PENGARUH KEPEMIMPINAN TRANSFORMASIONAL TERHADAP PERSEPSI PERAWAT TENTANG HANDOVER DI RUMAH SAKIT

LITERATUR REVIEW

SKRIPSI

Oleh:
Vikki Lesmana
NIM. 18010019

PROGRAM STUDI ILMU KEPERAWATAN
FAKULTAS ILMU KESEHATAN
UNIVERSITAS dr. SOEBANDI JEMBER
2022

PENGARUH KEPEMIMPINAN TRANSFORMASIONAL TERHADAP PERSEPSI PERAWAT TENTANG HANDOVER DI RUMAH SAKIT

LITERATUR REVIEW

SKRIPSI

Untuk Memenuhi Persyaratan

Memperoleh Gelar Sarjana Keperawatan

Oleh:
Vikki Lesmana
NIM. 18010019

PROGRAM STUDI ILMU KEPERAWATAN
FAKULTAS ILMU KESEHATAN
UNIVERSITAS dr. SOEBANDI JEMBER
2022

HALAMAN PERSEMBAHAN

Segala puji bagi Allah SWT yang telah melimpahkan Rahmat dan Hidayah-nya yang selalu memberikan kemudahan, petunjuk, keyakinan dan kelancaran sehingga saya dapat menyelesaikan penyusunan skripsi ini tepat pada waktunya. Skripsi ini saya persembahkan untuk:

1. Terima kasih kepada Bapak tercinta dan Ibu tercinta adik laki – laki saya tercinta dan keluarga besar saya yang telah memberikan kasih sayang penuh, support, materi dan doa sehingga saya mampu menyelesaikan pendidikan S1 Ilmu Keperawatan di Universitas dr. Soebandi Jember.
2. Terimakasih untuk diri saya sendiri .
3. Terimakasih saya ucapkan kepada Sahabat saya tercintayang senantiasa memberi support, motivasi, tempat berdiskusi dan berkeluh kesah, serta bantuan ide selama dibangku perkuliahan dan penyusunan karya ilmiah ini di S1 Ilmu Keperawatan di Universitas dr. Soebandi Jember.
4. Almamater Universitas dr. Soebandi Jember dan pihak lembaga terkait.

MOTTO

LEMBAR PERSETUJUAN

Literature review ini telah diperiksa oleh pembimbing dan telah disetujui untuk mengikuti seminar hasil pada Progam Studi Sarjana Ilmu Keperawatan Universitas dr. Soebandi Jember.

Jember, 28 September 2022

Pembimbing Utama

Lulut Sasmito, S.Kep.,Ns.,M.Kep
NIDN. 4009056901

Pembimbing Anggota

Akhmad Efrizal Amrullah, S.Kep.,Ns.,M.Si
NIDN. 0719128102

HALAMAN PENGESAHAN

Skripsi yang berjudul "Pengaruh Kepemipinan Transformasional terhadap Persepsi Perawat tentang Handover di Rumah Sakit *literatur review*." telah diuji dan disahkan oleh Fakultas Ilmu Kesehatan Program Studi S1 Ilmu Keperawatan pada:

Hari : Rabu

Tanggal : 28 September 2022

Tempat : Via Zoom

Tim Penguji

Ketua,

Sutrisno, S.ST., M.M.

NIDN. 40060355

Penguji II

Lulut Sasmito, S.Kep.,Ns.,M.Kep
NIDN. 4009056901

Penguji III

Akhmad Efrizal Amrullah, S.Kep.,Ns.,M.Si
NIDN. 0719128102

Mengesahkan,
Dekan Fakultas Ilmu Kesehatan
Universitas dr. Soebandi,

Hella Meldy Tursina, S.Kep., Ns., M.Kep
NIDN. 0706109104

PERNYATAAN KEASLIAN PENELITIAN

Yang bertandatangan dibawah ini :

Nama : Vikki Lesmana

Tempat, Tanggal Lahir : Kebumen, 09 September 1999

NIM : 18010019

Menyatakan dengan sesungguhnya bahan skripsi *Literature Review* saya yang berjudul "Pengaruh Kepemimpinan Transformasional terhadap Persepsi Perawat tentang Handover *Literature Review*" adalah karya saya sendiri dan belum pernah diajukan untuk memperoleh gelar kesarjanaan suatu perguruan tinggi manapun. Adapun bagian-bagian tertentu dalam penyusunan Skripsi *Literatur Review* ini yang saya kutip dari karya hasil orang lain telah dituliskan sumbernya secara jelas sesuai dengan norma, kaidah, dan etika penulisan ilmiah. Apabila kemudian hari ditemukan adanya kecurangan dalam penyusunan skripsi *Literature Review* ini, saya bersedia menerima sanksi sesuai dengan peraturan perundang - undangan yang berlaku.

Jember, 23 Agustus 2022

Vikki

NIM. 18010019

KATA PENGANTAR

Alhamdulillah segala puji syukur bagi Allah SWT yang telah melimpahkan rahmat dan hidayah-Nya sehingga penyusunan skripsi ini dapat terselesaikan. Skripsi ini disusun untuk memenuhi salah satu persyaratan menyelesaikan pendidikan Program Sarjana Keperawatan Universitas dr. Soebandi Jember dengan judul "Pengaruh Kepemipinan Transformasional terhadap Persepsi Perawat tentang Handover *literatur review*" Selama proses penyusunan skripsi ini penulis dibimbing dan dibantu oleh berbagai pihak, oleh karena itu penulis mengucapkan terimakasih kepada :

1. Hella Meldy Tursina, S.Kep., Ns., M.Kep selaku Dekan Fakultas Ilmu Kesehatan Universitas dr. Soebandi.
2. Ns. Irwina Angelia Silvanasari, S.Kep., M. Kep selaku Ketua Program Studi Ilmu Keperawatan Universitas dr. Soebandi
3. Sutrisno, S.ST., M.M. selaku selaku ketua penguji yang membantu bimbingan dan memberikan masukan dan saran demi kesempurnaan skripsi
4. Lulut Sasmito, S.Kep., Ns., M.Kep selaku pembimbing utama yang membantu bimbingan dan memberikan masukan dan saran demi kesempurnaan skripsi
5. Akhnad Efrizal Amrullah, S.kep.,Ns.,M.Si selaku pembimbing utama yang membantu bimbingan dan memberikan masukan dan saran demi kesempurnaan skripsi
6. Koordinator dan tim pengelola skripsi program Studi Ilmu Keperawatan

Dalam penyusunan skripsi ini penulis menyadari masih jauh dari kesempurnaan, untuk itu penulis sangat mengharapkan kritik dan saran untuk perbaikan di masa mendatang.

Jember, 23 Agustus 2022

VIKKI LESMANA

SKRIPSI

PENGARUH KEPEMIMPINAN TRANSFORMASIONAL TERHADAP PERSEPSI PERAWAT TENTANG HANDOVER DI RUMAH SAKIT

LITERATURE REVIEW

Oleh:
Vikki Lesmana
18010019

Pembimbing

Dosen Pembimbing Utama : Lulut Sasmito, S.Kep., Ns., M.Kep
Dosen Pembimbing Anggota : Akhnad Efrizal Amrullah, S.kep.,Ns.,M.Si

ABSTRAK

Vikki Lesmana*, Lulut sasmito **, Akhnad Efrizal Amrullah ***2022. **Pengaruh Kepemimpinan Tranformasional Terhadap Persepsi Perawat Tentang Handover *Literature Review*.** Program Sarjana Keperawatan Universitas dr. Soebandi Jember

Pendahuluan kepemimpinan transformasional berpengaruh signifikan positif terhadap kinerja karyawan. semakin baik kepemimpinan maka proses pelaksanaan handover akan semakin baik. Saat mengikuti handover, kelengkapan perawat sangat diperlukan untuk menjadikan penyampaian informasi yang lebih akurat dan jelas, sehingga tanggung jawab dan tugas dari masing-masing perawat bisa terlaksana dengan baik. Gaya kepemipinan Transformasional yang diterapkan dalam Pelaksaan handover di Indonesia masih belum terpenuhi. **Metode Penelitian** Penelitian ini menggunakan literature review. Pencarian artikel menggunakan Pubmed dan google scholar, artikel tahun 2017-2021 yang telah dilakukan proses seleksi menggunakan PEOS dengan kriteria inklusi. **Hasil** review artikel tantang Kepemimpinan Tranformasional menyatakan kategori baik. Hasil review artikel tantang persepsi perawat dalam handover menunjukan kategori baik. **Kesimpulan** Berdasarkan hasil review artikel terdapat pengaruh kepemimpinan tranformasional tehadap persepsi perawat tentang handover. **Diskusi** kepemimpinan tranformasional yang baik akan berperan aktif dalam melaksanakan handover dan membimbing serta memberikan perhatian dan motivasi kepada perawat untuk selalu melaksanakan handover dengan baik.

Kata Kunci : kepemimpinan transformasional, persepsi perawat dan *handover*

*Peneliti
** Pembimbing 1
***Pembimbing 2

ABSTRAK

Vikki Lesmana*, Lulut sasmito **, Akhnad Efrizal Amrullah ***2022 **The Effect of Transformational Leadership on Nurses' Perceptions of Handover *Literature Review*.** Program Sarjana Keperawatan Universitas dr. Soebandi Jember

Introduction transformational leadership has a significant positive effect on employee performance. The better the leadership, the better the handover implementation process will be. When participating in a handover, the completeness of nurses is needed to make the delivery of information more accurate and clear, so that the responsibilities and duties of each nurse can be carried out properly. The transformational leadership style applied in handover implementation in Indonesia is still not fulfilled. **Research Methods** This study uses a literature review. Search articles using Pubmed and Google Scholar, articles for 2017-2021 which have been selected using PEOS with inclusion criteria. **The results** of the review of articles on Transformational Leadership stated that the category was good. The results of the review of articles on nurses' perceptions in handovers showed a good category. **Conclusion** Based on the results of the article review, there is an effect of transformational leadership on nurses' perceptions of handover. **Discussions** of good transformational leadership will play an active role in carrying out handovers and guiding and giving attention and motivation to nurses to always carry out handovers well.

Keywords: transformational leadership, nurse perception and handover

*Researcher

** Advisor 1

***Supervisor 2

DAFTAR ISI

DAFTAR TABEL

DAFTAR GAMBAR

BAB 1

PENDAHULUAN

1.1 Latar Belakang

Penerapan handover di Indonesia sendiri masih belum dilaksanakan secara baik. Berdasarkan hasil penelitian sebelumnya menunjukkan hasil bahwa pelaksanaan handover belum optimal dan masih banyak informasi/komponen yang dilewatkan selama handover. Hal iniidikarenakan pandangan/pengetahuan yang berbeda-beda dari perawat. Hasil dari penelitian sebelumnya menyebutkan bahwa sebagian besar perawat menganggap handover tidak penting. Masing-masing perawat juga memiliki pandangan yang berbeda tentang pelaksanaan handover. Persepsi perawat terkait pelaksanaan handover bisa berbeda-beda setiap orangnya. Persepsi yang salah terkait pelaksanaan handover akan mempengaruhi proses komunikasi itu sendiri, persepsi yang positif atau negatif akan ditunjukkan seseorang melalui kinerjanya. Ketika perawat mempresepsikan handover itu tidaklah penting, maka perawat akan melakukan handover dengan seadanya dan tidak sesuai dengan standar. Dalam artian, persepsi perawat tentang pelaksanaan handover akan mempengaruhi pelaksanaan handover. Peran pemimpinijuga sangat penting dalam mempengaruhi persepsi/pandangan para anggotanya. Karena keberhasilan suatu organisasi bergantung pada gaya kepemimpinan yang dipakai dalam organisasi tersebut. Gaya kepemimpinan seorang pemimpin menjadi model yang akan mengispirasi para bawahan. Keberhasilan

organisasi dalam mencapai tujuan dan sasarannya tergantung pada pemimpin dan gaya kepemipinan yang diterapkannya.

Pelaksaan handover di Indonesia masih kurang optimal, penelitian Triwibowo et al., (2016) di RumahiSakit Paru Sidawangi Provinsi Jawa Barat, pelaksanaan handover sebesar 46,8% tidak baik, penelitian Istiningtyas (2016) di Ruang Rawat Inap RSUD Sukoharjo, diperoleh hasil sebesar 46,2% pelaksanaan handover buruk. Rata-rata skor pelaksanaan handover di RSUD Jambi yaitu sebesar 65% yang artinya masih belum masuk dalam kategori yang baik. Berdasarkan fenomena tersebut, menunjukkan bahwa kondisi handover baik di luar negeri maupun di dalam negeri masih banyak memerlukan perbaikan dan rekomendasi untuk menjadi proses yang lebih baik. Faktor-faktor yang mempengaruhi pelaksanaan handover adalah kepemimpinan. Kepemimpinan kepala ruang dalam pelaksanaan handover memiliki peranan yang penting secarailangsung dalam pelaksaaan handover (Istiningtyas & Wulandari, 2018). Hal tersebut juga sesuai dengan penelitian Kesrianti dan Noer (2014) yang menyatakan bahwa semakin baik kepemimpinan maka proses pelaksanaan handover akan semakin baik.Saat mengikuti handover, kelengkapan perawat sangat diperlukan untuk menjadikan penyampaian informasi yang lebih akurat dan jelas, sehingga tanggung jawab dan tugas dari masing-masing perawat bisa terlaksana dengan baik. Adanya dukungan teman sejawat akan menghasilkan kerjasama yang baik dan menjadikanikerja tim lebih optimal dalam pelaksanaan handover (Nursalam, 2010)

Departemen Kesehatan RI menyebutkan kegagalan komunikasi saat pelaksanaan timbang terima menimbulkan dampak serius diantaranya tidak tepatnya pengobatan, hilangnya informasi penting pasien, serta kesalahan dalam merencanakan asuhan ikeperawatan (Kesrianti, Noor, & Maidin, 2014). World Health Organization(WHO) tahun 2013 melaporkan kasus kecacatan permanen pada pasien di Australia sebanyak 25.000-30.000, 11% diantaranya karena kegagalan dalam berkomunikasi (Supinganto, dkk, 2015). Hasil studi yang dilakukan Cohen dan Hilligoss menyebutkan32% dari 889 kasus malpraktek, disebabkan karena kesalahan berkomunikasi saat melakukani timbang terima (Kesrianti, Noor &Maidin 2014).

Menurut Subroto (2010) menyimpulkan dalam penelitiannya bahwa kepemimpinan transformasional berpengaruh signifikan positif terhadap kinerja karyawan, dimana hasil penelitian menunjukan jenis kepemimpinan transformasional membuat karyawan merasa menjadiibagian perusahaan dan merasa dihargai karena diberi kesempatan untuk terlibat dan berpatisipasi dalam pengambilan keputusan. Suharnomo (2013) menyatakan bahwa kepemimpinan transformasional berpengaruh positif terhadap kinerja karyawan.

Dari berbagai uraian tersebut diatas maka dapat diasumsikan bahwa persepsi terhadap gaya kepemimpinan transformasional yang di terapkan atasan berkaitan dengan tercapainya pelayanan yang baik. Hal ini kemudian menjadi sumber ketetarikan peneliti untuk meneliti apakah ada pengaruh kepemimpinan transformasional terhadap persepsi perawat dalam handover.

1.2 Rumusan Masalah

Rumusan masalah dalam *literature review* adalah“ Bagaimana pengaruh Kepemimpinan Tranformasional terhadap persepsi perawat dalam handover” berdasarkan *literature review*?

1.3 Tujuan Penelitian

1.3.1 Tujuan Umum

Mengetahui adanya “ Pengaruh Kepemimpinan Tranformasional terhadap persepsi perawat dalam handover” berdasarkan*literature review*

1.3.2 Tujuan Khusus

1) Mengidentifikasi kepemimpinan transformasional berdasarkan *literature review*
2) Mengidentifikasi perawar tentang handover berdasarkan *literature review*
3) Mendeskripsikan hasil analisis adanya Kepemimpinan Tranformasional tehadapa persepsi perawat tentang handover berdasarkan *literature review*

1.4 Manfaat Penelitian

1.4.1 Bagi Institusi Keperawatan

Diharapkan *literatur review* ini dapat memperkaya khazanah bagi Ilmu Keperawatan dalam pengembangan keilmuan khususnya Manajemen Keperawatan serta diharapkan dapat menjadi acuan dan peningkatan pengetahuan dalam upaya turut serta berperan aktif dalam upaya pengendalian gaya kepemimpinan terhadap persepsi perawat dalam handover.

1.4.2 Bagi Peneliti

Diharapkan *literatur review* ini memberikan pengalaman baru bagi peneliti sebagai peneliti pemula khususnya terkait dengan kepemimpinan terhadap persepsi perawat dalam handover

1.4.3 Bagi Peneliti Selanjutnya

Diharapkan *literatur review* ini menjadi sumber data bagi penelitian selanjutnya serta sebagai dasar untuk pengembangan penelitian selanjutnya baik penelitian kuantitatif maupun kualitatif berkaitan dengan kejadian kepemimpinan transformasional terhadap persepsi perawat.

BAB 2

TINJAUAN PUSTAKA

2.1 Konsep Gaya Kepemimpinan Transformasional

2.1.1 Gaya Kepemimpinan Transformasional

Letak keberhasilan suatu organisasi tergantung pada gaya kepemimpinan yangdipakai dalam organisasi tersebut. Gaya kepemimpinan seorang pemimpin menjadi model yangiakan mengispirasi para bawahan. Keberhasilan organisasi dalam mencapai tujuan dan sasarannya tergantung pada pemimpin dan gaya kepemipinan yang diterapkannya M.L Voon, et al,(2011). Robbins dan Judge menyatakan, pemimpin transformasional adalah pemimpin yang menginspirasi para pengikutnya untuk mengenyampingkan kepentingan pribadi mereka demi kebaikan organisasi dan mereka mampu memiliki pengaruh yang luar biasa pada diri para pengikutnya. Mereka menaruh perhatian terhadap kebutuhan pengembangan diri para pengikutnya, mengubah kesadaran para pengikut atas isu-isu yang ada dengan cara membantu orang lain memandang masalah lama dengan cara yang baru, serta mampu menyenangkan hati dan menginspirasi para pengikutnya untuk bekerja keras guna mencapai tujuan-tujuan bersama.

Menurut Robbins dan Judge (2008), terdapat empat indikator kepemimpinan transformasional, yaitu: Pengaruh Ideal/Kharismatik (Idealized Influence) yaitu memberikan visi dan misi,imemunculkan rasa bangga, mendapatkan respek dan kepercayaan. Motivasi Inspirasional (Inspirational Motivation) yaitu

mengkomunikasikan harapan tinggi, menggunakan symbol simbol untuk memfokuskan usaha, mengekspresikan tujuan penting dalam cara yang sederhana. Stimulasi Intelektual (Intellectual Stimulation) yaitu menunjukkan inteligensi, rasional, pemecahan masalahisecara hati-hati. Pertimbangan Individual (Individualized Consideration) yaitu menunjukkan perhatian terhadap pribadi, memperlakukan karyawan secara individual, melatih, menasehati. James MacGregor Burns dalam Luthans (2006:653) mengidentifikasikandua jenis kepemimpinan politis, yaitu transaksional dan transformasional. Kepemimpinan transaksional tradisional mencakup hubungan pertukaraniantara pemimpin dan pengikut, tetapi kepemimpinan transformasional lebih mendasarkan pada pergeseran nilai dan kepercayaan pemimpin, serta kebutuhan pengikutnya. Kepemimpinan transaksional adalah resep bagi keadaan seimbang, sedangkan kepemimpinan transformasional membawa keadaan menuju kinerja tinggi pada organisasi yang menghadapi tuntutan pembaruan dan perubahan yang komplek.

Pemimpin transformasional adalah pemimpin yang mampu mendatangkan perubahan dari individu dan semua organisasi untuk mencapai pada serangkaian organisasi yang menekankanikemungkinan baru dan memiliki pengertian yang kuat dalam memberikan visi masa depan organisasi dan memanifestasikan inspirasi yang menggairah kan sebagai perilaku model kepemimpinan yang sesuai.

Menurut Burns (1987), orang yang disebut-sebut sebagai yang pertama kali mendefinisikan bahwa kepemimpinan transformasional adalah suatu proses, yaitu

pemimpin dan pengikutnyaisaling merang sang diri satu sama lain untuk penciptaan level yang tinggi dari moralitas dan moti vasi yang dikaitkan dengan tugas pokok dan fungsi dari tiap individu. Gaya kepemimpinan semacam ini akan mampu membawa kesadaran para pengikut (followers) dengan memunculkan ide-ide produktif, hubungan yang sinergikal, tanggung jawab, kepedulian edukasional, citacita bersama dan nilai-nilai moral (moral value) (Danim, 2003).

Menurut Rivai (2012: 42), gaya kepemimpinan adalah seperangkat karakteristik yang digunakan pemimpin untuk mempengaruhi bawahan mereka sampai tujuan organisasi tercapai, atau gaya kepemimpinan adalah dan juga merupakan pola perilaku dan strategi yang disukaiiyang sering diterapkan. Menurut Robbins dan Coutler (2010: 455), gaya kepemimpinan transformasional memengaruhi sikap anggota atau karyawan dan memimpin tindakan kepemimpinan dengan perubahan besar dalam membangun komitmen terhadap misi, tujuan, dan strategi perusahaan. menjadi. Untuk menjadi pemimpin yang transformasional, seorang pemimpin harus menyampaikan visi yang jelas dan menarik dan harus selalu percaya diri dan optimis. Ada beberapaidimensi gaya kepemimpinan transformasional menurut Indra Kharis (2015):

Melakukan pemberian arahan pada kepentingan bawahan. Pimpinan transformasional memberikan arahan yang terarah kepada para bawahannya. Pimpinan adalah seseorang yang mampu di percaya dimana memiliki kemampuan yang luar biasa, teguh dalam usahanya danipengambilan keputusan. Pemimpin yang memiliki

komponen ini juga serang yang bersedia mengambil risiko dan konsisten dalam setiap keputusannya. Mereka dapat dipercaya untuk melakukan segala sesuatu dengan benar, serta menunjukkan standar elis dan moral yang tinggi.

Memberikan perhatian pada nilai-nilai etis. Pemimpin transformasional memberikan perhatian kepada bawahan seperti perhatian terhada nilai-nilai etis. Dimana nilai etis merupakan nilai suatu hal yang berkaitan dengan moral atau pun prinsip-prinsip dari moralitas. Seperti bawahan haru bersikap keadilan, martabat, kesetaraan, kejujuran, keragaman dan hak-hak dari suatu individu.

Memberikan mengaktifkan pengikut untuk melakukan inovasi. Pemimpin transformasional memberikan rangsangan terhadap pengikutnya untuk berusaha menjadi inovatif dan kreatif dengan bertanya secara aktif mengenai asumsi yang dimiliki, menggali permasalahan yang ada sebelumnya. Dan memperbaharui pendekatan lama dengan pendekataniyang baru. Pemimpin tidak pernah memberikan kritik terhadap kesalahan pengikut dengan orang banyak, merek juga terbuka terhadap ide baru dan pemecahan masalah secara kreatif yang disampaikan pengikut.

