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This essay will critically appraise the indiscriminate use of bedrails on vulnerable adult in the hospital setting. The author will propose a change that can be embedded in the use of bedrails on vulnerable adult in acute setting. The change is premised on a preferred change model which ensures that continuous risk assessment is conducted daily before the use of bedrails on vulnerable adults. The proposed approach will reflect the ethical principles of Beauchamp and Childress (2001), as vulnerability in adult care and the use of bedrails are both complex and controversial. Furthermore, the essay will look at the government policy and guidelines on the use of bedrails given some of the controversies and conflicting policy direction on restraint. Some studies on bedrails have categorised bedrails as restraint, adding that their use is unethical as it constitutes ‘intentional restriction of a person’s voluntary movement or behaviour’ (Healey et al., 2008). Hence, the importance of political awareness for nurses and the role nurses play in influencing policy in relation to effective healthcare delivery will be discussed. One important aspect of improving healthcare delivery is leadership and literature on nursing management abounds (Marshall, 2010). Consequently, the essay will move on to discuss leadership and explore the differences between leadership styles and management. The reason for reforms in the leadership and management approaches in the national health service (NHS) will also be explored. Extensive elaboration of transformational (TL), transactional theories, skills and practices in relation to the concept of leadership will be critically analysed within the purview of effective leadership in healthcare.

In the last part of the essay will be a critical analysis of the concept of team working and identification of a wide range of performance strategies available for team effectiveness. Delegation in democratic leadership is foregrounded with an appraisal on the need to delegate to staff with the right skills needed to complete a task including giving support to team members when it is necessary, especially as it concerns effective risk management. Lastly, the process of transitioning from student nurse to registered healthcare professional will be critically appraised in discussing and providing the tools such as swot analysis (see appendix 1) and professional development plan (PDP) see (appendix 3) available for continue professional development to reflect on authors own developmental needs.

Bed rail use are prevalent in the UK in spite of the controversies surrounding its use in the acute hospital setting (Hignett et al., 2013). Falls around the bed or out of bed are common in vulnerable adult in acute hospital settings and can often result in patients being badly injured. Falls are associated with injury and may cause temporary or permanent disabilities, functional impairment and even lead to death (Parker and Miles, 1997). Complaints and litigation bothering on falls reported from hospitals and care homes lead to significant cost to the NHS (NHS Improvement, 2017). NHS Improvement (2017), confirmed 204,269 falls were reported alone in 2015/16, according to the report from the national reporting and learning system. Approximately one-fourth of falls in healthcare setting are from bed (National Institute for Health and Care Excellence, 2013).

Some of these falls occur from rolling out of bed by accident and others from falling just or while getting out of bed (National Institute for Health and Care Excellence, 2019). Consequently, prevention of falls was the most commonly reported reason for using bedrails (O’Keeffe et al., 1996). Bedrails are, therefore, commonly used to protect vulnerable adults from accidentally sliding, slipping or falling out of bed (NHS Improvement, 2017). In recent years, there has been growing concern about the use of bedrails and all other forms of restraints in healthcare (Gunawerdena and Smithard, 2019). Studies reported that bedrails are indiscriminately used and some inadvertent use of bedrails as a form of restraint on vulnerable adults are seen as unethical (Healey et al., 2016). There are contradictory published evidences regarding the use of bedrails with suggestions that it can either promote or compromise vulnerable adult’s safety as physical restraints can increase falls and serious injuries or increase risk of deaths (Marques et al., 2017).

Bedrail use will not prevent vulnerable adult from getting out of bed and are not designed to inhibit patients from getting out of bed. Instead, it increases the likelihood of patients trying to escape especially when they suffered from delirium or temporarily have a cognitive problem due to hospital treatments (Gunawardena and Smithard, 2019). Therefore, bedrails should only be permitted in immobile, bedbound or hoist-dependent patients (Jehan, 2019). Healey et al. (2016), highlighted that decision making, risk assessment on the use of bedrails have being raised as concerns by coroner in courts as it is associated with harms on vulnerable adults in acute settings.

