Reflective and critical review of Master Thesis

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CONTENT

FOREWORD

This reflective and critical review aims to appraise and propose a implementation plan for the systematic review on prehospital leadership (Parkhe, 2021) submitted as a Master Thesis a part of the degree programme *Leadership in Nordic Healthcare* at Arcada - University of Applied Sciences, Helsinki, Finland. Due to copy rights, the Thesis is not published on Arcada Theseus but available on request.

The first part of the review examines the study purpose and background in order to justify implementation. Secondly, the content of the article is scrutinised by reviewing method, material and result. In order to review the quality of the systematic review, a checklist recommended by the Joanna Briggs Institute (Aromataris et al., 2015) is applied and analysed. Finally, a suggested implementation process or change plan off the knowledge derived from the thesis is discussed using the Triple C model validated in the healthcare setting involving consultation, collaboration and consolidation (Khalil & Kynoch, 2021).

On a personal note, the author would like to express her gratitude to Principal Lecturers Ira Jeglinsky and Pamela Gray who have been unwavering in their support throughout the writing process. Without their guidance and experience, the process would not have been the rich experience it has become.

1 BACKGROUND AND AIM

Synthesizing the quality of evidence of prehospital leadership presents a unique opportunity to expand the prehospital evidence base. The aim of the study opens the opportunity to improved leadership strategies justified by the results showing the impact of leadership on patient safety and staff satisfaction. By examining current methods of delivering leadership in the prehospital setting and its impact on patient safety as well as staff satisfaction, the overall aim can be accomplished. Thus, the aim of the systematic review is clearly described and motivated. The objectives are achievable and specific. The value and uniqueness of the study is highlighted in the first few paragraphs of the introductory chapter of the systematic review. Similar to other healthcare settings, the prehospital setting is experiencing more pressures in the shape of increased operational demand in combination with inexperienced and underexposed staff. The need for change is also highlighted with increasing staff turnover and the impact leadership has in this area in other healthcare settings. A potential gap in the prehospital evidence base is discussed as no published systematic reviews on prehospital leadership have been found to the authors' knowledge.

The background chapter describes the journey of leadership theories followed by a more in-depth look at the healthcare setting. The prehospital setting is defined to provide a robust understanding of variations in this group of healthcare professional and its unique setting described. Subsequently, the means of measuring the impact of leadership is outlined on both a macro and micro scale. This is then contextualized in the prehospital context to provide a framework for the results and discussion. The concepts discussed are relevant to the study and provide a robust overview of the relevant literature required to give a context to the study results and discussion. Each component is discussed and tied in with the results of the study, supporting the study results.

The degree in which the aim and objectives of the study are achieved is evaluated in the discussion chapter of the study. The challenge of justifying an implementation of the results is evident in both the background and results discussion through an in-depth analysis on the difficulty of measuring the impact of leadership. Once again, supporting

the justification to further explore the topic, which is suggested as future research in the discussion part.

2 CONTENT

The overall content of the systematic review follows a logical order where the study aim, objectives and research question are justified in the context of a background. Following this, the study method is described, findings shown then discussed. The following chapter aims to critically review the method and results section.

2.1 Method and results

The study design is clearly motivated by the study aim and supported by published literature (Boland et al., 2017 & Munn et al., 2014). The search inclusion and exclusion criteria are clearly set out and justified with the help of the pneumonic PICOSS, appropriate to determine eligibility. In addition to this, the author's own knowledge of the unique prehospital context is considered and justified. For example, studies looking at physician- or other emergency services-led systems are excluded as well as educational non-patient-facing settings. Both time period and language are limited but justified and taken into account in the discussion by the author.

The search, screening and extrication process is described in detail then exemplified well in tables or figures. Ethical considerations, conflict of interest, sampling-, instrumental, and data collection bias are considered. The data extrication process is clearly outlined and referred to in the methods and materials section. The advantage of choosing the study design of systematic review as the study method is to provide a comprehensive, reliable and useful study to inform readers of evidence-based practice and decision-making. However, challenges the author faces is a long-drawn process, running the risk of not having enough research in the literature to analyze, therefore, dependent on what has already been published. Likewise, the results of the study may quickly become outdated. The results are summarized in a table in the manuscript as well as detailed tables in the appendixes.