Memberikan stimulasi. Memberikan stimulasi merupakan memberikan gambaran seorang pemimpin mampu mendorong karyawan untuk memecahkan masalah lama dengan cara yang baru. Pemimpin berupaya mendorong perhatian dan kesadaran bawahan akan permasalahan yang dihadapi. Pemimpin kemudian berusaha

mengembangkan kemampuan bawahan untuk menyelesaikan permasalahan dengan pendekatan-pendekatan ataupersperktif baru.

Menghidupkan dialog melalui komunikasi yang sehat. Pemimpin transformasional harus dapat menghidupkan atau memulai dialog kepada bawahannya melalui berkomunikasi yang sehat dan baik antara pimpinan dan bawahan.

Sisi positif dari kepemimpinan transformasional :

a) Tidak membutuhkan biaya yang besar (organisasi profit)
b) Komitmen yang timbul pada karyawan bersifat mengikat emosional
c) Mampu memberdayakan potensi karyawand.Meningkatkan hubungan interpersonal

Sisi negatif dari kepemimpinan transaksional :

a) Waktu yang lama agar komitmen bawahan tumbuh terhadap pemimpin
b) Tidak ada jaminan keberhasilan pada bawahan secara menyeluruh.
c) Membutuhkan pehatian pada detaild.Sulit dilakukan pada jumlah bawahan yang banyak

2.1.2 Karakteristik Kepemimpinan Transformasional

Seorang Pemimpin berkewajiban juga untuk melakukan kegiatan pengendalian, agar dalam usahanya memengaruhi pikiran, perasaan, sikap dan perilaku anggota organisasi, selalu terarah pada tujuan organisasi. Adapun karakteristik

kepemimpinanitransformasional menurut Avolio dkk (Stone et al, 2004) adalah sebagai berikut:

1) Idealized influence (or charismatic influence) Idealized influence mempunyai makna bahwa seorang pemimpin transformasional harus kharisma yang mampu "menyihir" bawahan untuk bereaksi mengikuti pimppinan. Dalam bentuk konkrit, kharisma ini ditunjukan melalui perilaku pemahaman terhadap visi dan misi organisasi, mempunyai pendirian yang kukuh, komitmen dan konsisten terhadap setiap keputusan yang telah diambil, dan menghargai bawahan. Dengan kata lain, pemimpin transformasional menjadi role model yang dikagumi, dihargai, dan diikuti oleh bawahannya.

2) Inspirational motivation Inspirational motivation berarti karakter seorang pemimpin yang mampu menerapkan standar yang tinngi akan tetapi sekaligus mampu mendorong bawahaniuntuk mencapai standar tersebut. Karakter seperti ini mampu membangkitkan optimisme dan antusiasme yang tinggi dari pawa bawahan. Dengan kata lain, pemimpin transformasional senantiasa memberikan inspirasi dan memotivasi bawahannya.

3) Intellectual stimulation Intellectual stimulation karakter seorang pemimpin transformasional yang mampu mendorong bawahannya untuk menyelesaikan permasalahan dengan cermat dan rasional. Selain itu, karakter ini mendorong para bawahan untuk menemukan cara baru yang lbih efektif dalam

menyelesaikan masalah. Dengan kata lain, pemimpin transformasional mampu mendorong (menstimulasi) bawahan untuk selalu kreatif dan inovatif.

4) Individualized consideration Individualized consideration berarti karakter seorang pemimpin yang mampu memahami perbedaan individual para bawahannya. Dalam hal ini, pemimpin transformasional mau dan mampu untuk mendengar aspirasi, mendidik, dan melatih bawahan. Selain itu, seorang pemimpin transformasionalimampu melihat potensi prestasi dan kebutuhan berkembang para bawahan serta memfasilitasinya. Dengan kata lain, pemimpin transformasional mampu memahami dan menghargai bawahan berdasarkan kebutuhan bawahan dan memperhatikan keinginan berprestas dan berkembang para bawahan.

2.2 Peran Kepemimpinan Terhadap Persepsi Perawat Dalam Pelaksanaan Handover

2.2.1 Handover

Handover adalah komunikasi oral mengenai pasien yang dilakukan oleh perawat pada pergantian shiftijaga (Kamil, 2018). Pelaksanaan handover pasien merupakan tindakan keperawatan yang dibangun sebagai sarana untuk menyampaikan tanggung jawab serta penyerahan legalitas yang berkaitan dengan pelayanan keperawatan padaipasien (Dewi, 2019). Pelaksanaan handover baik yang ada di dalam maupun luar negeri menunjukkan banyak mengalami hambatan. Faktor dari dalam maupun luar individu perawat menjadi pertimbangan dalam pelaksanaan handover.

Handover termasuk dalam perilaku kerja perawat dalam lingkungan kerjanya karena terdapat aktivitas berdiskusi, mencatat, berkomunikasi dengan sejawat dan pasien. Faktor-faktor yangimempengaruhi perilaku kerja adalah variabel individu (kemampuan dan keterampilan, latar belakang demografis), variabel psikologis (persepsi, sikap, kepribadian, motivasi, kedisiplinan) dan variabel organisasi (sumber daya, kepemimpinan, imbalan, struktur, desain pekerjaan) (R, 2019). Variabel organisasi seperti sumber daya yang berkaitan dengan ketersediaan jumlah tenaga perawat yang sesuai dengan kebutuhan ruangan, fasilitas serta sarana prasarana yang akan menjadi penentu terhadap pelaksanaan handover (Istiningtyas, 2018).

Kegiatan kepemimpinan dilakukan untuk mempengaruhi pikiran dan tindakan orang lain agar berbuat sesuai dengan keinginan supaya tercapainya tujuan bersama. Kepemimpinan mencakup hal kebijakaniserta dukungan, bimbingan yang baik dari seorang pemimpin Jurnal Ners Indonesia, Vol.11 No.2, Maret 2021 132 didalam melaksanakan tugas dan kewajiban. Pelaksanaan handover sangat berpengaruh terhadap perilaku kerja dalam pemberian pelayanan yang lebih baik (Hardinata, 2018). Kepemimpinan paling mempengaruhi dalam hal pengawasan pelaksanaan handover ini adalah dari kepala ruangan.

Hand over atau yang biasa dikenal dengan istilah serah terima pasien adalah proses pengalihan wewenang danitanggung jawab utama untuk memberikan perawatan klinis kepada pasien dari satu pemberi asuhan ke pemberi asuhan lainnya (The Joint Commission Journal on Quality and Patient Safety, 2010). Pemberi asuhan yang

dimaksud adalah perawat. Menurut Keliat & Akemat, tahun 2012, handovermerupakan salah satu kegiatan komunikasi dan serah terima pekerjaan antara perawat yang berdianas pagi, siang, dan malam. Tujuan dari pelaksanaan handover adalah untuk memberikan informasi tentang kondisi pasien dan mempertahankan keselamatan pasien melalui penerapan komunikasi efektif sehingga dapat meningkatkan kualitas pelayanan yang ada di RS (KARS, 2017).

Pelaksanaan handover yang tidak efektif dapat mempengaruhi informasi kondisi dan keselamatan pasien. Hal ini dapat mengakibatkan kelalaian informasi penting terkait kondisi pasien dan keterlambatan dalam pemberian perawatan. Hal tersebut dapat menimbulkan bahaya bagi pasien bahkan berkontribusi dalam peningkatan kematian pasien (Saleem et al., 2015). Bahaya-bahaya yang muncul sebagian besar terjadi karena kurang efektifnya komunikasi antar petugas medis maupun tenagakesehatan lainnya (Zaboli et al., 2018). Penelitian lain juga menunjukan bahwa pelaksanaan handover yang baik berdampak pada baiknya pengelolaan obat oleh perawat selama masa pandemic Covid-19. Hal ini dipengaruhi oleh faktor pendidikaniterkahir perawat dan kemampuan komunikasi yang objektifantar perawat selama pelaksanaan handover (Cahyaningtyas et al., 2020).

2.2.2 Efek Handover dalam Shift jaga

Efek Psikososial Efek ini berpengeruh adanya gangguan kehidupan keluarga, efek fisiologis hilangnya waktuiluang, kecil kesempatan untuk berinteraksi dengan teman, dan mengganggu aktivitas kelompok dalam masyarakat.Saksono (2010)

mengemukakan pekerjaan malam berpengaruh terhadap kehidupan masyarakat yang biasanya dilakukan pada siang atau sore hari.Sementara pada saat itu bagi pekerja malam dipergunakan untuk istirahat atau tidur, sehingga tidak dapat berpartisipasi aktif dalam kegiatan tersebut, akibat tersisih dari lingkungan masyarakat.

Efek Terhadap Keselamatan Kerja Survei pengaruh shift kerja terhadap kesehatan dan keselamatan kerjaiyang dilakukan Smith et. Al, melaporkan bahwa frekuensi kecelakaan paling tinggi terjadi pada akhir rotasi shift kerja (malam) dengan rata-rata jumlah kecelakaan 0,69 % per tenaga kerja. Tetapi tidak semua penelitian menyebutkan bahwa kenaikan tingkat kecelakaan industri terjadi pada shift malam. Terdapat suatu kenyataan bahwa kecelakaan cenderung banyak terjadi selama shift pagi dan lebih banyak terjadi pada shift malam(Adiwardana, 2011),

2.2.3 Faktor-faktor kepemimpinan terhadap pelaksanaan perawat handover

Faktor-faktor yang mempengaruhi pelaksanaan handover adalah kepemimpinan. Kepemimpinan kepala ruang dalam pelaksanaan handover memiliki peranan yang penting secarailangsung dalam pelaksaaan handover (Istiningtyas & Wulandari, 2018). Hal tersebut juga sesuai dengan penelitian Kesrianti dan Noer (2014) yang menyatakan bahwa semakin baik kepemimpinan maka proses pelaksanaan handover akan semakin baik.Saat mengikuti handover, kelengkapan perawat sangat diperlukan untuk menjadikan penyampaian informasi yang lebih akurat dan jelas, sehingga tanggung jawab dan tugas dari masing-masing perawat bisa terlaksana dengan baik. Adanya dukungan teman sejawat akan menghasilkan kerjasama yang baik

danimenjadikan kerja tim lebih optimal dalam pelaksanaan handover (Nursalam, Detta Trinesa Et All Faktor – Faktor Yang Berhubungan Dengan Pelaksanaan Handover Perawat (448-457) LLDIKTI Wilayah X 450 2010).

Menurut Kesrianti dan Noer (2014), variabel dukungan rekan kerja berpengaruh terhadap pelaksanaan handover di[Instalasi Rawat Inap Rumah Sakit Universitas Hasanuddin. Menurut Ayuni, Almahdy, & Afriyanti (2019), dukungan teman sejawat berpengaruh terhadap pelaksanaan handover. Selain dukungan teman sejawat, ketersediaan sumber dayaijuga berhubungan dengan pelaksanaan handover. Istiningtyas, (2016), menyatakan bahwa segala sarana prasarana dan fasilitas yang mendukung terhadap pelaksanaan handover sangat membantu terhadap pelaksanaan handover dan terdapat hubungan yang bermakna antara sumberdayaidengan pelaksanaan handover. Menurut Nursalam (2010), sumberdaya sebagai pendukung pelaksanaan handover adalah SOP, kelengkapan perawat, dokumentasi handover, tempat diskusi, catatan pribadi, status pasienidan papan identifikasi. Istiningtyas (2016) menyatakan bahwa sumberdaya dalam pelaksanaan handover di RSUD Sukoharjo sebesar 43,3% berada dalam kategori kurang baik. Keterbaruan penelitian ini adalah bertujuan untuk mengetahui hubunganifaktor kepemimpinan kepala ruang, dukungan teman sejawat dan sumberdaya dengan pelaksanaan handover.

2.3 Persepsi perawat terhadap Gaya kepemimpinan

2.3.1 Persepsi

Persepsi adalah interpretasi dari apa yang dirasakan oleh individu dalam memahami informasi tentang lingkungannya Menurut Tjiptono, persepsi adalah penafsiran seseorang setelah melalui proses kognitif tentang apa yang dilihat, dirasakan, didengar, dialami atau dibaca, sehingga mempengaruhi perilaku, pandangan, serta perasaaniseseorang. Setiap individu dapat memiliki persepsi yang berbeda meskipun objeknya sama. Persepsi yang positif atau negatif akan ditunjukkan seseorang melalui kinerjanya. Persepsi menjadi sangat Jurnal Manajemen Kesehatan Indonesia Manajemen Kesehatan Manajemen Kesehatan Indonesia penting karena perilaku sesorang didasarkan pada persepsi mereka terhadap realitas itu, bukan mengenai realita itu sendiri. Setiap orang dapat mempunyai persepsi yang berbeda-beda, hal ini dikarenakan tingkat pendidikan yang berbeda-beda, sikap/perilaku pribadi, motivasi, kepentingan, minat, pengalaman dan harapan terhadap suatu yang dipersepsikan.

Persepsi sangat penting karena perilaku sesorang didasarkan pada persepsi mereka terhadap realitas itu, bukan mengenai realita itu sendiri . Seorang perawat dalam melakukan setiap tindakan sangat dipengaruhi oleh bagaimana persepsi perawat itu sendiri. Penerapan handover di Indonesia sendiri masih belum dilaksanakan secara baik. Berdasarkan hasil penelitian sebelumnya menunjukkan hasil bahwa pelaksanaan handover belum optimal dan masih banyak informasi/komponen yang dilewatkan

selama handover. Hal ini dikarenakan pandangan/pengetahuan yang berbeda-beda dari perawat. Hasil dari penelitian sebelumnya menyebutkan bahwa sebagian besar perawat menganggap handover tidak penting. Masing-masing perawat jugaimemiliki pandangan yang berbeda tentang pelaksanaan handover. Persepsi perawat terkait pelaksanaan handover bisa berbeda-beda setiap orangnya. Persepsi yang salah terkait pelaksanaan handover akan mempengaruhi proses komunikasi itu sendiri , persepsi yang positif atau negatif akan ditunjukkan seseorang melalui kinerjanya. Ketika perawat mempresepsikan handover itu tidaklah penting, maka perawat akan melakukan handover dengan seadanya dan tidak sesuai dengan standar. Dalam artian, persepsi perawat tentang pelaksanaan handover akan mempengaruhi pelaksanaan handover. Peran pemimpin juga sangat penting dalam mempengaruhi persepsi/pandangan para anggotanya. Karena keberhasilan suatu organisasi bergantung pada gaya kepemimpinan yang dipakai dalam organisasi tersebut.

2.3.2 Faktor yang mempengaruhi persepsi perawat

Gaya kepemimpinan seorang pemimpin menjadi model yang akan mengispirasi para bawahan. Keberhasilan organisasi dalam mencapai tujuan dan sasarannya tergantung pada pemimpin dan gaya kepemipinan yang diterapkannya. Kepemimpinan transformasional dinilaiilebih unggul daripada model kepemimpinan lainnya. Kepemimpinan transformasional merupakan proses mempengaruhi individu untuk mencapai tujuan organisasi dengan mendahulukan kepentingan organisasi. Pemimpin transformasional memilki kemampuan untuk menginspirasi para pengikutnya untuk

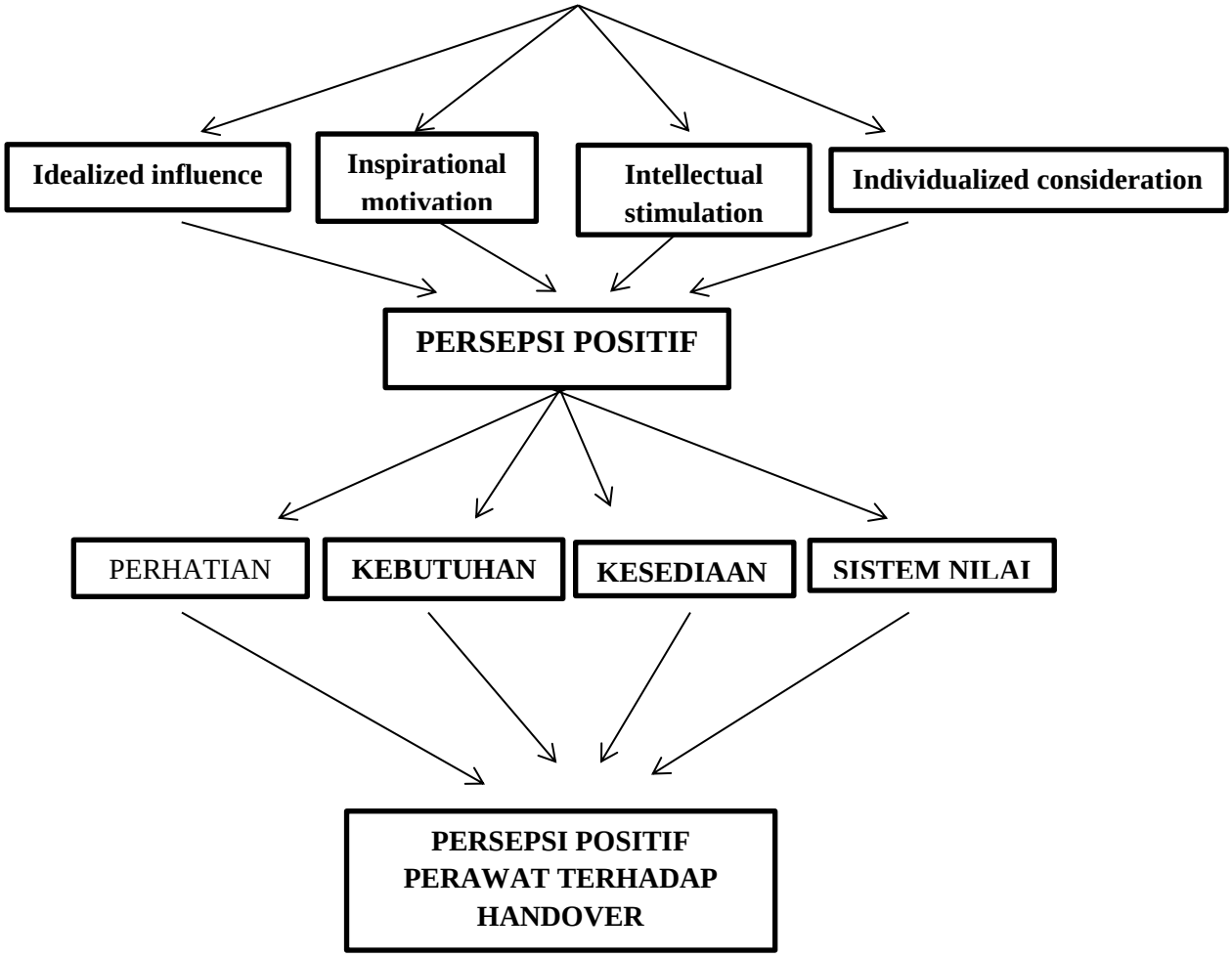
mengenyampingkan kepentingan pribadi mereka demi kebaikan organisasi dan mereka mampu memiliki pengaruh yang luar biasa pada diri para pengikutnya. 8–12 Robbins dan Judge menyatakan, pemimpin transformasional adalah pemimpin yang menginspirasi para pengikutnya untuk mengenyampingkan kepentingan pribadi mereka demi kebaikan organisasi dan mereka mampu memiliki pengaruh yang luar biasa pada diri para pengikutnya.

Menurut Arisandy (2003) faktor utama yang mempengaruhi persepsi adalah :

1) Perhatian, terjadinya persepsi pertama kali diawali oleh adanya perhatian, tidak secara bersamaan, perhatianikita tertujua pada satu atau dua objek yang menarik bagi kita
2) Kebutuhan, setiap orang mempunyai kebutuhan yang harus di penuhi, baik itu kebutuhan yang menetap maupun sesaat.
3) Kesediaan, adalah harapan seseorang terhadap suatu stimulus yang muncul, agar memberikan reaksi terhadap stimulus yang diterima lebih efisien sehingga akan lebih baik apabila orang tersebut telah siap terlebih dahulu.
4) Sitem nilai, sistem nilai yang berlaku dalam diri seseorang atau masyarakat akan berpengaruh terhadap persepsi seseorang

2.4 Kerangka Teori

KEPEMIMPINAN TRANSFORMASIONAL



Gambar 2.1 Diagram Kerangka Kerja *Literatur review* kepemimpinan tranformasional terhadap persepsi perawat tentang handover

BAB 3

METODE PENELITIAN

3.1 Disain Studi Penelitian

Disain penelitian adalah sebuah peta jalan bagi peneliti yang menuntun serta menentukan arah berlangsungnya proses penelitian secara benar dan tepat sesuai dengan tujuaniyang telah ditetapkan, tanpa disaign yang benar peneliti tidak akan dapat melakukan penelitian dengan baik karena yang bersangkutan tidak mempunyai pedoman arah yang jelas (Arikunto,2010).

Penelitian ini menggunakan jenis penelitian literati study literatur. Study literatur adalah penelitian kepustakaan yaitu teknik pengumpulan data dengan melakukanipenelaahan terhadap buku, literature, catatan, serta berbagai laporan yang berhubung dengan masalah (Sari and Asmendari, 2018). Penelitian ini menggunakan metode *Systematic Mapping Study (Scoping Study)* yaitu metode literature review yang sistematis dengan menggunakan tahapan-tahapan yang telah ditetapkan sebelumnya. Pemilihan pepper ini juga telah dilalukan secara subjektif oleh peneliti akan tetapi tetep menngunakan protokol filter yang telah ditetapkan diawal saat menentukan tujuan penelitian. Metode ini memiliki hasil berupa klaster dan kualifikasi dari temuan-temuan yang didapatkan dapa suatu topik penelitian.

3.2 Strategi Pencarian *Literature*

3.2.1 Protokol dan Registrasi

Rangkuman menyeluruh dalam bentuk *literature review* mengenai kepemimpinan transformasional dalam meningkatkan persepsi perawat terhadap *handover*. Protokolidan evaluasi dari *literature review* akan menggunakan ceklist

PRISMA sebagai upaya menentukan pemilihan studi yang telah ditemukan dan disesuaikan dengan tujuan dari *literature review* ini.

3.2.2 *Database* Pencarian

Penelitian ini merupakan *literature review*, dimana data dalam penelitian ini menggunakan data sekunder yang bukan diperoleh dari pengamatan langsung, akan tetapi diperoleh dari hasil penelitian yang telah dilakukan oleh peneliti terdahulu. Pencarian sumberidata sekunder dilakukan pada bulan Desember – Januari 2022 berupa artikel atau jurnal nasional dan jurnal internasional yang menggunakan *pubmed* dan Google Scholar.

