physicians. Some of the reasons given for not confronting people in crucial situations include the belief that it is not their job, they have low confidence that it will do any good, lack of time or opportunity, and fear of retaliation. The study did show that while one does not confront, there is discussion with other workers about the situation – blowing off steam or venting.

A small minority of people feel comfortable approaching others related to these seven crucial conversations. These people do make a positive difference, for if a problem is allowed to continue it lowers morale, productivity suffers, and patients are at risk for injury or other problems. By demonstrating effective communication skills through discussions and approaching difficult situations, the registered nurse can support optimal outcomes for the patient. While there are problems with communication and confrontation, there are solutions available.

- *The Healthy Work Environment*. Evidence provided by the Silence Kills study indicates that unhealthy work environments exist. Poor communication and collaboration can lead to harm to patients and nurses. Nurses experience burnout and are leaving the work force due to dissatisfaction related to unhealthy work environments. In response to these very real concerns, the AACN created a resource for nurse managers and other leaders titled, "AACN Standards for Establishing and Sustaining Healthy Work Environments: A Journey to Excellence".³⁴

The Healthy Work Environment Initiative was developed over several years with the purpose of demonstrating to nurses, employers, and the nursing profession the importance of working collaboratively to improve the environments in which nurses work. The AACN believes that this is an urgent matter that requires attention by all those involved.

The focus of this initiative is on addressing the issues related to communication and collaboration and the barriers that restrict open conversation and dealing with issues of competence and teamwork. The body of the work focuses on creating professionally and psychologically sound environments. AACN sees this as an extremely vital aspect of patient safety and nurse retention and recruitment. The standards are listed in Table 4. (Details on how to accomplish the standards can be found in the publication accessible at <http://www.aacn.org/hwe>).

Table 4 – AACN Standards for Establishing and Sustaining Healthy Work Environments³⁵

Standard 1 – Skilled Communication

Nurses must be as proficient in communication skills as they are in clinical skills.

Standard 2 – True Collaboration

Nurses must be relentless in pursuing and fostering true collaboration.

Standard 3 – Effective Decision-Making

Nurses must be valued and committed partners in making policy, directing and evaluating clinical care, and leading organizational operations.

Standard 4 – Appropriate Staffing

Staffing must ensure the effective match between patient needs and nurse competencies.

Standard 5 – Meaningful Recognition

Nurses must be recognized and must recognize each other for the value each brings to the work of the organization.

Standard 6 – Authentic Leadership

Nurse leaders must fully embrace the imperative of a healthy work environment, authentically live it, and engage others in its achievement.

The standards interact to support the *Healthy Work Environment*, forming an *interrelationship* with Clinical Excellence and Optimal Patient Outcomes.

The nurse must embrace the opportunity to make a change in the culture and environment that has existed for far too long. By using the AACN Standards as a guide for professional development and strength, the professional nurse takes responsibility for personal growth as well as supporting others in the struggle to make positive changes. Supported by health care institutions and administrations

that desire to improve patient and staff safety, these standards can be followed and new cultures developed. Some of the ways in which organizations can help promote a healthy culture include providing professional development courses, using professional facilitators to assist in improving working relationships, using simulators to improve clinical skills, providing training programs in communication techniques to physicians and other health care personnel, and incorporating communication and team skills training in patient safety and orientation programs.³⁶

Lack of trust is evident when colleagues cannot have a conversation to address concerns over competence or behaviors that are unacceptable or disruptive. This results in unsafe conditions for patient care and disengaged employees. These employees often decide to leave a culture that is undesirable and unchangeable. Changing the culture is the focus of the Healthy Work Environment Initiative. While it will take time to change, it is possible and necessary.

- *Standardized Communication.* Communication can be influenced by many variables. To facilitate communication and collaboration to support safe patient care, tools that enhance communication must be developed and used. A variety of tools may be used. Some of these are specific to medical/surgical or intensive care units while others can be generalized for use throughout the health care system, including the perioperative arena.³⁷
 - Patient Safety Briefings – Provide information to caregivers in a briefing format:
 - Easy, efficient;
 - Keep members of the clinical unit informed;
 - Anticipate needs;
 - Make appropriate plans;
 - Conduct at a designated place at predetermined times; and
 - 3-5 questions to prompt staff.
 - Daily Patient Goal Sheets – Sheets that define the patient care goals for the day or the shift:
 - Simple, multidisciplinary, patient-centered;
 - Define explicit goals for the day;
 - Nurse and/or physician completes the sheet;
 - Sheet should contain information specific to the clinical unit; and
 - Update throughout the day.

