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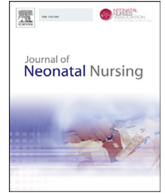

Original Article

Team coaching and rounding as a framework to enhance organizational wellbeing, & team performance

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A B S T R A C T

Becoming an effective front-line nurse manager is a complex and dynamic process, particularly when nurses progress to these roles within their own unit when multifaceted interpersonal factors may feature. This article reports on a project referred to as, 'Coaching and Rounding' in the neonatal intensive care unit of the Women's Hospital in Qatar. This project integrated leadership coaching activities with staff rounding on nurses they supervised using a structured framework. This project was designed to equip front-line nurse leaders with enhanced skills and techniques to promote a framework for developing relational leadership styles. Evaluation involved the charge nurses and staff under their supervision. Results suggested that there was improved supervisor-supervisee relationships, increased motivation and more frequent constructive feedback. The challenges to sustain these initial gains are the focus of ongoing initiatives.

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Introduction

In Qatar, like elsewhere (see Hunn, 2016) expert clinical nurses are often promoted into more senior positions where they are expected to manage and lead a team. These front-line nurse managers are known variously as charge nurses, team leaders, ward sisters or unit managers. In this article we use the term charge nurse (CN) to refer to nurses undertaking this role. These people operate at the interface between bedside nurses and the organization. The roles they fulfil are essential to the delivery of high quality and safe patient care. This article reports on a program delivered in a neonatal intensive care unit (NICU) in the state of Qatar. The initiative sought to empower and develop CNs managerial skill set to enable them to better support their nursing teams and ultimately enhance team cohesion and patient care. However, a key strategic driver was a desire to move towards more relational leadership styles amongst nurse managers.

Qatar

The State of Qatar is a Muslim country of around 11,500 square kilometres. It is located in the Gulf region of the Middle East and has a population of around 2.6 million indigenous and expatriate guest workers from over 100 countries. Geographically it is a peninsula bordered on three sides by the Arabian Gulf with a short land border with the Kingdom of Saudi Arabia. The capital is Doha, where two fifths of the population resides and the largest health facilities are located.

Background

CNs operate in complex and demanding healthcare environments and have influence over staff well-being, the creation of a safe practice environment and achievement of local and national health goals (Henrikson, 2016; Gunawan and Aungsuroch, 2017). On a day-to-day basis, the CN role can include giving and delegating patient care, supervising others, budgeting, undertaking performance reviews, ensuring adherence to policy and monitoring quality indicators (Westcott, 2016). According to one study (Adami and Eilon-Moshe, 2016) CN work stresses, regardless of cultural context, centre around balancing responsibilities with a perceived

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lack of resources to deliver on these responsibilities. On this unit CN's had between 8 months and 18 years' prior experience in the role and were not usually allocated to providing patient care. Instead they were expected to undertake the majority of managerial and administrative tasks required for the department to function. At the beginning of the project many of these tasks included what CNs perceived as nursing and non-nursing responsibilities. For example: duty rostering, preparing salary timesheets, ordering supplies, organizing planned preventative maintenance and repairs of equipment and buildings, collecting audit data, committee work and allocating admissions to medical teams.

Leadership is widely viewed as an important component of the nurses' role (Galuska, 2012). Historically the leadership education and support needs of newly appointed CNs were largely met by unfocused and ad hoc measures. More recent years have witnessed some attempts to formalize the preparation for individuals undertaking and transitioning to more senior roles with a leadership expectation (Hunn, 2016; Shaw et al., 2016, for example). Feedback from practitioners suggested that shortcomings in existing leadership preparation existed which included a perceived discontinuity between theory and the realities of practice.

To perform effectively CNs need a sharp skill set which includes organizational (staffing and workload), interpersonal (relationships with peers and managers), structural (physical environments) and professional (quality of care) expertise (Galuska, 2014). Whilst traditional classroom based programs are of value in the acquisition of leadership and management knowledge, the significance of experiential approaches to professional development have long been recognized (Galuska, 2014; Westcott, 2016).