3.2.3 Kata Kunci

Pencarian artikel atau jurnalimenggunakan *keyword* berbasis Boolean operator (AND, OR, NOT) yang digunakan untuk memperluas atau menspesifikan pencarian, sehinggaimempermudah dalam penentuan artikel atau jurnal yang digunakan. kata kunci dalam *literature review* ini disesuaikan dengan *Medical Subject Heading (MeSH)* dan terdiri sebagai berikut : "kepemimpinan transformasional*" OR "transformational leadership*" AND " peningaktan persepsi perawat*" OR* "*nurse perception improvement*" AND "peningaktan persepsi perawat dalam *handover*" OR *"improvement of nurses perception in handover.*

3.3 Kriteria Inklusi

Strategi yang digunakan dalam mencari artikel menggunakan PEOS *framework*, yaitu terdiri dari :

1) *Population/Problem* yaitu populasi atau masalah yang akan di analisis sesuai dengan tema yang sudah ditentukan dalam *literature review*.
2) *Ekprosure* yaitu suatu tindakan penatalaksanaan terhadap kasus perorangan ataupun masyarakat serta pemaparan tentang penatalaksanaan studi sesuai dengan tema yang sudah ditentukan dalam *literature review*.
3) *Outcome* yaitu hasil atau luaran yang diperoleh pada studi terdahulu yang sesuai dengan tema yang sudah ditentukan dalam *literature review*.
4) *Study design* yaitu Desain penelitian yang digunakan oleh jurnal yang akan di *review*. Desain dari *literatur review* adalah seluruhnya berjenis kuantitatif.

Tabel 3.2 Format *PEOS* dalam *Literature Review*

Kriteria	Inklusi
Population/ Problem	Artikel yang terkait perawat dalam Handover di rumah sakit.
Ekprosure	Kepemimpinan transformasional .
Outcome	Ada tidaknya peningkatkan persepsi perawat tentang *handover* di Rumah sakit
Study design	*case control*
Tahun Terbit	Artikel 2017-2021

3.4 Seleksi Studi dan Penilaian Kualitas

Analisis kualitas metodologi dalam setiap studi (n = 5) dengan *Checklist* daftar penilaian dengan beberapa pertanyaan untuk menilai kualitas dari studi. Penilaian kriteria diberi nilai „ya“, „tidak“, „tidak jelas“ atau „tidak berlaku“ dan setiap kriteria

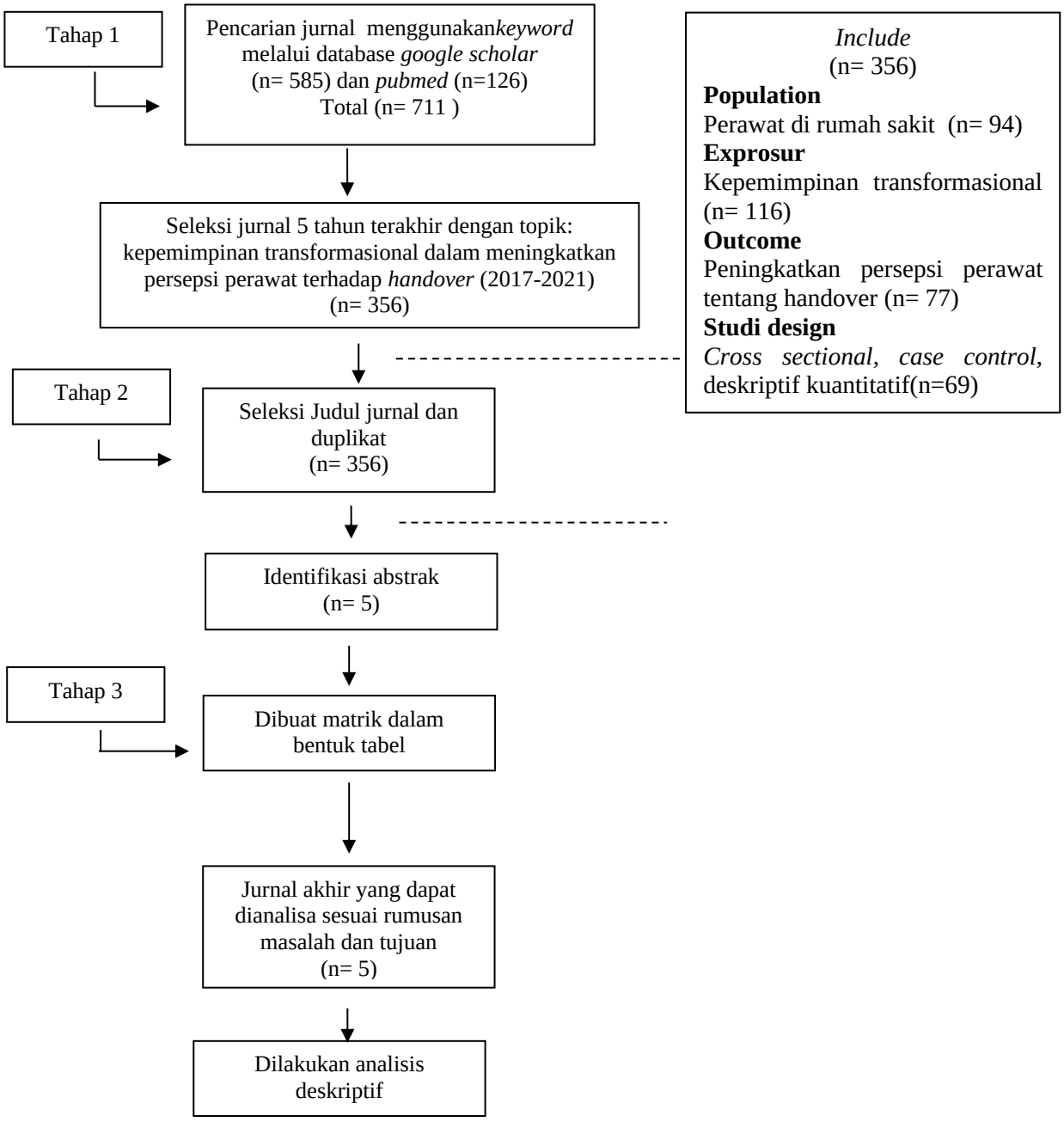
dengan skor „ya‟ diberi satu point dan nilai lainnya adalah nol, setiap skor studi kemudian dihitung dan dijumlahkan. *Critical apprasial* dengan nilai titik *cut-of* yang telahidisepakati oleh peneliti, studi dimasukkan ke dalam kriteria inklusi. Penel iti mengecualikan studi yang berkualitas rendah untuk menghindari bias dalam validitasihasil dan rekomendasi ulasan. Dalam skrining terakhir, 5 studi mencapai skor lebih tinggi dari 50% dan siap untuk melakukan sintesis. Risiko bias dalam *literature review* ini menggunakan *asesmen* pada metode penilaian masing-masing studi, yang terdiri dari (Nursalam,2020):

1) Teori: teori yang tidak sesuai, sudah kadaluarsa, dan kredibilitas yang kurang
2) Desain: desain kurang sesuai dengan tujuan penelitian
3) Sample: ada empat hal yang harus diperhatikan yaitu populasi, sampel, sampling, dan besar sampel yang tidak sesuai dengan kaidah pengambilan sampel
4) Variabel: variabel yang ditetapkan kurang sesuai dari segi jumlah, pengontrolan variabel perancu, dan variabel lainnya.
5) Instrument: Instrumen yang digunakan tidak memiliki sensitivitas, spesivikasi dan validitas-reabilitas
6) Analisa Data: Analisa data tidak sesuai dengan kaidah analisis yang sesuai dengan standar.

3.5 Hasil pencarian dan seleksi study

Berdasarkan hasil pencarian *literature* melalui publikasi di dua *database* dan menggunakan kata kunci yang sudah disesuaikan dengan MeSH, peneliti

mendapatkanimelalui database *google scholar* dan *pubmed* sebanyak 711 artikel yang sesuai dengan kata kunci tersebut. Hasil pencarian yang sudah didapatkan kemudian diperiksa 5 tahun terakhir dan didapatkan sebanyak 356 artikel.Hasil pencaharian yangisudah didapatkan kemudian diperiksa kembali terkait duplikasi. Diskrining kembali sesuai dengan *PEOS* mendapatkan 345 artikel, kemudian dilakukan penilaian *critical appraisal* memenuhi kriteria diatas 50% dan disesuaikan dengan tema *literature review* mendapatkan 7 artikel. *Assessment* yang dilakukan berdasarkan kelayakan terhadap kriteria inklusi dan eksklusi didapatkan sebanyak 5 artikel yang bisa dipergunakan dalam *literature review*.Hasil seleksi artikel studi dapat digambarkan dalam Diagram Alur.



Gambar 3.1 Diagram Kerangka Kerja *Literatur review* kepemimpinan tranformasional terhadap persepsi perawat dalam handover

BAB 4
HASIL DAN ANALISA

4.1 Hasil

4.1.1 Karakteristik Studi

Hasil penelusuran artikel pada penelitian berdasarkan literature review dengan judul "kepemimpinan tranformasional terhadap persepsi perawat dalam handover" didapatkan lima artikel. Berikut ini hasil analisis artikel yang ditampilkan dalam bentuk tabel sebagai berikut:

Tabel 4.1 Rencana hasil review

No	Author Dan Tahun	Sumber Artikel (Nama Jurnal, No. Jurnal)	Judul	Metode Penelitian (Desain, Populasi, Sample,Sampling Tempat Waktu, Variable, Instrumen, Analisis Data)	Hasil Penelitian	Database
1	Lina W (2018)	Psikovedia Volume 18 No 1	Peran Kepemimpinan Transformasional dalam Meningkatkan Persepsi Perawat terhadap Handover	**Desain Penelitian** *cross-sectional* **Sampel** 15 Perawat **Teknik Sampling** *Simple Random Sampling* **Variabel Penelitian** Kepemimpinan transformasional, Peningkatkan persepsi perawat tentang *handover* **Instrument** **Pengumpulan data** kuisioner **Analisa Data** uji korelasi *product moment* .	Hasil penelitian menyebutkan dengan p = 0,000 dinyatakan sangat signifikan, artinya ada hubungan Kepemimpinan Transformasional dalam Meningkatkan Persepsi Perawat terhadap Handover	*Google Shcolar*
2	Ragita Septyan	-	Hubungan Kepemimpinan	**Desain Penelitian** correlational research	Hasil Hasil penelitian menunjukkan p = 0,000	*Google Shcolar*

	a Cahyani (2021)		Dengan persepsi perawat saat Komunikasi SBAR Saat Timbang Terima Di Ruang rawat Inap RSUD Simo Boyolali	**Sampel** 60 responden **Teknik Sampling** *Simple Random Sampling* **Variabel Penelitian** Kepemimpinan transformasional, Peningkatkan persepsi perawat tentang *handover* **Instrument Pengumpulan data** kuisioner **Analisa Data** uji *chisquare*	bahwa terdapat Hubungan Kepemimpinan Dengan persepsi perawat saat Komunikasi SBAR Saat Timbang Terima Di Ruang rawat Inap RSUD Simo Boyolali	
3	Ayu Nuraini Soleha (2021)	jurnal Kepemimpinan dan Manajemen Keperawatan, Vol 4No 2	Pengaruh Kepemimpinan dalam Handover Perawat Terhadap Insiden Keselamatan Pasien	**Desain Penelitian** *cross sectional* **Sampel** 111 responden **Teknik Sampling** *Total sampling* **Variabel Penelitian** Kepemimpinan transformasional, Peningkatkan persepsi perawat tentang *handover* **Instrument Pengumpulan data** kuesioner **Analisa Data** -	Hasil penelitian menunjukkan dengan p = 0,000 dinyatakan bahwa terdapat Pengaruh Kepemimpinan dalam Handover Perawat Terhadap Insiden Keselamatan Pasien .	*Google Shcolar*
4	wawan pradana (2019)	Open Journal Systems Vol.14 No.4	Pengaruh Kepemimpinan Transformasional, Kepuasan Kerja, terhadap persepsi perawat saat timbang terima	**Desain Penelitian** *cross-sectional* **Sampel** 75 responden **Teknik Sampling** *Simple Random Sampling* **Variabel Penelitian** Kepemimpinan transformasional, Peningkatkan persepsi perawat tentang *handover*	Hasil penelitian menunjukan nilai signifikansi F dengan α (0,05). yang berarti terdapat Pengaruh Kepemimpinan Transformasional, Kepuasan Kerja, terhadap persepsi perawat saat timbang terima	*Google Shcolar*

				Instrument **Pengumpulan data** kuisioner **Analisa Data** Uji Chi-Square.		
5	Dewi B (2022)	-	*Transformational Leadership Meets Innovative Strategy: How Nurse Leaders and Clinical Nurses Redesigned Bedside Handover to Improve Nursing Practice*	**Desain Penelitian** *cross-sectional* **Sampel** 186 responden **Teknik Sampling** *Simple Random Sampling* **Variabel Penelitian** Kepemimpinan transformasional, terhadap persepsi perawat tentang *handover* **Instrument** **Pengumpulan data** kuisioner **Analisa Data** uji *chi square* dan *risk estimate.* .	Hasil penelitian menunjukkan bahwa nilai signifikan (p<.001) yang artinya terdapat hubungan antara kepememimpinan Transformasional terhadap persepsi perawat saat timbang terima.	*Pubmed*

4.1.2 Karakteristik Responden Studi

Karakteristik responden berdasarkan usia, dan jenis kelamin dari kelima artikel yang didapat yakni :

a.Usia

Tabel 4.2 Karakteristik Responden Berdasarkan Usia

Artikel	**26-35 Tahun n (%)**	**36-45 Tahun n (%)**	**46-55 Tahun n (%)**	**56 -atas n (%)**
1	2 (6,7%)	7 (23,3%)	9 (30,0%)	12 (40,0%)
2	0%	0%	0%	0%
3	0%	0%	0%	0%
4	0%	0%	0%	0%
5	8 (11,3%)	23 (32,9%)	25 (35,7%)	9 (12,2%)

Berdasarkan tabel 4.2 didapatkan bahwa dari lima artikel, artikel satu usia responden yaitu 56 tahun ke atas (40,0%), artikel dua tidak menjelaskan tentang usia responden, artikel tiga tidak menjelaskan tentang usia responden, artikel empat tidak menjelaskan tentang usia responden, artikel lima usia responden yaitu 46-55 tahun ke atas (35,7%).

b. Jenis Kelamin

Tabel 4.3 Karakteristik Responden Berdasarkan Jenis Kelamin

No	Penulis dan Tahun Terbit	Jenis Kelamin responden	Jumlah	%
11	Lina W (2018)	Laki-laki	14	46,7%
		Perempuan	16	53,3%
2	Ragita Septyana Cahyani (2021)	Laki-laki	0	0
		Perempuan	0	0
3	Ayu Nuraini Soleh (2021)	Laki-laki	0	4,37%
		Perempuan	0	4,57%
4	wawan pradana (2019)	Laki-laki	0	0
		Perempuan	0	0
5	Dewi B (2022)	Laki-laki	20	31,1%
		Perempuan	48	68,8%

Berdasarkan tabel 4.3 didapatkan hasil dari lima artikel didapatkan dari artikel satu mayoritas responden berjenis kelamin perempuan,

4.2 Analisis

4.2.1 Perilaku Kepemimpinan Transformasional

Hasil review pada 5 artikel disampaikan secara deskriptif mengenai Kepemimpinan Transformasional sesuai dengan artikel yang direview dapat dilihat pada tabel berikut:

Tabel 4.4 Kepemimpinan Transformasional

No	Penulis dan Tahun Terbit	Kepemimpinan Transformasional	Jumlah (N)	%
1	Lina W (2018)	Baik	16	53,3
		kurang	0	0
		cukup	14	46,7

2	Ragita Septyana Cahyani (2021)	Baik Kurang	44 27	62 38
3	Ayu Nuraini Soleh (2021)	Baik Kurang	26 13	60,4 40.2
4	wawan pradana (2019)	Baik Kurang	67 13	83,8 16,2
5	Dewi B (2022)	Baik Kurang	15 55	21,4 76,8

Berdasarkan tabel 4.4 di dapatkan hasil artikel satu menyatakan mayoritas Kepemimpinan Transformasional dengan kategori baik, artikel dua mayoritas Kepemimpinan Transformasional dengan kategori baik, artikel tiga mayoritas Kepemimpinan Transformasional dengan kategori baik, artikel empat mayoritas Kepemimpinan Transformasional dengan kategori *baik* artikel lima mayoritas Kepemimpinan Transformasional dengan kategori kurang.

4.2.2 identifikas persepsi perawat dalam handover

Hasil review pada 5 artikel disampaikan secara deskriptif mengenai perawat dalam handover sesuai dengan artikel yang direview dapat dilihat pada tabel berikut:

Tabel 4.5 perawat dalam handover

No	Penulis dan Tahun Terbit	perawat dalam handover	Jumlah (N)	%
1	Lina W (2018)	Baik cukup kurang	11 10 9	36,7 33,3 30,0
2	Ragita Septyana Cahyani (2021)	Baik cukup kurang	11 36 17	15,5 50,7 28,9
3	Ayu Nuraini Soleh (2021)	Baik Cukup	12 20	51,9

				48,6
4	wawan pradana (2019)	Baik cukup kurang	13 48 19	16,2 60,0 23,8
5	Dewi B (2022)	Baik Cukup	10 60	14,3 76,8

Berdasarkan tabel 4.5 di dapatkan hasil artikel satu menyatakan mayoritas perawat dalam handover dengan kategori baik artikel dua mayoritas perawat dalam handover dengan kategori baik, artikel tiga mayoritas perawat dalam handover dengan kategori baik artikel empat mayoritas perawat dalam handover dengan kategori cukup, artikel lima mayoritas tingkat perawat dalam handover dengan kategori baik.

4.2.3 Pengaruh Kepemimpinan Tranformasional Tehadapa Persepsi Perawat Dalam Handover

Hasil review pada 5 artikel disampaikan secara deskriptif Pengaruh Kepemimpinan Tranformasional Tehadapa Persepsi Perawat Dalam Handover sesuai dengan artikel yang direview dapat dilihat pada tabel berikut:

Tabel 4.6 Pengaruh Kepemimpinan Tranformasional Tehadapa Persepsi Perawat Dalam Handover

No	Penulis dan Tahun Terbit	Hasil Temuan
1	Lina W (2018)	Hasil penelitian menyebutkan dengan p = 0,000 dinyatakan sangat signifikan, artinya ada hubungan Kepemimpinan Transformasional dalam Meningkatkan Persepsi Perawat terhadap Handover
2	Febria Rizky Aulia (2020)	Hasil Hasil penelitian menunjukkan bahwa kepemimpinan transformasional mempunyai peran yang positif terhadap persepsi para perawat dalam melakukan handover.
3	Dewi B (2020)	Hasil penelitian menunjukkan dengan p = 0,000 dinyatakan bahwa terdapat Pengaruh Gaya Kepemimpinan Transformasional Pada persepsi kinerja perawat saat melakukan handover dengan SBAR

4	wawan pradana (2019)	Hasil penelitian menunjukan nilai signifikansi F dengan α (0,05). yang berarti terdapat Pengaruh Kepemimpinan Transformasional, Kepuasan Kerja, terhadap persepsi perawat saat timbang terima
5	Bilkis Akter, Dr Arayna Chaowalit	Hasil penelitian menunjukkan bahwa masing-masing dimensi harapan perawat terhadap kepemimpinan transformasional supervisor perawat secara signifikan lebih tinggi daripada persepsi perawat (p<.001).

Berdasarkan tabel 4.6 hasil analisis lima artikel didapatkan bahwa lima artikel menunjukkan nilai *p value* < 0,05 dan dapat disimpulkan bahwa terdapat Pengaruh Kepemimpinan Tranformasional Tehadapa Persepsi Perawat Dalam Handover.

BAB 5

PEMBAHASAN

5.1 Pembahasan

5.1.1 Identifikasi Gaya Kepemimpinan Transformasional

Berdasarkan tabel di dapatkan hasil artikel satu menyatakan mayoritas Kepemimpinan Transformasional dengan kategori baik, artikel dua mayoritas Kepemimpinan Transformasional dengan kategori baik, artikel tiga mayoritas Kepemimpinan Transformasional dengan kategori baik, artikel empat mayoritas Kepemimpinan Transformasional dengan kategori *baik* artikel lima mayoritas Kepemimpinan Transformasional dengan kategori kurang.

Secara teori menyatakan kepemimpinan transformasional dinilai lebih unggul daripada model kepemimpinan lainnya. Kepemimpinan transformasional merupakan proses mempengaruhi individu untuk mencapai tujuan organisasi dengan mendahulukan kepentingan organisasi (Baihaqi, 2017). Pemimpin transformasional memilki kemampuan untuk menginspirasi para pengikutnya untuk mengenyampingkan kepentingan pribadi mereka demi kebaikan organisasi dan mereka mampu memiliki pengaruh yang luar biasa pada diri para pengikutnya (Nailil, 2018). Menurut Robbins dan Judge (2016) menyatakan, pemimpin transformasional adalah pemimpin yang menginspirasi para pengikutnya untuk mengenyampingkan kepentingan pribadi mereka demi kebaikan organisasi dan mereka mampu memiliki pengaruh yang luar biasa pada diri para pengikutnya.

Penerapan kepemimpinan transformasional berpengaruh terhadap soft skill perawat (pengetahuan dan pengalaman). Ini dibuktikan dengan penelitian yang dilakukan oleh Tri Hartiti (2019) yang menyatakan bahwa kepemimpinan transformasional mempunyai korelasi terhadap soft skill perawat pelaksana dalam hal kemampuan beradaptasi, kemampuan berkomunikasi, kemampuan bekerjasama tim, dan ketelitian. Penerapan gaya kepemimpinan transformasional ini, maka pemimpin dapat memberikan contoh, motivasi, pengharapannya, dan pandangannya terhadap pelaksanaan handover. Peningkatan persepsi perawat terhadap pelaksanaan handover itu sendiri, maka pelaksanaan handoverpun akan lebih baik dan lebih optimal. Terlewatnya komponen saat pelaporan, kesalahan pelaporan pasien, dan durasi waktu yang lama saat pelaporan tidak akan ada lagi. Semakin pemimpin transformasional mampu menginspirasi para perawat terkait pelaksanaan handover, maka semakin baik persepsi perawat terhadap pelaksanaan handover, dan semakin baik pula pelaksanaan handover itu sendiri (Gunawan, 2017).

Opini peneliti menyebutkan bahwa kepemimpinan transformasional mempunyai peran yang positif terhadap persepsi para perawat. Gaya kepemimpinan transformasional ini bisa dijadikan sebuah solusi dan sangat disarankan untuk digunakan oleh para manajer/kepala ruang sebagai salah satu solusi untuk meningkatkan persepsi perawat. Pemimpin transformasional dapat memberikan contoh, motivasi, pengharapannya, dan pandangannya terhadap pelaksanaan handover melalui keempat unsur kepemimpinan transformasional.

Pemimpin transformasional memilki kemampuan untuk menginspirasi para pengikutnya dan memiliki pengaruh yang luar biasa pada pengikutnya, diharapkan melalui penerapan kepemimpinan transformasional ini dapat meningkatkan persepsi perawat dan kualitas handover dapat meningkat.