-
- Nurse Shift Report at Bedside – Nurses travel to the bedside together to discuss transfer of care:
 - For transfer of care from one caregiver to another;
 - Puts patient at the center when performed at bedside; and
 - Provides opportunity to actively ask questions and visually inspect patient.
 - SBAR – An acronym tool to provide specific guidelines for reporting transfer of care:
 - Situation–Background–Assessment–Recommendation;
 - Structured, orderly;
 - Accurate, relevant information in a standardized format; and
 - Keeps message clear and succinct.

These types of tools can be effective in improving communication when used appropriately. Each member of the perioperative team demonstrates his/her commitment to patient safety by taking an active role in implementing and using the communication tool that best suits the situation. Perioperative team members continue to learn about new methods for communication by reading journals, benchmarking, and networking through such portals as specialty organization list services, at professional conferences, and educational offerings.

- *Cultivating a Culture of Safety.* The development of a culture of safety is also an important aspect in facilitating effective communication in the work environment. Culture in the perioperative setting is developed based on processes and behaviors that may be decades old. The first step in cultivating a culture of safety within the perioperative environment is to identify the barriers that interfere with this development. One hospital created the “Safe Passage Nurse Program” to provide nurses with the tools necessary to promote patient and workplace safety.³⁸ A Safe Passage Nursing Council was formed with the goal “to ensure a patient’s safety during his or her passage through the perioperative process”. The nurses based the program on key elements including anticipation of safety issues; communication of safety issues to administration, risk management, and all Safe Passage nurses; resolution of safety issues; and evaluation of the changes made. The mission of the program was to achieve safe outcomes through the provision of care that included safe practices throughout the continuum of care. Methods used to support a safe environment included treating errors or safety situations as learning tools in a non-threatening, non-punitive manner. Incorporating the nurse council, a basis of the Magnet culture as described by the American Nurses Association, allows collaboration and individual leadership. The Safe Passage Program has been a positive experience resulting in a culture of enhanced patient safety and outcomes.

Research at a hospital in San Antonio, Texas was aimed at determining the components of a healthy OR workplace.³⁹ The study included nurse managers and staff nurses in the perioperative area. The research findings indicate that the major components of a healthy OR workplace include:

- Quality practice standards – Meet or exceed current standards of practice;
- Excellence in patient care systems—requires good scheduling processes, technical support, good clinical care, and timely care throughout the perioperative experience;
- Effective staffing systems – Appropriate staffing of all personnel levels based on the needs, active recruiting and retention programs, ongoing education, and new employee orientation;
- Guidelines for teamwork – Guidelines for behavioral norms, desired behaviors between staff members that demonstrate cooperation, helping others, supporting each other, and being friendly;
- A functional physical environment – Providing appropriate equipment and supplies and adequate space; and
- Meaningful, clear role definition – Clearly defined roles for each staff member, including those given special assignments or cross-training.

The findings in this study mirror many of the elements discussed earlier in the AACN's Healthy Work Environment recommendations. The general consensus confirms that respect is a key element in a culture that supports a safe, positive work environment. Leadership is demonstrated through support of this environment from all levels of the perioperative staff.

NATIONAL GUIDELINES, STANDARDS, AND RECOMMENDED PRACTICES FOR IMPROVED COMMUNICATION AND A CULTURE OF SAFETY

With the increasing attention to patient safety and positive outcomes, including minimizing the potential complications of surgical intervention, perioperative leaders as well as all members of the perioperative team are responsible for the development and implementation of actions that support effective communication in order to promote patient safety. As previously noted, in recognition of the impact of poor communication on medical errors, several national agencies and organizations have promulgated initiatives to improve communication and therefore, support the safe care of patients. The connection between effective communication and patient safety is explored through the discussion of these guidelines.

The Joint Commission

Patient safety is a primary concern of the Joint Commission, as outlined in its leadership standards, National Patient Safety Goals (NPSGs), and strategies to improve communication.

- Joint Commission Standards.⁴⁰

The Joint Commission identifies the goal of any health care organization as safe, high-quality patient care. The quality and safety of care provided by a health care organization depend on many factors; some of the most important of these are:

- A culture that fosters safety and quality;
- The planning and provision of services that meet the needs of patients;
- The availability of resources – human, financial, physical, and information – for providing care;
- A sufficient number of competent staff and other care providers; and
- Ongoing evaluation and improvement of performance.

Only the *leaders* of a health care organization have the resources, influence, and control to provide for these factors. That is, it is the leaders who can together establish and promulgate the organization's mission, vision, and goals; it is the leaders who can strategically plan for the provision of services, acquire and allocate resources, and set priorities for improved performance; and it is the leaders who establish the organization's culture through not only their words, but also their expectations for action, and behavior – a culture that values high-quality, and safe patient care, responsible use of resources, community service, and ethical behavior; or a culture in which these goals are not valued. While leadership's responsibility includes strategically addressing the organization's culture, planning and provision of services, acquiring and allocating resources, providing sufficient staff, and setting priorities for improvement, the organization's leaders must also actively manage each of these factors. As previously noted, the leaders focus on strategic thinking (ie, "the where to go") while management focuses on implementing a plan and sustaining the activities needed to get there. And in between the *where* and the *implementation* lies determination of *how* to achieve the strategic goal – a determination that requires both strategic skills and management skills.