Coaching

The transfer of knowledge through experiential learning is defined as: 'the process whereby knowledge is created through the transformation of experience …. the combination of grasping and transforming experience' (Kolb, 1984: p41). This approach, Kolb (1984) argues supports individuals construct meaning from concrete experiences and incorporates the thinking, feeling and psychomotor domains in the acquisition of knowledge. The benefits of experiential learning are reflected in the complex nature of nursing care, which relies on the overlay of management theory to practice (Benner et al., 2009; Cathcart et al., 2010). As Schon (1987: p8) describes much of what nurses' daily encounter exists within 'indeterminate zones of practice'. That is there is uncertainty and nurses face unique situations which require ability to 'think on one's feet' using situational knowledge and expertise. CN leadership is centred on professional relationships. It embraces expert communication and sophisticated relational interactions and contextual decision making, skills which require education and development.

Coaching in the workplace encompasses an experiential approach to learning. Through this approach, it is possible to achieve the skills necessary for enhanced performance by developing reflective thinking and critical decision making. Coaching encourages people to take professional responsibility for making positive changes and to cultivate the expertise needed to effect changes (Nelson-Jones, 2007). Coaching can increase resilience, confidence and help individuals develop better coping mechanisms (Westcott, 2016). Furthermore, coaching is a useful strategy to employ as it stimulates the translation of learning into action, engages clinical teams in improving care and underpins the development of effective leaders (Medland and Stern, 2009).

Rounding

The concept and practice of rounding is known by various phrases and trademarks. For example: 'rounding for outcomes' (Studer, 2003), 'foundational rounding' (Baker, 2010), 'smart rounding' (Customer Feedback Systems LP, 2017) and 'intentional rounding' (National Nursing Research Unit, (NNRU), 2012; Harrington et al., 2013). Regardless of their exact phrasing all these initiatives bear similarities. In essence they extend the mantra proposed by Peters and Waterman (1982), so called: 'management by wandering/walking about (MBWA)'. However, proponents of rounding make an important distinction, in that; whereas MBWA is casual and unstructured rounding is invariably framed as a proactive endeavour that is 'intentional' and 'purposeful' (Baker, 2010; Capstone Leadership Solutions, 2017; Wong et al., 2013). Most rounding frameworks follow a structured script and a set routine.

MBWA is firmly focused on employee management whilst rounding can take several different perspectives and approaches. As such the purposes of rounding can vary. For example, some rounding frameworks focus on direct dialogue with different groups of people (leader-staff member, leader-clinician, leader-patient, leader-staff member and patient). Others suggest different frequencies of contact (quarterly, daily, hourly or once every shift). Under the umbrella trademark term of 'rounding for outcomes' Studer (2003) identifies three main distinctions in health care organizations. Specifically, these are: leaders rounding on staff who directly report to them (to develop staff engagement), rounding on patients (to improve patient perceptions of care quality and ascertain satisfaction with care) and hourly rounding on patients (as a strategy to reduce hospital morbidities like falls, healthcare associated infection and the like). How rounding on staff might influence and enhance patient experience and wellbeing is a subject of conjecture. Some (NNRU, 2012; Thomas and Galla, 2013; Kvist et al., 2014) suggest that developing shared goals to resolve conflicts early and amicably can be helpful in promoting a cultural climate of nurturing and healing.

Because of familiarity of the term 'rounding for outcomes' to many senior staff, we chose the term to describe our practical strategy of using structured conversations between CN and staff nurse (SN). This strategy enhanced stakeholder support across the organization, up to and including executive level. Studer (2010) suggests the central concern of nurse leaders rounding on those under their supervision is the desire to build effective relationships and develop trust. This he suggests can lead to greater staff engagement through recognition of achievements and the ability to raise and effectively resolve concerns. This perspective informed our own project.

Coaching and rounding project

Context

In Qatar virtually all births take place in hospital. The NICU referred to in this article is the largest of four units in the public sector and is located in a maternity unit that has around 19,000 deliveries per annum. The NICU has around 2000 admissions per year. As the tertiary centre for the country at the time of the project it had 107 cot spaces arranged over four separate areas. The unit was staffed by around 365 fulltime (40 h per week) nurses in total: 4 acting Head Nurses, 13 CN's and the remainder staff nurses, some bedside and some in specialized roles, working a standard 3 shift pattern.

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