5.1.2 Identifikasi Kinerja Perawat Dalam Handover

Berdasarkan tabel di dapatkan hasil artikel satu menyatakan mayoritas perawat dalam handover dengan kategori baik artikel dua mayoritas perawat dalam handover dengan kategori baik, artikel tiga mayoritas perawat dalam handover dengan kategori baik artikel empat mayoritas perawat dalam handover dengan kategori cukup, artikel lima mayoritas tingkat perawat dalam handover dengan kategori baik.

Secara teori menyatakan bahwa pelayanan keperawatan yang bermutu merupakan tujuan yang ingin dicapai oleh perawat. Pelayanan keperawatan yang bermutu memerlukan tenaga profesional yang didukung oleh faktor eksternal. Salah satu faktor eksternal tersebut ialah peran pemimpin atau manager. Salah satu peranan pimpinan ialah menerapkan sistem atau timbang terima pasien. Timbang terima merupakan komunikasi yang dilakukan perawat saat pergantian dinas. Masing-masing perawat berperan sesuai dengan kewenangan dan tanggung jawab masing-masing. Profesionalisme pelayanan keperawatan di rumah sakit dapat ditingkatkan melalui pengoptimalan peran dan fungsi perawat khususnya pelayanan keperawatan mandiri (Manado, 2017). Disiplin kerja dapat diartikan apabila karyawan selalu datang dan pulang

tepat pada waktunya, mengerjakan seluruh pekerjaan dengan baik, mematuhi norma dan aturan yang berlaku (Hasibuan, 2015). Ada beberapa faktor yang berhubungan dengan disiplin kerja diantaranya yaitu tujuan dan kemampuan, keteladanan pemimpin, balas jasa, keadilan, pengawasan, sanksi hukuman, ketegasan dan hubungan kemanusiaan (Setiawati, 2016).

Dampak dari timbang terima yang tidak optimal dapat menimbulkan kesalahan informasi antar perawat dan perawat dengan pasien, kesalahpahaman tentang intervensi atau rencana keperawatan, kehilangan informasi, kesalahan pada tes penunjang, kesalahan dalam pemberian obat dan potensial resiko dapat mengakibatkan cidera terhadap pasien dan akhirnya berdampak pada kesinambungan pelayanan keperawatan serta sasaran keselamatan pasien (Nursalam, 2014).

Opini peneliti menyebutkan semakin baik kepemimpinan maka proses pelaksanaan handover akan semakin baik. Saat mengikuti handover, kelengkapan perawat sangat diperlukan untuk menjadikan penyampaian informasi yang lebih akurat dan jelas, sehingga tanggung jawab dan tugas dari masing-masing perawat bisa terlaksana dengan baik. dengan kepemimpinan kepala ruang yang baik maka akan mempengaruhi terhadap pelaksanaan handover. Kepala ruang yang memiliki kepemimpinan yang baik akan berperan aktif dalam melaksanakan handover dan membimbing serta memberikan perhatian dan motivasi kepada perawat / anggotanya untuk selalu melaksanakan handover dengan baik, penuh tanggung jawab dan sesuai dengan prosedur.

Kepala ruang yang memiliki kepemimpinan dengan baik akan dapat membantu dalam memperbaiki kualitas perawatan pasien, juga memperbaiki lingkungan kerja perawat dan profesional lainnya.

5.1.3 Pengaruh Kepemimpinan Tranformasional Tehadap Persepsi Perawat Dalam Handover

Berdasarkan tabel hasil analisis lima artikel didapatkan bahwa lima artikel menunjukkan nilai *p value* < 0,05 dan dapat disimpulkan bahwa terdapat Pengaruh Kepemimpinan Tranformasional Tehadapa Persepsi Perawat Dalam Handover.

Secara teori menyebutkan gaya kepemimpinan transformasional menjadikan para pengikut merasakan kepercayaan, kekaguman, kesetiaan dan penghormatan terhadap pemimpin dan mereka termotivasi untuk melakukan lebih daripada yang semula diharapkan dari mereka. Dari sinilah perlu adanya gaya kepemimpianan transformasional dibandingkan dengan gaya kepemimpinan yang lainnya. Menurut Robbins (2018) gaya kepemimpinan transformasional merupakan pemimpin yang mampu memberi inspirasi karyawannya untuk lebih mengutamakan kemajuan organisasi dari pada kepentingan pribadi, memberikan perhatian yang baik terhadap karyawan dan mampu merubah kesadaran karyawannya dalam melihat permasalahan lama dengan cara yang baru (Hirayki, 2019).

Kegiatan komunikasi yang sering terjadi di dunia pelayanan kesehatan adalah kegiatan serah terima atau handover. Handover merupakan proses

komunikasi antara shift perawat untuk memberikan informasi yang berkaitan dengan pasien dan kelanjutan perawatan pasien. Fakta menunjukkan bahwa komunikasi yang kurang efektif selama handover dapat meningkatkan resiko medication error, ketidakpuasan pasien, penundaan terapi dan membuat waktu perawatan lebih lama (Nuriah, 2016). Persepsi perawat terkait pelaksanaan handover bisa berbeda-beda setiap orangnya. Persepsi yang salah terkait pelaksanaan handover akan mempengaruhi proses komunikasi itu sendiri , persepsi yang positif atau negatif akan ditunjukkan seseorang melalui kinerjanya. Ketika perawat mempresepsikan handover itu tidaklah penting, maka perawat akan melakukan handover dengan seadanya dan tidak sesuai dengan standar. Dalam artian, persepsi perawat tentang pelaksanaan handover akan mempengaruhi pelaksanaan handover (Andrika, 2018).

Opini peneliti menyebutkan gaya kepemimpinan transformasional adalah pemimpin yang dapat memotivasi karyawan untuk tercapainya kesuksesan dalam bekerja supaya memiliki pengertian yang kuat dalam memberikan visi masa depan dalam organisasi dan memanifestasikan inspirasi yang menggairahkan sebagai perilaku model kepemimpinan yang sesuai. kepemimpinan transformasional dapat meningkatkan pengharapan perawat, dikarenakan kepemimpinan transformasional berkenaan dengan pengaruh pemimpin terhadap anggotanya. Para anggota merasakan adanya kepercayaan, kebanggaan, loyalitas dan rasa respek terhadap pemimpin dan mereka termotivasi untuk melakukan melebihi apa yang diharapkan.

BAB 6

KESIMPULAN

6.1 Kesimpulan

1) Hasil review artikel tantang Kepemimpinan Tranformasional menyatakan kategori baik.

2) Hasil review artikel tantang Persepsi Perawat Dalam Handover menunjukan kategori baik
3) Berdasarkan hasil penelitian yang telah di review terdapat pengaruh kepemimpinan tranformasional tehadapa persepsi perawat dalam handover.

6.2 Saran

6.2.1 Bagi Peneliti

Hasil *literature review* ini dapat digunakan menjadi rujukan, sumber informasi, dan bahan referensi penelitian selanjutnya agar bisa lebih dikembangkan dalam materi - materi yang lainnya untuk melakukan asuhan keperawatan dengan meningkatkan persepsi perawat dalam handover.

6.2.2 Bagi Institusi pendidikan keperawatan

Hasil *literatur review* ini dapat menambah bahan referensi bagi instusi pendidikan mengenai kepemimpinan tranformasional tehadapa persepsi perawat dalam handover.

6.2.3 Bagi tenaga kesehatan

Hasil *literatur review* ini bisa di terapkan kepada perawat di rumah sakit saat melakukan handover dengan menggunakan metode kepemimpinan tranformasional tehadapa persepsi perawat.

DAFTAR PUSTAKA

Akter, B., Chaowalit, A., & Nasae, T. (2010). Moral behaviours of nurse supervisors expected and perceived by nurses in Bangladesh. *2nd International Conference on Humanities and Social Sciences*, 1–13.

Alzahrani, S., & Hasan, A. A. (2019). Transformational Leadership Style on Nursing Job Satisfaction Amongst Nurses in Hospital Settings: Findings From Systematic

Review. *Global Journal of Health Science*, *11*(6), 25. https://doi.org/10.5539/gjhs.v11n6p25

Bardah, D., Afriani, T., & Yatnikasari, A. (2021).Analisis Fishbone dalam Meningkatkan Efektifitas Pelaksanaan Handover Di Rumah Sakit Pemerintah.*Jurnal Kepemimpinan Dan Manajemen Keperawatan*, *4*(1). https://doi.org/10.32584/jkmk.v4i1.917

Detta, T., Arif, Y., & Dewi, M. (2020).Faktor–Faktor yang Berhubungan Dengan Pelaksanaan Handover Perawat.*Jurnal Endurance: Kajian Ilmiah …*, *5*(3), 448–457. Retrieved from http://ejournal.lldikti10.id/index.php/endurance/article/view/5283

Kamil, H. (2011). Handover Dalam Pelayanan Keperawatan. *Idea Nursing Journal*, *2*(3). https://doi.org/10.52199/inj.v2i3.6491

Kepemimpinan, H., Ruangan, K., Kedisiplinan, D. A. N., Noer, R. M., Hidayah, J., Agusthia, M., … Rawat, R. (2021). DI RUANG RAWAT INAP mempengaruhi pikiran dan tindakan orang lain,*11*(2).

Mahendra, K., & Mujiati, N. (2015).Pengaruh Kepemimpinan Transformasional, Disiplin Kerja, Dan Burnout Pada Kinerja Karyawan Arma Museum and Resort.*E-Jurnal Manajemen Universitas Udayana*, *4*(10), 255182.

Narsa, I. M. (2011). KARAKTERISTIK KEPEMIMPINAN: Transformasional versus Transaksional. *Jurnal Manajemen Dan Kewirausahaan*, *14*(2). https://doi.org/10.9744/jmk.14.2.102-108

Penerapan, D. A. N. (2021). HIGH ALERT MEDICATION SESUDAH PELATIHAN, *8*(2).

Andira dan Subroto B. (2017).Pengaruh Perilaku Kepemimpinan dan Transaksional terhadap Kinerja Karyawan Lini Depan Perusahaan Jasa. Tesis Tidak dipublikasikan: Malang. Ilmu Manajemen Program Pascasarjana Universitas Brawijaya.

Afif, M.U. (2017). Hubungan kemampuan kepala ruang dalam penjadwalan sistem kerja shift tenaga perawat dengan kinerja perawat di bangsal rawat inap RSISA Semarang.Program studi S1 fakutas ilmu keperawatan unissula. Tidak dipublikasikan

Arikunto, S. (2017). Manajemen Penelitian. Jakarta: Rineka Cipta.

Aminuddin, L. (2015).Hubungan budaya organisasi dengan kinerja perawat di RSUD Kota Semarang. Program studi S1 fakultas ilmu keperawatan unissula. Tidak dipublikasikan

Anjaryani dan Diah W. (2019). Kepuasan pasien rawat inap terhadap pelayanan perawat di RSU Tugurejo Semarang. Tesis. Semarang: UNDIP. Diakses 14 Maret 2012. http//eprints.undip.ac.id/23824/1/WIKEDIAHNJARYANI

Arjuna. (2012). Pengaruh kepemimpinan tranformasional dan transaksional kepala ruang terhadap kinerja perawat di RS PKU Muhammadiyah Bantul. Tesis. Yogyakarta: UMY

Arofiati, Fitri dan Wahyuni. (2018). Hubungan antara Tingkat Pengetahuan Perawat tentang Kode Etik Keperawatan dan Hukum Kesehatan dengan Kinerja Perawat dalam Memberikan Asuhan Keperawatan di RS. PKU Muhammadiyah Yogyakarta Tahun 2009. Jurnal Kesehatan Suara Forikes. Vol 11 (No. 2) Hal 117.

Dharmayanti, Elmasari.(2016). Kepemimpinan Transformasional dan Minat Kerja sebagai Prediktor Komitmen Organisasi pada Pegawai Dinas Pendapatan Daerah Provinsi Riau. Jurnal Psikologi. Vol 5 (No. 2) Hal 201.

Harsiwi, Agung. M. (2019). Hubungan kepemimpinan transformasional dari karakteristik personal pemimpin. Yogyakarta: Artikel

Humairah. (2015). Hubungan Gaya Kepemimpinan Transformasional dan Transaksional terhadap Efektifitas Kinerja Perawat di Rumah Sakit Jantung Harapan Kita. Tesis Tidak dipublikasikan. Yogyakarta: Program Pascasarjana Universitas Gajah Mada

Hidajah U, Harnida H. Peran Komunikasi SBAR Dalam Pelaksanaan Handover di Ruang Rawat Inap RSPS. J Keperawatan dan Kebidanan. 2016;72–81.

Haryanti T, Pujianto TI, Adinatha NN. Analisis Pengaruh Persepsi Perawat Pelaksana Tentang Fungsi Manajerial Kepala Ruang Terhadap Pendokumentasian Asuhan Keperawatan Di Ruang Rawat Inap Rumah Sakit Swasta Di Semarang. J Manaj Keperawatan. 2013;1(2):131–7.

Astuti N, Ilmi B. Penerapan Komunikasi Situation, Background, Assesment, Recomendation (SBAR) Pada Perawat Dalam Melaksanakan Handover. J Nurs Pract. 2019;3(1):42–51. 6.

Dewi Arianti N. Gambaran Komunikasi SBAR Saat Transfer Pasien Pada Perawat Di RSUD K.R.M.T. Wongsonegoro. Universitas Diponegoro; 2017. 7.

Nursalam. Manajemen Keperawatan Aplikasi Keperawatan Profesional Edisi 4. 2014;342.

Suweko H, Dwiantoro L. Kepemimpinan Transformasional Dalam Meningkatkan Kepuasan Kerja Perawat. J Ilmu Keperawatan dan Kebidanan. 2011;2011(1):71–85

Elmonita Y, Dwiantoro L. Transformasional leadership dalam meningkatkan perilaku edukatif perawat dalam pelayanan. Semin Nas dan Call Pap [Internet]. 2017;182–91. Available from: http://eprints.undip.ac.id/61162/1/12.p df 15

Savitri AD. Pengaruh Gaya Kepemimpinan Transformasional Terhadap Motivasi Kerja Perawat Di Instalasi Rawat Inap (Irna) II RSUD Dr. Saiful Anwar Malang. 2014;18(1). 16.

Arifiani R, Astuti E, Ruhana I. Pengaruh Kepemimpinan Transformasional Terhadap Organizational Citizenship Behavior Dan Kepuasan Kerja (Studi pada Tenaga Perawat RSUD. Dr. Saiful Anwar Malang). J Adm Bisnis S1 Univ Brawijaya. 2016;33(1):127–35.

Prayudi, A. (2020). Pengaruh Gaya Kepemimpinan Transformasional Terhadap Kinerja Karyawan Dengan Motivasi Kerja Sebagai Variabel Intervening (Studi Pada Karyawan PD. Pembangunan Kota Binjai).*Jurnal Manajemen*, *6*(2), 64–72.

S.E., M. (2017).Pengaruh Gaya Kepemimpinan Transformasional Dan Disiplin Kerja Terhadap Kinerja Pegawai.*Bisma: Jurnal Manajemen*, *5*(1), 9–16. https://doi.org/10.23887/bjm.v5i1.21976

Suweko, H., & Dwiantoro, L. (2020). Kepemimpinan Transformasional Dalam Meningkatkan Kepuasan Kerja Perawat: Literature Review. *Jurnal Ilmu Keperawatan Dan Kebidanan*, *11*(1), 106. https://doi.org/10.26751/jikk.v11i1.775

Willy Yuberto Andrisma, S. .(2007). Metadata, citation and similar papers at core.ac.u 1.*Pembagian Harta Waris Dalam Adat Tionghoa Di Kecamatan Ilir Timur I Kota Palembang*, *1*(14 June 2007), 1–13. Retrieved from https://core.ac.uk/download/pdf/11715904.pdf

LAMPIRAN 1 JADWAL KEGIATAN PENELITIAN

Kegiatan	**Sept**	**Okt**	**Nov**	**Des**	**Jan**	**Feb**	**Mar**	**Apr**	**Mei**	**Jun**	**Jul**	**Ags**	**Sept**
Pengajuan judul dan Pembimbingan	√												
Penyusunan Proposal		√	√	√	√	√	√						

Seminar Proposal								√					
Penyusunan Hasil dan Pembahasan									√	√	√	√	
Sidang Akhir Skripsi													√

LAMPIRAN 2 : ARTIKEL

Jurnal
Manajemen Kesehatan Indonesia

Volume 8 Nomor 3 Desember 2020

Literature Review: Peran Kepemimpinan Transformasional dalam Meningkatkan Persepsi Perawat terhadap *Handover*

Febria Rizky Aulia, Luky Dwiantoro**
**Departemen Ilmu Keperawatan Fakultas Kedokteran, Universitas Diponegoro*
Email: febriarizkyaulia@students.undip.ac.id; lukydwiantoro@yahoo.com

ABSTRACT

Nurses' perceptions of the implementation of handovers is various. The wrong perception of the implementation of handovers can affect the communication process that threatens patient satisfaction and safety. The head of space as a transformational leader has an important role in influencing nurses' perceptions in the implementation of handovers. The method used in this paper is study literature from several journal articles. The author analyses and synthesizes to describe the role of transformational leadership in increasing nurses' perceptions of the implementation of the handover from the literature study that has been done, the four elements of transformational leadership have a positive role in influencing factors affecting nurses' perceptions. The more positive the impact of transformational leadership on perception factors, the more will have a positive impact on nurses' perceptions. Through the application of transformational leadership, nurses' perceptions and the quality of handovers can improve. It can be concluded that transformational leadership has a positive role in increasing the perception of nurses. This transformational leadership style can be used as a solution and is highly recommended for use by managers / heads of space as one solution to improve nurses' perceptions

Keywords: *Nurse leadership, Transformational Leadership, Nurse handover*

PENDAHULUAN

Kegiatan komunikasi yang sering terjadi di dunia pelayanan kesehatan adalah kegiatan serah terima atau *handover*. Handover merupakan proses komunikasi antara 2 shift perawat untuk memberikan informasi yang berkaitan dengan pasien dan kelanjutan perawatan pasien.[1] Fakta menunjukkan bahwa komunikasi yang kurang efektif selama *handover* dapat meningkatkan resiko *medication error*, ketidakpuasan pasien, penundaan terapi dan membuat waktu perawatan lebih lama.[2]

Persepsi adalah interpretasi dari apa yang dirasakan oleh individu dalam memahami informasi tentang lingkungannya.[3] Menurut Tjiptono, persepsi adalah penafsiran seseorang setelah melalui proses kognitif tentang apa yang dilihat, dirasakan, didengar, dialami atau dibaca, sehingga mempengaruhi perilaku, pandangan, serta perasaan seseorang. Setiap individu dapat memiliki persepsi yang berbeda meskipun objeknya sama. Persepsi yang positif atau negatif akan ditunjukkan seseorang melalui kinerjanya.[4] Persepsi menjadi sangat

penting karena perilaku sesorang didasarkan pada persepsi mereka terhadap realitas itu, bukan mengenai realita itu sendiri.[3]

Setiap orang dapat mempunyai persepsi yang berbeda-beda, hal ini dikarenakan tingkat pendidikan yang berbeda-beda, sikap/perilaku pribadi, motivasi, kepentingan, minat, pengalaman dan harapan terhadap suatu yang dipersepsikan.[4] Persepsi sangat penting karena perilaku sesorang didasarkan pada persepsi mereka terhadap realitas itu, bukan mengenai realita itu sendiri[3]. Seorang perawat dalam melakukan setiap tindakan sangat dipengaruhi oleh bagaimana persepsi perawat itu sendiri.

Penerapan *handover* di Indonesia sendiri masih belum dilaksanakan secara baik. Berdasarkan hasil penelitian sebelumnya menunjukkan hasil bahwa pelaksanaan *handover* belum optimal dan masih banyak informasi/komponen yang dilewatkan selama *handover*. Hal ini dikarenakan pandangan/pengetahuan yang berbeda-beda dari perawat.[5] Hasil dari penelitian sebelumnya menyebutkan bahwa sebagian besar perawat menganggap *handover* tidak penting. Masing-masing perawat juga memiliki pandangan yang berbeda tentang pelaksanaan *handover*.[6]

Persepsi perawat terkait pelaksanaan *handover* bisa berbeda-beda setiap orangnya. Persepsi yang salah terkait pelaksanaan handover akan mempengaruhi proses komunikasi itu sendiri[6], persepsi yang positif atau negatif akan ditunjukkan seseorang melalui kinerjanya.[4] Ketika perawat mempresepsikan *handover* itu tidaklah penting, maka perawat akan melakukan *handover* dengan seadanya dan tidak sesuai dengan standar. Dalam artian, persepsi perawat tentang pelaksanaan *handover* akan mempengaruhi pelaksanaan *handover*.

