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Integrated Leadership Capability: building a model for today and tomorrow

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Abstract
In 2010, the senior management team at Kingston Centre, a stand-alone 315 bed sub-acute, residential and aged persons mental health service located in the south-eastern suburbs of Melbourne, embarked on an ambitious leadership development strategy to meet both current and projected challenges facing their service. This case study provides a description of the development, implementation and early outcomes of a local interprofessional development program for frontline leaders.

A three stage collaborative interprofessional approach was used that included aspirational planning, gap analyses, local solution development, action learning sets and ongoing professional support.

Strong ward based interprofessional leadership and active and visible nursing leadership around the clock were essential to success. Ongoing leadership development for all staff groups is a key component of succession planning to ensure that the service is well-positioned to meet future challenges. The findings provide useful learnings for similar organisations.

Abbreviations: ANUM – Associate Nurse Unit Manager; CB – Code Blue; MET – Medical Emergency Team.

Key words: Allied health; capability; change management; high performing ward teams; Interdisciplinary; leadership; nursing.

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Background
The landscape of the healthcare industry in Victoria, Australia, and internationally is constantly changing. Busy daily clinical demands, complex organisations, technological innovations, new treatments, and new regulations provide a continuous source of change demand in health service delivery. Within this context, leaders in healthcare settings seek to pursue an overarching goal to improve value in health services for their patients and community. In particular, efficient patient flow in the sub-acute area is integral to ensuring timely and accessible care for patients across the entire organisation and is a key area of focus for ward leadership teams. [1] Effective unit level leadership is critical to improving outcomes for patients. [2-4] This case study describes the process used by leaders at one health service who set out to achieve this goal by developing the individuals and teams within their organisation to be agile, capable and responsive to change demands.
In 2010, the senior management team at Kingston Centre, a stand-alone 315 bed sub-acute, residential and aged persons mental health service located in the south-eastern suburbs of Melbourne, embarked on an ambitious leadership development strategy expected to meet both current and projected challenges facing their service. Catalysts for embarking on the leadership development strategy included: rapidly increasing demand due to changes in the acuity, complexity and volume of patients using the service; a major organisational restructure and redistribution of services; commissioning of major capital works that provided a significantly different patient and staff environment; and changes in services and key personnel.

The site senior management team agreed that establishing high performing frontaline leadership teams was essential to meet future demand. They recognised strong and effective ward based teams and interdisciplinary leadership that synthesises and links multiple disciplines into a coherent team (5-6) as fundamental to developing high performing ward teams that: 1) are committed to achieving ward goals that align with organisational priorities; 2) have a clear focus on their common purpose and 3) have a high level of shared trust. 2] The team projected that to reach their goal at the Kingston Centre site, developing strong local leadership would be the critical difference between success and failure and good versus great outcomes. They also identified that multiple strategies which embody principles of care that required as a standardised approach were not always viable and was unlikely to deliver the desired results.

This case study provides a description of the development, implementation and outcomes of a local interprofessional leadership development program at a single sub-acute hospital site within a larger organisation. The focus of the professional development initiatives described in this case study were predominantly nurse leaders in recognition that nurse leaders provided the most constant presence in frontline clinical leadership; hence were critical for the success of collaborative interprofessional frontline leadership teams. [6] Discussion of the development of frontline leaders from other disciplines is beyond the scope of this paper although other disciplines also embraced the change in work processes. The findings are expected to provide useful learnings for similar organisations.

**Aims**
The goal of the program was to strengthen interprofessional ward based leadership to establish high performing frontline teams and deliver enhanced ward performance.

The specific aims of this initiative were to:
- Improve leadership practices by establishing effective and sustainable ward based interdisciplinary leadership teams;
- Improve interdisciplinary communication and collaboration;
- Build leadership capability at all levels of clinical management;
- Re-focus care to become more patient centred by providing ‘round the clock’ patient-centred nursing leadership;
- Improve quality and safety practices;
- Improve operational efficiency and effectiveness; and
- Raise the profile and advance the reputation of the Kingston Centre.

**Method/approach**
The three stage collaborative interprofessional approach used aspirational planning, gap analyses, local solution development, action learning sets and ongoing professional support.

**Stage 1**
An interdisciplinary leadership steering committee was formed to provide direction for strategies to enhance and deliver improved interdisciplinary ward leadership and collaboration. Strong organisational and frontaline interdisciplinary leadership was one of four key objectives resulting from an interdisciplinary model of care review conducted at the site in 2011. With the assistance of the organisational development and learning team the committee agreed on core leadership capabilities that were used to identify the learning needs and skill development requirements of frontline clinical nurse leaders, and design the proposed solution. We used analyses from leadership skill surveys and one on one individual interviews with nurse managers at all levels to identify common gaps in skills and knowledge and priorities for development. The findings informed the design of a series of tailored leadership programs for nurse leaders.