In this regard, an effective perioperative leader will assist staff members in the creation of well-designed processes, measure the performance of the existing processes, assess processes based on measurement of data, and improve outcomes through redesigning existing processes or developing new ones when needed.⁴¹ Furthermore, it is the leader's responsibility to demonstrate a commitment to the process of quality improvement as evidenced by personal involvement and constant attention to the program.

- National Patient Safety Goals and Universal Protocol.⁴²

Because patient safety is a very specific area of concern of the Joint Commission, the list of NPSGs is updated annually to hospitals that desire to maintain accreditation or for those who are applying for accredited status. One of the 2011 NPSGs and the Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery™ directly relate to communication.

- National Patient Safety Goal 2 – Improve the effectiveness of communication among caregivers.
- Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery.™

Evidence indicates that procedures that place the patient at the most risk include those that involve general anesthesia or deep sedation, although other procedures may also affect patient safety. Hospitals can enhance safety by correctly identifying the patient, the appropriate procedure, and the correct site of the procedure. The Universal Protocol is based on the following principles:

- Wrong-person, wrong-site, and wrong-procedure surgery can and must be prevented.
- A robust approach using multiple, complementary strategies is necessary to achieve the goal of always conducting the correct procedure on the correct person, at the correct site.
- Active involvement and use of effective methods to improve communication among all members of the procedure team are important for success.
- To the extent possible, the patient and, as needed, the family are involved in the process.
- Consistent implementation of a standardized protocol is most effective in achieving safety.

The Universal Protocol is implemented most successfully in hospitals with a culture that promotes teamwork and where all individuals feel empowered to protect patient safety. A hospital should consider its culture when designing processes to meet the Universal Protocol. In some hospitals, it may be necessary to be more prescriptive on certain elements of the Universal Protocol or to create processes that are not specifically addressed within these requirements. Hospitals should identify the timing and location of the preprocedure verification and site marking based on what works best for their own unique circumstances. The frequency and scope of the preprocedure verification will depend on the type and complexity of the procedure. The three components of the Universal Protocol are not necessarily presented in chronological order (although the preprocedure verification and site marking precede the final verification in the time-out). Preprocedure verification, site marking, and the time-out procedures should be as consistent as possible throughout the hospital.

All members of the perioperative team play an integral role in assuring compliance with the Universal Protocol from the initial marking of the site through the final documentation of the “time out”. This aspect of the surgical process is of extreme importance and requires clear communication by all members of the perioperative team.

- Strategies for Communication Improvement.⁴³

In addition to the NPSGs related to communication and the Universal Protocol outlined above, the Joint Commission also provides key strategies to assist in the implementation of communication-improvement activities. In order to successfully implement a communication initiative – regardless if it entails a cultural shift, process change, or new system – the following nine steps should be taken:

- Take an organized approach to implementation.
- Involve the stakeholders in every implementation step.
- Set goals for the initiative.
- Assign responsibility for the implementation steps.
- Develop a communication strategy.
- Measure the success.
- Refine the process as needed.
- Reward good performance.
- Celebrate wins.

Institute for Healthcare Improvement (IHI)

The Institute for Healthcare Improvement is a non-profit organization that focuses on the improvement of health care worldwide. The IHI instituted the “Protecting 5 Million Lives from Harm” campaign that includes the interventions that were originally designed for the 100,000 Lives Campaign plus several more interventions aimed at preventing loss, illness, and complications. The interventions for the Protecting 5 Million Live from Harm Campaign identified by IHI are outlined below.⁴⁴

- The six interventions from the 100,000 Lives Campaign:
 - Deploy Rapid Response Teams...at the first sign of patient decline.
 - Deliver Reliable, Evidence-Based Care for Acute Myocardial Infarction...to prevent deaths from heart attack.
 - Prevent Adverse Drug Events (ADEs)...by implementing medication reconciliation.
 - Prevent Central Line Infections...by implementing a series of interdependent, scientifically grounded steps.
 - Prevent Surgical Site Infections...by reliably delivering the correct perioperative antibiotics at the proper time.
 - Prevent Ventilator-Associated Pneumonia...by implementing a series of interdependent, scientifically grounded steps.