Medicine Healthcare Product Regulatory Agency (MHRA) (2020) stated that bedrail use is not only confined to falls but also recognised that the use leads to entanglement or entrapment. There are further reported risk associated with the use, that it causes morbidity, increases mortality due to entanglement or entrapment or result to falls from a greater height which consequently increases the risk of harm (Marques et al., 2017). Decisions making process for using bedrail or not using it can be straight forward, however, it can be complex with cognitive impaired vulnerable adults (Hedge and Ellajosyula, 2016). So, respect for such individuals’ abilities to decide, choose and take responsibility for their own life underscores one of the four principles of biomedical ethics espoused by Beauchamp and Childress (2001), under “autonomy”. Other principles include beneficence, non-maleficence and justice (Mcdermott-Levy et al., 2018). Beneficence is the principle that undergird nurses’ action which is about having the best interest of the other in mind (Halstead, 2012). Non-maleficence as to do with the principle the Hippocratic Oath which forbids doing harm and justice, which is a concept that emphasises fairness and equity among individuals (Riedel, 2015). As ethics dictates, a careful assessment of the situation must always be considered before the use of bedrails (Health and Safety Executive, 2020).

The MHRA (2020) and HSE (2020), states that a full individual risk assessment must be carried out to ensure that the use of bedrail is appropriate and necessary, nurses have to ensure rationale and document accurately in the patient care plan, discussion between families and patients including ongoing assessment need for bedrails.

Nurse’s need to be able to engage and support vulnerable adult in decision making when deem necessary in order to improve their ethical care (Hegde and Ellajosyula, 2016). As professionals bound by the association’s ethics, nurses also need to understand and apply safe and sound principles of decision making (Heale and Shorten, 2017). As a leader, the author is committed to ensure that adequate daily risk assessments and appropriate daily risk management are carried out before the use of bedrail on vulnerable older adults. This step will require all nurses’ professional collaboration and organisation in leading this change (Cameron et al., 2001). This could be done by articulating the vision and a plan of direction with input from all the practice decision-makers, the approach will enable divergent perspective to be express and addressed in order to reach agreement (Silversin and Kornacki, 2003). The resulting vision would be communicated to all in practice and continue to be reinforced to foster a culture that is ready for the change that is required to move towards the vision (Morley, 2010). This will begin from the local to the national level in partnership with patients and the local populations (Gesme and Wiseman, 2010).

Given the above, appropriate change management is presented in this essay as a structured approach to transitioning organisation, individuals or teams from a current situation to a future desire state. This include organisational change management processes or individual management models, being used to manage people’s side of change (Gopee and Galloway, 2014).

There are many forces that drive change in the healthcare (Etheredge et al., 2016). Technological, medical advancements and social and financial imperatives have all triggered change in the realm of healthcare (Garson and Levin, 2010). Others in the realm of healthcare include medical treatment, shortages of skilled staff in the workforce, growing of geriatric population and policy change based on clinical research and records of inefficiency of healthcare worker or equipment such as bedrails (Oakland and Tanner, 2007). With continual discoveries being reported, it takes an average of 17 years to enhance practice in view (Frist, 2005). This situation has led, in some cases, to extreme destabilisation and constant need to promote better quality and future nurses will even be expected to be more adaptable than they have been in the past to keep up with future changes (Al-Abri, 2017). Kaluzyn and O’Brein (2011), argued that whatever changes are made to work environment, there are some that will embrace the changes, and some will resist or find it very difficult to adapt to changes. Albeit, the fear of change is the most common barriers identified to change (Robinson and Rosher, 2016). When subordinates are afraid, they try to be emotionally distant from situation causing them fear (Norton, 2002). Therefore, maintaining an open communication to identify the fear, giving them more fact about the change and explore the source of worries can support resistance to change (Gesme and Wiseman, 2010).

There are a number of change management theories and models that can help nursing professionals to inspire confidence and improve performance in healthcare delivery (Aziz, 2017). There is some evidence that implementing interventions based on the evidence-based developed chronic care model for instance may improve process or outcome performances (Gason and Levin, 2010). Also, evidence has shown performance improvement by interventions based on the ‘expert-based developed Malcom Baldridge Quality Award [MBQA] criteria and the European Foundation Quality Management [EFQM] Excellence model is limited (Minkman et al., 2007). Other commonly used change models include, Kotter’s Change Management model, McKinsey’s 7-S model, Prosci’s ADKAR (Awareness, Desire, Knowledge, Ability and Reinforcement) model, Kubler-Ross model, including Lewin’s model and Kotter and Bridges 3 phases models (Campbell, 2008; Varkey and Antonio, 2010).

