Leading *and* Managing Healthcare

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Transition from Newly Qualified Registrant to Frontline Manager

Chapter Objectives

The chapter objectives for frontline healthcare managers in relation to transition from newly qualified registrant to frontline manager are:

- Appreciate the scope of responsibilities bestowed on newly qualified healthcare professionals and their evolving aspirations from becoming a qualified healthcare professional to becoming a team member;
- Assimilate the requirements of preceptorship programmes for newly registered healthcare professionals (NRHP), the organisational culture in care settings, and delivering and leading person-centred and evidence-informed care competently;
- Develop skills in ways of fulfilling responsibilities related to organising, and leading daily care competently, and managing communication related to delegation, record keeping, and statement writing and report writing;
- Fulfil accountability and deliver ethical practice by ensuring safe, effective and compassionate practice through ensuring adherence to the profession's code of practice, and being accountable to the employer for the achievement of agreed objectives;
- Manage teaching and supervision of team members' learning requirements, and those of students and other learners;

- Be cognisant of challenges encountered by frontline care professionals such as feeling stressed, bullied or harassed, and managing them through pointing to a wide range of formal and non-formal support mechanisms that can be accessed by healthcare professionals;
- Develop competence in personal self-management through caring for own health and wellbeing, and through developing emotional resilience and other strategies, and utilising available resources.

Introduction

Over more than three decades, research in nursing and other healthcare professions has consistently highlighted that despite the three- or four-year-long pre-registration preparation programme to become a qualified healthcare professional, at the point of registration many NRHPs experience awe, anxiety and uncertainty at the prospect of the responsibility of being a registrant, and of the expectations that accompany being employed as a qualified professional. These feelings are in addition to the anticipation and excitement of being employed, and the autonomy, wages, etc. that being a qualified healthcare professional will bring. For these reasons, the final year of the pre-registration programmes incorporates various specific preparation activities for students aimed at easing the transition from student to registrant.

However, the transition from being a novice registrant to one who feels competent and confident to assess, plan and deliver care autonomously in most specialisms takes time. The process can be eased with the appropriate supervised learning and support in situ, which is usually already available in many care settings. Nonetheless, current research still highlights deficits in the transition process, principally in terms of support (e.g. Kumaran and Carney, 2014; Wain, 2017).

Twenty-four different strategies to support graduate transition into the workplace were identified from an integrative review conducted by Rogers et al. (2021), which include preceptoring programme, supernumerary/shadowing time, structured peer-learning activities, clinical skill competency assessments and regular feedback sessions from preceptors. However, Rogers et al also conclude that the efficacy of these strategies should focus on work readiness, which in turn include personal work characteristics of the individual, their work competence, as well as 'social intelligence' and 'organisational acumen'.

While NRHPs' responsibilities, accountability and challenges are examined in detail in this chapter, other key components of NRHPs' duties are only briefly addressed here because they are explored extensively in other chapters of this book, and are signposted accordingly. Continuing learning in healthcare professionals' careers includes learning relevant specialist clinical skills, then later attending specialist or advanced practice courses (see Figure 10.1 for illustration), and components of management training.

On Becoming a Qualified Healthcare Professional

As noted in the introduction, this chapter begins by examining the expectations and experiences of NRHPs. More specifically, it explores the responsibilities of NRHPs as employees beginning to become part of a team of healthcare professionals in practice settings, awareness of the local and organisational culture, delivering and managing person-centred, evidence-based care, and developing confidence and competence after the initial induction programme.

The responsibilities of the newly qualified healthcare professional as a team member

On gaining employment and starting work as a healthcare professional, becoming part of a team is usually a very rewarding experience as NRHPs are normally welcomed by the clinical team. Nonetheless, it often becomes apparent that the responsibilities and workload of the registrant is much more wide-ranging than experienced as finalist students on management practice placements.

As noted in the introduction section of Chapter 1 of this book, healthcare professionals' duties can be grouped under the six headings: clinical role; organising care for the span of duty; managing care resources; engaging with research; educating students, service users and others; and leadership. There are several strands to the registrant's job role that the NRHP has to develop professionally, as partly illustrated in Figure 2.1, and more shortly in this chapter under roles of the FHMs.

Brief details of these job role considerations or demands on NRHPs are as follows:

Social	Work is often a social activity (in teams), belongingness, team-working.
Psychological	Adaptation to the job requirements, rewarding to see patients recover health.
Personal	More responsibility, a salary.
Autonomy	Performing clinical interventions unsupervised professionally and being accountable for each action.
Support	With developing clinical skills and knowledge.
Skill development	The felt need to learn or further develop own clinical interventions skills.
Workload	Registrants' perceptions of workload as comfortable, never-ending, or in-between.

The preparation for transition from final year student to registrant is usually comprehensive, based on the NMC's (2018a) competencies that have to be achieved

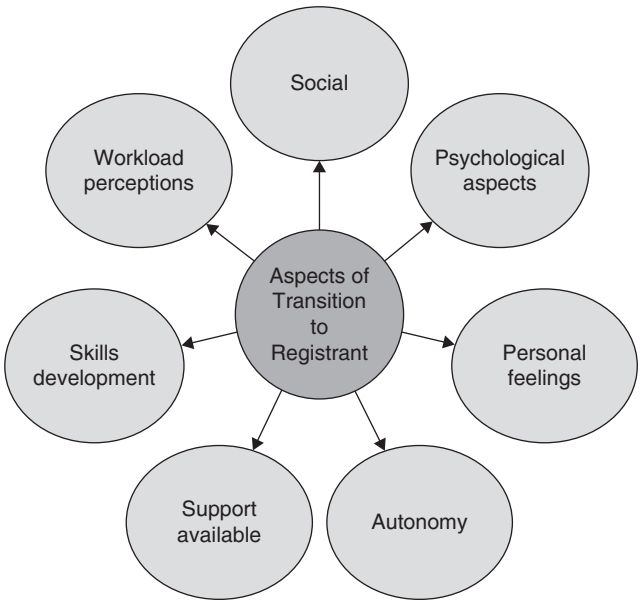

Figure 2.1 Aspects of newly qualified registrant's job role

before being allowed to join the NMC's register, and therefore should be a smooth journey. However, despite the pre-registration educational preparation, issues are likely to surface that will need to be resolved. As, for example, Wain's (2017) qualitative research found, there are situations that would prove tricky for the NRHP to resolve such as inequality in preceptorship provision, protected time with preceptors, and inadequate staffing that may be due to shortage of supply of staff to recruit from, and therefore of time and support.

ACTION POINT 2.1
Registrants' workload

A number of daily professional duties and roles of FHMs were identified in relation to Action point 1.1 in Chapter 1 of this book. Approach a recently qualified registrant and ask them if they could tell you a bit about the following.

1. Their perceptions of their workload
2. What are the effects of not having a practice supervisor to go to for advice and support as a NRHP, which finalist students have?

Several management activities were cited in response to Action point 1.1. Many of the challenges that newly registered nurses (NRN) could encounter as

frontline managers will be discussed later in this chapter and throughout this book, followed by support that may be available. A general guide to the employee's responsibilities are outlined in their own job description, which in turn is based on the relevant section of the *Knowledge and Skills Framework* (NHS KSF) (DH, 2004; NHS Employers, 2019b). A number of aspects of NRHPs' responsibilities during the transitional stage are now examined.

