



## Promoting Evidence-Based Nursing Practice: Clinical Leadership Programme

By Andy Kelly, CNC Mental Health

### Introduction

The purpose of this newsletter is to describe the Clinical Leadership Programme, which was developed by the Royal College of Nursing (RCN) in the UK and is spreading with acclaim throughout Europe and other parts of the world. The Clinical Leadership programme was adopted by the Royal Adelaide Hospital (RAH) and trialled with nursing staff from a number of health units across South Australia. I aim to describe this particular programme, its process and the experiences and specific outcomes it produced for me as a participant of the initial programme.

### What is the Clinical Leadership Programme?

Dr Leslye Long brought the Clinical Leadership Programme to Australia after negotiations with the Department of Human Services in South Australia and the RCN. The programme was launched in February 2003 by the Director of the RCN Leadership Programme, Ms Geraldine Cunningham, who has since gone on to implement the programme across England, Wales, Scotland, Switzerland and Belgium. The programme will be introduced in some other states of Australia during 2004-5.

The programme is being evaluated during its first two years by Dr Susan Mann, Director and Lead Facilitator for the programme. Dr Mann also provides supervision for a group of Local Facilitators (LFs). LFs are in turn responsible for providing supervision for a stable group of about six Clinical Leaders (CLs) as they work through the programme. Clinical Leaders were selected predominantly from level three nurses who had applied to an Expressions of Interest notice for the programme. What is interesting about this aspect was that almost all participants applied despite the strategic paucity of information about the programme and its expected outcomes. A very small number of staff were directed into the programme by their own workplace supervisors.

### Focus on Patient-Centred Leadership

The Clinical Leadership Programme differs from other Leadership and Management programmes in that it maintains a focus specifically on the goal of improving patient/client care. The primary aim of the programme is to assist health care practitioners to develop patient-centred leadership strategies to deal with the realities of day to day practice.

To facilitate this, a number of strategies were developed to assist participating nurses to implement and sustain change within their workplace setting. These strategies typically included exercises to enhance personal development and awareness, team building, networking and political awareness. Two simple but powerful exercises in particular helped keep participants' focus tightly on the client's experience of care. Observations of Care and Patient Stories helped participants to step outside of their own roles and perceptions to gain unique insights into the experiences of their clients.

### How does the Programme work?

CLs commenced the programme by completing a 360 degree feedback and a Personal Development Plan (PDP). Feedback forms were also sent to key people in each participant CLs worksite. These people were nominated by

each CL and typically included supervisors and those for whom they had supervisory responsibilities.

The Personal Development Plans form the major goals for participants during the life of the programme. Often CLs were surprised at how easily they were able to achieve these goals through the structure and learning that occurred as they moved through the programme. The 360 degree feedback process was valuable because it allowed each CL to compare their own self evaluation with those done by others. It allowed CLs to discover how they were perceived by those who lead them and by those that they lead.

Formally, the programme commenced by attending a one day workshop with three other LFs and their CL teams. This workshop provided an orientation to the programme and was the start of our understanding about the advantages and demands that we would later feel as we worked our way through the experience.

One important aspect of this first session was our involvement in exercises that would sharpen our focus on our own needs and drives and increase our understanding of each other. These were predictably the foundations for future team work in our smaller CL teams and in networking generally.

These whole-day workshops occurred monthly and provided opportunity for education, discussion and sharing in the larger group. Every month, each CL had a one-to-one meeting with a LF. These meetings allowed a depth of disclosure and mentoring-type of support that most found extremely valuable. With the aim of developing each individual CL, all issues no matter how personal or apparently clinically related, were considered reasonable grist for these meetings. There was a clear appreciation that the effectiveness of each CL is affected and motivated by the events occurring at personal, relationship, system and clinical levels. Needless to say, LFs require higher order interpersonal skills in order to make these sessions effective.

Perhaps the most powerful ongoing strategy within the programme involved the development of Action Learning Sets (ALS) within each team of CLs. ALS occur on a monthly basis at a site agreed to by the participant CLs. Each ALS is facilitated by their LF. CLs bring to the ALS real life and current issues that they are attempting to deal with in the health service setting. The discipline of each meeting results in CLs developing confidence in their own ability to find resolution to problems that are all in some way related to service and care delivery. The movement of each ALS through the predictable stages of group development ensures that participants are confronted with challenging opportunities to develop critical interpersonal, assertion, conflict resolution and problem solving skills.