-
- New interventions targeted at harm:
 - Prevent Harm from High-Alert Medications...starting with a focus on anticoagulants, sedatives, narcotics, and insulin.
 - Reduce Surgical Complications...by reliably implementing all of the changes in care recommended by SCIP, the Surgical Care Improvement Project.
 - Prevent Pressure Ulcers...by reliably using science-based guidelines for their prevention.
 - Reduce Methicillin-Resistant *Staphylococcus aureus* (MRSA) infection...by reliably implementing scientifically proven infection control practices.
 - Deliver Reliable, Evidence-Based Care for Congestive Heart Failure...to avoid readmissions.
 - Get Boards on Board...by defining and spreading the best-known leveraged processes for hospital Boards of Directors so that they can become far more effective in accelerating organizational progress toward safe care.

All members of the perioperative team can implement many of the interventions listed in this Campaign to support quality patient care and ultimately, improve patient safety.

Association of periOperative Registered Nurses (AORN)

AORN provides numerous resources for the perioperative nurse to support safe perioperative nursing practice guided through the development and ongoing update of evidence-based standards and recommended practices. With regard to effective communication, one of the more recently developed recommended practices were those related to transfer of patient care information; those related to communication are as follow⁴⁵:

- Recommendation I – A transfer of patient information process should be developed, standardized, and based upon the best available and most current evidence.

Standardized documentation formats (eg, checklists, electronic records, scripts, briefings) should be adopted in processes for the transfer of patient information. Practitioners should ensure that the format for the safe transfer of patient information allows for a smooth and efficient exchange of information. Standardized documentation formats provide adequate and purposeful information to ensure safe patient care transitions. Standardized transfers and hand-off protocols have the potential to reduce communication breakdowns. Examples of standardized documentation formats include:

- SBAR: situation, background, assessment, recommendation;
- I PASS the BATON: introduction, patient, assessment, situation, safety concerns, (the) background, actions, timing, ownership, next;
- SURgical PATient Safety System (SURPASS); and
- SHARED: situation, history, assessment, request, evaluate, document.

Health care organization leaders should support the implementation of a process for the transfer of patient information. Support at all levels of the organization, including clinical, is needed to implement safe patient practices. Encouragement on the part of health care organization leaders creates a familiar environment in which all team members feel safe to speak and participate. It was found in a prospective study that OR leaders and managers were supportive if shown how the use of a preoperative checklist could improve communication and promote safer teamwork.

- Recommendation III – Personnel should receive education, training, and competency validation on effective communication skills and processes for the transfer of patient information.

For perioperative leaders, AORN, in its Position Statement on Creating a Patient Safety Culture, outlines that all health care organizations must strive to create a culture of safety, which provides an atmosphere where all perioperative team members can openly discuss errors, process improvements, or system issues without fear of reprisal, based on the precepts that include but are not limited to⁴⁶:

- A commitment to safety must be articulated at all levels of the organization;
- Most patient safety initiatives will fail in the absence of a viable safety culture;
- Safety should be valued as a top priority, even at the expense of productivity; and
- Organizations should allocate an appropriate amount of resources and provide the necessary incentive or rewards to promote a healthy patient safety culture.

CONTEMPORARY RESEARCH DATA: IMPLICATIONS OF LEADERSHIP AND COMMUNICATION ON PATIENT SAFETY AND CLINICAL OUTCOMES

In today's dynamic health care environment, the implications of effective leadership and communication on performance, quality initiatives, and ultimately patient safety take on greater significance. Some of the relevant research studies are outlined below.

- Squires, et al,⁴⁷ conducted a cross-sectional survey of 600 acute-care registered nurses (RNs) to test and refine a model that examined relationships among leadership, interactional justice, the quality of the nursing work environment, and safety climate with patient and nurse safety outcomes. Their results demonstrated that resonant leadership and interactional justice influenced the quality of the leader-nurse relationship, which in turn affected the quality of the work environment and safety climate; ultimately, this was associated with a reduction in reported medication errors, intentions to leave the work place, and emotional exhaustion. The authors concluded that quality relationships based on fairness and empathy play a pivotal role in creating positive safety climates and work environments. The implication for nurse managers was that, in order to advocate

for safe work environments, managers must strive to develop high-quality relationships through just leadership practices.