However, in this essay, the author will utilise Lewin theory as it does lead to better understanding of how change can affect organisation, identify the barriers for successful implementation (Varkey and Antonio, 2010). It is also useful for detecting opposing forces that act up on human behaviours during implementation of change and compare it briefly with the newest developments in complexity theory and chaos theory (Mitchell, 2013). Lewin’s Change model is presented in this essay as the management model that can be adopted to suit bedrail use in acute hospital setting. The rationale for the choice of this model is based on its simplicity and fitness to the context of bedrail use within the context of adult nursing. The model will be adopted within the context of lean healthcare, an approach that is fast gaining grounds in hospitals to increase efficiency and quality of care (Rossum et al., 2015)

Lewin (1951) identified 3 stages in which change must proceed before any planned change can be embedded in a system of working or in an organisation. These change stages are unfreezing, change and refreezing (Cummings et al., 2016). Unfreezing is when the change agent proposes a convincing plan for change to the management or subordinates (Aij, 2015). Proposing a convincing plan will draw out concerns and anxieties of the team members who are not keen on the change (Lee, 2016). At this point, members will either become increasingly aware of the need to change or discontented about the proposal (Campbell, 2008). In view of this, the author as a skilful leader will put effort into convincing team members and minimising their anxieties before setting out to use bedrails to prevent falls. This will eradicate fear from the minds of team members given that fear is found to be associated to not wanting to change including the risks highlighted in the literature stemming from incorrect use of bedrails. McGarry et al. (2012), claimed that the important part of leadership role is understanding the different perspectives of individuals and aligning the changes to be meaningful for them.

During unfreezing stage, the author will take account of the balance between stability and change, as too much change can lead to instability, which will end in insecurity, anxiety and feelings of lack of control (Schriner et al., 2010). The author will, in this instance, assess the members to determine the forces who are for and of those who are against the change (Tinkler et al., 2014). For example, reviewing the extent of the proposed change, the depth of motivation of stakeholders and the environment in which the change will occur (it could be political, local and national) is key (Ellis and Bach, 2015). It is necessary that the driving forces for change will need to surpass the opposing forces for change to be successful (Shirey, 2013).

In the second stage called the change phase (also movement in some literature), the author will be moving towards accepting the change by carefully setting out plan of action and implementation (Gesme and Wiseman, 2010). Change takes time because people need to adjust to the invention, come to understand the benefits of the proposal and eventually adapt to the change (Wojeceichowski et al., 2016). Therefore, part of the planning process for this change managements will include, time for recognition, addressing and overcoming resistance to the proposal arising from stakeholder’s perceptions, attitudes and their personal values (Doolin et al., 2011).

The freezing stage expresses that change needs time before it is accepted by people as a part of system (cumming et al., 2015). After the change is implemented, support will be required to embed the change (Mahmood, 2018). The author will help with the continued integration of the change into practice to ensure that the change is becoming part of the normal practice. If this does not happen, the previous behaviour will emerge (Mahmood, 2018). One way of ensuring the effect of change perceived as beneficial is to measure the outcome of the proposal or make an improvement to the proposal as a result of feedback from the outcome measures (Shirey, 2013).

Above all, effective change is also premise on communication (Tappen et al., 2017). Effective communication empowers stakeholders in the change process to be participants in the creation of change (Gesme and Wiseman, 2010). Individuals who will be directly affected by the changes often can provide valuable insights from experience to aid the change process (Mahmood, 2018). Providing systems of communication and feedback through which physicians, nurses, staff, allied health professionals, patients, and all health systems involved can communicate is pertinent to effective change upon introduction (Tarvernier et al., 2018). Feedback mechanisms should be installed to assess the impact of bedrails on patients bearing in mind the provisions of the personalised care (Wojceichowski et al., 2016). A useful tool to keep track of methods of communication for different stakeholders is the stakeholder communication matrix (Varkey and Antonio, 2010). Another example of such a matrix, is modified from Lehman’s version of the same, which is used by nursing administrators involved in staff development (Cummings et al., 2015). Be that as it may, critics acknowledge the relevance of Lewin’s theory half of a century ago (Burnes, 2011). However, the three stages were argued that it is only suitable for small change project and ignore the organisational politics, power and assumes that organisation operate in a stable state (Tarvernier et al., 2018).