Preceptorship programmes for NRHPs

Newly qualified care setting managers' responsibilities in relation to managing learning in the care setting include consolidation of own previous learning as well as substantial new learning, and managing learning for all team members and learners, and education for service users and their carers. It also includes accommodating learning for the wider inter-disciplinary team members. Managing learning implies much of the teaching is performed by appropriate healthcare professionals in the team, not necessarily by the FHM.

For NRHPs, starting work as a qualified professional is a prospect full of hope and anticipation, but can also be anxiety-provoking, which is the reason for the widespread availability of preceptorship programmes, which entails supervised practice for a specified length of time (with some flexibility built in). Structured preceptorship programmes contribute to making care settings more attractive for recruitment and retention purposes as well.

The aim of structured preceptorship programmes is to ease NRHPs into functioning competently as registrants, and being accountable for their practice, as well as to enable further development of their competence in the area of employment. These programmes encompass having supernumerary status and structured protected time for precepteeship, which involve enabling the preceptee to maximise learning while in this role, and maybe constituting a personal development plan. The FHM's role comprises enabling new colleagues' transition from NRHP to competent healthcare professional, and includes providing feedback when in the preceptor role.

Preceptorship constitutes a fully structured time-defined period of supervised clinical learning, and a preceptor is a registrant who has had at least 12 months' experience in the same area of practice as the NRHP, and who is willing to teach, counsel and be a role model for the professional development of NRHPs; that is, to enable them to develop clinical skills, and for socialisation and integration into the team.

While the preceptor role refers specifically to facilitation of practice-based learning for NRHPs, other such roles include 'practice supervisor' and 'clinical educator', which tend to refer to facilitation of learning for pre-registration students while on placement in care settings. The term preceptor also has different meanings in different countries, but in the UK, preceptorship refers to implementing a

specified but flexible period of supervised practice for NRHPs. The Department of Health (2010b: 6) defines a preceptor as 'a registered practitioner who has been given a formal responsibility to support a newly registered practitioner through preceptorship'.

So, at care setting level, preceptorship often incorporates its induction programme, which in addition to brief orientation to the care setting includes learning many competencies that are pertinent for service user care in the specific care setting. The organisation's induction programme for all new employees generally include familiarisation with its mission statement and aims, the trust's policies on safety procedures, etc.

ACTION POINT 2.2
Anticipations of NRHPs

As a FHM, think back to the time when you were a NRHP and took your first employment as a registrant on Band 5, and think of your feelings since the point of applying for the post and a few days into the post. Consider your hopes and anxieties as a newly registered healthcare appointee, and jot down these hopes and anxieties, followed by some of the possible reasons for them as well as potential solutions.

Different hopes and apprehensions can be experienced by NRHPs about to start their first employment after gaining their professional qualification and registering it with the relevant regulatory body. Examples of hopes include being initially accepted as a person and a professional by members of the team that the NRHP is joining, and support from them in terms of being allowed to take time to become accustomed with new care interventions and activities. They might hope to be given a comprehensive orientation to the practice setting and associated areas, and systems, introduction to team members and an identified period of preceptorship, and later to be valued and supported for further professional learning.

Apprehensions expressed by NRHPs might include:

- not fitting in with the clinical team;
- isolation (lack of support) due to staff shortages;
- lack of access to preceptor;
- personal expectations of care standards not being met;
- not being valued;
- making mistakes;
- personality clashes;

- aggressive patients/staff;
- lacking in competence, and fear of litigation;
- insufficient professional development time;
- being unable to deal with complaints due to lack of experience.

As can be deduced from the responses to Action point 2.2, the NRHP requires more than orientation to the new care setting and to the healthcare organisation's policies and competencies. To manage some of the new registrants' fears or apprehensions, some of the actions that FHMs can take are as follows. For fear of feeling a lack of support, or of making mistakes, FHMs can encourage NRHPs to ensure they follow the set clinical guidelines and procedures, and learn from more experienced colleagues who they consider to be role models. They can also advise them to attend appropriate structured learning events and activities.

For fear of personality clashes, NRHPs need to learn to resolve these by using systematic problem-solving approaches (see Chapter 7) if they occur. For lack of self-confidence in dealing with complaints, the NRHP can familiarise themselves fully with appropriate policies and procedures, which include documentation. Structured preceptorship or 'facilitated transition' can incorporate discussions on ways to manage such apprehensions.

That NRHPs need support for effective transition from NRHP to confident practitioner has been documented over a number of years (e.g. Kramer, 1974; Labrague and De los Santos, 2020), and the absence of such support tends to lead to dissatisfaction at work and to attrition. Therefore, formal recognition of the role of preceptorship is required by management and a culture of support, along with preparation for preceptorship.

In their cross-sectional study of NRHPs' transition to autonomous professional, Labrague and De los Santos (2020) found that NRHPs' greatest challenges were related to their expectations in the work environment, balancing their professional and personal lives, and that higher levels of reality shock were associated with adverse patient events. They recommend provision of flexible work arrangement, reasonable workload, adequate staffing, limited mandatory overtime and self-scheduling to facilitate a reasonable work–life balance.

However, even relatively recent research has revealed that transition from student to staff nurse remains 'a difficult time for many new graduate nurses, with significant numbers of graduates being dissatisfied, ultimately considering leaving or exiting the profession' (Phillips et al., 2015: 118). To resolve such difficulties, preceptorship should include addressing autonomous working, teamworking, conflict resolution, etc., which should lead to greater levels of job satisfaction, increased commitment to an organisation and thereby staff retention. Staff retention strategies are explored in detail in Chapter 5 of this book in relation to human resources.

Preceptorship programmes tend to vary in length, mode of delivery and content. The *Flying Start* programme (NHS Education for Scotland, 2021), for example, is delivered either entirely online, or in combination with a one-day workshop and subsequent problem-solving support as deemed appropriate.

A few programmes comprise a credit-rated preceptorship module at university, with extensive work-based learning components, but remains without a formal professional preceptor qualification. In the majority of instances, however, preceptorship comprises between six- to twelve-month programmes run by the employing healthcare organisation, with some flexibility built in, depending on the NRHP's individual learning needs. The programmes can include identifying the preceptee's learning style, reflective practice, etc., and they often incorporate induction to the organisation and the practice setting.

On empirical evaluation of a mandatory preceptorship programme for Band 5 NRNs, Forde-Johnston (2017) found that the programme had positive value and improved the experience of NRNs during their first year of clinical practice, amongst several other benefits. The year-long programme content comprised components previously suggested by NRNs, and include communication, team working, documentation, clinical skills, risk assessment and clinical governance.

Furthermore, preceptorship is often also available for registrants who return to practice following a long break in employment, registered professionals joining a new part of the NMC register, individuals returning to practice after re-joining the register, and for qualified nurses coming to work in the UK from other countries (NMC, 2020a).

The FHM may have to take on the preceptor role for one of the novice registrants, with other NRHPs being allocated to other team members who have had preparation to do so. As noted earlier in this section, the ways in which front-line managers manage preceptorship in their care setting is examined further in Chapter 10 of this book.