2.2 Quality assessment

In this section the quality of the systematic review is assessed using a checklist recommended by the Joanna Briggs Institute (Aromataris et al., 2015). The purpose of appraising the systematic review is to assess the methodological quality and to determine the extent to which a study has addressed the possibility of bias in its design, conduct and analysis. Table one depicts the assessment and its results discussed in the following paragraph.

Question	**Answer**
Is the review question clearly and explicitly stated?	Yes
Were the inclusion criteria appropriate for the review question?	Yes
Was the search strategy appropriate	Yes
Were the sources and resources used to search for studies adequate?	Yes
Were the criteria for appraising studies appropriate	Yes
Was critical appraisal conducted by two or more reviewers independently	Yes
Were the methods to minimize errors in data extraction?	Yes
Were there methods used to combine studies appropriate?	Yes
Was the likelihood of publication bias assessed?	No
Were recommendation for policy and/or practice supported by the reported data?	Yes
Were the specific directives for new research appropriate?	Yes

Table 1 Quality assessment checklist

The most essential step of a systematic review process is stating the review question clearly informing appropriate inclusion criteria. On review, these steps are clearly outlined in the systematic review by Parkhe (2021). The search strategy is evidenced step by step with a clear search strategy addressing the components of the review question. Limitations are discussed in depth, such as time, setting and language. It remains unclear if other search terms would have yielded more results. The sources and resources used to identify the available evidence is justified in a comprehensive search strategy. Multiple electronic data bases are searched relevant to the question. However, grey literature or unpublished studies are not included but deemed irrelevant to the particular study topic. The review clearly states the method of critical appraisal and the tool chosen appropriate

for the review question. The critical appraisal is conducted by one main author and cross checked by an independent reviewer. The authors are described to confer when necessary to reach a decision regarding the eligibility of a study on the basis of quality. No tools or instruments are used to guide data extrication, however a data extrication pilot is detailed and described as cross-checked with an independent reviewer. The narrative synthesis is guided by the research question, but heterogeneity of the included studies is not considered and an overall lack of synthesis of the findings congruent to the stated methodology review is evident. Over half of the studies included are of a qualitative nature, thus publication bias arguably less likely. However, this is not considered in the remaining included studies. The study provides recommendations for practice and future research possibilities. In summary, the quality assessment reveals a high-quality score of 90%, only falling short of an assessment of the likelihood of unpublished data and its influence on the results.

2.3 Discussion and conclusion

The discussion and conclusion scrutinize the aim of the study by comparing the objectives and study aim with the results. Methods of delivering prehospital leadership are identified to be on a patient-facing level as well as on an organizational level. This provides a valuable framework to define prehospital leadership in order to support further development. Recommended characteristics of prehospital leaders and leadership models are then discussed, which are in line with recommendations in other healthcare settings. Finally, to motivate further exploration of the topic, the impact of prehospital leadership is summarized to have a positive impact on patient safety, staff engagement and satisfaction.

3 IMPLEMENTATION

The systematic review (Parkhe, 2021) highlights the presence of leadership in prehospital organizations at different levels. Therefore, this implementation discussion will be held with the assumption that organizations already have an existing leadership structure and that implementing the review results would involve improving its current practice through

improved understanding of the methods and means to carry out effective prehospital leadership as well as its impact.

The implementation of prehospital leadership at different levels to improve staff satisfaction and patient safety is assumed to be in accordance with core values of any healthcare centered organization. In order to discuss the implementation or change process further, a study by Khalil & Kynoch (2021) is explored to aid a structured approach. This three-stage implementation model is shaped based on an extensive literature review on sustainable implementation in the healthcare setting. The Triple C model offers a new approach for healthcare clinicians to support sustainability of organizational change and stands for consultation, collaboration and consolidation (Khalil & Kynoch, 2021).

3.1 Consultation

The systematic review provides an overview of the evidence base on prehospital leadership and supports the implementation of improved prehospital leadership strategies by encouraging shared leadership models. The review justifies the implementation of these strategies by exploring its impact on patient safety and staff satisfaction. Therefore, the implementation or change process can materialize as a guide in the continued training and recruitment of prehospital leaders. The elements discussed within the consultation section are training, funding, context, definitions and conceptualization.