Peran pemimpin juga sangat penting dalam mempengaruhi persepsi/pandangan para anggotanya. Karena keberhasilan suatu organisasi bergantung pada gaya kepemimpinan yang dipakai dalam organisasi tersebut. Gaya kepemimpinan seorang pemimpin menjadi model yang akan mengispirasi para bawahan. Keberhasilan organisasi dalam mencapai tujuan dan sasarannya tergantung pada pemimpin dan gaya kepemipinan yang diterapkannya.[7]

Kepemimpinan transformasional dinilai lebih unggul daripada model kepemimpinan lainnya. Kepemimpinan transformasional merupakan proses mempengaruhi individu untuk mencapai tujuan organisasi dengan mendahulukan kepentingan organisasi. Pemimpin transformasional memilki kemampuan untuk menginspirasi para pengikutnya untuk mengenyampingkan kepentingan pribadi mereka demi kebaikan organisasi dan mereka mampu memiliki pengaruh yang luar biasa pada diri para pengikutnya.[8–12] Robbins dan Judge menyatakan, pemimpin transformasional adalah pemimpin yang menginspirasi para pengikutnya untuk mengenyampingkan kepentingan pribadi mereka demi kebaikan organisasi dan mereka mampu memiliki pengaruh yang luar biasa pada diri para pengikutnya.[8]

Oleh karena itu, diperlukan study lebih lanjut untuk mengetahui peran dari kepemimpinan transformasional dalam meningkatkan persepsi perawat terhadap pelaksanaan *handover*

METODE PENELITIAN

Penulis menggunakan study literature dari beberapa artikel jurnal untuk menyusun tulisan ilmiah ini. Study literatur ini menganalisis tentang persepsi perawat dan menganalisis tentang kepemimpinan transformasional, lalu dilakukan sintesa untuk mendeskripsikan peran kepemimpinan transformasional dalam meningkatkan persepsi perawat terhadap pelaksanaan handover. Sumber pustaka yang digunakan dalam penulisan ini adalah dengan menelaah jurnal dan buku referensi terkait. Pencarian literatur dilakukan secara komprehensif melalui database jurnal dan buku referensi. Tahun penerbitan yang

handover pada hasil diagram analisis hasil diatas dijelaskan sebagai berikut:

a. *Idealized Influence (Charismatic)*

Seorang pemimpin yang memiliki karisma, memiliki kemampuan untuk membuat anggotanya memiliki keyakinan yang mendalam pada pemimpinnya, merasa senang dan bangga bisa bekerja bersama dengan pemimpinnya, dan mempercayai kapasitas pemimpinnya.[13]

Kharismatik kepemimpinan transformasional dapat meningkatkan pengharapan perawat, dikarenakan kepemimpinan transformasional berkenaan dengan pengaruh pemimpin terhadap anggotanya. Para anggota merasakan adanya kepercayaan, kebanggaan, loyalitas dan rasa respek terhadap pemimpin dan mereka termotivasi untuk melakukan melebihi apa yang diharapkan[8]. Perilaku kharismatik seorang pemimpin dapat mempengaruhi perilaku karyawan secara positif. Perilaku kharismatik akan memberikan dampak positif terhadap pengharapan perawat. Sikap kharismatik juga dapat berdampak positif terhadap perilaku perawat kearah yang lebih baik.[14]

b. *Inspirational Motivation*

Pemimpin transformasional cenderung menyampaikan ide/gagasan yang futuristic, tujuan yang ideal untuk dicapai atau memperbaiki keadaan. Pemimpin mulai memberikan motivasi kepada pengikutnya melalui inspirasi yang diciptakannya. Pemimpin mampu menjelaskan dengan rinci mengenai visi misi serta sasaran program kerjanya kepada semua anggotanya, sebagai akibatnya, para anggota akan merasa antusias untuk berusaha mencapai visi misi tersebut.[13]

Ayu Dewiati melakukan penelitian untuk mengetahui pengaruh kepemimpinan transformasional terhadap motivasi perawat. dari penelitian tersebut disimpulkan bahwa ada pengaruh gaya kepemimpinan transformasional terhadap motivasi dan minat perawat. Hal ini disebabkan bahwa gaya kepemimpinan transformasional adalah pemimpin yang dapat memotivasi karyawan untuk tercapainya kesuksesan dalam bekerja supaya memiliki pengertian yang kuat dalam memberikan visi masa depan dalam organisasi dan memanifestasikan inspirasi yang menggairahkan sebagai perilaku model kepemimpinan yang sesuai.[15]

c. *Individualized Consideration*

Pemimpin harus mampu menjadi mentor bagi para anggotanya. Peran sebagai mentor harus dijalankan dengan memperhatikan para anggotanya secara individual dan berorientasi pada pengembangan karakteristik individu.[13]

Penelitian menyebutkan bahwa kepemimpinan transformasional terbukti dapat berpengaruh positif terhadap kepuasan kerja perawat.[16] Dalam penelitian yang dilakukan oleh Murtiningsing juga ditemukan adanya pengaruh yang sifnifikan terhadap kinerja perawat dengan menerapkan kepemimpinan transformasional. Hal ini disebabkan gaya kepemimpinan transformasional adalah salah satu gaya kepemimpinan yang dapat membangkitkan dan memotivasi karyawan, sehingga dapat berkembang dan mencapai kinerja pada tingkat yang tinggi, melebihi dari apa yang mereka perkirakan sebelumnya.[9] Terbukti bahwa kepemimpinan transformasional berpengaruh positif terhadap sikap/perilaku perawat.

d. *Intellectual Stimulation*

Pemimpin transformasional selalu memiliki cara yang kreatif dalam menyelesaikan masalahnya. Selain itu, mereka juga memiliki cara berfikir yang lebih maju. Pemimpin seringkali memberikan tantangan kepada para anggotanya bagaimana menyelesaikan masalah dengan cara mereka sendiri sehingga mereka terbiasa berfikir kreatif. Dengan cara seperti ini secara tidak langsung seorang pemimpin sudah menginspirasi anggotanya untuk selalu percaya diri mereka sendiri dan berfikir kreatif dalam menghadapi masalah.[13]

Penerapan kepemimpinan transformasional berpengaruh terhadap s*oft skill* perawat (pengetahuan dan pengalaman). Ini dibuktikan dengan penelitian yang dilakukan oleh Tri Hartiti. Dalam penelitiannya, dia menyimpulkan bahwa kepemimpinan transformasional mempunyai korelasi terhadap *soft skill* perawat pelaksana dalam hal kemampuan beradaptasi, kemampuan berkomunikasi, kemampuan bekerjasama tim, dan ketelitian.[17]

Dari keempat perilaku pemimpin transformasional, semuanya memiliki dampak yang positif terhadap sikap dan persepsi para perawat. Seperti yang sudah diketahui bahwa persepsi sangat penting karena perilaku sesorang didasarkan pada persepsi mereka terhadap realitas itu, bukan mengenai realita itu sendiri.[3]

Penerapan gaya kepemimpinan transformasional ini, maka pemimpin dapat memberikan contoh, motivasi, pengharapannya, dan pandangannya terhadap pelaksanaan *handover*. Peningkatan persepsi perawat terhadap pelaksanaan *handover* itu sendiri, maka pelaksanaan *handover*pun akan lebih baik dan lebih optimal. Terlewatnya komponen saat pelaporan, kesalahan pelaporan pasien, dan durasi waktu yang lama saat pelaporan tidak akan ada lagi. Semakin pemimpin transformasional mampu menginspirasi para perawat terkait pelaksanaan *handover*, maka semakin baik persepsi perawat terhadap pelaksanaan *handover*, dan semakin baik pula pelaksanaan *handover* itu sendiri.

KESIMPULAN

Dapat disimpulkan bahwa kepemimpinan transformasional mempunyai peran yang positif terhadap persepsi para perawat. Gaya kepemimpinan transformasional ini bisa dijadikan sebuah solusi dan sangat disarankan untuk digunakan oleh para manajer/kepala ruang sebagai salah satu solusi untuk meningkatkan persepsi perawat. Pemimpin transformasional dapat memberikan contoh, motivasi, pengharapannya, dan pandangannya terhadap pelaksanaan handover melalui keempat unsur kepemimpinan transformasional. Pemimpin transformasional memilki kemampuan untuk menginspirasi para pengikutnya dan memiliki pengaruh yang luar biasa pada pengikutnya, diharapkan melalui penerapan kepemimpinan transformasional ini dapat meningkatkan persepsi perawat dan kualitas handover dapat meningkat.

UCAPAN TERIMA KASIH

Terimakasih peneliti sampaikan kepada dosen pembimbing yaitu Dr. Luky Dwiantoro S.Kp. M.Kep yang sudah membimbing peneliti dengan baik. Dan terimakasih kepada pihak yang sudah membantu dari awal sampai akhir proses penelitian.

DAFTAR PUSTAKA

1. Hidajah U, Harnida H. Peran Komunikasi SBAR Dalam Pelaksanaan Handover di Ruang Rawat Inap RSPS. J Keperawatan dan Kebidanan. 2016;72–81.

2. Malekzadeh J, Mazluom SR, Etezadi T, Tasseri A. A standardized shift handover protocol: improving nurses' safe practice in intensive care units. J caring Sci [Internet]. 2013;2(3):177–85. Available from: http://www.ncbi.nlm.nih.gov/pubmed/25276725%0Ahttp://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=PMC4134157

3. Haryanti T, Pujianto TI, Adinatha NN. Analisis Pengaruh Persepsi Perawat Pelaksana Tentang Fungsi Manajerial Kepala Ruang Terhadap Pendokumentasian Asuhan Keperawatan Di Ruang Rawat Inap Rumah Sakit Swasta Di Semarang. J Manaj Keperawatan. 2013;1(2):131–7.

4. Trimumpuni EN. Analisis Pengaruh Persepsi Mutu Pelayanan Asuhan Keperawatan terhadap Kepuasan Klien

digunakan untuk literature review adalah 10 tahun terakhir, yakni 2010-2020. Penelusuran digunakan dengan memasukkan kata kunci sesuai topik.

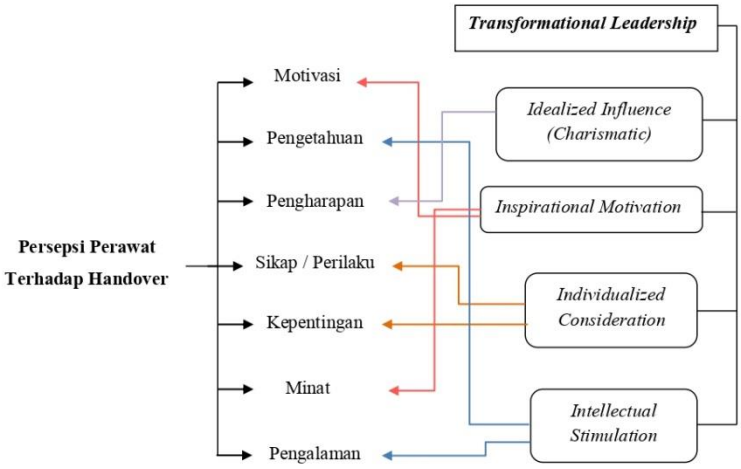
HASIL DAN PEMBAHASAN

Semua literature yang sudah ditemukan dari database jurnal dan buku referensi dilakukan penyaringan sesuai kriteria inklusi eksklusi melalui proses *Flow Diagram*. Setelah proses inklusi eksklusi, terdapat 8 artikel yang memenuhi kriteria. Dari 8 artikel yang ditemukan, selanjutnya dilakukan sintesa dan dianalisa isi dan hasilnya untuk mendapatkan jawaban pertanyaan penelitian ini.

Setiap orang dapat mempunyai persepsi yang berbeda-beda, hal ini dikarenakan tingkat pendidikan yang berbeda-beda, sikap/perilaku pribadi, motivasi, kepentingan, minat, pengalaman dan harapan terhadap suatu yang dipersepsikan.[4] Persepsi sangat penting karena perilaku sesorang didasarkan pada persepsi mereka terhadap realitas itu, bukan mengenai realita itu sendiri.[3]

Menurut Robbins dan Judge (2008), terdapat empat indikator kepemimpinan transformasional, yaitu:[8–12]

a. Pengaruh Ideal/Kharismatik *(Idealized Influence)* yaitu memberikan visi dan misi, memunculkan rasa bangga, mendapatkan respek dan kepercayaan.
b. Motivasi Inspirasional *(Inspirational Motivation*) yaitu mengkomunikasikan harapan tinggi, menggunakan symbol symbol untuk memfokuskan usaha, mengekspresikan tujuan penting dalam cara yang sederhana.
c. Stimulasi Intelektual *(Intellectual Stimulation)* yaitu menunjukkan inteligensi, rasional, pemecahan masalah secara hati-hati.
d. Pertimbangan Individual *(Individualized Consideration)* yaitu menunjukkan perhatian terhadap pribadi, memperlakukan karyawan secara individual, melatih, menasehati.



Gambar 1. Proses Transformasional Leadership Dalam Meningkatkan Persepsi Perawat

Perilaku pemimpin melalui pendekatan kepemimpinan transformasional untuk meningkatkan persepsi perawat terhadap pelaksanaan

Rawat Inap di RSU Puri Asih Salatiga. Tesis J Undip [Internet]. 2009; Available from: http://eprints.undip.ac.id/17427/

5. Astuti N, Ilmi B. Penerapan Komunikasi Situation, Background, Assesment, Recomendation (SBAR) Pada Perawat Dalam Melaksanakan Handover. J Nurs Pract. 2019;3(1):42–51.

6. Dewi Arianti N. Gambaran Komunikasi SBAR Saat Transfer Pasien Pada Perawat Di RSUD K.R.M.T. Wongsonegoro. Universitas Diponegoro; 2017.

7. Nursalam. Manajemen Keperawatan Aplikasi Keperawatan Profesional Edisi 4. 2014;342.

8. Suweko H, Dwiantoro L. Kepemimpinan Transformasional Dalam Meningkatkan Kepuasan Kerja Perawat. J Ilmu Keperawatan dan Kebidanan. 2011;2011(1):71–85.

9. Murtiningsih. Pengaruh Gaya Kepemimpinan Transformasional Pada Kinerja Perawat Rumah Sakit Islam Siti Aisyah Madiun. J Ekon Manaj Sumber Daya. 2015;17(2):54–65.

10. Purnomo L. Pengaruh Gaya Kepemimpinan Kepala Ruang Terhadap Kepuasan Kerja Perawat. Semin Nas dan Call Pap. 2015;225–36.

11. Wayan. Manajemen keperawatan. 2006;117.

12. Nursalam. Manajemen Keperawatan Aplikasi dalam Praktik Keperawatan Profesional Edisi 3. Salemba Medika. 2011. 1–359 p.

13. Budi Nugroho Y. Kepemimpinan Untuk Mahasiswa : Teori dan Aplikasi. Jakarta: Unika Atma Jaya; 2019. 202 p.

14. Elmonita Y, Dwiantoro L. Transformasional leadership dalam meningkatkan perilaku edukatif perawat dalam pelayanan. Semin Nas dan Call Pap [Internet]. 2017;182–91. Available from: http://eprints.undip.ac.id/61162/1/12.pdf

15. Savitri AD. Pengaruh Gaya Kepemimpinan Transformasional Terhadap Motivasi Kerja Perawat Di Instalasi Rawat Inap (Irna) II RSUD Dr. Saiful Anwar Malang. 2014;18(1).

16. Arifiani R, Astuti E, Ruhana I. Pengaruh Kepemimpinan Transformasional Terhadap Organizational Citizenship Behavior Dan Kepuasan Kerja (Studi pada Tenaga Perawat RSUD. Dr. Saiful Anwar Malang). J Adm Bisnis S1 Univ Brawijaya. 2016;33(1):127–35.

17. Hartiti T. Peningkatan Softskill Perawat Melalui Kepemimpinan Transformasional Kepala Ruang Pada Rs Swasta Di Semarang. J Manaj Keperawatan. 2013;1(2):111397.

Transformational Leadership of Nurse Supervisors Expected and Perceived by Nurses in Bangladesh

Bilkis Akter[1], Dr Arayna Chaowalit[2], Dr. Tasanee Nasae [3].

1. Master Student in Nursing Administration, Faculty of Nursing, Prince of Songkla University, Hat Yai Campus, Thailand
2. Associate professor, Department of Nursing Administration, Faculty of Nursing, Prince of Songkla University, Thailand
3. Assistant Professor, Department of Nursing Administration Faculty of Nursing, Prince of Songkla University, Thailand

Abstract

Transformational leadership is a process that motivates followers by appealing to higher principles and moral values and ability to bring about significant changes, adjustment in the organization's vision, strategy, develop leadership behavior, and culture as well as promotion and innovation. This study aimed to identify the level of transformational leadership of nurse supervisors expected and perceived by nurses and to compare the nurses' expectation and their perception.

Data were collected from 186 nurses at a tertiary hospital in Bangladesh. A majority was female, and had working experience more than 10 years. The instrument used in this study consisted of two parts, part I: Demographic Data Form and part II: The Transformational Leadership of Nurse Supervisors Questionnaire (TLNSQ). The reliability of the questionnaire was tested by using Cronbach's alpha coefficients. The alpha of nurses' expectation and perception were .79, and .87, respectively. Data were analyzed by using paired t – test.

The result revealed that the mean score of nurses' total expectation was at a high level (M= 3.63, SD = 0.21), and nurses' total perception was at a moderate level (M = 1.47, SD = 0.29). The total mean score and mean scores of each dimension of nurses' expectation towards nurse supervisors' transformational leadership were significantly higher than those of nurses' perception ($p < .001$). This study provides an empirical support in the area of nursing administration in Bangladesh. The results can be used to improve transformational leadership of nurse supervisors in order to lead nursing quality to the maximum standard.

Key words: Leadership, transformational leadership, expectation, perception

Background and Significance of the Problem

Complex events and chaotic development throughout the world denote that nurse leaders are facing massive changes. In many developed and developing countries, health system reform is a major part of restructuring of health care delivery system (Shaw, 2002).

Nurse leaders need to be more creative and innovative than before to survive, compete, and lead effectively (Gumusluoglu & Ilsev, 2008).

The existing situation of the nursing profession in Bangladesh is not well accepted. Nursing care is not up to the level of standard patient care. Hadley and Roques (2007) investigated the nursing activities between government and non government hospitals. They found that for government hospital only 5.3% of nurses' time was spent in direct contact with patient care, 32.4% was for indirect patient care and paperwork. 50.1% was spent their time with maintaining ward accessories like; count linen, instruments, handover and taken over of equipments, and remaining time was spent away from the ward and chatting with other nurses. These findings flag the nurse leaders to improve this situation. They need to be more active in participating and contributing to health and public policy and be able to influence changes in nursing practice.

Transformational leaders have a comprehensive vision and most importantly they manage, communicate, influence and motivate the followers effectively (Bass, 1990 as cited in Epitropaki, 2001). These leaders are directly responsible for involving others in an environment of participatory decision making. They are closely associated with followers' working conditions, and job satisfaction (Nielsen, Yarker, Brenner, Randall, & Borg, 2008). These leaders employ a visionary style of leadership that inspires employees to become deeply interested in their work and to be innovative and creative and communicate it effectively to all employees (Nielsen, Randall, Yarker & Brenner, 2008).

Transformational leaders broaden and promote the interests of their people, when they generate awareness and acceptance of the purposes and mission of their group, and when they encourage their people to look beyond self-interest for the well-being of their group (Bass, 1985). The transformational leaders are characterized by (1) idealized influence or charismas, being role models for their followers; (2) individualized consideration, respect for the individuality of each follower; (3) intellectual stimulation, encourage problem-solving and innovation; and (4) inspirational motivation, motivate and inspire followers to make meaning and challenge their own work (Bass, 1985).

Currently, there was no known study regarding transformational leadership of nurse supervisors in Bangladesh. Therefore, it was not known whether nursing supervisors in Bangladesh possessed transformational leadership characteristics. This transformational leadership of nurse supervisors could be investigated by asking nurses who are working under their supervision. Nurses may expect their supervisors to possess transformational leadership characteristics whereas in the reality the supervisors may or may not possess

(actual practice). The researchers were interested in exploring transformational leadership of nurse supervisors as expected and perceived by nurses in Bangladesh. The result of this study would be used as a baseline data in order to further improve nurse supervisors' transformational leadership.

Objectives of the Study

1. To identify the level of transformational leadership of nurse supervisors expected by nurses

2. To identify the level of transformational leadership of nurse supervisors perceived by nurses

3. To compare the differences between nurses' expectation and perception regarding nurse supervisors' transformational leadership in Bangladesh

Conceptual Framework

The conceptual framework of this study was constructed, based on the four dimensions of transformational leadership model developed by Bass (1985).There are four dimensions of transformational leadership as follows:

Transformational leadership: (1) Idealized influence, (2) Individualized consideration, (3) Intellectual stimulation, and (4) Inspirational motivation.

Technical Terms of Transformational Leadership of Nurse Supervisors Expected and Perceived by nurses

Expectation: Transformational leadership of nurse supervisors expected by nurses was defined as nurses' perception towards their nurse supervisors' ideal behaviors of a visionary leadership style. These behaviors included: idealized influence (charisma), individualized consideration, intellectual stimulation, and inspirational motivation. It was measured by the questionnaire developed by the researchers based on Bass's framework of transformational leadership (Bass, 1985).The higher score indicated higher expectation of nurses on the nurse supervisors' transformational leadership.

Perception: Transformational leadership of nurse supervisors perceived by nurses was defined as nurses' perception towards their nurse supervisors' actual behaviors of a visionary leadership style, identical to the ones nurses expect their leaders to possess. It was measured by the questionnaire paralleled to the transformational leadership of nurse supervisors expected by nurses. The higher score indicated higher perception of nurses on the nurse supervisors' transformational leadership.

Research Methodology

The descriptive study was used to identify the level of nurse supervisors' transformational leadership expected and perceived by nurses in Bangladesh.

Sample: The sample of this study was nurses working at the study setting and met the inclusion criteria. 186 nurses were selected through systematic random sampling.

Instrument: The instrument in this study consisted of two parts, part I: Demographic Data Form, and part II: The Transformational Leadership of Nurse Supervisors Questionnaire which was developed by researcher based on Bass's transformational leadership model (1985). The 40-item TLNSQ contained four dimensions of transformational leadership including idealized influence (11items), individualized consideration (11 items), intellectual stimulation (9 items), and inspirational motivation (9 items). Subjects were asked to rate their perception of nurse supervisors' ideal behaviors and actual behaviors regarding their transformational leadership using a 5-point Likert scale (0-not at all to 4-very much). The levels of transformational leadership of nurse supervisors expected and perceived by nurses were classified into three levels: 0.00-1.33 = low, 1.34-2.66 = moderate and 2.67-4.00 = high.

Ethical consideration: Permission was taken from the Institutional Review Board, Faculty of Nursing, Prince of Songkla University. The issues of confidentially, anonymity, and the right of withdrawal were addressed prior to the data collection. Subjects were assured about their rights in participating in this study.

Validity and reliability: The questionnaire was validated and back translated by a panel of experts. The reliability of the questionnaire was tested by using Cronbach's alpha coefficients. The alpha of nurses' expectation and perception were .79, and .87, respectively.

Data collection and analysis: Data were collected from 186 nurses through systematic random sampling and who met the inclusion criteria. Data were analyzed and presented with descriptive statistics and inferential statistics, paired t-test.

Results

In this study, most of the subjects were female (93.0%) with the average age of 37.53 years (SD = 3.77). Majority of the subjects were Muslim (78%) and married (96.2%). Approximately 74 percent of them had Diploma in Nursing and Midwifery, 61.8 percent of subjects had 11-20 years of experience in nursing service. After completion of diploma, 73.7 percent of the subjects did not have any clinical nursing training. Most of the subjects (67.3%) did not have experience in attending conference or seminar related in nursing administration.

1. Nurse Supervisors' Transformational Leadership Expected by Nurses.

The results of this study showed that the total mean score of nurses' expectation towards nurse supervisors' transformational leadership (M = 3.63, SD = 0.21) was at a high level. Considering each dimension, it was found that mean score of every dimension was at a high level respectively (Table 1).

2. Nurses Supervisors' Transformational Leadership Perceived by Nurses.

The results of this study showed that the total mean score of nurses' perception toward nurse supervisors' transformational leadership (M = 1.47, SD = 0.29) was at a moderate level. Considering each dimension, it was found that mean score of every dimension was at a moderate level respectively (Table 1).

3. Comparison between Nurses' Expectation and Perception toward Nurse Supervisors' Transformational Leadership.

The total mean score and mean score of nurses' expectation of every dimension were significantly higher than those of nurses' perception toward nurse supervisors' transformational leadership at .001 level respectively (Table 1).