Organisational culture

New appointees such as NRHPs generally appreciate that each organisation and care setting often have a culture and sub-culture of their own respectively, which in essence refers to the team's values, beliefs, terminologies and abbreviations used, customs, etc. that make them unique. To settle into the team and become a team member who feels they are an integral part of the team, NRHPs need to become aware of the nature of the sub-culture and endeavour to integrate some of the elements in their day-to-day work activities.

Organisational culture that supports high-quality care is explored in some depth in Chapter 8 of this book and in Chapter 10 in the context of learning culture in care organisations.

ACTION POINT 2.3
Organisational culture

Consider the following questions:

1. Does organisational culture have an effect on the level of person-centred care provided in your practice setting, or in another practice setting that you are very familiar with?
2. How does the culture in the practice setting affect how fully NRHPs settle and feel they belong to the setting's team?
3. What are the problems or issues that you have encountered in your endeavour to be fully accepted as a team member, if any? If you encountered difficulties, did you constitute a personal action plan to resolve or overcome these problems?

Delivering and leading person-centred and evidence-informed care

As a role model for learners and team members, and in the interest of highest quality of care, FHMs have to apply person-centred care in their normal day-to-day activities, and do so with confidence. The application of person-centred care is advocated in several policy documents and also explained by many, and FHMs will have examined the concept in detail during their pre-registration programmes.

Detailed explanation of the term is provided by the Skills for Health (2021), for example, which indicates that person-centred care describes care which is responsive to an individual's personal circumstances, values, needs and preferences – care which is specific to the patient's individual requirements and, therefore, focusing on caring about a patient's needs rather than the needs of the service. It is based on four principles:

- Care is personalised.
- Care is co-ordinated.
- Care is enabling.
- The person is treated with dignity, compassion, respect.

Providing person-centred care also means being aware of their spiritual wellbeing, that is person's religious beliefs, it takes into consideration relationships and family members, values and some individuals' need for self-expression, maybe their employment worries, and thereby improving the quality of healthcare provided, and a more positive patient experience while accessing health services.

Furthermore, leadership in person-centred healthcare is enhanced by 'shared values' (e.g. Kouzes and Posner, 2017), which the NHS Constitution (DHSC, 2019a) refers to as 'NHS values'. McCarthy and Rose (2010) refer to professional values as going beyond evidence-based practice (EBP), which is seen as mechanical, and then incorporating humanistic values that are inherent components of holistic care, professional judgement, intuition and considering service users' preferences. Values include care and compassion, awareness of self and of others, respect, maintaining human dignity, tolerance and being ethical, which are also integral to the profession's code of practice (e.g. NMC, 2018b).

Evidence-informed practice is discussed in fair detail in Chapter 9 of this book in relation to managing change and improvement.

Frontline Managers' Responsibilities Related to Organising Care

Frontline managers' responsibilities incorporate leadership in organising care for the shift, and communicating planned care which includes delegation, record keeping and ensuring evidence-based practice. This section explores some of the options available to FHMs for ways of organising day-to-day care.

Organising daily care

An important dimension of the management of service users' care is the day-to-day organisation of their care so that their plans of care are safely, effectively and sensitively implemented, and all objectives of the shift are achieved. Care is of course delivered collaboratively with doctors and AHPs as identified in the patient's individualised care pathway, and is also influenced by various codes of practice, policies, guidance and legislation, as well as service users' individual choice whenever feasible.

Healthcare is provided and delivered 24 hours per day, every single day of the year, and it has to be done efficiently and effectively, and therefore the modes in which care is organised is very important. These modes can affect the results of patient satisfaction surveys, level of complaints, clinical effectiveness and other quality metrics. It is also important to note that a combination of higher number of registrants and lower number of unqualified healthcare staff usually results in higher quality of care (e.g. Francis, 2013), as acknowledged in Chapter 8.

When organising care, FHMs also have to take into account the continuity of care of service users already under their care, the assessment of newly admitted service users and planning their care, individual patients' dependency level, communication with various parties, the resources that are available to them including skill mix (registered to non-registered staff ratio – discussed in Chapter 5) and the level of supervision and developmental needs of junior staff and learners.

The majority of care that FHMs are involved in is based on integrated care pathways, which are widely used in acute care settings to manage the decision-making and care processes together with inter-disciplinary input, resulting in improved quality of care, increased patient satisfaction, reduced risk and enhanced efficiency, as noted by Oosterholt et al. (2017).

An Integrated Care Partnership can be defined as a multidisciplinary outline of anticipated care and organisation of care processes, for a well-defined group of patients or set of symptoms for an appropriate timeframe, to help a patient progress smoothly through to positive outcomes. Consequently, care pathways comprise a standardised and effective approach that enables mutual decision-making with the service user based on multi-professional assessment of their health problems, and include specification of goals and evaluation points on the patient's journey through health and/or social care services.

Another key benefit of care pathways is that it is a one-stop shop for documentation and record-keeping with inter-disciplinary team members recording their interventions and observations in one document. Integrated Care Partnerships can be developed through process mapping (e.g. NHSI, 2020b), which essentially constitutes full details of the service user's anticipated journey through care systems.

However, several generalised care pathways are already available on NICE (2020a), Scottish Intercollegiate Guidelines Network (SIGN) and other organisations' websites for numerous health conditions and interventions, including 'Sepsis: recognition, diagnosis and early management', 'Obsessive-compulsive disorder and body dysmorphic disorder', which tend to begin with a flowchart, and has icons for further details, resources, etc.

For implementation of care, the FHM would be aware of different modes of organisation of care. The most popular current modes of care organisation are named nurse and team nursing (with equivalent titles for other healthcare professions). Other modes that are appropriate for specific settings include keyworker method, case management, care programme approach, task allocation, etc.

The named nurse is a RN with responsibility for delivering and co-ordinating all the care interventions required for a designated service user, thereby ensuring that all required care that is due during the span of duty is delivered. It was instituted several years ago and is also one of the several recommendations of the Francis Report (2013). It has previously also been known as 'case method', 'patient allocation' and 'total patient care' and is consistent with holistic approach and person-centred care.

Team nursing usually comprises a skill mix of team members such as a Band 6 registered practitioner as team leader, a Band 5 registered practitioner and healthcare support workers (HSWs) who are allocated groups of patients for the span of duty or longer. The team leader plans, delegates, co-ordinates, supervises, monitors and evaluates the care delivered, and assigns patients based on the competencies of individual team members. It is based on collaborative teamwork and facilitates

the supervision of more junior team members, but also fosters patient satisfaction as it supports the delivery of holistic care.

Many of the ways of organising care initially came into being either from research or as innovations. However, each of these methods can have weaknesses in spite of their advantages, and therefore cannot be applied universally. In particular, for task allocation, several decades ago Menzies (1960) identified problems with this method of care organisation, indicating that task-orientated nursing alienates patients from staff because of the impersonal and mechanical nature of this mode of caring for service users. It demotivates staff and is counter to the philosophy of holistic care, which is a concept and practice that uniquely distinguishes nursing from other care professions.

For the named nurse method of organising care, despite its wide implementation and advantages, it can be challenging when working 12-hour shifts or part-time short shifts. This method also requires a high level of expertise, and the named nurse is accountable for all their actions, as all registrants are of course, and therefore should assume the responsibility only when competent and confident, and under supervision for as long as required especially in more acute settings. They should, however, be able to delegate interventions to other team members including HSWs as appropriate.