For effective change to become institutionalised, there must be appropriate leadership and management structure in place to inspire transformation (Boamah and Tremblay, 2018). When individuals are inspired with a common vision by a transformational leader, they are intrinsically motivated to accomplish the set goal instead of being satisfied with the status quo (Marshall, 2010). Leaders guide and motivate nurses to achieve their care provision goals as they practise nursing (Huber, 2017). Leadership is the process of influencing people to accomplish goals (Xu, 2017). Effective leadership is important in nursing because of its impact on the quality of nurses’ work lives because it functions as a stabilizing influence during constant change, and because it underpins nurses’ productivity and quality of care delivery (Goosen, 2015). Hence, in ensuring that bedrails are utilised within the aforementioned change management model, a suitable ‘transformational’ leadership style is needed to manage the change process and deliverable (Aaron et al., 2015). Management is operationally defined as ‘the coordination and integration of resources through planning, organising, and coordination, directing, and controlling to accomplish specific institutional goals and objectives’ (Huber, 2017). Although the leader’s focus is on people while the manager’s focus is on systems and structure, these overlapping concepts are vital to accomplish healthcare goals such as effective use of bedrails in adult care service provision by nurses.

Nurses use managerial and leadership skills to facilitate delivery of quality nursing care (Stanley, 2016). Nurses need to have a solid foundation of knowledge in leadership and care management at all levels although depth and focus of care management roles and skills may vary (Hersey et al., 2013). A number leadership styles, drawn from existing theoretical frameworks, have been recommended in view of formal and informal leadership roles of nurses (Vandenberghe et al, 2018). These leadership theories are grouped as trait, attitudinal, and situational (Huber, 2017). The trait approach focuses on identifying specific characteristics of leaders (Saravo et al., 2017). The attitudinal approach evaluates attitude toward leader behaviour, while the situational approach focuses on observed behaviours of leaders and how leadership styles can be matched to situations (Xu, 2017). While the early focus has been on the traits or characteristics of the leader by examining what constitute the unique traits or character of the person of a leader, there has been a shift away from this direction in recent times to focus on the behavioural aspects of the leader in relation to the situation (Hutchinson and Jackson, 2013). A recipe for leadership according to Bennis (1994), include, a guiding vision, passion, integrity, (including self-knowledge, candour, and maturity), trust, curiosity, and daring (adventurous).

Huber (2017) added some more characteristics including the ability to ask appropriate questions, activeness (rather than being passive), and social influence. These are needed to be infused into human relation behavioural acts such as empathy, expertise, risk taking and innovative (Kouzes and Posner, 2012). Although the lists of leadership characteristics and competencies vary, certain skills are at the core of leadership activity (Rossengarten, 2019). Scholars have identified the following skills in leaders, the ability to engage others in shared meaning, a distinctive and compelling vocal tone, a sense of integrity, and a combination of hardiness and ability to grasp context, called adaptive capacity (Bennis and Thomas, 2002; Huber, 2017). Kouzes and Posner (2012), itemised five practices of exemplary Leadership as, modelling the way (setting examples), inspiring a shared vision (envisioning the future goal and carrying others along), challenging the process (going beyond the status quo), enabling others to act (delegation of responsibilities), and encouraging the heart (that is the appreciative candour of leaders). Above all, trust and vision stand out as functional characteristics of a leader (Guerrero et al., 2015).

Leadership styles are products of consistent behavioural acts of the leader in the process of effecting leadership and which influence the activities of others around them (Hersey et al., 2013). There are different combinations of task and relationship behaviours used to influence others to accomplish goals (Huber, 2010). Against the backdrop of leadership styles (classic and contemporary) are the following leadership styles placed on a continuum, according to Tannenbaum and Schmidt (1973), relationship oriented, task oriented, democratic and authoritarian. (See appendix 2).

Having explored the three distinct styles based on this continuum (that is authoritarian, democratic, and laissez-faire), the author in this instance adopts democratic leadership style for consideration as the leadership style to adopt for the management of effective use of bedrails in acute adult care hospital setting. While authoritarian leadership style primarily uses directive behaviours with policy decision making coming from the leader alone, democratic approach is based on relationship, delegation of roles and team working (Vanddenberghe et al., 2012). Laissez-faire leadership style promotes complete freedom for group or individual decisions (Agotness et al., 2018). There is minimum leadership participation given that the leader is either permissive and genuinely fostering freedom or they are completely inept (Sfantou et al., 2017). Literature does not suggest that one style is better than the other (Avery, 2004). The choice is based on contextual and situational factors and a mixture of these styles may evolve at any point in time (Chen et al., 2018).