In order to have a successful implementation process, the consultation stage encompasses all stakeholders getting together to initiate ideas (Khalil & Kynoch, 2021). The stakeholders are in charge of the implementation process and would in the prehospital setting include existing patient-facing staff and leaders, strategic and tactical management as well as the executive leadership team. Together, a process map to explore the context of the current work place with key steps involved in the project to support a clear pathway of the project trajectory is to be laid out. This process map is a way for the team and wider organization to conceptualize the change process ahead.

This process is to include planning of continued training opportunities of existing leaders in enhancing leadership techniques based on the study recommendation of shared leadership models as most effective. This can be carried out by initially identifying

current leadership patterns through self-assessed surveys, then followed by training to shape and encourage a model of shared leadership. External experts can be employed to implement the principles of shared leadership in current prehospital leaders as well as educate recruitment leads for future employment of leaders. Funding is therefore elemental to this stage and needs to be secured and reviewed throughout the process.

Khalil & Kynoch (2021) highlight that the five key factors for the consultant process mapping stage is: appropriate and easy visual representation of the project; information collected from stakeholders; the ability of the facilitator to gather ideas from those involved and capture them on the map; knowledge of software and equipment used if needed and the ability to follow-up any missing steps or information throughout the process. A timeline for the process is to be clearly agreed upon and set out making each collaborator responsible. In addition, a consideration for increasing the numbers of leaders at every level is to be considered based on the stakeholders' ideas then applied in the context appropriate in order to improve staff satisfaction and patient safety. The consultation process will aim to map these out as well, whilst the justification for implementation is to be highlighted throughout the process at the center of the visual representation of the project. By increasing awareness of the need for improved leadership in the organization, the implementation is more likely to succeed. Therefore, by justifying the proposed change to be in line with already established values and needs, change may be encouraged.

3.2 Collaboration

The collaboration stage of the Triple C model aims to identify who should be involved in the project based on skills, knowledge and contribution to the overall project (Khalil & Kynoch, 2021). This may include inviting clinicians to engage in the idea by moving to work in dual roles; part-time as project as researchers or collaborators whilst remaining patient-facing as well to improve overall collaboration with the wider workforce. Others to involve may be staff from various levels of the organization, including Human Resources or the recruitment team and the educational department. A higher education research student could be considered to be invited into the implementation process.

Enablers of good collaboration include establishing relationships, alignment of goals and priorities, skilled team members, clear communication, mutual trust and honesty between team members (Khalil & Kynoch, 2021). The stakeholders are to come together to form these relationships, establishing common goals and priorities with clear communication with each other and the rest of the organization. Trust and honesty should be emphasized throughout the process of meeting and planning.

The challenges of successful collaboration include lack of clarity around roles and responsibilities in the project plan, organisational changes such as staff turnover, changing of policies or priorities and cultural differences amongst the project team (Khalil & Kynoch, 2021). National, societal and organizational culture may have an impact on the implementation of improved prehospital leadership strategies. In any healthcare setting, including the prehospital, the growing and shifting supply or demand patterns vary, applying additional pressure to a proposed improved leadership model. Aspects such as population growth, ageing population, hospital capacity issues, budget constraints, shortage of staff and lack of leadership training may all complicate the implementation on a societal level.

Organizational challenges include resistance from a dominant hierarchical culture, excessive bureaucracy and lack of incentives for front-line leaders to operationalize executive strategic directions. On an individual level, issues of implementing prehospital leadership may be further complicated with a poor universal understanding and standard of definition for prehospital leaders as well as a defined competency standard. Yet, the shift to more combined dual clinician- and leadership roles may encourage the informal or shared leadership on the front-line in combination with formal management. Resistance to change is to be expected and should be addressed early as well as formally by identifying the root cause of resistance by engaging appropriate resistance managers. For example, increasing the number or prehospital leaders may be perceived as controlling and should be mitigated by the ensuring its positive impact on patient safety as well as staff satisfaction through thorough recruitment. By identifying the source of the resistance and its impact on the wider staff group, the source of power within the organization can be identified aiding further negotiations. By expecting resistance as a normal human reaction at the early stages of the change process, it may be mitigated and used as an effective tool to activate as well

as engage employees. Activities to do so may include engaging senior and other existing leaders to be visible sponsors of the change through various communication channels in the organization. Also, resistance will constantly be mitigated by communicating the need for change by answering the questions from the employees' point of view, which is to drive the implementation process.