From another perspective, from a systematic review of a wide range of ways of organising care compared to team nursing, Fernandez et al. (2012) concluded that with team nursing there are lower incidences of medication errors, significantly lower pain scores, less adverse events related to intravenous medication and earlier discharge from hospital, although there was no difference in incidence of falls, pressure injuries and nurses' job satisfaction.

Frontline healthcare managers would be aware that successful organisation of service users' care, which is often based on ICPs, requires collaboration and effective communication, which is explored next.

Management communication

In addition to being a crucially important element of care delivery, communication also forms a fundamental basis of teamwork. Communication is also examined in fair detail in Chapters 4 and 6 of this book in the context of principles of management in healthcare and of teamworking respectively. Only two forms of management communication – delegation and record keeping – are explored in this section of the book. Suggestions are made in relation to more details regarding statement writing and report writing.

A widely implemented model of day-to-day communication used for handover reports, etc. is the Situation-Background-Assessment-Recommendation (SBAR) framework. SBAR provides an effective means of communication of information to team members which is sufficient and succinct while also supporting a culture of patient safety as well as effectiveness and efficiency.

SBAR focuses attention on healthcare professionals' input throughout the patient journey, and across primary, secondary, community and social care, and its utilisation is acknowledged by NHSI (2018a). Using the example of patient handover (also known as 'handoff') reports, or in everyday communication situations such as telephoning a doctor to request a review of a patient, or transferring the care of a patient to a district nurse or GP, the minimum information that needs to be imparted under the four sections of SBAR are:

1. *Situation:* Your name, title and workplace; the name of the patient and reason for the communication; the issue or concern.
2. *Background:* Relevant information about the patient, e.g. reason for, and date of, admission; procedure of interventions already performed; and the last set of observations.
3. *Assessment:* Your assessment of the current situation, e.g. deteriorating vital signs, is in severe pain, showing signs of delirium.
4. *Recommendation:* What you need, e.g. doctor to assess the patient, district nurse to visit; ask if there is anything you should do while waiting for doctor to arrive; any medication change.

For example, at the handover report or when contacting a doctor regarding a patient with left hip replacement (background) and who is in pain (assessment), etc., if not all team members know each other, then 'situation' does include knowing in what capacity the person reporting is speaking (e.g. as the ward sister, or as a final year student). As for the 'Recommendation' section, more junior team members may be reluctant to make recommendations, but this could also be addressed by the communicator asking the addressee what interventions they recommend are to be performed straightway.

Other examples of when SBAR contributes to improving communication is (1) when the A&E Department or the admission ward at the acute hospital contacts a nursing home to report on a resident who was sent to the hospital; and (2) when the nurse contacts the on-call doctor regarding a patient whose condition is deteriorating.

Evidence of the effectiveness of SBAR includes a review of research by Shahid and Thomas (2018) who concluded that SBAR comprises a structured reliable and validated communication tool which has also shown a reduction in adverse events in a hospital setting, and thereby tends to contribute to patient safety.

Delegation

Recognising that delegation of healthcare duties to appropriately skilled team members is one of the primary functions of frontline managers, this management activity is discussed in detail in Chapter 4 of this book in relation to management communication, where it indicates that the principles of delegation are

also identified in the NMC's (2018b) Code of practice, for example, and specific guidelines have been published by the RCN (2017a) and other organisations. It also addresses five styles of delegation identified by Magnusson et al. (2017), as well as stages of effective delegation in Figure 4.5.

Record keeping and record management

Yet another crucial component of FHMs' role is accurate documentation of all care activities. Encompassing documentation, at times referred to as record-keeping, is records management, which reflects the bigger picture of information documented. Accurate documentation as an aspect of the FHM's daily management activity is also analysed in fair detail in Chapter 4 of this book.

Interestingly, the concept has also been analysed in the context of the phrase, 'If it's not written down; it didn't happen ….'. Andrews and St Aubyn (2015) investigated this well-publicised statement made previously in a court of law, and re-emphasise the significance of accurate record keeping of patient-related activities. Consequently, they suggest 6Cs of good record keeping as follows, but it is advisable to read the whole article (details in Further Reading section) and with the NMC's (2018b) code of practice. The characteristic 6Cs of skilled record-keeping are:

1. *Contemporaneous* – complete the documentation as soon after the event as is possible.
2. *Continuity* – date and time all entries chronologically, with the patient's name on each page.
3. *Correct* – clear writing; clear message; clear communication; clear conscience. Write legibly and with clarity, accurately, and without expressing opinions, and without abbreviations if possible.
4. *Claim* – include your name on your records, and your designation, and sign your entries.
5. *Candour* – the quality of being frank and honest about events in the care setting in the interest of maintaining patient safety.
6. *Contain* – maintain confidentiality and store all records according to local policies/procedures.

Statement writing and report writing

Other areas of management communication including statement writing and report writing, which are integral to healthcare professionals' and FHMs' duties. A written statement may be required in relation to an incident in the practice setting. In *Statements: how to write them,* the RCN (2021) indicates that healthcare

professionals could be asked to write a statement on an incident as an involved person; or as a witness; or for an inquest or criminal court. The NMC (2018b) code of practice indicates that nurses and midwives have a duty to assist in investigations, which also implies statement writing.

Detailed recommendations on statement writing is also offered by the RCN (2021a), which include ensuring the request to write a statement is itself in writing; not to sign if someone else has prepared a statement for you; and keeping a copy of your written statement. More statement writing guidelines are available over the internet, but the above-mentioned RCN's recommendations constitute comprehensive advice on how to do so safely.

Report writing is often based on a project that you may have led, or an educational visit to explore how an innovation is being applied elsewhere in your specialism. Reports usually start with either 'Terms of Reference' or 'Aims' of the report directly following the title page. You may consider writing an executive summary, but before this, including a contents list with page numbers adds substantial clarity related to what the report is about. Thereafter, it has to have an introduction, and later a conclusion and recommendations. In the body of the report there will be a number of themes, or main areas. Detailed guidelines for writing reports are also generously available on the internet, for example University of Leicester (2018).

Accountability and Ethical Practice

'Registered nurses play a vital role in providing, leading and co-ordinating care that is compassionate, evidence-based and person-centred', states the NMC's (2018b: 3) code of practice, and are accountable for their practice and fitness to practise. As is well documented, healthcare professionals are accountable to various parties. We are accountable to our respective regulatory bodies (e.g. NMC, HCPC), to the patient, the public, our employer, etc. The NRHP is accountable for their practice both as an individual and as part of a team of healthcare professionals.

Accountability and ethical practice can be achieved by ensuring adherence to the profession's code of practice, and accountability to the employer through individual development and performance review (IDPR) meetings, for example.

ACTION POINT 2.4
Your accountability

Remind yourself all parties you are accountable to in the course of your work duties, and for which actions/interventions, and list them.

Healthcare professionals' accountability is clearly identified in their professional regulatory body's code of practice, for example HCPC's (2016) *Standards of Conduct, Performance and Ethics,* and, as the title indicates, codes are based on principles of ethical practice.

Ensuring adherence to the profession's code of practice and duty of candour

The importance of healthcare professionals' code of practice was highlighted in Chapter 1 of this book and, as expected, all healthcare professionals have a duty to comply with all the clauses of the respective professional regulators' code of practice.