**Stage 2**
A series of ‘interdisciplinary learning centres’ attended by all local nursing, medical and allied health leaders were used to build the core leadership capabilities identified during the review as well as identify any additional capability gaps to guide future development. All senior nurse managers and Nurse Unit Managers (NUMs) within the service completed a customised leadership development program. This was
followed by a series of one-day workshops designed to equip them with the skills and confidence to meet current and future service delivery challenges and consolidate their learning. They also participated in ongoing monthly professional development sessions.

**Stage 3**
A number of strategies were introduced to provide ongoing support for leadership teams. A practice improvement and innovation team was formed to support ongoing leadership development for NUMs via action learning sets and one-on-one coaching sessions. Leaders were allocated mentors for support. An interdisciplinary executive management team was formed to assist ward teams with the effective management of patient flow, with a particular focus on long stay patients. Finally, electronic documentation support in the form of Web QI TM was also introduced to improve medical discharge processes.

In 2012, the nursing leadership development program was extended to include Associate Nurse Unit Managers (ANUMs). We recognised that developing the capabilities of this group of frontline leaders was pivotal to ensuring the quality, effectiveness and efficiency of care delivery around the clock. A comprehensive program based on desired capability, knowledge and skill development was devised and delivered over a four month period.

**Results and outcomes**

**Leadership development**
Leadership group guidelines established for all sub-acute units in 2011 outlined the objectives, group function, leadership capabilities, key roles, responsibilities and accountabilities of frontline leadership teams; members included the NUM, medical consultant and allied health leads. The support and resources needed for implementation with each leader group was also identified.

In 2012 we conducted our first leadership development course for ANUMs. All participants demonstrated improvement in functional leadership capability from the perspective of both the participant and their NUM. A customised 89 item pre-post program assessment, developed from leadership skill surveys and gaps and priorities identified in stage 1 was used in evaluation. The greatest improvement was reflected in the item ‘Establishes collaborative networks across teams for mutual benefit’. Similarly, substantial improvement was also identified for items measuring ‘change leadership’ capability; however, this remains the item with the greatest potential for further improvement. Training in using LEAN methodology was a feature of the leadership development course for ANUMs and participants worked together in small groups on quality improvement projects outlined below.

We also witnessed significant performance improvements among our Deputy Directors of Nursing and NUMs. All of our Deputy Directors and NUMs have engaged in a variety of ongoing leadership development activities that have resulted in significant clinical professional recognition. For example, nursing staff at Kingston Centre attracted research funding for the first time. They were funded to undertake an in-depth qualitative study to examine the patient experience in their service. The results of this research is being used to inform future patient-centred care initiatives at Kingston Centre. A manuscript outlining the study’s findings has been submitted to the *Journal of Clinical Nursing* for publication. Funding was also received from the Victorian Clinical Stroke Network to develop an evidenced based pathway for stroke patients in the sub-acute setting which was an interdisciplinary project led by allied health. Recently, allied health and nursing staff also received Department of Health scholarships for post graduate studies.

Significant clinical improvements were also achieved as discussed below.

**Service improvements**
Initiatives to enhance service improvement were identified and implemented by the leadership teams as part of the development program, these included: a Medical Emergency Team (MET) response to clinical deterioration; improvements in processes to support frontline service delivery; and review of roles and responsibilities of key staff to improve patient centred care delivery.

A significant achievement was to develop and introduce a modified MET response specific to managing patient deterioration in the sub-acute setting in a timely and effective way. Senior nursing staff collaborated with senior medical staff to develop and introduce the modified MET in June 2011 as an addition to the pre-existing Code Blue system. Between June 2011 and 2012, in the first 12 months after introducing the modified MET response; 181 medical emergencies were attended at the site. This included 31 Code Blue calls (CBs) (11.6%) and 160 MET calls (88.4%); 9 of the MET calls progressed to CBs (Table 1). This represented a dramatic increase in emergency calls when compared to the previous year, where between June 2010 and June 2011 (before the introduction of MET calls) only 10 CB calls were attended (Table 1). These findings suggest the MET call system has contributed to improved patient outcomes such as early detection and prevention of clinical deterioration.
Table 1: Medical Emergencies by place of treatment and outcome, Kingston Centre, June 2011 to May 2012