### What have been the Changes to Leadership?

By August 2003, the programme Director was receiving feedback from many health units that the development of many participants was already evident. Many health units were experiencing that their CLs were asking more questions, driving more changes and assuming more

decisiveness in their leadership at unit and organisational level.

### **Who are Mentors?**

The identification, attraction and procurement of a professional mentor was encouraged for each CL. All who followed the recommended strategy were able to successfully engage a mentor. Professional mentors are described by RCN as: *Someone who gives you information, advice and helps you assess your progress towards your goals. The important elements in the relationship are mutual respect, commitment and the mentor's readiness to pay particular attention to your needs.*

Mentors are seen as beneficial to CLs because they may provide many benefits including access to role models, assistance in enhancing communication, professional and leadership qualities and skills and opportunities to reflect on quality feedback. Although not all CLs chose to engage a mentor, those who did are loudly appreciative of the new relationships that they have and the opportunities that have developed as a result.

### **Learning through Specific Assignment**

Although the PDP establishes their major goals for the programme, CLs also must complete two specific assignments to complete the course successfully.

The first, Observations of Care, involves participants pairing up to assist in making observations of some aspect of care delivery in a particular health unit. Observations may be of a discrete client contact such as those that could occur during any hour in a medical unit bay, or they could be observations of how clients are received at a reception area in a nursing clinic. CLs become 'fly-on-the-wall' observers in an area for a specified time. They record their observations and use them to provide opportunities for improvement for the staff employed in the area and those clients receiving care there. Most CLs are amazed at the opportunities they 'discover' during this exercise.

The second assignment, Patient Stories, involves one-to-one interviews with patients/client where the activity was aimed at hearing about all aspects of that person's current or most recent episode of care. In the process, unique opportunities to engineer quality service responses to the feedback gained through the experience is achieved. For example, feedback from one client that he would have preferred to attend a Nursing Clinic if the Clinic had different opening hours allowed clinical and management staff the opportunity to review opening times around client access times. Feedback from this process gave opportunities to feedback to other organisations or departments within an organisation about the ways that they were contributing to client care and service outcomes. The feedback to a department of one of the participating organisations included that which described how consumers experienced a commonly used departmental response as uncaring, unhelpful and a discouragement to using the service.

### **What were the Demands of the Course?**

Participants all regularly feedback how demanding the programme was on their time. A minimum of 20 hours each month is a huge impost on work time that often left

participants confused and guilty about the resultant failure by themselves to meet ongoing work pressures and about having to ask others to pick up more while the CL is off the unit. Of interest though is the realisation for most CLs that their absence also has the benefit of allowing others to become more proficient at dealing with more of the clinical leadership demands of a unit while they are away. Reading, reflection and networking added to the burden but were experienced as more purposeful than when those activities occurred prior to the programme. Many participants explored and utilised newly developed networks and mentors to gain strategic experience on DHS, NBSA or other leadership organisation workgroups. This of course led to benefits to those groups having fresh and enthusiastic 'new blood' in their groups and also assisted CLs to be exposed to more leadership role models and practices as well as bigger picture information.

### **From Aggregate to Community**

In many instances, nurses in clinical leadership roles form aggregates. They stand alone despite recognising that they have some common attributes and needs as others in similar positions. Rarely however do they have opportunity to access the strategies and resources that give them the sense of truly belonging to the nursing and Clinical Leadership community.

But this is exactly what the Clinical Leadership Programme achieves. The self disclosure, sharing, supporting, relating, confronting and acclaiming leads each to recognise the similarities and differences that exist in us all. Months after the programme has finished, participants can be found meeting for coffee, sharing a resource, phoning for advice or emailing a joke. This is a sign that new connections and relationships have been developed around a respect and admiration for the unique skills, experience and wisdom of each other. Each now understands that they have a right and responsibility to actively participate in the community in which they now belong.

Future groups, having the advantage of the learning of earlier participants may find that their organisations are able to support them more in participating in the programme and in operationalising the opportunities they discover in the process.

I applied to be in this first group because I wanted the skills to take a greater role in driving health agenda in our organisation and in the health sector generally. I believe that nurses will take-up their rightful roles and responsibilities as leaders in a health system if they are given the tools that this programme provides.

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