Ethical practice constitutes professionalism, which in turn incorporates duty of candour when patient safety incidents occur. In the context of healthcare professionals encountering mistakes, failures and patient incidents, the NMC and GMC (2019: 1) jointly indicate that registrants have to 'be open and honest in reporting adverse incidents or near misses that may have led to harm', which is also a way of achieving and maintaining a culture of quality. Openness, honesty, frankness and truthfulness are states that are consistent with the concept 'duty of candour'.

The CQC (2015) also indicates that it expects all healthcare providers to meet duty of candour requirements, which was also one of the many recommendations in the Francis Report (2013), which asserted the need for transparency, which in turn signifies allowing information about patient incidents, performance and outcomes to be shared with staff, service users and the public. The Report indicated that fulfilling the duty of candour means that any service user harmed through the provision of healthcare is informed of the incident and an appropriate remedy offered, regardless of whether the service user or their family or carer have questioned or raised a complaint about the incident.

The British Association for Counselling and Psychotherapy (BACP) (2018) also suggests that healthcare professionals demonstrate accountability and candour by: (a) being willing to discuss with clients openly and honestly any known risks involved in the work and how best to work towards our clients' desired outcomes by communicating any benefits, costs and commitments that clients may reasonably expect.

Accountability to employer and performance appraisal

Staff performance appraisal and their training needs have been a feature of human resource management for several years. It gathered impetus with the introduction of management by objectives (MBO) (e.g. Drucker, 2007: 11), a style of management that is discussed further in Chapter 4 of this book. As the term implies, the

manager has to agree the team member's professional objectives, typically for one year at a time. MBO is the opposite of more autocratic management styles whereupon the manager determines all the employee's work-related activities.

MBO features in the organisation's business plan in the form of operational and strategic objectives, which the organisation's employees have to achieve on behalf of the organisation. Consequently, individual employees' work objectives for the year contributes to the organisation's objectives; the specific objectives will have been negotiated and agreed between the team member and their line manager during IDPR. At IDPR meetings between manager and employee, the focus is on individual employees' strengths and achievements at work as well as their further development and training needs.

Guidance on annual IDPRs for care professionals working in health services is indicated in the NHS KSF (DH, 2004). The framework provides a structure that directly links the care organisation's skill needs for the achievement of its corporate objectives with the individual employee's clinical skills and responsibilities, and their professional development needs. These skills and responsibilities are identified as competence items under six core dimensions (see Figure 2.2).

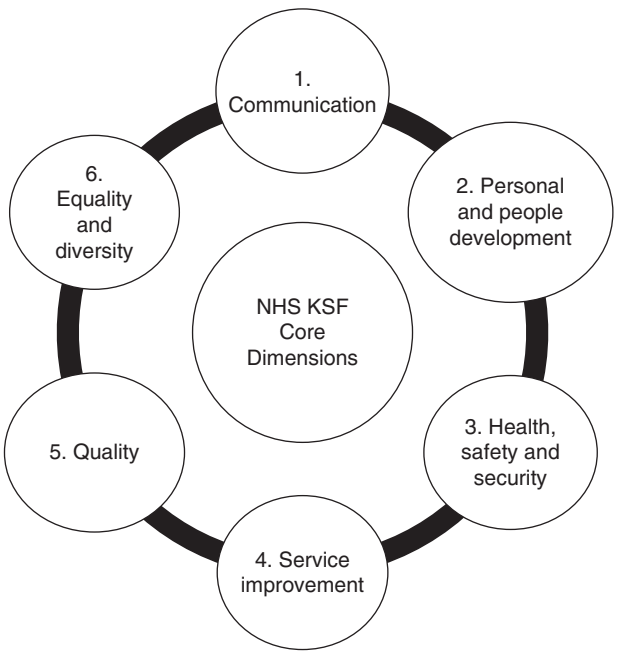

Figure 2.2 Dimensions of NHS Knowledge and Skills Framework

Later versions of the NHS KSF (NHS Employers, 2019b) include the optional leadership and management dimension aimed at more senior roles in response to feedback from employers. Furthermore, to complement the NHS

KSF skills, other frameworks are published by professional organisations. For social work, for example, the 'Professional Capabilities Framework' published by British Association of Social Workers (2020) identifies professional capabilities that can be achieved at different stages during career progression. The capabilities are identified under nine domains which are grouped under the three super-domains purpose, practice and impact that, on qualifying, social workers should be capable of performing competently, before moving on with their careers.

One of the nine domains is professional leadership, under which one of the capabilities is 'contribute to collective/collaborative professional leadership through participating in or initiating purposeful peer support, social work forums and meetings within and/or outside my organisation' (p. 1). The regulator of social workers is Social Work England (2020), which has also published the professional standards that all social workers in England must be competent in, along with other necessary guidance publication on, for example, their education and training, CPD, etc.

More broadly, eight 'job performance factors' have been identified by Arnold et al. (2020), which are:

1. Job-specific core task proficiency
2. Non-job-specific proficiency
3. Written and oral communication
4. Demonstrating effort
5. Maintaining discipline
6. Facilitating team/peer performance
7. Supervision/leadership
8. Management/administration

When preparing for an IDPR or appraisal meeting, the registrant needs to be aware of such job performance factors, but more directly, they should revisit their job description to reacquaint themselves with the components of their job role to self-ascertain their performance over the past year, and identify training needs for either the same post or for career progression, from Band 5 for example to Band 6. This includes constituting a personal development plan (PDP), which is also included in the NHS KSF.

The personal development objectives in PDPs should also meet the criteria for SMART objectives, with the acronym signifying specific, measurable, achievable, realistic (or relevant) and time-bound. These criteria can be applied to all objectives, be they annual objectives or shorter-term ones. However, some of the objectives are less measurable, for example, building working relationship with team members, delivering excellent service, respect and compassion.

ACTION POINT 2.5
Personal Development Plans

The aim of this Action point is to prompt you to create a PDP for yourself to ensure first-hand experience at compiling PDPs, in readiness for enabling more junior registrants to do so.

Based on the six components of healthcare professional roles identified in Figure 1.2, and the seven dimensions of the NHS KSF (those presented on Figures 2.2 as well as the leadership dimension), create a PDP where you identify how you are going to enhance your competence and self-confidence in either of the component areas with a view to enhancing both your own development and service user care.

Teaching and learning supervision

The NRHP role as frontline manager encompasses teaching and practice supervision, which includes supervising students and having current knowledge of students' curricula. It is also FHMs' job requirement to teach all team members as well as service users and their relatives as required. Of course, a vast number of teaching duties are delegated implicitly or explicitly to other appropriately competent registrants. Teaching and supervision of learning duties of frontline healthcare managers is explored in some detail in Chapter 10 of this book.

Challenges for Frontline Care Professionals

Frontline healthcare managers have continuing demands made of them by various parties, who seek further information related to service users, or have queries related to any other aspect of the service being provided, both during any single span of duty and over longer periods of time. This is in addition to their service user care obligations. A number of these demands on FHMs are due to insufficient time being available, including:

- queries from patients' relatives that need to be responded to sensitively and with time;
- evidence base of care interventions;
- monitoring competence of novice registrants and responding to their queries;
- care co-ordination with MDT members;
- attending to students' education needs;
- quality monitoring metrics;
- queries related to bed availability;

- staff transfers;
- report of staff bullying or harassment incidents.