Table 1

Means, Standard Deviations, Levels, and Comparison between Nurses' Expectation and Perception toward Nurse Supervisors' Transformational Leadership.
(N=186)

Transformational Leadership of Nurse Supervisors	Expectation			Perception			t
	M	SD	Level	M	SD	Level	
1. Individualized consideration	3.66	0.21	High	1.50	0.36	Moderate	73.56**
2. Idealized influence	3.62	0.24	High	1.46	0.33	Moderate	81.76**
3. Inspirational motivation	3.62	0.27	High	1.65	0.41	Moderate	55.05**
4. Intellectual stimulation	3.57	0.26	High	1.42	0.33	Moderate	72.31**
Total	3.63	0.21	High	1.47	0.29	Moderate	84.46**

** $p < .001$

4. Nurses' Expectation and Perception toward Nurse Supervisors' Individualized Consideration.

All items of nurses' expectation towards individualized consideration of nurse supervisors were at a high level. The two highest mean scores of the items were (1) 'provide opportunity for nurses to continue education' (M = 3.84, SD = 0.36), (2) 'creates a new learning environment for nurses' (M =3.77, SD = 0.42) (Table 2).

All items of nurses' perception toward individualized consideration of nurse supervisors' were at a moderate level, and one item which was (1) 'acts as a mentor/coach for each nurse based on her needs/capabilities' (M = 1.26, SD = 0.61) was at a low level.

The two highest mean scores were at a moderate level (1) 'provide opportunity for nurses to continue education' (M = 1.62, SD = 0.63) (M = 1.62, SD = 0.65), and (2) 'creates new learning environment for nurses' (M = 1.59, SD = 0.67), (Table 2).

Table 2.

Nurses' Expectation and Perception toward Nurse Supervisors' Individualized Consideration (N= 186)

Individualized consideration	Expectation			Perception			t
	M	SD	Level	M	SD	Level	
1. Provide opportunity for nurses to continue education	3.84	0.36	High	1.62	0.63	Moderate	42.49**
2. Creates new learning environment for nurses	3.77	0.42	High	1.59	0.67	Moderate	40.56**
3. Acts as a mentor/coach for each nurse based on her needs/capabilities	3.44	0.50	High	1.26	0.61	Low	39.39**

5. Nurses' Expectation and Perception towards Nurse Supervisors' Idealized Influence.

Mean score of all items of nurses' expectation toward idealized influence of nurse supervisors were at a high level. The two highest mean scores were (1) 'acts as a role model for nurses' (M = 3.84, SD = 0.37), (2) 'shows positive response toward nurses' performance' (M = 3.77, SD = 0.42) (Table 3).

Nurses' perception towards idealized influence of nurse supervisors, it was found that mean scores of all items were at a moderate level. Among those items, the two highest mean scores were (1) 'acts as a role model for nurses' (M = 1.70, SD = 0.67), (2) 'shows positive response toward nurses' performance' (M = 1.66, SD = 0.70). Mean scores of the other two items of nurses' perception towards idealized influence of nurse supervisors were at a low level. Which included (1) 'takes risk for the benefit of organization' (M = 1.25, SD = 0.52), (2) 'devotes self for organization' (M= 1.23, SD = 0.58) (Table 3).

Table 3

Nurses' Expectation and Perception toward Nurse Supervisors' Idealized Influence (N= 186)

Idealized influence	Expectation			Perception			t
	M	SD	Level	M	SD	Level	
1. Acts as a role model for nurses	3.84	0.37	High	1.70	0.67	Moderate	40.02**
2. Shows positive response towards nurses' performance	3.77	0.42	High	1.66	0.70	Moderate	39.46**
3. Takes risk for the benefit of organization	3.53	0.50	High	1.25	0.52	Low	50.73**
4. Devotes self for organization	3.42	0.50	High	1.23	0.58	Low	43.57**

. 6. Nurses' Expectation and Perception towards 'Nurse Supervisors' inspirational Motivation.

All items of nurses' expectation toward inspirational motivation of nurse supervisors were at a high level. The two highest mean scores were (1) 'motivates nurses to work with sense of purpose' (M = 3.75, SD = 0.45), (2) 'challenges nurses to work with high standard' (M = 3.74, SD = 0.44) (Table 4). Nurses' perceptions toward inspirational motivation of nurse supervisors were at a moderate level. The two highest mean scores were (1) 'motivates nurses to work with sense of purpose' (M = 1.81, SD = 0.64), (2) 'challenges nurses to work with high standard' (M = 1.65, SD = 0.70). Only one item had a mean score at a low level that was 'communicates vision clearly to nurses' (M= 1.24, SD = 0.50) (Table 4).

Table 4.

Nurses' Expectation and Perception toward Nurse Supervisors' Inspirational Motivation (N= 186)

Inspirational Motivation	Expectation			Perception			t
	M	SD	Level	M	SD	Level	
1. Motivates nurses to work with sense of purpose	3.75	0.45	High	1.81	0.64	Moderate	34.58**
2. Challenges nurses to work with high standard	3.74	0.44	High	1.65	0.70	Moderate	40.13**
3. Communicates vision clearly to nurses	3.53	0.52	High	1.24	0.50	low	49.95**

7. Nurses' Expectation and Perception towards Nurse Supervisors' Intellectual Stimulation.

All items of nurses' expectation toward intellectual stimulation of nurse supervisors were at a high level. The two highest mean scores were (1) 'assist nurses when they work in critical situation' (M = 3.78, SD = 0.41), (2) 'uses different perspectives/approaches to solve problems' (M = 3.71, SD = 0.45).

Nurses' perception toward intellectual stimulation of nurse supervisors were at a moderate level. The two highest mean scores were (1) 'assist nurses when they work in critical situation' (M = 1.70, SD = 0.70), (2) 'uses different perspectives/approaches to solve problems' (M= 1.60, SD = 0.56). One item's mean scores were at a low level included 'seeks new ideas from nurses' (M = 1.25, SD = 0.51) (Table 5).

Table 5.

Nurses' Expectation and Perception toward Nurse Supervisors' Intellectual Stimulation (N= 186).

Intellectual Stimulation	Expectation			Perception			t
	M	SD	Level	M	SD	Level	
1. Assist nurses when they work in critical situation	3.78	0.41	High	1.70	0.70	Moderate	37.83**
2. Uses different perspectives/ approaches to solve problems	3.71	0.45	High	1.60	0.56	Moderate	45.37**
4. Seeks new ideas from nurses	3.46	0.50	High	1.25	0.51	Low	45.00**

Conclusions

The result of this study revealed that nurses' total expectation was higher than those of nurses' total perception. There was a significant difference between nurses' expectation and perception toward nurse supervisors' transformational leadership.

Discussion

The findings of this study are presented as follows:

1. Demographic characteristics of the subjects.

Subjects in this study were middle age female adults (M = 37.53, SD = 3.77), and had been working for more than 10 years (79.6%), with this regard they had adequately observed and perceived. The majority of them had completed only basic nursing education, diploma in nursing and midwifery (70.4%).

2. Nurses' expectation toward supervisors' transformational leadership.

The total mean score (M =3.63, SD = 0.21) and mean score of every dimension of nurses' expectation toward nurse supervisors' transformational leadership were at a high level with the mean score ranged from 3.66 - 3.57 (Table 1). Nurses' expectation was high towards their supervisors' transformational leadership due to low professional status of nursing. 70.4 percent nurses had diploma in nursing and midwifery, which needs a leader to guide them, help them, to provide quality of care, and these nurses expected their leaders to increase their status up to high level. Expectation of people in society needs high quality of care, need leaders to support their expectation. Nurses' expected their supervisor to lead them to higher status as professional nurses. Nurses have been socialized to work with inferiority to physicians and their higher authority for a long time (Hadley et al., 2007).

Nurses in this study were highly expected towards their supervisors' 'individualized consideration' (M = 3.66, SD = 0.21). As, nurses have different goals, values, and beliefs. Each of them has different requirements, needs and demand. They perceived nurse supervisor

to respect and consider them individually to satisfy their needs. Nurses expected, supervisors would create learning environment and to continue their study for their professional growth. The results of this study showed that nurses expectation was high on the items: (1) 'provide opportunity for nurses to continue education' (2) 'create a new learning environment' (Table 5). Nurses in Bangladesh needed higher education, salary, acceptances, knowledge and skills to perform maximum standard of care. As Bass (1985) stated that; supervisors can make available learning opportunity for the individual development.

Nurses' expectation in the 'inspirational motivation' was at a high level (M = 3.62, SD = 0.27), (Table 2). Nursing situation in Bangladesh, nurses are always discouraged such as: status, position, poor salary, workload, autonomy, poor working environment (Uddin, Islam, & Ullah, 2006). The results of this study showed that nurses expected highly on the items; (1) 'motivates nurses to work with sense of purpose' (M= 3.75, SD = 0.45), (2) 'challenges nurses to work with high standard' (M = 3.74, SD = 0.44). They expect leaders to motivate them toward quality of care, encourage and support them for their professional development. (Table 4).

Nurses' expectation toward 'idealized influence' of nurse supervisors' transformational leadership was at a high level (M = 3.62, SD = 0.24) (Table 1). The results of this study indicated that nurses' expectation was high among the items: (1) 'acts as a role model for nurses' (M = 3.84, SD = 0.37), (2) 'shows positive response toward nurses' performance' (M = 3.77, SD = 0.42) (Table 3). According to Jooste (2004), nurse leaders have a crucial role on changing global health care environment moving to the new dimension. They expected supervisor to be role model for them. Nurses' need leaders who demonstrate plan to work, lead and control their activities.

Nurses' expectation toward 'intellectual stimulation' of nurse supervisors' transformational leadership was at a high level (M = 3.57, SD = 0.26) (Table 1). The two highest mean scores were (1) 'assist nurses when they work in critical situation' (M = 3.78, SD = 0.41), (2) 'uses different perspectives/approaches to solve problems' (M =3.71, SD = 0.45). Nurses need to leaders who assist them when they work in critical situation, give more attention to the intellectuality, and move to problem solving attitudes (Jooste, 2004).

3. Nurses' perception toward nurse supervisors' transformational leadership.

The total mean scores (M = 1.47, SD = 0.29) and mean scores of every dimension of nurses' perception towards nurse supervisors' transformational leadership were at a moderate level with the mean score ranged from 1.42 - 1.65 (Table 1). Nurses perceived moderately toward their supervisors' transformational leadership because, nurse supervisors

were recruited based on length of service experiences not based on education and competencies, workload, there is no specific remuneration system for specific work.

The findings of this study showed that nurses' perception toward 'inspirational motivation' was at a moderate level (M = 1.65, SD = 0.41). The two highest mean scores of nurses' perception were (1) 'motivates nurses to work with sense of purpose' (1.81, SD = 0.64), (2) 'challenges nurses to work with high standard' (M = 1.65, SD = 0.70). One item that nurses perceived at a low level 'communicate vision clearly to nurses' (M =1.24, SD = 0.50) (Table 4). According to job description of nursing supervisor in Bangladesh (Directorate of Nursing Services and Ministry of Health, population Control and Family Planning, Bangladesh, 1979) nurse supervisor's responsibility includes, maintain communication between nurses and authority. Therefore inappropriate supervisor nurse ratio, education, training, competencies of supervisor are important to lead the nurses.

Nurses perception toward 'individualized consideration' was at a moderate level (M = 1.50, SD = 0.36) (Table 1). The two highest mean scores of nurses' perception were (1) 'expresses appreciation toward nurses' performance' (M= 1.70, SD = 0.63), (2) 'provide opportunity for nurses to continue education' (M= 1.62, SD = 0.63) (Table 2). The results of this study revealed that nurses perceived the lowest mean score in 'acts as a mentor/coach for each nurse based on her needs/capabilities' (M = 1.26, SD =0.61) (Table 2), due to mentoring system is not established, workload of nurse supervisor, and low educational level.

Uddin, Islam, & Ullah, (2006) investigated that nurses' workload, lack of proper training, poor salary, lack of giving rewards of merit to individuals, lack of overtime facilities were the hinders to performed supervisors' leadership. This study setting had 616 nurses, 31 nurse supervisors, (Personal communication, DMCH, May, 2009). This study revealed that, it was not possible for supervisors to perform their ideal leadership behavior, hence the nurses' perception was reflected at the moderate level.

4. Comparison between nurses' expectation and perception toward nurse supervisors' transformational leadership

The total mean score of nurses' expectation (M = 3.63, SD = 0.21) toward nurse supervisors' transformational leadership was significantly higher than the total mean score of nurses' perception (M = 1.47, SD = 0.29) at 0.001 level. In addition, mean scores of all dimension of nurses' expectation were significantly higher than those of nurses' perception at 0.001 level (Table 1).

Recommendation

Nurse supervisors need to train themselves to perform transformational leadership. The findings of this study can be used for further research.

Limitation

This study was performed in only one hospital in Bangladesh; therefore, the generalization of the study is limited.

References

Bass, B. M. (1985). *Leadership and performance beyond expectations*. New York: The Free Press.

Epitropaki, O. (2001). *Transformational leadership.* Institute of Work Psychology, University of Sheffield, England.

Gumusluoglu, L. & Ilsev, A. (2008). Transformational leadership, creativity, and organizational innovation. *Journal of Business Research,* 1-13.

Hadley, M. B., & Roques, A. (2007). Nursing in Bangladesh: Rhetoric and reality. *Social Science & Medicine, 64*, 1153- 1165.

Hadley, M. B., Blum, L. S., Mujaddid, S., Perveen, S., Nuremowla, S., Haque, M. E., et al. (2007). Why Bangladeshi nurses avoid 'nursing'; Social and structural factors on hospital wards in Bangladesh. *Social Science & Medicine, 64*.

Jooste, K. (2004). Leadership: a new perspective. *Journal of Nursing Management* 12,217–223.

Job Descriptions of Nursing Officers and all categories of Nursing Personnel (1979). Directorate of Nursing Services, Ministry of Health, Population Control and Family Planning, Government of the Republic of Bangladesh.

Nielson, K., Randall, R., Yarker, J., & Brenner, S. O. (2008). The effects of transformational leadership on followers' perceived work characteristics and psychological well-being: A longitudinal study. *Work & Stress*, *22*, 16-32.

Nielson, K., Randall, R.,Yarker, J., Brenner, S. O., & Borg, V. (2008). The importance of transformational leadership style for well- being of employees working with older people. *Journal of Advanced Nursing 63*, 465-475.

Shaw, S. (2002). *Leadership for change program*. International Council of Nurses. Geneva, Switzerland.

Uddin, M. T., Islam, M. T., & Ullah, M. O. (2006). A study of the quality of Government hospitals in Bangladesh. *Journal of Pakistan Academic Science, 43*, 121-129.

Transformational Leadership Meets Innovative Strategy: How Nurse Leaders and Clinical Nurses Redesigned Bedside Handover to Improve Nursing Practice

Dewi Brown-Deveaux, DNP, BS, RN, Sarah Kaplan, MSN, RN, Laura Gabbe, MS, LAc, and Laura Mansfield, MSN, RN

In 2000, the Institute of Medicine (IOM) published *To Err Is Human: Building a Safer Health System*, highlighting medical errors resulting from failure in perception, assumption, and communication. The handover process is a high-risk activity prone to the communication vulnerabilities described in the IOM report. The handover project started as a 3-month pilot with plans to expand to the entire facility. The handover education had 4 elements: questionnaire, presentation, video, and simulation. Compliance with the new process was measured using audits completed by the unit managers. Sixty-four registered nurses on 2 acute units were educated by nurse champions. After a successful implementation, the surge of COVID-19 patients in spring of 2020 required us to adjust expectations regarding bedside handover. As the number of hospitalized COVID patients began to decrease, we reinvigorated the project and re-established the expectation that handover be performed at the bedside. A post-questionnaire was completed after implementation and revealed more favorable responses toward bedside handover. We also saw improvements in our patient satisfaction scores (Hospital Consumer Assessment of Healthcare Providers and Systems [HCAHPS]). With direct observation and a checklist, we were able to return to the practice of bedside handover following the surge of COVID-19 patients. As a direct result of the bedside RN involvement, we created and implemented a handover process that prioritized nursing needs and concerns. Our implementation of this evidence-based practice enhanced patient experience and improved safety. Through education, observational audits, and use of a checklist, we were able to re-establish the expectation and practice of handover being completed at the bedside.

KEY POINTS

- **Involving bedside RNs is essential to successful practice change to gain support and ensure new processes align with actual workflows.**
- **Surges of patients with COVID-19 require flexibility in the provision of nursing care.**
- **As the COVID-19 pandemic persists, we need to actively reimplement best practices while providing support to the frontline staff.**

The transferring of professional responsibility and accountability for the care of patients between nursing staff is a high risk component in healthcare.[1] In 2000, the Institute of Medicine (IOM) published its groundbreaking report, *To Err Is Human: Building a Safer Health System.* The IOM report highlighted the staggering number of adverse events experienced by patients as a result of communication

failure.[2] Nearly 20 years later, health care systems continue to create innovative solutions to mitigate harm associated with handover.[3]

In 2017, The Joint Commission released a Sentinel Event Alert related to handover communication stating, "Potential for patient harm—from minor to the severe—is introduced when the receiver gets information that is inaccurate, incomplete, not timely, misinterpreted, or otherwise not what is needed."[4] Inaccurate information can be incorporated into the patient's plan of care and create safety risks.[5] The handover process allows the caregiver to present the necessary information needed to manage care for the patient. Nursing handover should be structured, detailed, pertinent, complete, and accurate.[6]

A standardized handover process reduces risks and demonstrates benefits for the registered nurse (RN), patient, and organization. According to Ernst et al.,[6] a consistent handover approach streamlines information and compensates for different caregiver communication styles. Nurses encounter increased efficiency and clarity during the patient report. Organizational benefits include decreased adverse events, improved nursing-sensitive indicators, and enhanced patient experience levels. Patients benefit by participating in their individualized plan of care, which can reduce anxiety related to their care.[7] Prior clinical handover studies show recurrent themes of improved patient safety, time effectiveness, patient/family engagement, and bidirectional satisfaction for patients and staff.[4,8-10]

To enhance and elevate patient safety in our organization, we chose to redesign and standardize the process for nursing bedside handovers at our institution in 2018. We had a successful pilot and organization-wide implementation. The surge of COVID-19 patients in spring of 2020 required us to adjust expectations regarding bedside handover.[11] As the number of hospitalized patients with COVID diminished, we reinvigorated the project and re-established the expectation that handover be performed at the bedside.

BACKGROUND

Our institution, an urban, 450-bed, full-service teaching hospital and level 1 trauma center, aligns its aims for patient care with the Institute of Medicine: effectiveness, safety, timeliness, patient-centeredness, efficiency, and equity.[12] All quality initiatives are designed and implemented with the principles of a highly reliable organization (HRO) such as preoccupation with failure, reluctance to simplify, sensitivity to operations, commitment to resiliency, and deference to expertise.[13]

Although our facility has performed bedside handover at change of shift for many years, in August 2016, we implemented a new electronic medical record (EMR) that contains a screen that organizes patient information in one place to facilitate the handover process. Information includes but is not limited to the patient diagnoses, medications, recent labs, and vital signs. The organization adopted the mnemonic IPASS (illness severity, patient summary, action list, situation awareness and contingency planning, synthesis by receiver) to standardize and guide handover communication. Initial handover observational practice audits revealed the process was not performed consistently, and patients were not routinely active participants.

The senior director of nursing for medicine/surgery held a 2-hour meeting to address concerns and brainstorm solutions. The meeting was attended by key stakeholders: clinical staff nurses from the pilot units, directors of nursing, nursing quality, nursing managers from the pilot units, senior vice president of nursing, patient experience, nursing education, and nursing informatics. Communication issues that contribute to patient harm and low patient satisfaction scores were discussed. Bedside handover was highlighted as a key initiative that would positively contribute to patient safety and satisfaction through consistent communication between nurses.[6,8,9] The Handover Redesign Team was formed to create a standardized nurse bedside handover process to guide practice and improve communication among clinical nursing staff.[6]

Our project was designed as a quality improvement project using educational interventions and a pre- and post-questionnaire. The project's success was measured using post-questionnaire results, quality outcomes specific to falls, and patient experience outcomes. The quality and patient experience outcomes were benchmarked against each unit's historic performance to establish a baseline. Patient falls are tracked monthly through the nursing quality department. Patient experience scores are measured through survey responses via HCAHPS. Through bedside handover, we hypothesized we would see a reduction in the number of falls and an improvement in our patient experience scores relating to nurse communication and discharge information.

The pilot phase of the handover project ran for 3 months on a 20-bed neuroscience unit and a 36-bed adult surgical unit. Handover education included 4 main elements: pre- and post- questionnaire, PowerPoint presentation, video, and simulation. The project was further supported by adjusting nursing shift start times and installing patient Care Boards.

Instruments

A literature search was conducted to ascertain best practices for nursing handover and identify potential implementation barriers. Nursing quality developed a 9-item questionnaire to assess nursing opinions and views regarding the bedside handover process (*Table 1*). The questionnaire used a yes/no question format and a 5-point Likert scale (strongly agree, agree, neither agree nor disagree, disagree, strongly disagree). The

Table 1. Handover Questionnaire Results

Question	Pre- and Post-Education Comparison			
	Yes		No	
	Pre	Post	Pre	Post
I prefer to receive handover at the patient's bedside, %	66	87	34	13

	15 Minutes		20 Minutes		25 Minutes		30 Minutes		>30 Minutes	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Average amount of minutes it currently takes to give handover, %	24	2	24	29	20	17	22	42	9	10

	Strongly Agree		Agree		Neither Agree nor Disagree		Disagree		Strongly Disagree	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Bedside handover is an efficient use of the nurses time, %	28	39	46	46	7	7	19	2	0	5
By doing bedside handover, I can prioritize patient care, %	35	42	41	39	11	10	13	5	0	5
Bedside handover makes it easier for me to take over the care of patients I have not previously cared for, %	43	44	31	39	11	10	13	2	2	5
I have concerns about patient confidentiality while performing bedside handover, %	54	27	33	46	4	7	7	12	2	7
Through bedside handover, patients experience less anxiety about their care, %	6	17	33	34	35	35	19	7	7	7
Bedside handover allows patients and families the opportunity to communicate more effectively with the nursing team, %	17	29	46	46	18	12	17	7	2	5

questionnaire addressed handover preferences, estimated time to perform handover, nurse perceptions of patient care prioritization, patient confidentiality concerns, and patient experience with bedside handover.

METHODS

The questionnaire was administered using Qualtrics® and distributed to the RNs through e-mail by the nurse managers. Participation was voluntary, and the results were anonymous. Sixty-four RNs participated in the initial stage. We used the pre-education intervention questionnaire to inform development of educational components and work flow transitions. The post-education questionnaire was administered 6 months after the implementation of the new handover process.

Care Boards

The promotion of patient participation and engagement during the handover process was accomplished in part by the installation of Care Boards on each nursing unit. The Patient Experience Team collaborated with individual nursing units to design content for custom whiteboards for each patient that display information important to the plan of care. Care Boards increase patients' knowledge of the care team, understanding of individual goals, and improve patient satisfaction.[14] Our Care Boards included the care team's names,

pain medication schedule, daily patient goals, and known assistive devices.

New Standardized Bedside Handover PowerPoint Presentation

The Handover Redesign Team used the questionnaire data to create a customized education program highlighting the benefits of bedside handover while proactively addressing staff concerns. The target audience for the educational program included RNs, nursing assistants, and ward clerks. Nurse managers nominated clinical nurses with a passion for the handover project to act as champions. These champions participated in the team meetings, contributed to the scripts, starred in the video, and provided staff education and handover facilitation at the unit level.