Be that as it may, democratic leadership style as proposed in this essay for effective bedrail use will involve subordinates in decision making process. It will enable creativity, motivation, morale in such a way that inter-professional collaboration will be allowed (Gopee and Galoway, 2014). Although, the leadership may make the final decisions in the process, however, those who are involved in the change process within the democratic style being adopted will always appreciate been consulted (Sftalou et al., 2017).

Consequent upon the aforementioned, it is important that nurses are well educated in leadership, nurses’ role in influencing healthcare policy is unquantifiable (Joseph and Huber, 2015). Therefore, advocating role and political involvement in the policy arena is the most effective way nurses can demonstrate their leadership competencies (Stanley, 2016). Apart from the fact that this will promote quality service, it will also safeguard the public from ineffective policies and address inadequacies of the healthcare services (Alhassan et al., 2019). Nurses primary role is to ensure that our patients are safe and very well cared for, so, nursing leader have added challenges of adhering to policies and maintaining efficiency whilst at the same time keeping up the staffs engagement and morale, the nurse leader who chooses to approach these goals can have a great impact on healthcare system (Major, 2019).

Ethel Gordon Fenwick was a former matron in London who campaign for over 30 years for nurses’ registration, when nurse’s registration act was eventually passed in 1919, she advocated that nurses should be brought together under one umbrella (Callaghan, 2019). Ethel demonstrated great leadership qualities; she is a model for the need for nurses to participate in politics, nurses involvement in politics is for their voice to be heard in order to improve patients’ safety and positive outcomes (Nursing and Midwifery Council, 2019).

Mid Staffordshire enquiry is an example of where a good leadership was not portrayed, where suboptimal care was identified to have taken a negative ethos that involves a tolerance of standards which highlighted the need for immediate effective leadership in the NHS (Chaffer, 2016). Despite this, there are still concerns on failures of nursing leadership affecting the quality of nurses working environs and clinical outcomes (Hutchinson and Jackson, 2012).

Partly in reference to Frances report in (2013) the NHS leadership model was formulated for a betterment of all health care professionals (HCPS) in order to become a leader, it described nine dimensions that nurses should be doing at work and how all HCPs can progress as a leader, one of the core element articulated that nurses must lead the care, such as providing care in a safe environment that will enable workers to deliver their jobs effectively, providing care for patients, having the essential qualities for leaders, understanding the unique qualities and need of a team, as all will enable leaders to understand the problems that is affecting their teams and supporting them to manage unsettling feelings in order to focus their energy on delivering an impeccable services that will result in positive experience for patients and families (NHS Leadership Academy, 2013).

Teamwork (TW) is alluded as when two or more healthcare professionals with complementary skills are committed to a common purpose for which they are mutually accountable (Thistlewaite and Mckimm, 2015). Robust evidence shows that TW improves organisation effectiveness, patient safety/care and increase job satisfaction (Rosen et al., 2018). Team intervention work well at enhancing teamwork, the effectiveness of intervention is determined with range of conditions that include cognitive, team and individual based behaviour (Shirley, 2011).

Literature also reveal that 70 to 80 % of errors in hospitals are caused by human errors and it is associated with poor teamwork and lack of communication (West & Lyubovnika, 2013). Barbiker et al. (2014), opposed that the nature of team is complex and varied, although, many healthcare users may think the most effective care can only be delivered through multidisciplinary team (MDTs) thus, team may be delivered by a single person out of the professional group (Rydenfalt et al., 2017). This statement echoed the role of nurses in advocating for patients, equally highlights the significance of an effective leader in healthcare (Weller et al., 2014).

Effective teamwork requires situation awareness, effective communication, mutual support and effective leadership in order to aid teamwork to positively affect patient quality outcome (Thomas, 2011). For example, a technically skilled nurse may diagnose a patient condition, but ensuring the situation is escalated in timely manner to the relevant team does not require the non- technical skills of teamwork and communication (Casimiro et al., 2015).