A range of demands on FHMs will have been identified in response to Action points 2.1 and 2.2, which can be added to those identified above. Another challenge is the constantly repeated requirement in health service policy for the need for efficiency savings while still ensuring best outcomes for service users. Furthermore, an unexpected patient death in the care setting, or an unanticipated physically aggressive episode by a service user, for instance, could prove emotionally demanding, and mechanisms and time for a debrief following such incidents often prove most valuable when feeling stressed from such demands.

Managing stress, bullying, etc. and their aftermaths

Health and care professions have often been recognised as some of the most demanding and potentially stressful occupations (e.g. Dean, 2012; RCN, 2015a), and frontline managers have a duty to prevent staff feeling stressed in their care settings. They also have to manage their own feelings of stress.

Several factors could cause stress in care professions such as interruptions when attending to a patient, working with inexperienced staff, insufficient resources, competing demands on your time, sickness and vacancies, unannounced changes in off-duty roster, lack of career opportunities, managing under-achieving students and multitasking. Sources of stress for community care professionals can include having to learn to use new medical and digital devices, increased caseloads, etc.

Stress tends to manifest itself with such symptoms as fatigue, physical unwellness, distress and feeling emotionally overwhelmed, according to Hawkins and McMahon (2020), as well as loss of appetite, insomnia, headaches or migraine, indigestion, inability to concentrate, paranoid thoughts, avoiding friends/colleagues, increased alcohol intake and even overeating. Over time, unrelieved stress results in 'burnout', which Hawkins and McMahon (2020) suggest is a state of emotional and physical exhaustion accompanied by a lack of interest in one's job, low trust in others, a loss of caring, cynicism towards others, self-deprecation, low morale and a sense of failure. This is because burnout can also have negative effects on quality of care, it can lower patient satisfaction and increase medical errors.

Similar problems are encountered by UK GPs, according to Lacobucci (2020), in that a substantial number of GPs feel stressed and overburdened because of short patient appointment times, increasing number of patients, etc. Research by Jones-Berry (2016) revealed that almost a third of intensive care nurses experience severe burnout, which puts them at risk of post-traumatic stress disorder, possibly alcohol abuse and even suicidal thoughts.

A study conducted by the *British Medical Journal* less than a decade ago revealed that 42% of nurses in England stated that they felt they were experiencing burnout (Dean, 2012). In a more recent survey of nurses, midwives and

nursing associates entering and leaving its register, the NMC (2019) reports that almost a third of those who left cited stress and/or their mental health as the reason for leaving.

Healthcare employers therefore should monitor job dissatisfaction and burnout rates among employees regularly and manage them promptly when they occur. Such consequences could be avoided, or their effects reduced markedly, if appropriate support mechanisms or structures are instituted and utilised.

Support mechanisms, which can be mutual, that can be instituted by employing organisations include buddying, clinical supervision and socialisation opportunities, that in turn can facilitate prevention or reduction of stress and enable care professionals to manage challenging situations more objectively. Instituting such mechanisms is also consistent with the human relations theory of management, which is explored in Chapter 4.

ACTION POINT 2.6
Support available for staff experiencing excessive stress

Access the document 'Stress and You: A Short Guide to Coping with Pressure and Stress' (RCN, 2015a) (available at: www.rcn.org.uk/professional-development/publications/pub-004966), and view page 6 which identifies a number of the symptoms of stress experienced by nurses.

Then, consider whether you personally experience any of these symptoms. If you do, think of those who you turn to for support either in your personal life or at the workplace when feeling stressed. Consider also which other forms of support might be available at the employment base, and even regional or national support mechanisms for healthcare professionals.

The RCN (2015a) document mentioned in Action point 2.6 also provides a short 'Top Tips' tick box list of ways of managing stress, which includes ways of improving our mental wellbeing and resilience. Further positive ways of preventing or managing stress that can be adopted by healthcare staff include moderate physical exercise, eating healthily and general personal care, as opposed to giving in to negative strategies such as ruminating on the day's issues. Potential ways of resolving those challenging situations also include broaching difficult situations at team meetings, or using group reflection-on-practice or debriefing mechanisms.

NHS.uk (2018) suggests various 'stress busting' actions that healthcare staff can purposefully engage in for their own psychological health, which include being active, connecting with friendly people, having some 'me time', avoiding unhealthy habits and accepting the things that are outside our control. Such

actions can also promote staff resilience, and endeavours to become resilient are worth investing efforts into to manage disproportionate amount of work stress.

Furthermore, in a systematic review of randomised controlled trials (RCTs) exploring the effects of the use of stress reduction techniques such as mindfulness-based stress reduction programme, yoga, cognitive behavioural therapy, massage therapy and relaxation techniques, Alkhawaldeh et al. (2020) found that overall such programmes are effective in reducing occupational stress levels.

On the other hand, the results of the *International Standard for Organisations (ISO)* accredited 2019 NHS England Survey Co-ordination Centre [NHSESCC] (2020) revealed that in addition to over 40% of NHS staff in England reporting having felt unwell as a result of work-related stress, 29% experienced at least one incident of harassment, bullying or abuse at work from patients/service users, their relatives or other members of the public, and even violence.

Earlier research by NHS Employers (2013) also found that 20% of staff in the NHS reported having been bullied by other staff, of whom 51% indicated that the most common source of bullying was supervisors/managers themselves, which caused them psychological distress and affected patient care. Prevention or management of bullying by managers is one of the NHSE+I's (2020a) criteria (metrics) for ICSs, representing standards that they (which includes all healthcare providers) have to meet to be deemed 'autonomous'.

Bullying can be verbal or physical, explicit or covert, and is characterised by offensive, insulting or intimidating behaviour, and an abuse or misuse of power that undermines, humiliates or emotionally injures the recipient. In their online cross-sectional survey of experience of workplace bullying among nurses, Brewer et al. (2020) found that repeated occurrence of being bullied results in burnout, job dissatisfaction and absenteeism.

Based on the various guidelines on the actions that organisations, employers, managers and individuals should take in relation to bullying or harassment at work, the following comprise the main actions that should be taken:

- Ask the person to stop the behaviour.
- Explain to the person bullying how their behaviour makes you feel.
- Explain to the person how it is interfering with your work.
- Maintain a written log or diary of bullying incidents.
- Keep a note of everything that is said.
- Update your knowledge of workplace policy, and discuss with a trade union representative.
- Inform your manager or senior colleague if the person continues to bully you.

Such practical steps to prevent and manage bullying or harassment usually feature in health service organisations' own local policies, guidelines and procedures as well.

Support Mechanisms for Healthcare Staff

The provision of support mechanisms that have been instituted for healthcare practitioners is consistent with the human relations theory of management, which takes into account the social aspects of work, together with employees' personal aspirations at work, as discussed in Chapter 4 of this book. It can be provided as formal facilities, non-formal and informal. Support mechanisms that are usually available for care practitioners to draw on comprise a number of formal mechanisms, for example the Occupational Health Department of the organisation.