The handover presentation was done using peer-to-peer educational techniques. Handover champions presented the material with nurse leader support. The program began with an icebreaker exercise that demonstrated the importance of communication and engaged the participants in education. A slide presentation covered the following topics:

- **Background of Bedside Handover**—RNs need to maintain clinical inquiry in their work; excellent nursing practice is based on the best available evidence. Literature was provided to staff on patient safety and communication practices in health care.
- **Professional Practice Model**—We discussed how this practice change aligns with the guiding principles of our professional practice model: caring, advocacy, professionalism, and patient-centered care.
- **High Reliability Organization (HRO)**—Our project goal was to reduce variability in the bedside handover process: this supports the organization's HRO goals.
- **Care Delivery Model**—Bedside handover is foundational to nursing practice and prioritizes patient care.
- **Questionnaire Results**—Education specifically addressed low-scoring items from the pre-intervention questionnaire, such as concerns about patient confidentiality. HIPAA strategies included discussing sensitive information outside the room prior (i.e., HIV status) and asking the patient on admission if family/friend would be present during the change of shift. Information that is potentially overheard during bedside handover is considered incidental disclosure and does not place the RN at any risk of violating confidentiality laws.
- **IPASS and Handover Screen in EMR**—The EMR handover screen provides vital patient information in 1 centrally accessed location including recent vitals, intravenous lines, pressure injuries, pending labs, and medications. The screen is utilized by all staff during the nursing handover process.
- **Pre-Round**—We evaluate patient concerns in a pre-handover round to prevent interruptions and set expectations for patients during handover. During the pre-round, the RN explains that handover will be occurring in 30 to 60 minutes and ensures the patient has or does not have family present. The pre-round also encompasses Care Connection rounds, addressing pain, toileting, possessions, and position.

Video

The Handover Redesign Team developed an educational video to portray the expected handover process. The clinical nurse champions were members of the Handover Redesign Team, starred in the video, and contributed to writing the script. The video demonstrated the bedside handover process step by step from the pre-round to the handover, with emphasis on the discussion of sensitive patient information outside room, bedside handover using IPASS, and methods to engage patients in the handover process. The video included nurse manager rounds that depict how to validate nursing handover practice. After staff viewed the video, the nurse champions facilitated open discussion and answered questions.

Simulation

As the last element of the education, the RNs participated in a simulation exercise to practice the handover techniques they learned during class. Predetermined patients were chosen from our test EMR for the simulation session. A mock patient room was set up with a Care Board and workstation on wheels to simulate nursing bedside handover. Each RN was given the opportunity to give handover as the outgoing and incoming nurse. Following completion of simulation, clinical nurse champions provided performance feedback and addressed any RN questions or concerns.

Validation of Practice Change

The nurse managers on the pilot units conducted monthly observational audits following the go-live. These live observations of the handover process ensured that the process was occurring in a standardized fashion, and provided coaching and reinforcement of positive practice. The nurse managers also validated the patients' handover experience through their daily rounds.

RESULTS

Registered Nurse Questionnaire

Fifty-four (84%) of the total 64 RNs completed the pre-questionnaire and forty-four (69%) participated in the post-questionnaire. The participants had a more

favorable response in post-questionnaire across all categories (*Table 1*). In response to the question "I prefer to receive handover at the bedside," 87% of post-questionnaire respondents agreed, compared to 66% in the pre-questionnaire. In addition, there was a significant improvement in the nurse's perception of efficiency of bedside handover. In the post-questionnaire, 85% of nurses agreed or strongly agreed that bedside handover is an efficient use of the nurse's time, compared to 74% pre-questionnaire. Through bedside handover, the RNs perceived that patients experienced less anxiety about their care (51%, compared to 39%). Finally, "bedside handover allows patients and families the opportunity to communicate more effectively with the nursing team" improved from 63% to 75%. RNs continued to report concerns of infringement on patient confidentiality, though there was a decrease from 87% to 73%.

The pre-intervention questionnaire showed patient confidentiality and insufficient shift time overlap to be biggest nursing concerns. Particularly, shift time overlap time needed to be addressed to ensure successful educational and process improvement initiatives. The questionnaire showed that 15 minutes was not sufficient time to perform handover: most nurses reported shift-to-shift handover taking 20 minutes or more.

Nursing leadership recognized shift start and end times presented a challenge to the effective transfer of patient health care information. The RN shift start times only allowed for a 15-minute timeframe for nurses to perform handover. Handover research conveys an average of 5.4 minutes to give an individual patient report.[15] Clinical nurses on the pilot units had to handover 4 to 6 patients at the change of shift. The time constraint of 15 minutes contributed to fragmented and limited information exchange between nurses and the inability to have interactive care discussions with patients/families. Collaborating with the nursing union, shift times were formally adjusted to 7:00 to 7:30, allowing 30 minutes' overlap for change of shift handover. The results of the change were demonstrated in the questionnaire with 22% of RNs responding that handover took 30 minutes in the post-questionnaire, compared to the pre-questionnaire results of 22%.

Patient Safety and Experience Outcomes

Historical unit performance in quality and patient experience were assessed for sustained improvement for patient experience and nurse-sensitive indicators to determine effectiveness. We compared the data 2 calendar quarters before the intervention to 2 calendar quarters post-intervention; the neuroscience unit had a 60% decrease in falls. The surgical unit did not reduce falls but maintained their fall rate.

In the patient experience domain of "communication with nurses," the neuroscience unit saw a significant increase of 22% in the HCAHPS survey top box scores. However, the surgical unit HCAHPS scores remained unchanged in the pre- and post-intervention period.

Lessons Learned

Several lessons were learned during the quality improvement project. Streamlining the bedside handover methodology required unit-specific nurse champions, leadership oversight, and continuous communication, and might impact the patient's experience on varied pilot units.

First, the project's central strength was to empower some of the high performer nurses to become change agents. These nurses serve as champions in developing and disseminating the project's objectives to their peers to facilitate buy-ins. Second, leadership deployment to visualize bedside handover for closed-loop communication and provide coaching to the staff was another critical strength. Third, bedside handover was communicated frequently across diverse platforms such as during staff meetings, daily huddles, beginning of the shift, organization department meetings, and the nursing leadership council to maintain the project goals. Utilizing a multilevel communication approach kept the project relevant and lead to the adaptability of key stakeholders.

Finally, utilizing 2 independent units to pilot the quality improvement project highlighted the variances across both units, such as patients' limited participation during the handover process on the neuroscience progressive care unit due to patient acuity, whereas the surgical unit patients were less acute and were more involved in their care. These differences can manifest in the patient experience score variations. The pilot was deemed successful by nursing leadership and rolled out to the remaining units in the facility.

COVID-19

In March 2020, SARS-CoV-2 (COVID-19) impacted clinical practice in New York State and eventually the entire country. Health care organizations encountered an unprecedented burden of caring for patients with a novel virus and of protecting health care workers. The organization was challenged by the uncertainty of constantly changing recommendations and the surge of COVID-19 patients. Due to the incredible number of infected patients, there were insufficient nursing resources to maintain the staffing guidelines we had adopted to meet bedside handover requirements. Additionally, limited personal protective equipment (PPE) availability required nurses to prioritize which patients could have bedside handover and which could have handover completed outside the room. However, there were exceptions based on the patient severity requiring the staff to enter the patient's room. These are not limited to patients in imminent danger or if staff

members needed to review and address a patient-facing care issue. One specific feature that remained consistent was that staff performed a change of shift reports directly outside of the patient room. It was imperative, even though we were battling a pandemic, that the team maintain visibility, self-awareness, and the highest level of care within the defined limitations.

Post-COVID Surge

As the number of patients admitted with COVID-19 declined and PPE supplies improved, nursing leadership looked toward our HRO principle of commitment of resiliency. Commitment to resiliency is the ability to improve immediate problems while using innovation to create larger improvements. The team understood that we would have to adapt to the challenges of the new normal and resume essential activities, including bedside handover. It was necessary to balance those responsibilities with the realities of the tremendous stress placed on the staff and their families under the extreme circumstances of COVID-19. The staff experienced insurmountable stress and anxiety from the suffering of the pandemic. The organization acknowledged the lived experience of the staff and revised the bedside handover priorities on candid feedback from the nursing staff. The goal was to provide individualized quality healthcare with compassion, dignity, and respect. However, it was important for the bedside handover committee to pause and think methodically as an organization.

The nurse manager of 1 of the pilot programs and the senior director of women and children's services and nursing education reconvened the members of the original workgroup to plan the re-establishment of bedside handover. The workgroup determined the strategy of re-education through huddles and the creation of a checklist to guide the staff on the steps of bedside handover. Each checklist was modified based on feedback from the units about the needs of the patients and the staff. The information listed on the checklist includes an introduction, details of utilizing the IPASS, focused assessment, task pending, crucial labs, pain, addressing patient and family concerns, goal setting, and managing up the incoming nursing staff. The bedside handover checklist was laminated and displayed on each workstation on wheels. Finally, observational audits were completed by the unit managers to provide coaching and set the expectation that handover is once again to be completed at the bedside.

CONCLUSION

The project highlighted the importance of involving bedside RNs in process changes through both questionnaire and direct participation in the Handover Redesign Team. As a direct result of their involvement, the Handover Redesign Team was able to create and implement and handover process that addressed nursing concerns and prioritized their needs. The improvements in the HCAHPS scores in the patient experience domain "communication with nurses" indicate that the implementation of our evidence-based handover initiative has enhanced our patient's experience and improved their safety.

COVID-19 has forced our organization to think creatively regarding quality and nursing practice as the number of patients admitted with COVID-19 fluctuates. Although bedside handover has a litany of benefits, organizations must continue to include staff nurses who are still reeling and grappling from the experiences of the pandemic. The resilience of our staff to swiftly readopt bedside handover is a testament to their flexibility, commitment, and autonomy. As we adapt to the new, uncertain landscape of nursing and patient care, organizations must continue to engage the nurses at the bedside to re-establish best practices.

REFERENCES

1. Friesen MA, White SV, Byers JF. Patient Safety and Quality: An Evidence-Based Handbook for Nurses Chapter 34. *Agency for Healthcare Research and Quality (US)*; 2008. Available at: https://www.ncbi.nlm.nih.gov/books/NBK2649/. Accessed November 12, 2021
2. Institute of Medicine. *To Err Is Human: Building a Safer Health System*. Washington, DC: The National Academics Press; 2000.
3. Chism LA. *The Doctor of Nursing Practice: A Guidebook for Role Development and Professional Issues*. 4th ed. Burlington, MA: Library of Congress; 2019.
4. The Joint Commission. Sentinel Event Alert: inadequate hand-off communication. *Sentinel Event Alert*. 2017;(58):1-6.
5. Jukkala AM, James D, Autrey P, Azuero A. Developing a standardized tool to improve nurse communication during shift report. *J Nurs Care Qual*. 2012;27(3):240-246.
6. Ernst KM, McComb S, Ley C. Nurse-to-nurse shift handoffs on medical surgical units: A process within the flow of nursing care. *J Clin Nurs*. 2018;27(5–6):e1189-e1201.
7. Ofori-Atta J, Binienda M, Chalupka S. Bedside shift report: Implications for patient safety and quality of care. *Nursing*. 2015;45(8):1-4.
8. Foster S, Manser T. The effects of patient handoff characteristics on subsequent care: A systematic review and areas for future research. *Acad Med*. 2012;87(8):1105-1124.
9. Tobiano G, Bucknall T, Sladdin I, Whitty JA, Chaboyer W. Patient participation in nursing bedside handover: a systematic mixed-methods review. *Int J Nurs Stud*. 2018;77:243-258.
10. Whitty JA, Spinks J, Bucknall T, Tobiano G, Chaboyer W. Patient and nurse preferences for implementation of bedside handover: do they agree? Findings from a discrete choice experiment. *Health Expect*. 2017;20(4):742-750.
11. Centers for Disease Control. COVID-19 Outbreak — New York City, February 29–June 1, 2020. November 20, 2020. Available at: https://www.cdc.gov/mmwr/volumes/69/wr/mm6946a2.htm. Accessed September 14, 2021.
12. Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: The National Academics Press; 2001.
13. Babyar J. Direct reliability: strategies to revolutionize healthcare. *J Public Health*. 2020;29:89-95.

14. Tan M, Evans KH, Braddock III CH, Shieh L. Patient white-boards to improve patient-centered care in the hospital. *Postgrad Med J*. 2013;89:604-609.
15. Carroll JS, Williams M, Gallivan TM. The ins and outs of change of shift handoffs between nurses: a communication challenge. *BMJ Qual Saf*. 2012;21(7):1-8.

Dewi Brown-Deveaux, DNP, BS, RN, is nurse manager, Sarah Kaplan, MSN, RN, is nursing quality specialist, Laura Gabbe, MS, LAc, is research administrative manager for nursing, and Laura Mansfield, MSN, RN, is senior director of medical surgical nursing at NYU Langone Brooklyn in Brooklyn, New York.

Note: The authors declare no conflicts of interest.

1541-4612/2022/$ See front matter

https://doi.org/10.1016/j.mnl.2021.10.010

Received: 5 May 2022 | Revised: 10 August 2022 | Accepted: 29 August 2022

DOI: 10.1111/jonm.13775

ORIGINAL ARTICLE

WILEY

Medical–surgical nurse leaders' experiences with safety culture: An inductive qualitative descriptive study

Lisa Harton PhD, RN, FACHE, Chief Quality Officer | **Lisa Skemp PhD, FGSA, FAAN, Professor**

Marcella Niehoff School of Nursing, Loyola University Chicago, Chicago, Illinois, USA

Correspondence
Lisa Harton, 1016 BVM Hall, Marcella Neihoff School of Nursing, Lake Shore Campus, 1032 W. Sheridan Road, Chicago, IL 60660, USA.
Email: lisalharton@yahoo.com

Funding information
There are no sources of funding.

Abstract

Aim: The aim of this study is to describe safety culture as experienced by medical–surgical nurse leaders.

Background: Safety culture remains a barrier in safer patient care. Nurse leaders play an important role in creating and supporting a safety culture.

Methods: We used an inductive qualitative descriptive study using semistructured interviews, document review and observations in a Midwestern community hospital in the United States.

Results: Results of the study are as follows: making sure nurses are keeping patients safe, making sure nurses have nursing interventions in place, expecting nurses to stop unsafe acts or escalate when they feel uncomfortable, making sure nurses have what they need to provide safe care, organization prioritizes patient safety and making sure nurses are learning and growing emerged as themes describing safety culture.

Conclusions: Nurse leaders made sure patients were safe by making sure everyone was doing their best to provide safe care. Insufficient time, too many priorities, insufficient resources, poor physician behaviours and lack of respect for their role emerged as barriers to leading a safety culture.

Implications for Nursing Management: Organizations must remove barriers for nurse leaders to develop and lead a safety culture. Nurse leaders must learn to advocate successfully for safe nursing care and professional work environments.

KEYWORDS
acute care, nurse manager, patient safety, safety culture

1 | BACKGROUND

The Institute of Medicine (IOM, 2000) seminal report on preventable patient harm identified 44,000–98,000 deaths annually from avoidable medical errors. Health care system leadership and researchers responded to this problem by studying systems that led to errors to create safer care processes while also addressing safety culture (Gandhi et al., 2016). Despite efforts to improve patient safety, one in 20 patients continue to experience preventable harm (Panagioti et al., 2019). Delivering safe care requires leaders to establish, lead and sustain safety as a core value resulting in improved safety culture (Gandhi et al., 2016). Safety culture is the product of

individual and group values, attitudes, perceptions, competencies, and patterns of behavior that can determine the commitment to, and the style and proficiency of an organization's health and safety management plan (Health and Safety Commission Advisory Committee on the Safety of Nuclear Installations, 1993, p.339). A positive safety culture in hospital nursing units resulted in fewer reported adverse patient outcomes including decreased patient falls, medication errors, pressure injuries, hospital associated infections and higher patient satisfaction (Alanazi et al., 2022).

Leader expectations, support, prioritization and commitment to patient safety, accountability, sharing data, daily management practices, focusing on safety behaviours, teamwork and communication, learning and improvement and executive rounding positively impact safety culture (Campione & Famolaro, 2018; Churruca et al., 2021; Frush et al., 2018). A systematic review identified that organizational safety cultures are underdeveloped or weak in regard to staffing, nonpunitive response to errors, handovers and transitions of care and teamwork across units (Reis et al., 2018). Failure of leadership to prioritize and support patient safety has been associated with poor patient safety outcomes (Patient Safety Advisory Group [PSAG], 2017).

Efforts to develop a safety culture have not had a significant impact. For example, the Agency for Health care Research and Quality (AHRQ) Hospital Survey on Patient Safety Culture (SOPS) 2021 trending report identified a 1% decrease in overall perception of patient safety and 40% of hospitals reported a 5-point or more decrease in management support for patient safety (Famolaro et al., 2021). Nurse leaders (NLs) are a subset of administration and management respondents that have the most favourable safety culture perceptions. They lead Registered Nurses (RNs), a subset of nurse respondents within the AHRQ SOPS survey, who, in contrast, have the least favourable perception of safety culture.

Nurse leaders play an important role in creating and supporting a safety culture and leading a professional nursing work environment. A professional nursing work environment has been associated with better safety culture and patient outcomes (Lee & Dahinten, 2020; Olds et al., 2017). Adequate staffing, managerial support for nurses and good nurse–physician relations contribute to a professional nurse work environment (IOM, 2004). Hospital manager behaviours that promote patient safety and transformational leadership styles influence and predict nurse-perceived patient safety (Anderson et al., 2019; Campbell et al., 2021; Ferreira et al., 2022; Lee & Dahinten, 2020; Weaver et al., 2017). Transformational leadership had a significant indirect effect on adverse patient outcomes through structural empowerment (Boamah et al., 2018). Structural empowerment explains how leaders can influence employees to accomplish their work effectively by providing access to information, support, resources and opportunities (Kanter, 1993).

Transformational leadership is a relational leadership style in which followers have trust and respect for the leader and are motivated to do more than is formally expected of them to achieve organizational goals (Bass, 1985). Transformational leadership consists of four core dimensions. Idealized influence describes a leader who is an exemplary role model, sets high standards of conduct and articulates the vision of the organization. Inspirational motivation occurs when leaders articulate a compelling vision. Intellectual stimulation occurs when leaders solicit a variety of opinions perspectives in making decisions and empower employees to constantly be learning, looking for and acting upon opportunities (Bass, 1985). Finally, individualized consideration occurs when leaders coach or mentor to the individual differences in needs of employees to help them reach their full potential (Avolio et al., 1999).

Assessing safety culture in health care has relied predominantly on quantitative methods that measure varying dimensions of a safety culture but lack an understanding of cultural assumptions and behaviours (Churruca et al., 2021). Through a better understanding of nurse leader experiences within the situational context of a medical–surgical unit, safety culture perceptions will be better understood, behaviours described and facilitators and challenges identified to provide insight into areas for prioritization or improvement. Therefore, this study aimed to describe medical–surgical nurse leader experiences with safety culture in a Midwestern United States hospital to inform factors that support leading a safety culture in nursing. This study is part of a larger study describing the similarities and differences in safety culture experiences between RNs and nurse leaders.

2 | METHODS

2.1 | Design and participants

An inductive qualitative descriptive study was used for data collection and analysis. A purposive sample of nurse leaders with at least 6 months experience supporting the medical–surgical units were recruited through flyers, a recruitment email and during hospital safety huddles. Safety huddles or short, stand-up meetings occurred each morning between nurse leaders and their staff allowing teams to actively manage quality and safety by looking back at performance and looking ahead to proactively discuss safety concerns (AHRQ, 2017). Data saturation was reached at 10 nurse leader participants. Nurse leaders were at a minimum bachelor's prepared RNs that had 24 h accountability for a direct care unit or units.

2.2 | Data collection

Informed consent was obtained. Data were collected through a semi-structured interview guide. Interviews were conducted by the first author, a nurse researcher with over 15 years of leadership experience in acute care settings. Interviews were conducted in secure and comfortable locations chosen by the participants and lasted, on average, 1 h. Confidentiality was maintained by using pseudonyms during transcription. Audio tapes of interviews were transcribed verbatim, reviewed line-by-line and compared with the audio recordings to ensure accuracy. The second author, a nurse researcher with expertise in qualitative research, reviewed a sample of audio recordings and all transcripts to validate transcriptions. Key policies, protocols and

documents discussed in interviews were collected and reviewed to enhance the credibility of data collection. Observations of 16 safety huddles allowed the researcher to observe group safety behaviours and were captured in field notes.

2.3 | Data analysis

Data analysis was conducted by two qualitative nurse researchers. Inductive qualitative content analysis was applied to analyse and summarize data resulting in six themes (Sandelowski, 2000). Analysis was manual and occurred concurrently with data collection using a five-step process (Miles et al., 2014). First, data were managed and organized into secure files. Second, data were read and re-read while memoing emergent ideas to capture phrases and words to identify initial codes. Third, in vivo coding allowed clustering of similar data using first cycle coding that was continuously revised to accommodate new data. Then, pattern codes were generated through second cycle coding to identify emerging themes. Subthemes provided rich description of participant experiences by providing quotes, emotions and context to ensure that the voices, feelings, meanings and actions of the participants were described in sufficient detail. In the fourth step, interpretations were developed and assessed. Fifth, results were validated by member checking and by researcher triangulation through consensus. Findings were compared with what is known in the literature.

2.4 | Rigour

Rigour was established by adhering to the four criteria described by Lincoln and Guba (1985). Credibility was ensured by pilot testing the interview guide, flexible, systematic, purposive sampling, ensuring participants had the freedom to provide rich information, participant-driven data until saturation was reached, triangulation of data collection through multiple sources, accurate and timely transcription, data-driven coding with member checking, investigatory triangulation and on-going attention to context. Confirmability was ensured through bracketing personal bias, investigator triangulation and member checking. Dependability was ensured through a documented extensive, detailed audit trail. Transferability or fittingness of the results is determined by the reader.

2.5 | Ethical considerations

The study was approved by the University IRB and the study site research ethics review committee.

3 | RESULTS

The 10 participants were female and held at minimum a bachelor's degree in nursing as was required for the role. There was variation in age (28–62 years of age) and years of experience as a nurse leader (2–21 years). All nurse leaders worked at least 40 h a week predominantly on the day shift (90%) (Table 1).

Six themes described nurse leader experiences with safety culture. Within the themes, 16 subthemes provided rich description of the meaning of those experiences (Figure 1). This resulted in nurse leaders making sure patients were safe by making sure everyone was doing their best to provide safe care.