- Hiscock and Shuldham,⁴⁸ noting that there is a direct relationship between leadership and quality of care, explored patient-centered leadership at every level in an organization, focusing on the key issue that leadership development, with the emphasis on the patient, drives improvements in service delivery and patient safety. The authors concluded that patient-centered leadership is demonstrated when there is support at the top of the organization and that politically aware nurses make effective patient-centered leaders. Leadership development programs provide staff with opportunities to acquire the requisite skills and qualities in order to contribute to the vision of the organization. Based on these results, managers should support staff and take risks in order to empower nurses to implement initiatives that improve patient care. A process of communication using a variety of tools can have an impact on a range of staff. Patient-centered leaders are role models for tomorrow's leaders and their impact has lasting effects and wider implications within an organization and beyond.
- Booiij⁴⁹ reported on various factors related to team performance and conflicts that impact the quality and safety of health care. The author noted that operating teams, which consist of individuals, with specific roles, requiring specific expertise and skills, and performing interdependent tasks with patient treatment as a common goal, are prone to conflicts. Examples of these conflicts are disputes, disagreements, or differences of opinion related to patient management, which require some decision or action. Many factors, which vary between different hospitals and teams, determine the character of the conflicts; these factors include culture, professional social status, personality of members, etc. While conflicts can induce innovation, they also can result in job dissatisfaction and even affect the functioning of the hospital. On average, four conflicts can be observed per surgical procedure, which are usually solved immediately. Communication in an open atmosphere is a major issue in dealing with conflicts. If conflicts are unresolved, they grow into relationship conflicts, which are difficult to handle. Understanding the factors that contribute to the conflict is important for mediators. Most conflicts arise about OR management, case acceptance, unexpected changes in the team, or incapability of one of its members. The author concluded that while there are many possible causes of conflicts, they should be immediately resolved by open communication and respectful discussion.
- Wong and Cummings⁵⁰ conducted a literature review looking at the relationship between nursing leadership and patient outcomes. Their report described the findings of a systematic review of studies that examine the relationship between nursing leadership and patient outcomes. They reviewed published, English-only research articles that examined formal nursing leadership and patient outcomes that were selected from computerized databases and manual searches. Data extraction and methodological quality assessment were completed for the final seven quantitative research articles. They found significant associations

between positive leadership behaviors, styles, or practices and increased patient satisfaction and reduced adverse events. They concluded that the findings of this review suggest that an emphasis on developing transformational nursing leadership is an important organizational strategy to improve patient outcomes.

- Ferguson, et al,⁵¹ described how a cohort of clinical leaders who were undertaking a leadership development program used a relatively simple, patient-focused intervention called the “observation of care” to help focus the clinical team’s attention on areas for improvement within the clinical setting. The main quality and safety themes arising out of the observations that were undertaken by the Clinical Leaders (CLs) were related to the environment, occupational health and safety, communication and team function, clinical practice, and patient care. The observations of care also provided the CLs with many opportunities to acknowledge and celebrate exemplary practice as it was observed as a means of enhancing the development of a quality and safety culture within the clinical setting. The “observation of care” intervention also can be used by Clinical Leaders to engage and motivate clinical teams to focus on continuously improving the safety and quality of their own work environment and the care delivered to patients within that environment.
- Vogus and Sutcliffe⁵² designed a study to examine the joint benefits of safety organizing and other contextual factors believed to foster safety; specifically, they examined the benefits of bundling safety organizing with leadership (trust in manager) and design (use of care pathways) factors on reported medication errors. The subjects consisted of a total of 1,033 RNs and 78 nurse managers in 78 emergency, internal medicine, intensive care, and surgery nursing units in 10 acute care hospitals in Indiana, Iowa, Maryland, Michigan, and Ohio, who completed questionnaires between December 2003 and June 2004. A cross-sectional analysis of medication errors reported to the hospital incident reporting system for the six months after the administration of the survey linked to survey data on safety organizing, trust in manager, use of care pathways, and RN characteristics and staffing. The statistical analyses indicated that the benefits of safety organizing on reported medication errors were amplified when combined with high levels of trust in the manager or the use of care pathways. The authors concluded that safety organizing plays a key role in improving patient safety on hospital nursing units, especially when bundled with other organizational components of a safety supportive system.
- A study conducted by Khatri, et al,⁵³ was designed to determine a theoretical framework that recognized the relationship between management style and clinical outcomes. This study was based on previous work that indicated that only one-third of medical errors were unpreventable, meaning that to prevent them would require advances in medical science. The remaining two-thirds of errors are preventable by the improvement of health care culture and systems. The study concluded that in a control-based management practice where behaviors are closely monitored and controlled, the employees feel constrained and demoralized. This results in a restriction of initiative, creativity, and morale while

undermining learning from mistakes. It also supports a culture of blame. The inverse is true for a commitment-based management style. This style supports openness, cooperation, and teamwork. The result is improved clinical outcomes and a lower incidence of errors through improved communication, organizational learning, and information sharing in an environment of camaraderie and high employee morale. This study provides further evidence of the importance of a versatile repertoire of leadership skills in promoting positive patient outcomes.