Additionally, there are non-formal mechanisms, which are those that staff self-negotiate amongst their peers and colleagues, which they initiate themselves with people of their choice, on topics of their choice, at places of their mutual choosing and in their own time, and include, for example, staff socialisation encouraged by managers.

It is useful for frontline managers to have knowledge of the organisational, personal and professional support mechanisms that are available so that they can direct team members to them if required.

Formal support mechanisms

The support mechanisms that have been formally instituted to support staff manage the challenges that they encounter (noted earlier in this chapter) can be available at individual level, organisational level and supra-organisational level. Table 2.1 identifies some of the most common formal support mechanisms.

Line managers, for example, comprise an important and easily accessed source of formal support that NRNs can access, and which FHMs should provide to those who they manage. Being genuinely interested in the welfare of staff that care managers manage and providing them with an appropriate level of support are components of the human relations theory of management. This includes considering the social aspects of work, together with employees' personal circumstance, beside ensuring that the day's work is completed to a high standard.

Additionally, healthcare professionals might have access to counselling, cognitive behavioural therapy (CBT), meditation and hypnotherapy (Dean, 2012: 18). Another mechanism is clinical supervision (e.g. Driscoll et al., 2019), which comprises emotional support from non-managerial sources. Clinical supervision entails clinical supervisor and supervisee holding regular pre-arranged support meetings to facilitate the supervisee to reflect on their work and areas of their development for both self-improvement and enhancement of patient care.

Also referred to as 'clinical support' or 'peer supervision', clinical supervision should occur throughout healthcare professionals' careers as a mechanism for continuing professional development. It can be conducted at one-to-one level

Table 2.1 Formal support mechanisms for health and social care practitioners

Support mechanism	Details
Own line manager	FHMs can provide a fair level of support to their colleagues and team members in the form of empathetic listening and guidance; and they can access support for themselves from their own line managers when required.
Action learning sets	Comprise small discussion groups, with pre-agreed membership, who meet regularly to discuss proposed service improvement, issues, new policies or guidelines and professional development needs.
The occupational health department	For *ad hoc* advice and for counselling on work-related issues; for 'return to work' programmes, for early retirement on grounds of poor health, etc., which are provided via telephone or on a 'drop-in' basis.
Flexible shifts and agile working	Work scheduling to accommodate family commitments where feasible, and agile working facilities to accommodate employees' other commitments aimed at enabling staff to lead more balanced working lives and thereby improve their mental wellbeing and resilience, and motivation to work.
Reflection-on-action mechanisms and huddles	Structured reflection can be undertaken by individuals through writing up on incidents, or through mentor/supervisor facilitation. Huddles are short meetings directly addressing patient safety risks, which can be reflected upon afterwards.
Clinical supervision	Structured sessions for professional peer support (more details below).
Preceptorship	Structured learning programmes to facilitate smooth transition from finalist student to competent practitioner (discussed earlier in this chapter).
Peer learning	Recognition and support for colleagues learning from each other, which includes colleagues bringing new knowledge and skills acquired from conferences and workshops, and sharing with the team.
Professional forums	Comprise special interest groups that have been formed by clinical specialists locally or nationally for peer guidance and organising formal conferences. The RCN has approximately 85 professional forums, including forums for critical care nurses, mental health nurses, etc.
Personal life coach	Personal fee-based coaching addressing career and personal aspirations.

with a more experienced care practitioner supervising someone less experienced, or as small group supervision. However, the supervisor–supervisee relationship needs to be non-competitive, clear and objectives-focused.

It also needs to be supported by the conditions of therapeutic relationships, which according to Rogers and Freiberg (1994) include unconditional 'acceptance' of the supervisee for who they are and the situation that they find themselves in;

genuineness (i.e. being honest about oneself as a person); and empathy. A thorough analysis of the ways in which effective working relationships are formed is presented in Chapter 2 of Gopee's (2010) book entitled *Practice Teaching in Healthcare*.

A possible weakness of clinical supervision is that care practitioners might be apprehensive about this provision, fearing that it could be associated with individuals' weaknesses being identified by management. Another is the erratic implementation of clinical supervision, and yet others include insufficient adequately trained supervisors, and the cost associated with time taken for clinical supervision. If the supervisor–supervisee relationship breaks down, this can be problematic as well. Consequently, career-long mentorship-type programmes have been mooted to extend clinical supervision-type support beyond episodic events to a more continuous activity.

The practice of clinical supervision can be strengthened by a systematic approach through the use of a framework or model of clinical supervision. Two popular models of clinical supervision are: (1) Proctor's (2001) three-function interactive approach – normative, formative and restorative; and (2) Heron's (1989) six-category intervention analysis framework comprising prescriptive, informative, confronting, cathartic, catalytic and supportive interventions.

Non-formal support mechanisms

The various non-formal (and informal) support mechanisms that healthcare staff can utilise as and when they need them include peer support, peer-mentoring and buddying systems amongst peers, and peer review; professional forums; and social and peer learning mechanisms. Non-formal support mechanisms are those that are available either within the institutional setting or outside that individuals can access by virtue of being healthcare professionals.

The term peer basically signifies other registrants who are approximately or very slightly ahead in their careers as healthcare professionals. The concept of 'support' can entail someone of appropriate status giving the FHM time, and actively listening to an issue or problem that the FHM is involved in. Peer support can be obtained informally from colleagues, and in a more structured way through clinical supervision.

For peer-mentoring, Johnston et al. (2020) report on the successful implementation of a peer-mentoring programme for Marie Curie nurses whose role tends to entail working remotely and in isolation, whereupon named peer-mentors respond to the needs of newly appointed RNs and provide support and guidance as required.

Yet another form of peer support ensues from peer reviews, which refer to knowledgeable professionals in the same clinical specialism and similar professional status from a different care organisation providing feedback to individuals on proposed new ways of working. Thus, when the healthcare professional or

team is allocated a new clinical activity or project, then after planning the activity (e.g. a new procedure) in detail, they forward it to peers in the same specialism for critical review and comments, and maybe pose questions on any key component that is not stated sufficiently clearly.

Work associated with peer review can also be useful for senior healthcare professionals (e.g. clinical nurse specialists, lead nurses) who, as they become more autonomous in their practices and decision-making, feel they could benefit from periodic feedback on their practices. It is also implemented in medicine in relation to performance assessment of doctors when concerns have been expressed in relation to their competence.

Personal Resources and Self-Management

In addition to the wide variety of potential staff support avenues just discussed, the NRHP also needs to draw on personal resources through self-care and self-management of one's own health and wellbeing as a basis for developing essential personal skills and coping strategies such as emotional resilience which includes emotional intelligence and self-awareness.

Caring for own health and wellbeing

Increasingly, healthcare professionals are being made aware that it is important to care for their own health and wellbeing, which is also referred to as self-management or managing oneself, which constitutes intentional and planned efforts made by individuals to develop their physical, mental, social and economic resources. These personal resources can form a sound platform for developing such coping strategies as resilience and mindfulness, which are concepts and skills that registrants will normally have encountered during undergraduate programmes.

ACTION POINT 2.7
Your own health and wellbeing

Having realised the extent of the range of FHMs' duties soon after acceding to the role, consider and identify a full range of strategies and sources of support that you can draw on to maintain your own emotional resilience.

Consider and identify also all the strategies that you use, and those that you could also use, to ensure your own health and wellbeing. Allow 10 minutes for this Action point and write down some details.