Lack of purposeful team work can lead to unnecessary waste since the aim of forming teamwork is to produce something of value, it is therefore important to intervene whether the team are performing well, for example, if members of the team are not performing a task, as a leader, communicating with the staff member to identify the problem is essential, training/ support might be required by the particular member of staff in giving them ability to complete task when allocated to them (Rossen et al., 2018). This corroborate the nursing and midwifery council (2010), stipulations which states that nurse’s must take responsibilities of accountability from delegating care to others and able to justify their decision making.

As a registered nurse, we have a legal liability and duty of care to patients, when delegating task, nurses must ensure that task are appropriately delegated, we must ensure that staff who is assign to carry out the task have the skills and knowledge needed to carry out the tasks (Thistlewaite and Mckimm, 2015). Achieving the right balance is pivotal, because delegating too much can result in a loss of control, equally, failing to delegate or not delegating enough task can lead to inadequate care or uncooperative team (Shirley, 2011). Teamwork can be improved by using situation background assessment and recommendation (SBAR) tools to improve communication; it is a communication tools that consists of four questions to ensure that HCPs are sharing focus information and to ensure information is transferred accurately between the teams (Achrekar et al., 2016; National Health Service improvement, 2018).

According to the NMC (2018) code of conduct, nurses are accountable to their decisions when delegating tasks to another colleague, we are accountable to the nursing regulatory body in terms of patient care and practices, task must be perform competently and nurses must not practice beyond their competencies. Inadequate safe staffing leads to higher mortality, falls and medication error, it is nurses’ responsibilities as a leader to ensure safe staffing is available on every shift, and to consider skill mix when allocating staffs, we must act without a delay if we foresee that there is risk to patient safety (National Institute of Health Research, 2019). For example, having no staff to care for an elderly frail patient who is high risk of fall as well as having a cognitive impairment can lead to a major incident, consequently, raising a concern to the management will avert risk to the patient (NICE, 2013).

In addition, Anderson et al. (2019) asserted that teamwork does not only protect patient from harm, it also creates more positive and resilient working environment. Since teamwork is centred on communication, families and patients sometimes feel more comfortable to report or accept treatments and feel satisfied with their healthcare providers (Rossen et al., 2014). Communication failure is the cause of preventable harm and a contributing factor underlying other harms in acute settings, especially during transition of care between care areas or during hand offs is when important information about patient condition and plan of care can be miscommunicated, leading to delays in hospital treatment and inappropriate therapies (Rydenfalt et al., 2017). Patients are interested in their own care and they must be included in the communication process too, patients who are involve in decision making have been shown to minimise potential harm and errors (Rossen et al., 2014).

Communication and teamwork challenges in healthcare system evidence the problem of coordination neglect in healthcare, managing difficult tasks usually involves breaking the tasks and delegating work to ensure risk is averted by supervising staffs when they are allocated tasks, allocation to be shared among staffs based on the level of their competencies, however, across healthcare sectors, it is highly likely to lay emphasis on division of task and neglect the mechanisms of integration and coordination (Thomas, 2011).

Healthcare delivery is increasingly complex that no individual can assure that a patient will receives the best standard of care, neither can an individual protect patients from all potential harms that can occur to them stemming from powerful therapies, thus, despite increase level of interdependence, healthcare organisation have less invested in evidence based for managing teams, coordinating care and structures (Casimiro et al., 2014). Co-operation of sharing accountability and responsibilities between team members is beneficial; however, shared responsibilities without high quality teamwork can lead to immediate risk for patients (Anderson, 2019). For example, poor communication among HCPs, carers and patients was established to be the reason for patient taking a legal action against HCPs (Royal College of Nursing, 2020). Gordon et al. (2014), stated that adverse events and medical errors may also ensue because of inadequate of communication within team members even in a coherent team. Likewise, team with a lack of purpose can also lead to unnecessary waste (Nursing Times, 2016).

Therefore, identifying best practices may help in controlling cost and avoiding some of these dangers (Weller., 2014). TW can be improved by using situation background assessment and recommendation (SBAR) tools to improve communication. It is a communication tools that consists of four questions to ensure that HCPs are sharing focus information, concise and to ensure information is transferred accurately between the teams (Achrekar et al., 2016; NHS improvement, 2018).

