Dynamic nurse leadership in high-pressure situations

Adam Lloyd and colleagues assess the value and application of non-technical skills among emergency nurses working in resuscitation rooms

Abstract
Traditionally, healthcare professionals have been expected to acquire technical skills while minimal attention has been paid to the non-technical skills (NTS) they require to work in complex health environments, such as resuscitation rooms. This article explains the importance of NTS in improving patient outcomes and why a model of dynamic nurse leadership is useful in resuscitative care.

Keywords
Resuscitation, non-technical skills, human factors, leadership, work

SINCE THE publication of Kohn et al's (2000) landmark book about patient safety, To Err is Human, there has been a greater appreciation of the factors that affect professional performance in dynamic, complex healthcare environments. One subject of academic discussion in this context is practitioners’ non-technical skills (NTS), which can be defined as the ‘cognitive, social and personal resource skills that complement technical skills, and contribute to safe and efficient task performance’ (Flin et al 2008).

Practitioners in some specialties, including anaesthesia and surgery, have developed a vocabulary for the skills they require, such as situation awareness, teamwork and task management (Flin et al 2008). Emergency care practitioners have been slower to engage with NTS, however, and NTS for paramedics (Shields and Flin 2013), emergency helicopter services (Abrahamsen et al 2014) and emergency physicians (Flowerdew et al 2013) were explored only recently. Yet, these studies suggest that core NTS are necessary across healthcare professions.

This article explains the importance of NTS among nurses who work in the most acutely dynamic area of the emergency department (ED), the resuscitation room, and sets out a model of dynamic leadership for senior members of resuscitation teams.

Non-technical skills
Although nurses have the primary role in emergency care delivery, there has been little research into the repertoire of skills they possess. Such nurses are faced with unique challenges, including an enormous variety of clinical presentation, gender, sex, age and past medical history among patients, which make predictions of which patients require emergent care almost impossible.

Nurses who are members of multidisciplinary teams in resuscitation rooms must undertake investigations, interventions and clinical procedures urgently, and so have little time for planning and evaluation. Moreover, team members tend to work at different times of day and days of the week, and are unlikely to be familiar with each other. If patients have acute illnesses, staff from other parts of the hospital may be called to resuscitation rooms to give specialist input, and this further changes the team structure.

Because of these characteristics, team NTS are crucial determinants of clinical outcomes in resuscitation rooms (Andersen et al 2010a), and poor NTS often contribute to errors during cardiopulmonary resuscitation (Andersen et al 2010b, Yeung et al 2012) and trauma resuscitation (Lubbert et al 2009, Sarcevic et al 2012).

Yet, compared with the traditional leadership roles of physicians, the role of nurses in multidisciplinary teams is undefined. Surveys of
ED staff suggest that, during resuscitative care episodes, roles and responsibilities form a hierarchy (Porter et al 2014), which is reflected in resuscitation team assessment. This suggests that team dynamics are informed by individuals’ perceptions of their roles (McKay et al 2012).

Empirical evidence suggests, however, that team members’ roles are more nuanced (Tschan et al 2014), while observational studies indicate that nurses often assume transient leadership roles (Yun et al 2003, 2005, Klein et al 2006). This evidence suggests that a model of dynamic leadership may be developed in which nurses who are not labelled ‘team leader’ nevertheless ‘lead from the middle’.

This model raises questions of clinical competency and the maintenance of professional boundaries during resuscitative care (Currie and Crouch 2008). The former has largely been addressed through qualitative (Clements et al 2015) and experimental (Gillian et al 2005) research, which demonstrates that resuscitation room nurses can be trained in the technical skills and NTS they require to optimise patient outcomes. Owing to the novelty of the resuscitation nurse leader role, the latter issue is yet to be addressed.

**Nurse leadership**

During complex resuscitations, designated physician leaders usually provide emergent, task-complex care. However, such care provision can lead to impaired decision making (Schull et al 2001), task fixation (Driskell et al 1999) and poor team co-ordination (Moon et al 2005). Consequently, hands-on leaders are less likely to build structured teams and resuscitation tasks are performed less effectively (Cooper and Wakelam 1999). It is during these clinical episodes that resuscitation nurse leaders can have a crucial role in orchestrating team performance.

Frakes et al (2009) propose in their quality improvement case report the development of the role of senior nurse resuscitation leader to augment team performance in a hands-off capacity. This would probably involve coaching and mentoring less experienced staff, organising clinical procedures and equipment, managing resuscitation room environments and asking for or dismissing extra resuscitation staff depending on clinical necessity.

Exploration of this type of nursing leadership role will require identification of nurses’ NTS and an ethnographic study of leadership during high-performance resuscitation. Clarifying how nurses’ professional values, attitudes and beliefs shape their roles in resuscitation rooms, a process known as the socialisation of nursing (Royal College of Nursing 2013), will prompt further research into nurses’ NTS.

**References**