<table>
<thead>
<tr>
<th>TYPE OF CALL</th>
<th>TOTAL CALLS</th>
<th>MANAGED ON-SITE N (%)</th>
<th>TRANSFERRED N (%)</th>
<th>DIED ON-SITE</th>
<th>DIED AFTER TRANSFER</th>
<th>TOTAL DIED N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>METs</td>
<td>160 (88.4%)</td>
<td>98 (65%)</td>
<td>52 (35%)</td>
<td>8 (5%)</td>
<td>7 (5%)</td>
<td>15 (10%)</td>
</tr>
<tr>
<td>CBs</td>
<td>31* (11.6%)</td>
<td>11 (35%)</td>
<td>20 (65%)</td>
<td>7 (23%)</td>
<td>5 (16%)</td>
<td>12 (39%)</td>
</tr>
</tbody>
</table>

*9 of these were MET calls that progressed to Code Blue

Service enhancements to improve the delivery of patient centred care included review of key clinical roles. For example, the title of the pre-existing ‘key liaison person’ role was changed to ‘key contact person’ reflecting changes in the role responsibilities to enhance and streamline communication by providing a consistent link between the patient, family and carers, and the healthcare team.

The leadership teams, with support from senior management, identified and led the implementation of a range of frontline improvement measures; these included; journey board patient handovers; clear guidelines for the chairing and conduct of case conferences; admission processes for early identification of issues likely to complicate care delivery or delay discharge; electronic medical discharge summaries; and clear escalation guidelines for emerging issues. A review of these initiatives in March 2013 found that handover and case conference communication was more focused, concise and efficient; there was consistent use of goals for care planning and timely updates of any changes; improvements in documentation and communication of discharge plans.

Nurses have improved their change of shift handover process to occur at the bedside and explicitly focus on improving clinical communication and encourage patient participation. This improvement is still in progress as it is taking some time to fully embed as both nurses and patients adjust to this concept.

A specific quality project that arose from the ANUM leadership development program was to develop a continence management framework as a standard for planning and implementing strategies to optimise care for patients with continence impairment. Continence management was identified as a concern during an earlier project to improve efficiency in linen usage, the participants themselves identified this issue as a way to improve not only resource utilisation but also the quality of care and the patient experience.

Service efficiency

LEAN methodology was one of the tools that senior nurses learned and used to improve productivity. For example, they improved the efficiency of linen and stock management across the service; this resulted in a $72,000 (11%) reduction in linen costs and a reduction of $123,000 (16%) in medical/surgical supply costs in 2012/2013 financial year when compared to the previous year.

Discussion and future directions

Building the leadership skills of nurses and establishing a collaborative interdisciplinary model of care [5-6] at the site has created opportunity for greater synergy between health professionals. This has resulted in improved cohesion within the team and a shared focus on patients’ goals, rather than goals related to care delivered by individual professional groups. There has been no increase in length of stay for patients despite increases in patient acuity and complexity, and communication and collaboration among the health care team has also improved.

The clear improvement in service delivery and clinical practice, particularly in the management of the deteriorating patient has been attributed to the improved interprofessional collaboration to problem solve complex issues. We identified the recognition and response to clinical deterioration was a clinical priority in the setting of rapidly increasing patient acuity and demands on the service.

Prior to this work, we were aware that many of our nursing and medical staff were ill-equipped to meet this challenge and required up-skilling to be able to respond to this change in work practice. Senior nursing and medical staff worked together to facilitate inter-professional, simulated team learning that led to the successful introduction of the MET response as demonstrated by the data presented earlier in this paper. This model is now successfully embedded.

Equipping NUMs and ANUMs with knowledge and skills in leadership has similarly led to quality improvement and effective management of change to enhance service delivery. Lean methodology has become a key tool in our
armoury of quality improvement approaches and is now being applied by ward based teams to create innovative solutions to locally identified issues. As the unit based leadership groups become more confident and capable in their roles they will continue to work with their teams to establish clear role expectations for each member of staff, explicit ward-based values and standards of care and measureable objectives to achieve key quality and safety, patient flow, patient and staff experience and financial accountability goals.

Kingston Centre has gained a reputation both within the organisation and externally as a progressive and innovative workplace committed to excellence in patient centred care and staff development. Historically, frontline nursing management roles within the service attracted little interest and the quality of applicants was poor. In the last two years, vacancies have reduced and both the quality and quantity of applications has increased substantially.

Strong-ward based nursing leadership and ensuring that nursing leadership was active and visible around the clock was essential to this success. Ongoing leadership development among all staff groups is a key component of succession planning to ensure that the service is well-positioned to meet future challenges. The ANUM leadership development program is continuing into 2013 with a further three intakes planned for the year ahead. The program has also been recognised at an organisational level and will be used to inform the establishment of a nurse manager leadership development framework across the larger organisation of Monash Health.

**Competing interests**
The authors declare that they have no competing interests.

**References**