The transitioning of nursing students into practice workforce as Newly Qualified Nurses (NQNs) is turbulent and stressful (Whitehead et al., 2016). Drapper (2018), stresses that NQN encountered are related to lack of competencies that include clinical skill performance, responding appropriately to emergency situations, communicating with doctors, organising or prioritising duties causes NQN to leave their job within the transition period if the problems are unresolved during this time. Yu-cheng et al. (2013) also acknowledge that NQN experience stress, anxiety and shock as they acquire their competences in taking more responsibilities, performing patient care, learning more about nursing role and striving to meet role expectation during this period, therefore, having a supportive environment and preceptorship programme will help to improve clinical competencies for their first year of employment which helps them to overcome problems that might occur. Unavailability of mentors and qualified preceptors is a contributing factor to inadequate preparation for NQNs (Edward et al., 2015).

El- Haddad et al. (2017) noted that nurses who exhibit changes in their mental well-being are highly likely to resign early from the profession. Resilience is a personal capacity that aids NQNs to deal with their workplace demands and adversity, NQNs with high tolerance of resilience are highly likely to be healthy and remain in their profession, practising mindfulness is a remedy for building resilience, learning new skills can also contribute to professional confidence, growth and competence building (Foster, 2016). To be a good leader entails working with others and embracing framework that allows someone to see how we are all different in history, values and personalities that leads on to working with others as part of a team (Department of Health, 2014). Appreciating differences and building a successful relationship with colleagues is aided by the emotional intelligence (EI) built through the focus on self-awareness, it is important to have experience working with others to be a successful leader of change (HEE, 2018).

Tools that also enable nurses to learn about themselves professionally and clinically is swot analysis which is termed as an effective way to identify ones strength and weaknesses, as well as examining the opportunities and threat one faces, it helps one to focus activities on where they are strong and where opportunities lies in order to action planning process (Pesonen and Horn, 2013). Professional development plan (PDP) is a process that is undertaken by an individual to reflect on own learning, performance, and achievement to plan for their personal career development, it helps to manage own development/ identify what one want to observe, try or learn in a given situation (Quality Assurance Agency, 2007). All this tool will be beneficial to nurse’s leadership journey, as they enable nurses to understand their own strengths, attitudes, values and limitations in terms of developing their leadership skills, behaviours and knowledge (Gopee and Galloway, 2014).

In conclusion, all nurses have the abilities to contribute to the development of healthcare policy through professional political involvement due to rapid changing and the challenges the NHS is encountering. We can influence in the formulation of policies rather than government implementing unfavourable policies that negatively impact on healthcare services relating to patients care and services nurses delivered to the society.

In other words, as a nurse, advocating is our role as we are the front line of healthcare system due to our close communication with the communities, families and patients across the healthcare system. As a leader, we should seek for a formal education on public or health policies in order to have the knowledge and skills requires to be active in the policy arena.

Clinical nurse leaders must have a good communication skill and have an ability to build an effective team and must have mutual respect, therefore, we must build a culture that ensure delivering of care as leadership is the key factor in shaping the culture in the healthcare organisation. It is a crucial part of promoting professionalism and trust, we must provide leadership to ensure our patient wellbeing is protected at all time in order to improve patients and staff’s experiences of healthcare services.

NQNs moving from academia area to a chaos clinical setting should be self-aware as it is important approach to develop relationship with patient, families and our work colleagues.

Being positive and using new situation as opportunities to learn mean in turns that we will develop problem solving abilities, the ability to solve problems means that we are in control, not only of the situation, but also of ourselves. Understanding the effect of stress on ourselves and others is the important element of emotional intelligent which is a core skill for a leader.

Delegation of task in team working provide opportunities for staff development, task delegation should be carefully delegated to staff with the right skills requires for the task. As a leader, we must have the awareness not only of the work needs to be completed but also knowing the team and the skills mix within the team which will enable the team leader to make a right decisions about task delegation and will help to improve patient positive outcome.