Experience of stress is one of various psychological imbalances felt by individuals and, therefore, individuals' mental health and wellbeing have gradually become more prominent in the thinking of health and policy makers, along with funding to provide support for dealing with ensuing mental health issues, as also identified in NHS LTP (NHSE, 2019a: 117). Psychological health and wellbeing impact directly on physical and social wellbeing, and vice versa, which is why FHMs need to be cognisant of the organisational, personal and professional support mechanisms that are available to access and to direct staff to for help.

Additionally, NHSE+I and NHS Employers (2018) have collaboratively published the NHS *Workforce Health and Wellbeing Framework*, along with a 'Diagnostic tool', which is an interactive document that provides guidance on how organisations can plan and deliver a staff health and wellbeing strategy. The document also presents 'actionable steps' under 14 headings.

The authors argue that investing in staff health and wellbeing delivers benefits for employees, the employing organisation and ultimately the service users in the healthcare professional's care. The 14 component areas that should be considered by employers include effective line management, engaging with staff, psychological interventions for mental health of staff, lifestyle change interventions, etc.

Attributes of resilience include being emotionally intelligent, which in turn incorporates utilising self-awareness skills, and being capable of exercising mindfulness and empathy.

Developing emotional resilience and other strategies

A range of strategies can be harnessed by healthcare professionals for managing challenging situations. Resilience is one of them, which is a personal quality that can be developed by FHMs and team members, which refers to people's ability to recover quickly (or to 'bounce back') from problematic or adverse situations that has caused stress and possibly burnout. With reference to non-humans, in metallurgy for example, it refers to the ability of metal to absorb stress but return to normal shape straight afterwards.

Resilience is thus 'the ability to adapt to adverse conditions while maintaining a sense of purpose, balance and positive mental and physical well-being', indicate Hatler and Sturgeon (2013: 33). The characteristics of resilience include optimism, having courage, toughness, compassion, humility, willingness to take risks, altruism, tolerance and accepting differences, etc., and learning from mistakes. Resilience can be developed by healthcare professionals at individual level, at team level and organisational level.

Integral to resilience are also emotional intelligence (EI) and mindfulness. The emotionally intelligent person is someone who has wide-ranging interpersonal skills, including empathy, self-awareness and self-management. Emotional intelligence is the ability to identify, assess, manage and control one's own emotions

and to react to other people's (e.g. service users') emotions, the emotions being felt 'here and now', instead of suppressing them, according to Karimi et al. (2014: 178). Furthermore, from their research on EI among nurses, Raeissi et al. (2019) conclude that well-developed EI enhances communication skills among nurses.

Consequently, emotionally intelligent people know what to say during interactions in emotional situations, and when and how not to engage with others. Healthcare professionals can develop EI through mindfulness and higher self-awareness of their own feelings (e.g. of frustration, anger, excitement, etc.) in any given situation, their preferences, values and biases. Mindfulness can be developed through, for example, enhancing attention and concentration, by increasing flexibility and creativity, and acting with compassion and kindness, indicates NHS. UK (2019).

In a systematic review of mindfulness related to the effects of mindfulness-based interventions for informal palliative care givers, Jaffray et al. (2016) found that such interventions are beneficial, feasible and acceptable to care givers. However, rarer mindful interventions, such as possibly meditation classes, yoga and tai chi which are not widely available under the NHS, should only be offered with the service user's informed consent. Furthermore, mindfulness enables individuals to develop the attributes of compassionate leadership, which in turn contributes to the provision of safe and high-quality care, asserts NHSE (2014a).

Guidance for Managing Transition to Competent Autonomous Healthcare Professional

The following comprise guidance for NRHPs to manage frontline healthcare responsibilities and duties competently.

- Continually ascertain all your responsibilities, for which you are accountable, as a NRHP and a frontline manager.
- Harness opportunities to further develop and advance your competence related to safe, effective and compassionate clinical practice that is also person-centred and evidence-informed.
- Continually develop your competence related to your responsibility for leading daily care, and organise daily care delivery based on service users' care needs, and allocate named service users to staff with the relevant competence.
- Ensure you always adhere to your profession's code of practice and to legislation related to healthcare provision and delivery, and that all team members also do.
- Ensure time is put aside to ensure new employees joining your team including NRHPs are welcomed to the care setting and sufficient time is given to them to acquaint themselves with the setting, and their questions attended to.

- Constantly check that the organisational culture in the care setting supports delivery of competent person-centred and evidence-informed care under your leadership.
- Reflect on your management communication such as in delegation and documentation to ensure they are effective.
- Develop your skills at conducting individual development and performance reviews (IDPR) for junior team members, which include ensuring that the agreed objectives meet SMART criteria.
- Be cognisant of your responsibilities towards education and practice supervision of students on placement in your care setting, and at managing all other team members' learning needs, including learning related to IDPR objectives.
- Accept that challenging situations could be encountered by frontline care professionals such as when team members feel stressed, and bullied or harassed, and manage them yourself or through directing them to available support mechanisms.
- Develop competence in personal resources and self-management through caring for own health and wellbeing, and through developing emotional resilience and other coping strategies.

Chapter Summary

The transition from newly qualified registrant to frontline manager is a substantial leap in activity and responsibilities in the delivery and management of care, and in the various inherent components within them. Consequently, this chapter has focused on:

- The scope of responsibilities bestowed on newly qualified healthcare professionals and their own evolving aspirations from becoming a qualified healthcare professional to becoming a team member, preceptorship programmes for NRHPs, the organisational culture in care settings, and on delivering and leading person-centred and evidence-informed care competently;
- Ways of fulfilling responsibilities related to organising, and leading daily care competently, and management communication related to delegation, record keeping, and statement writing and report writing;
- Accountability and ethical practice by engaging in safe, effective and compassionate practice through ensuring adherence to the profession's code of practice and being accountable to employer for the achievement of agreed objectives;
- Managing teaching and practice supervision of students on placement and attending to team members' and other learners' learning needs;

- Challenges encountered by FHMs which include stress, and bullying or harassment, and managing them through formal and non-formal support mechanisms that can be accessed by healthcare professionals; and
- Developing personal resources and self-management through caring for own health and wellbeing, and through developing emotional resilience and other coping strategies.

Further Reading

- For a comprehensive analysis of record-keeping, see: Andrews A, St Aubyn B (2015) 'If it's not written down; it didn't happen…'. *Journal of Clinical Nursing,* 29 (5): 20–22.
- For a comprehensive discussion on the what, why and how of preceptorship, see: Capital Nurse (2017) *Preceptorship Framework.* Available at: www.hee.nhs.uk/sites/default/files/documents/CapitalNurse%20Preceptorship%20Framework.pdf. Accessed Date: 25 March 2021.
- For guidance on ways to improve staff experience of working in the healthcare organisation though direct and sincere consideration of each employee's wellbeing, see: NHS Improvement and NHS Employers (June 2018) *Start Well: Stay Well – a model to support new starter.* Available at: file:///C:/Users/lgope/AppData/Local/Packages/Microsoft.MicrosoftEdge_8wekyb3d8bbwe/TempState/Downloads/CUH-case-study-Final—June-2018%20(1).pdf. Accessed Date: 22 March 2020.