With these challenges in mind, the collaboration phase is vital to encourage any prehospital organization to embrace a change. Like suggested in the discussion (Parkhe, 2021) further research on the impact of prehospital leadership may aid in preparing an organization to receive the change and is to be adopted and changed to the specific organization through means of active collaboration throughout the change process.

3.3 Consolidation

Khalil & Kynoch (2021) describe the consolidation stage as the most important step as it supports the sustainability and incorporation of the change process into routine clinical care. This may consist of refinement of initial ideas followed by standardising policies and protocols to support the process. Staff mix and experience to consolidate the project will continue to be important at this stage, identified through patient data. The elements discussed within the consolidation section are measurement and analysis.

The success of the training courses carried out is to be measured against a set of standards to assess effectiveness and success. These are to be analysed, organised then researched for ongoing feedback and formalised in standardised organisational policies or protocols. The time line set out in the consultation stage is to be reviewed and updated. Also, the goals set out to be reassessed and published within the organization to maintain motivation for the project. The stakeholders are to appraise their own success and a wider organizational appraisal is to be carried out to guide and adapt the change process further. Leaders who have received training or newly recruited leaders are to appraise the change process through either written or verbal feedback forms, then analysed externally. Other feedback can also be sought through open discussion panels to encourage project visibility and ongoing development. The stake holders may also consider to invite new collaborators into the change process in a way to encourage continued improvement.

The budget is to be revaluated and discussed in order to continue the implementation process. Ongoing funding is to be justified and distributed appropriately to ensure continuation of the implementation process.

4 FINAL REFLECTION

The systematic review is a thoroughly conducted review, unique of its kinds and very relevant to its setting. The limitations of it are clearly and honestly discussed in the latter part of the study giving the results and conclusions validity and reliability for the wider profession.

Sustainability of an overall project is suggested by Proctor et al. (2015) to be reliant on factors such as training and funding, context, definitions, conceptualization, measurement and analysis. The aim of this review was to reflect on the implementation process of improving leadership strategies in the prehospital setting bases on the systematic review carried out by Parkhe in 2021. All factors suggested by Proctor et al. (2015) are a vital to the sustainability of an implementation plan have been considered and discussed within this critical review. Opportunities according to Khalil & Kynoch (2021) are good collaboration with skilled team members, clear communication about goals with mutual trust and honesty. These enablers are vital to the implementation plan and discussed within this critical review but also appear to be in line with the shared leadership model discussed in the systematic review (Parkhe, 2021). Thus, the success of implementing improved leadership strategies appear to depend on collaborating and building relationship between existing and future leaders and followers, which is in itself is a shared leadership strategy.

The challenges of successful implementation are lack of clarity around roles and responsibilities, organisational changes such as staff turnover, changing of policies or priorities and cultural differences amongst the project team (Khalil & Kynoch, 2021). Therefore, relationship building across cultural and organizational differences must be at the centre of the implementation. This in it self requires strong leadership and is therefore the cornerstone of both implementation and success.

REFERENCES

Aromataris E, Fernandez R, Godfrey C, Holly C, Kahlil H, Tungpunkom P. Summarizing systematic reviews: methodological development, conduct and reporting of an Umbrella review approach. Int J Evid Based Healthc. 2015;13(3):132-40.

Boland, A., Cherry, G. and Dickson, R. eds., 2017. Doing a systematic review: A student's guide.

Khalil, H. and Kynoch, K., 2021. Implementation of sustainable complex interventions in health care services: the triple C model. BMC Health Services Research, *21*(1), pp.1-10

Munn, Z., Tufanaru, C. and Aromataris, E., 2014. JBI's systematic reviews: data extraction and synthesis. AJN The American Journal of Nursing, 114(7), pp.49-54.

Parkhe, E. 2021. Prehospital leadership - a systematic review. Unpublished

Proctor, E.K., Powell, B.J. and McMillen, J.C., 2013. Implementation strategies: recommendations for specifying and reporting. Implementation Science, 8(1), pp.1-11.