SUMMARY

The role of the perioperative nurse is that of a leader. The nurse exhibits leadership in many ways including planning patient care. In the complex and diverse perioperative practice setting, effective leadership and communication skills are needed for the provision of safe patient care. Leadership is both an art and a skill; while both leadership and management are needed for success in today's increasingly complex health care environment, leadership is focused on change and results. Leaders get results by developing and communicating a vision of the future and then defining the strategies for creating the changes required to achieve this vision. Ultimately, leaders are considered to be successful based on what they accomplish, not on the basis of their characteristics or qualities. It is also critical that leaders, as well as all members of the perioperative team, demonstrate effective communication skills in this complex practice environment. Leaders must use communication to provide a culture of safety; as patient advocates, members of the perioperative team must work together to support changes and practices that improve communication and teamwork, decrease or eliminate fear or disrespect, support professionalism, and ultimately improve patient outcomes. Effective communication in a collegial, respectful culture that does not blame or intimidate others supports patient safety through the promotion of positive outcomes. As patient advocates, leadership and communication skills in all aspects of patient care are required not only of leaders, but of all members of the perioperative team. Through effective leadership and communication skills, the delivery of safe care and positive patient outcomes can be achieved.

GLOSSARY

Affiliative Leadership Style	The leadership style that creates harmony by connecting people to each other.
Assertion Skills	Verbal and nonverbal behaviors that allow a person to maintain respect, satisfy needs and defend rights without dominating, abusing, or controlling others.
Autocratic Leadership Style	The leadership style in which the leader retains as much power and decision-making authority as possible; it is often considered the classical approach.
Bureaucratic Leadership Style	The leadership style in which the leader manages “by the book”, ie, everything must be done according to procedure or policy.
Coaching Leadership Style	The leadership style that connects what a person wants with the organization’s goals.
Collaboration	The act of working together to support goals and achievements.
Collaborative Problem-Solving Skills	A means of resolving conflict needs and solving problems effectively.
Communication	The ability to clearly and accurately send and receive information between two or more team members with the opportunity to exchange information and ask questions.
Conflict Resolution Skills	Abilities that allow a person to deal with conflict while preserving or promoting closer relationships when the conflict is resolved.
Democratic Leadership Style	The leadership style that values people’s input and gets commitment through participation.
Dissonance	A leadership style that drives emotions in a negative direction. Dissonant leadership produces groups that are negative and uneven.
Emotional Intelligence	Leadership that is driven by how leaders handle themselves and their relationships. Emotional intelligence supports a healthy work environment.
I PASS THE BATON	Introduction, Patient, Assessment, Situation, Safety Concerns, Background, Actions, Timing, Ownership, Next.

Idealized Influence	The leadership attributes of being a role model who is admired, respected, and trusted.
Individualized Consideration	The leadership behaviors that pay attention to individual needs for achievement, and coach and mentor.
Inspirational Motivation	The leadership behaviors that motivate and inspire, provide meaningful and challenging work, and clearly communicate expectations.
Intellectual Stimulation	A leadership behavior that questions assumptions, stimulates creativity, and encourages new ways of addressing problems.
Laissez-faire Leadership Style	The leadership style in which the leader provides little to no direction and gives employees as much freedom as possible; it is also known as the "hands-off" or permissive style.
Leadership	The capacity or ability to lead; to guide or direct in a course; to guide the action or opinion of; to play a principal or guiding role; to act as commander, director, or guide.
Listening Skills	Active or conscious skills required to truly listen and understand, and effectively respond to what a person is saying.
Message Failure	Communication failure that occurs when the information is not transmitted even though the system exists.
Mobility Model	The model that recognizes that the health care worker is mobile, moving from job to job or institution to institution with loyalty focused on the work itself, not the facility.
Pacesetting Leadership Style	The leadership style that meets challenging and exciting goals.
Patient Safety	Freedom from accidental or preventable injuries produced by medical care.
Reception Failure	Communication failure in which the information was transmitted accurately, using the proper tools, was misinterpreted or arrived too late.

Resonance	A style of leadership that supports positive emotional experiences in a group; followers of a resonant leader are upbeat and engaged.
SBAR	An acronym tool to provide specific guidelines for reporting transfer of care: situation, background, assessment, recommendation.
System Failure	Communication failure that occurs when the process is not in place to support effective communication.
Skill Selection	Guidelines that enable a person to choose what communication skills to use in any given situation, including the use of appropriate humor.
Teamwork	The interaction or relationship of two or more health professionals who work interdependently to provide care for patients.
Transactional Leadership	The traditional form of leadership; it is aimed at maintaining equilibrium or status quo. Transactional leaders set goals, articulate clear expectations, provide feedback, and create motivating environments.
Transformational Leadership	A process in which one or more persons engage with others in such a way that leaders and followers raise one another to higher levels of motivation and morality.
Universal Protocol	A preoperative protocol created to address the continuing occurrence of wrong-site, wrong-procedure, and wrong-person surgery in Joint Commission accredited organizations. The “wrong site, wrong procedure, wrong person” prevention protocol must be conducted before each surgical procedure. There are three principal components of the Universal Protocol: conducting a preprocedure verification process, marking the procedure site, and performing a time-out before the procedure.
Visionary Leadership Style	A leadership style that moves people toward shared dreams.