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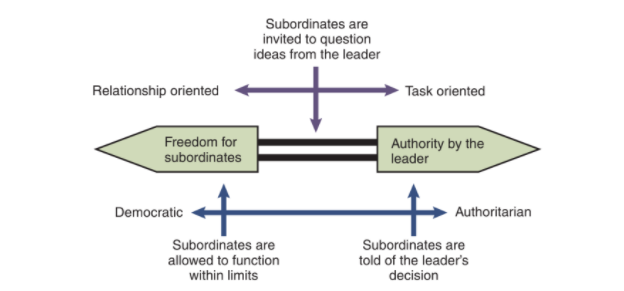
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**SWOT Analysis**

Appendix 1.

|  |  |
| --- | --- |
| **Strengths.**  Team working, I play a good role in team in practice in accomplishing daily nursing task.  Self- awareness, I am fully aware of my strength and limitation in practice and when to call for help when required. I recognised to work within my own sphere as not recognising this could in turn affect patient care/ experiences in unacceptable manner.  Time management, I am proactive in practice and manage time effectively in order to meet up patient demands when needed and I will uphold this in practice.  Raising a concern on patient wellbeing, I am able to cascade my concern to the relevant team members in practice when it is needed most specifically related to patient safety.  Resilience, I always continue to strive when over face with challenges in terms of nursing workload and in meeting patient’s needs.  Adaptive, changes are difficult, however, I am flexible in adapting to new changes when it emerges in practice.  Prioritising task when in practice, I am very organised by writing out my daily task in practice in order to ensure they are completed before the end of shifts. | **Weaknesses.**  Decision making. Poor decision making can affect patients care in practice, improving my decision-making skills will be beneficial to my patient’s positive outcomes.  Critical thinking. Been an advance beginner in practice, improving my critical thinking will enable me to identify key problems patients might be having regarding their wellbeing’s, because poor critical thinking can lead to patient deterioration or death.  Delegation. Not delegating task can affect patient care at the right time, therefore, delegating some of the task to the member of team with the skills needed will enables me to deal with other tasks that are required by train nurses. |
| **Opportunities**  Attending clinical training organised by my employer.  Adhering to my local policies and procedure to carry out tasks.  Attending simulation training to improve my clinical skills.  Attending conferences organised by the local trusts.  Learning good practice from senior nurses and doctors in practice.  Liaising with other multidisciplinary teams such as occupational or physio therapists, dieticians and pharmacy team when requires. | **Threats**  Not adhering to local policies and procedure.  Taking risk in delivering task without training.  Not upholding the Nursing and Midwifery code of conduct.  Not attending clinical skills required for my skills or not updating my clinical skills training.  Not escalating patient’s condition when it is required.  Not carrying out task on the best available evidence-based practice. |

Appendix 2



**Continuum of leader behaviour (*Source*: Huber, 2017, p. 10)**

Appendix 3

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| Name: | | | Personal / Academic / Professional goal (please underline) | | |
| **Self-Assessment and Needs Identified/ Date** | **Goals** | **Resources** | **Success Criteria** | **Review Date** | **Results of Review** |
| Decision making.  Critical Thinking.  Emotional Intelligence.  Delegation.  Communication skills.  Improving on my clinical skills. | In order to be able to make decisions for patients in my care, at the same time involving them in the decision making.  To be able prioritise and make key decisions that will save patient’s lives.  *To be able to adapt and understand the need of my patient’s.*  *To be able to delegate task to my team members when required.*  *Ability to communicate patient’s care effectively to the extended team when required.*  *To be able to complete complex task such as catheterisation and manual blood pressure on patients.* | Learning from good leaders in practice such as senior nurses and doctors.  Observing how important decisions are made in practice to save patient lives.  .  Learning from senior nurses and the whole of multidisciplinary teams.  Shadowing how senior nurses are delegating tasks when they are in charge.  Observing and reading patient multidisciplinary note regularly.  Practising on patient under supervision of senior member of staff to ascertain competency. | When I am able to fully involve in patient’s decisions making when required.  *When I can use my critical thinking ability as an advance beginner to utilise my critical thinking in making a decision that support in seeing a change in patient health conditions in practice.*  *When I am able to evaluate my patient’s emotions and ability for me to cope emotionally with stress, improve my social skills with my teams that will lead to a long-term benefit of my health.*  *When I am able to delegate tasks to appropriate teams with the right skills needed to complete tasks in practice.*  *When I witness changes in patient’s need through my communication.*  *When I am competent at recording manual blood pressure and able to complete complex task on my patients such as catheterisations and other related complex tasks.* | To be review after the first 6 months of been qualify.  In the First 6 months of been qualify.  First 6 months of been qualify.  First 6 months into my training.  First 6 months. |  |