REFERENCES

1. Feltner A, Mitchell B, Norris E, Wolfle C. Nurses' views on the characteristics of an effective leader. *AORN Journal*. 2008; 87(2):363-372.
2. Groah LK. Leadership roles in nursing management. *Leadership in Action: A Manager's Guide to Success*. Denver, CO:AORN, Inc; 2004:3.
3. Groah LK. Leadership roles in nursing management. *Leadership in Action: A Manager's Guide to Success*. Denver, CO:AORN, Inc; 2004:3.
4. Thompson JA. Leadership: learning module 2. *Certificate Program for Surgical Services Management*. Denver, CO:CCI; 2007:8.
5. Webster Dictionary. Leadership. <http://www.webster-dictionary.net/definition/Leadership>. Accessed July 17, 2013.
6. Feltner A, Mitchell B, Norris E, Wolfle C. Nurses' views on the characteristics of an effective leader. *AORN Journal*. 2008; 87(2):363-372.
7. Thompson JA. Leadership: learning module 2. *Certificate Program for Surgical Services Management*. Denver, CO:CCI; 2007:8.
8. Groah LK. Leadership roles in nursing management. *Leadership in Action: A Manager's Guide to Success*. Denver, CO:AORN, Inc; 2004:3.
9. Kotterman J. Leadership versus management: what's the difference? *The Journal for Quality and Participation*. 2006; 29(2):13-17.
10. Kotterman J. Leadership versus management: what's the difference? *The Journal for Quality and Participation*; 2006:29(2); p.15.
11. Gabel RA, Kulli JC, Lee BS, Spratt DG, Ward DS. Management services. *Operating Room Management*. Woburn, MA: Butterworth-Heinemann; 1999:77.
12. Goleman D, Boyatzis R, McKee A. *Primal Leadership: Realizing the Power of Emotional Intelligence*. Boston, MA: Harvard Business School Publishing; 2002:54.
13. Golememan D, Boyatzis R, McKee A. *Primal Leadership: Realizing the Power of Emotional Intelligence*. Boston, MA: Harvard Business School Publishing. 2002:55.
14. Thompson JA. Leadership: learning module 2. *Certificate Program for Surgical Services Management*. Denver, CO: CCI; 2007:11-12.
15. Thompson JA. Leadership: learning module 2. *Certificate Program for Surgical Services Management*. Denver, CO: CCI; 2007:9.
16. George B, Sims P, McLean A, & Mayer D. Discovering your authentic leadership. *Harvard Business Review*. 2007; 85:129-138.

-
17. Thompson JA. Leadership: learning module 2. *Certificate Program for Surgical Services Management*. Denver, CO: CCI; 2007:13-15.
 18. Iacocca L. *Where Have All the Leaders Gone?* New York, NY: Simon & Schuster, 2007.
 19. Groah LK. Leadership roles in nursing management. *Leadership in Action: A Manager's Guide to Success*. Denver, CO: AORN, Inc; 2004:3.
 20. Porter-O'Grady T. A different age for leadership, part 1: new context, new content. *Journal of Nursing Administration*. 2003; 33(2):105-110.
 21. Cain L B. Essential qualities of an effective clinical leader. *Dimensions of Critical Care Nursing*. 2005; 24(1):32-34.
 22. Porter-O'Grady T. A different age for leadership, part 1: new context, new content. *Journal of Nursing Administration*. 2003; 33(2):105-110.
 23. Porter-O'Grady T. A different age for leadership, part 1: new context, new content. *Journal of Nursing Administration*. 2003; 33(2):105-110.
 24. Schuster P M. *Communication: The Key to the Therapeutic Relationship*. Philadelphia, PA: F.A. Davis Company; 2000:4-6.
 25. D'Alfonso J. Communication. *CNOR Exam Study Guide and Practice Resource*, 2nd ed. Denver, CO: CCI; 2007:57-58.
 26. D'Alfonso J. Communication. *CNOR Exam Study Guide and Practice Resource*, 2nd ed. Denver, CO: CCI; 2007:58.
 27. Canadian Health Services Research Foundation. Teamwork in healthcare: Promoting effective teamwork in healthcare in Canada. http://www.chsrf.ca/Migrated/PDF/ResearchReports/CommissionedResearch/teamwork-synthesis-report_e.pdf. Accessed July 17, 2013.
 28. King CA. Communication and relationship management: learning module 3. *Certificate Program for Surgical Service Management*. Denver, CO: CCI; 2007:21.
 29. Manning M L. Improving clinical communication through structured conversation. *Nursing Economics*. 2006; 24(5):268-271.
 30. Manning M L. Improving clinical communication through structured conversation. *Nursing Economics*. 2006; 24(5):268-271.
 31. Joint Commission Resources. Communication: a vital link to high-quality improvement. *The Joint Commission Guide to Improving Staff Communication*. Oakbrook Terrace, IL: The Joint Commission on Accreditation of Healthcare Organizations; 2005:6.
 32. Vital Smarts. Silence kills: study overview. <http://www.silencekills.com/About-TheStudy.aspx>. Accessed July 17, 2013.
-

-
33. Maxfield D, Grenny J, McMillan R, Patterson K, Switzler A. Silence kills: the seven crucial conversations in healthcare. <http://www.silenttreatmentstudy.com/silencekills/SilenceKills.pdf>. Accessed July 17, 2013.
 34. AACN. AACN standards for establishing and sustaining healthy work environments: a journey to excellence. <http://www.aacn.org/WD/HWE/Docs/HWESStandards.pdf>. Accessed July 17, 2013.
 35. AACN. AACN standards for establishing and sustaining healthy work environments: a journey to excellence. <http://www.aacn.org/WD/HWE/Docs/HWESStandards.pdf>. Accessed July 17, 2013.
 36. Fontaine D K, Gerardi D. Healthier hospitals? *Nursing Management*. 2005; 36(10):34-44.
 37. Manning M L. Improving clinical communication through structured conversation. *Nursing Economics*. 2006; 24(5):268-271.
 38. Farrell V E, Davies K A. Shaping and cultivating a perioperative culture of safety. *AORN Journal*. 2006; 84(5):587-861.
 39. Parsons M L, Newcomb M. Developing a healthy OR workplace. *AORN Journal*. 2007; 85(6):1213-1223.
 40. The Joint Commission. Leadership in healthcare organizations: a guide to Joint Commission leadership standards. http://www.jointcommission.org/assets/1/18/WP_Leadership_Standards.pdf. Accessed July 17, 2013.
 41. Groah LK. Leadership roles in nursing management. *Leadership in Action: A Manager's Guide to Success*. Denver, CO: AORN, Inc.; 2004:13.
 42. The Joint Commission. Accreditation program: hospital national patient safety goals. Effective January 1, 2011. http://www.jointcommission.org/assets/1/6/2011_NPSGs_HAP.pdf. Accessed July 17, 2013.
 43. Joint Commission Resources. Implementing communication improvement initiatives. *The Joint Commission Guide to Improving Staff Communication*. Oakbrook Terrace, IL: The Joint Commission on Accreditation of Healthcare Organizations; 2005:93-94.
 44. Institute for Healthcare Improvement. Protecting 5 million lives from harm. <http://www.ihl.org/offering/Initiatives/PastStrategicInitiatives/5MillionLivesCampaign/Pages/default.aspx>. Accessed July 17, 2013.
 45. AORN. Recommended practices for transfer of patient care information. *Perioperative Standards and Recommended Practices*. Denver, CO: AORN, Inc.; 2013:445-450.
 46. AORN. AORN position statement on creating a patient safety culture. *Perioperative Standards and Recommended Practices*. Denver, CO: AORN, Inc.; 2010:709-712.
 47. Squires M, Tourangeau A, Spence Laschinger HK, Doran D. The link between leadership and safety outcomes in hospitals. *Journal of Nursing Management*. 2010; 18(8):914-925.
-

-
48. Hiscock M, Shuldham C. Patient centered leadership in practice. *Journal of Nursing Management*. 2008;16(8):900-904.
 49. Booi LH. Conflicts in the operating theatre. *Current Opinions in Anaesthesiology*. 2007;20(2):152-156.
 50. Wong CA, Cummings GG. The relationship between nursing leadership and patient outcomes: a systematic review. *Journal of Nursing Management*. 2007; 15(5):508-521.
 51. Ferguson L, Calvert J, Davie M, Fallon M, Fred N, Gersbach V, Sinclair L. Clinical leadership: using observations of care to focus risk management and quality improvement activities in the clinical setting. *Contemporary Nurse*. 2007; 24(2):212-224.
 52. Vogus TJ, Sutcliffe KM. The impact of safety organizing, trusted leadership, and care pathways on reported medication errors in hospital nursing units. *Medical Care*. 2007; 45(10):997-1002.
 53. Khatri N, Halbesleben R B, Petroski G F, Meyer W. Relationship between management philosophy and clinical outcomes. *Health Care Management Review*. 2007; 32(2):128-139.

***Please Click Here for the
Post-Test and Evaluation***