3.1 | Making sure nurses are keeping patients safe

Nurse leaders set expectations and held RNs accountable for gathering information from and about their patients and ensuring a

TABLE 1 Demographics

	NL ($n = 10$)	
Characteristic	**%**	**n**
Gender		
Male	0	0
Female	100	10
Role		
Supervisor	40	4
Manager	50	5
Director	10	1
Age		
20–29	10	1
30–39	50	5
40–49	30	3
50–59	10	1
Highest education level completed		
Bachelor's	90	9
Master's	10	1
RN, number of years		
4–5	10	1
6–10	20	2
> 10	70	7
Years as a nurse leader		
2–3	20	2
4–5	10	1
6–10	40	4
>10	30	3
Hours worked per week		
0–24	30	3
25–40	70	7
Shift most often worked		
Days	90	9
Nights	0	0
Rotating	10	1

Themes	Subthemes
Making sure nurses are keeping patients safe	• Knowing the patient by reviewing the electronic medical record • Bedside shift report to know the patient and catch things upstream • Risk assessments to determine patient risks
Making sure nurses have nursing interventions in place	• Setting expectations and holding nurses accountable for following nursing interventions • Checklists, alarms, warnings, and safety checks • Workarounds
Expecting nurses to stop unsafe practices or escalate when they feel uncomfortable	• I expect direct conversations about safety • Get the right eyes on the patient • We don't have great relationships with our physicians
Making sure nurses have what they need to provide safe care	• Balancing financially responsible staffing with patient needs is challenging • Supplies and working equipment aren't always available to keep nurses at the bedside
Organization prioritizes patient safety	• Establishing goals and providing transparency • Communicate, listen to understand, and respond to nurse concerns
Making sure nurses are learning and growing	• Nonpunitive response and follow through • Support nurse knowledge and education • Learning through audits and stories

Making Sure the Patient is Safe

Making sure everyone is doing their best to provide safe care

FIGURE 1 Results

collaborative plan to proactively keep patients safe. The subthemes described knowing the patient by reviewing the electronic medical record, bedside shift report to know the patient and catch things upstream and risk assessments, when completed, determined patient risks. This was described as the safest day.

> When the patient is admitted there is collaborative, effective communication with all care team members. There's a plan of care to keep the patient safe whether it's preventing falls, preventing any kind of harm. To make sure that we have the best standards in place to prevent harm from that patient. (RNL04)

Nurse leaders described RNs as spending a lot of time looking for information that was not always accurate and did not transfer from most settings outside of the hospital. Bedside shift report facilitated knowing the patient and involving them in the plan of care which helped RNs catch things upstream by validating the patient's condition and ensuring safety interventions were in place. Although they shared stories to help RNs understand the benefits of bedside shift report and conducted audits to increase compliance, they were not done consistently or accurately.

> Handover is mind-boggling to me that people have trouble getting nurses to buy into it because [I] can give examples that demonstrate from a patient perspective what that means. I talk to my nurses about the position they can put you in if you do not do it right. You did not do handover and the IV rate is wrong, you have an infiltrated IV. All these things that the previous nurse maybe was part of and now you cannot even ask those questions. Now you have got to explain the situation to the patient and doctor, and you do not have the background. (RNL02)

Finally, nurse leaders described risk assessments, when completed, determined patient risks to inform a clear plan to keep patients safe. A review of a risk assessments confirmed that prevention interventions were recommended based on a calculated risk score. However, NLs described that RNs not having time and being too busy were barriers to completing risk assessments.

3.2 | Making sure nurses have nursing interventions in place

Nurse leaders set expectations and held RNs accountable for having nursing interventions in place. Nursing interventions were defined as policies and protocols developed using professional standards and evidence-based practice for RNs to follow to guide safe patient care. The subthemes described setting expectations and holding staff nurses accountable for following nursing interventions: checklists, alarms, warnings and safety double checks and workarounds to keep patients safe.

> The IV policy is a reference that my nursing team utilizes. Recently there was another unit that wanted to transfer a patient who was on a nitro drip for high blood pressures that needed to be titrated. Currently our team is not competent in that, nor are we staffed to take care of that acuity to make sure that we are monitoring that patient safely. So, they were able to use that policy and stop it right there and figure out a different plan to keep that patient safe. (RNL02)

Nurse leaders could not agree on how prescriptive nursing interventions should be to support the use of nursing judgement. They acknowledged that RNs did not always follow nursing interventions placing patient safety at risk. Nursing interventions were not followed because they were too complicated, confusing, unrealistic, ever-changing, not easily accessible at the point of care, outdated and were too open to interpretation. 'You're trying to coach on fall prevention to the 17-page policy. By the time you get around to every nurse to personally coach them, they've changed it' (RNL04). Key policies were reviewed to confirm this result. During a safety huddle observation, a NL took over 15 min to explain a 17-page safety policy that RNs still found confusing and unreasonable. The organization had shared governance councils and improvement teams to incorporate RN input into nursing interventions; however, nurse leaders described a lack of RN engagement to participate. They also described not enough RN representation, members not trained on how to use evidence-based practice to develop nursing interventions and no training on managing group conflict as barriers.

Nurse leaders made sure RNs understood expectations through consistent, clear communication, auditing, rounding and feedback to ensure learning and compliance. They acknowledged inconsistency in how they set expectations and held RNs accountable.

> We have hounded on medication safety so much or even bigger is shift handover at the bedside. Finally, we all agreed between the hospital leadership we are really going to hold people accountable. You cannot turn your head. We've got to hold people accountable [slamming fist in hand]. (RNL06)

After tracking and coaching for so long, nurse leaders believed RNs did not follow standards because they lost sight of the patient in all the busyness and being overwhelmed.

Alarms, warnings, checklists and safety checks were supportive when they were working, easily accessible and responded to. Nurse leaders described that RNs did not always respond to alarms because they were too busy or perceived socialization took priority over answering alarms.

> A lot of socialization takes priority over patient care. I do not know if it's because half the time they are so busy and rundown that when they are not it's 'I have to breathe. I do not want to do any work, I just want to be able to chitchat and have some downtime' or if it's just a culture that we have grown. (RNL09)

They described that RNs did workarounds in nursing interventions because of real- or perceived-time pressure, knowledge gaps and lack of accountability.

3.3 | Expecting nurses to stop unsafe practices or escalate when they feel uncomfortable

Nurse leaders expected RNs to stop unsafe practices immediately, reach out to others with more expertise when they were in unfamiliar situations, and escalate, or reach up to the nurse leader or the rapid response team, to meet immediate patient needs. The subthemes described expecting direct conversations about safety, getting the right eyes on the patient and we do not have great relationships with our physicians.

> No fear. I [RN] would not think twice about stopping somebody from doing something if I felt it wasn't the right thing. I hear people talk about it, somebody will tell me I saw so-and-so do this and I'll say how did they react when you let them know. Of course, the answer I get is 'I did not'. Not having that fear would be a safety culture. They have the power to do it, I do not think they always believe they have the power. (RNL01)

Direct conversations about safety occurred when a RN would speak up immediately to anyone at any time to keep the patient safe by stopping unsafe practices, poor practices or disrespectful behaviour. Nurse leaders described RNs as struggling to have direct conversations and stopping unsafe practices that have resulted in patient harm.

> Sometimes they do not [speak up]. A lot of times that is due to hierarchy, poor relationships that they have, and some of it is based out of fear because they do not want the provider mad or to get yelled at. There's opportunities in pockets and opportunities for collaboration across the organization. (RNL10)

Nurse leaders coached, trained and encouraged direct conversations and stopping unsafe practices by recognizing and rewarding these behaviours. They also sought to empower RNs by promoting patient advocacy, reminding the RN of their duty and engaging the CEO in advocating for the important role of the RN in the organization. Nurse leaders had an open-door policy and followed up on RN concerns to model how to have direct conversations. Fear, lack of leader availability and lack of RN confidence were identified barriers. Fear was attributed to not wanting to look incompetent or challenging to physicians.

Nurse leaders believed RNs used their resources to keep patients safe in situations where they lacked experience or were unable to get what they needed to keep the patient safe. Resources included leaning on each other, other specialties, escalating to a nurse leader or calling a rapid response team that brought additional resources such as respiratory therapy and an intensive care unit nurse to the bedside to assist. The charge nurse was the most valuable resource when they were not busy and were approachable.

Nurse leaders described that resources were not available, barriers not removed and negative experiences when escalating a situation caused RNs to delay or question escalating, thereby placing patients at risk. In particular, a pattern of poor behaviours from physicians and other disciplines that was never addressed.

> If it's a one-time thing, you are having a bad night our nurses do not care. Everyone has a bad day. It's when it's a consistent repetitive [physician] behaviour that we have tried to address. It's just a slap in the face from the provider and honestly the organization because you are told we should not have to deal with this and to have it consistently ignored on all levels is just like a slap in the face. (RNL09)

Nurse leaders explained that RNs on their unit work well together as a team, however, described challenges working with other departments. Aligned goals, positive attitudes, being approachable and reliable, good communication and leading by example facilitated working together. They explained that developing relationships with other departments, disciplines and each other while learning to appreciate each other's unique roles facilitated a safety culture.

> The medical director is very engaged in providing education and answering questions, teaching on new procedures. That's good collaboration. That not only helps with patient safety because they are an integrated part of the care team but, they are helping develop nursing along the way. (RNL10)

They believed there were some RNs that just did not care, were too busy and burned out, prioritized socialization over helping and chose to not speak up as barriers to working together.

Nurse leaders identified that poor relationships with physicians contributed significantly to unsafe care.

> The most pressing thing to be addressed is a way to develop and foster relationships between these two [RNs and physicians]. If we do not have a foundational relationship, then we cannot respectfully work side-by-side and learn from each other. (RNL01)

Unsafe delays in care were related to a lack of or unprofessional response from physicians when RNs advocated for their patients' health and safety needs. A nurse leader described 'If the nurse feels belittled, they aren't going to bring something up that someone is going to put down because they don't feel comfortable based on responses they received in the past' (RNL03). As such, nurse leaders focused on the RNs and worked with them to cultivate relationships and professional, respectful communication between physicians and RNs by role modelling. On the other hand, reported poor physician behaviours were not addressed.

3.4 | Making sure nurses have what they need to provide safe care

Nurse leaders secured appropriate resources to keep RNs at the bedside. The subthemes described that balancing financially responsible staffing with patient needs is challenging, and supplies and working equipment are not always available to keep RNs at the bedside. Inadequate staffing contributed to the most unsafe day.

> If we do not have staff and there's patients that need help you are in a bind. The organization is here to serve the community, but if there is not nurses to take care of them, what do we do? It's been just take more patients and that makes a nurse feel like it's unsafe. Where do you stop? (RNL07)

Although nurse leaders described appropriate nurse–patient ratios, they acknowledged skill mix, inability to transfer high acuity patients to a higher level of care, geographic patient placement on the unit, patient and family dynamics, frequent discharges and admits and patients that required multiple RNs to assist in their care as barriers.

> When we are short staffed, I'm seeing patients not ambulating in the hallway, call lights going off which put our patients at risk of falling. Yesterday there was a dressing change that was supposed to take place in the morning, but it did not happen until the afternoon so risk for infection. The interventions need to be completed but they aren't because they just cannot get to them. (RNL03)

Low RN turnover, decreased vacancies, RNs helping each other, having and enforcing unit admission guidelines, dispersing acuity among assignments and support such as a transport team so the RN could focus on nursing care all facilitated safe care. They addressed staffing shortages by being available to help, forcing RNs to stay over their shift, calling in extra help, agency or travel RNs, showing appreciation for RNs that pick up extra shifts and using technology to supplement patient monitoring and responding to patient needs.

Nurse leaders acknowledged that supplies and working equipment were not always available to keep RNs at the bedside due to a lack of support from departments they depended on for delivery and repair. Nurse leaders felt disrespected as they were

unable to use their authority or influence to get resources to keep RNs at the bedside.

> I do not feel that I am respected. I was trying to work with our inventory supply to make sure that we had the right supplies at the right time for our nurses so we are not running around. He kept on going to the directors to get approval for things I wanted to try on my unit. So, it was very frustrating. (RNL02)

3.5 | Organization prioritizes patient safety

The organization prioritized patient safety by communicating to all departments and members of the health care team that patient safety was the overarching priority. The subthemes described establishing goals and providing transparency and communicating, listening to understand and responding to nurse concerns.

> It's everyone having the same understanding of what a culture of safety is. What does it look like, feel like and then having shared outcome goals to help pull that care team together more so that everyone's on the same page on providing that kind of care for that patient. When everybody is on the same page about safety it looks beautiful. (RNL02)

The CEO communicated and supported a vision of zero preventable harm. Then, patient safety goals were developed and aligned across all roles within the organization with routine transparency of outcomes.

> Being able to focus on the quality of care and having them be our metrics for the year has helped so the nurses know we are not just focusing on financials we are focusing on your patient and how we can prevent any harm. (RNL03)

Facilitators included an online incident reporting system, safety huddles and frequently reviewed visible patient safety dashboards. There was variation between departments of what safety as a priority for everyone meant, which left nurse leaders feeling disrespected and unable to remove barriers for RNs.

> My team members probably can speak to how I lead and how I speak about it and share what their thoughts are, but I believe from the actions from other departments that people do not share the same passion like we do. It's very frustrating and very sad because it's like banging your head on a wall. (RNL02)

Too many priorities and frequently changing priorities due to frequent turnover in executive leadership were barriers leaving nurse leaders feeling as if they were not doing anything good at all.

> There's so many quality indicators that we are trying to focus on and there's no support for any of that so it relies on me. You cannot focus on all of them every day and you feel like you aren't doing anything good at all. (RNL04)

> Sometimes I feel like we are firefighting. We're not preventing before it happens which then does not make it feel like a safety culture. You have to prioritize and it's very hard to understand where my focus needs to be. I know patient safety is the number one focus but with everything else coming at me what can I set aside to really be able to do what I need to do. (RNL03)

They prided themselves in communicating, listening to understand and responding to RN concerns. They described:

> It's always being open to listen and saying I appreciate you talking this through and just please be honest with me. I think some of that is just being open and having my door open and always letting people know that I'm here if you need anything. (RNL05)

Nurse leaders communicated through staff meetings, weekly updates, emails, daily rounds and daily huddles. They identified the barriers of inconsistent messaging among nurse leaders, a lack of sharing among nurse leaders to spread learnings and a lack of time for nurse leaders to spend time listening, communicating, and responding with RNs. Although they described themselves as advocates for RNs, they identified a disconnection between system expectations and what was happening at the bedside with an inability to effectively lead or advocate on behalf of RNs. They described how 'I think that there's sometimes a disconnect between what we'd like to do as a system and where we are right at the bedside … The communication chains are not always consistent and robust, and we don't share very well' (RNL06). Furthermore,

> If we could just get consistent leadership…it feels like we are always starting over and having to build new relationships. There's a lot of fear because of the lack of relationships and trust because no one really trusts anybody anymore because they do not know the people. You have to run things by them, notify them, versus just moving things faster because I do not want to get in trouble. (RNL04)

3.6 | Making sure nurses are learning and growing

There was a structure and process to learn from internal threats to patient safety and through formal programs to develop RN skills. The

subthemes described a nonpunitive response and follow through, supporting nurse knowledge and education and learning from audits and stories.

> If something happens, we do not point fingers and discipline you, we put in an incident report, gather data and then we build off of that, because it only makes everybody stronger instead of just pointing fingers. (RNL07)

Building trusting relationships with RNs and respectful coaching facilitated reporting of safety events.

> Relationship with your team is so important because they need to find comfort in their leader. I have said so many times how to get ahold of me when I'm not here. Daily connections provide comfort to nurses. They need as much information that pertains to them as possible because I think that reduces anxiety. (RNL04)

Providing real-time, nonjudgmental feedback helped RNs learn. At safety huddles, nurse leaders were observed following up by bringing issues back for learning. Meeting with individuals and other departments, sharing learnings through newsletters, debriefing in real time and supporting root cause analysis to identify and change system issues were facilitators.

Then RNs learned through an online learning system and through financial support for certification and conferences; however, nurse leaders acknowledged that RNs did not participate because on-going education was not required. They were concerned with RNs' ability to provide safe care because of the orientation process. Nurse leaders identified both role conflict and overload. For example, they did not feel qualified to develop their own orientation process and struggled finding competent preceptors to train new RNs. They also struggled with the lack of leader training or development for themselves. 'There is lack of orientation for leaders. You're trying to develop yourself, develop your team, maintain day-to-day practice, and then still make sure your team feels like you're available and there to support them' (RNL04). They also shared stories about clinical situations to create a learning environment. Finally, they audited key processes and shared the results and impact of not following key processes as a mechanism for learning.

4 | DISCUSSION

The role of the nurse leader is to provide the vital link between the organization's strategy and the frontline nurses (American Organization of Nurse Executive [AONE], 2015). Nurse leaders described that experiences with safety culture provided context to understand what is influencing safety culture perceptions. The organization aligned the vision to support patient safety; however, support for nurse leaders to deliver on this was lacking.

Nurse leaders described significant barriers in developing a safety culture including a lack of time, role overload, organizational constraints, inability to effectively lead, lack of power, role conflict and lack of respect for their role. Lack of time prevented nurse leaders from spending the time they wanted to build relationships with RNs. This left them feeling frustrated, disrespected and as if they were not doing anything good at all. Chronic fatigue associated with 24 h accountability and intense role expectations has been associated with nurse leader intent to leave the role (Steege et al., 2017). To address nurse leaders being too busy, recommendations include shifting from busy work to focused, strategic work through an energy preservation framework to promote vitality that drives engagement, productivity and innovation (Shirey & Hites, 2015). However, empirical support of nurse leader tactics to promote prioritization and accomplishment of duties is lacking. To retain nurse leaders and change the trajectory of safety culture in nursing, attention needs to be paid to these experiences which will require different organization understanding and support of the nurse leader role.

Nurse leaders need to be able to incorporate all dimensions of the transformational leadership framework to positively impact safety culture (Avolio et al., 1999) while being able to lead a professional work environment (IOM, 2004). Nurse leaders could not inspire and motivate through transformational leadership because of lack of power and inability to influence a professional work environment. This rendered them ineffective and led to unintended consequences including emotional stress and feelings of inadequacy. For example, they described a clear, compelling patient safety vision and multiple methods to communicate that vision and listen to RNs; however, they were unable to effectively address issues that were raised. Although they wanted to support RNs, they were unable to influence adequate staffing, could not obtain resources to keep RNs at the bedside and lacked power or organizational support to address poor physician behaviours. They also provided information and some levels of support but the inability to provide resources prohibited RNs from engaging in decision making and professional development, all components of structural empowerment (Kanter, 1993). Nurse leaders must become skilled at advocating for a professional work environment. The lack of power to create and sustain a healthy work environment must be further studied. One cannot empower others and expect them to perform beyond minimal requirements if basic resources are not available and if nurse leaders are not empowered themselves. The role of structural empowerment and a professional work environment in developing a safety culture should be further explored. Organizations must also take a stand and not tolerate poor behaviours from any members of the health care team.

The desire to support RNs to provide safe care within a positive safety culture without the power or ability to do so left nurse leaders feeling frustrated, disrespected, emotionally distressed and inadequate. These results suggest that nurse leaders' safety culture experiences are conflicting with or may be diluted by combining their results with nonnursing administrative and management participant results of the AHRQ SOPS. Isolating nurse leader results in addition to research focused on understanding the nurse leader role in creating a safety

culture to redesign or support differently the role is necessary to change the trajectory of safety culture in nursing.

5 | LIMITATIONS

A pandemic was experienced after three interviews; however, the hospital did not experience a surge of patients until the final validation of results. The researcher served in a leadership role at the organization without any formal or matrixed authority over the participants. While this research was conducted in one hospital in the Midwestern United States, research on how leadership and safety culture in different contexts nationally and internationally is needed to further enrich our understandings of safety culture in acute care. Although these results are not intended to be generalizable, the rich description will support the reader in determining the transferability of the results within their own practice.

6 | CONCLUSION

This study provided important insights into nurse leader experiences with safety culture and safe patient care within medical–surgical units in an acute care hospital. Nurse leaders described many barriers in developing and leading a safety culture and providing safe care. If nurse leaders are accountable for safe nursing care, they need to be able to use their knowledge, influence, power and authority to advocate for safe nursing care and a healthier professional work environment. Organizations must support differently or consider a fundamental redesign of the nurse leader role to support and empower nurse leaders as they are the connection between system strategy and safe execution at the bedside.

6.1 | Implications for Nursing Management

Safety culture is facilitated when organizational leadership is deeply involved with and attentive to issues frontline workers face and have an understanding of the established norms and hidden cultures that guide behaviours (AHRQ, 2019). Although nurse leaders described many processes for understanding issues RNs experienced in providing safe patient care, they described not having the ability or influence to advocate successfully on the behalf of RNs to resolve those issues. Nurses readily embrace advocating for the patient; however, advocating on behalf of the profession, oneself or the work environment although clearly outlined in nursing standards of practice and code of ethics must also be prioritized. Nurse leaders need to gain advocacy skills and engage in activities that promote the profession including teaching, mentoring, peer review, involvement in professional associations and knowledge development and dissemination (American Nurses Association, 2015).

Nurse leaders are influential in creating a professional environment and fostering a culture where interdisciplinary team members are able to contribute to optimal patient outcomes and grow professionally (AONE, 2015). However, these nurse leaders found themselves overwhelmed with too many priorities and not having enough time to effectively lead and achieve a safety culture. Nurse leaders were busy with too many priorities that prevented them from spending time developing RNs, facilitating relationships and assuring adequate resources for making sure patients were safe. Nurse leaders must incorporate all elements of transformation leadership into their practice while focusing on and prioritizing the elements of structural empowerment and creating a healthy professional work environment (American Association of Critical Care Nurses (AACN), 2016: Shirey & Hites, 2015). To do this, system level change is critical, change that clearly situates nurse leaders as transformational leaders who have the power and administrative support to lead. Furthermore, given the discrepancy between nurse leaders and RN perceptions of safety culture (AHRQ SOPS citation), research on RNs perceptions of safety culture is needed to more fully understand the acute care safety culture context to then improve nursing effectiveness and promote safe patient care.

CONFLICT OF INTEREST

The authors disclose no conflict of interest.

ETHICS STATEMENT

This study was approved by the Loyola University, Chicago Research Ethics Committee (approval number 212782). Informed consent was obtained from all participants in the study.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from IRB restricted access. Restrictions apply to the availability of these data, which were used under licence for this study. Data are available from the author(s) with the permission of IRB restricted access.

REFERENCES

Agency for Healthcare Research and Quality. (2017). Daily huddle component kit. https://www.ahrq.gov/hai/tools/ambulatory-surgery/sections/sustainability/management/huddles-comp-kit.html

Agency for Healthcare Research and Quality. (2019). Culture of safety. https://psnet.ahrq.gov/primer/culture-safety

Alanazi, F. K., Sim, J., & Lapkin, S. (2022). Systematic review: Nurses' safety attitudes and their impact on patient outcomes in acute-care hospitals. *Nursing Open*, *9*(1), 30–43. https://doi.org/10.1002/nop2.1063

American Association of Critical Care Nurses (AACN). (2016). Healthy work environment. https://www.aacn.org/nursing-excellence/healthy-work-environments

American Nurses Association. (2015). *Code of ethics for nurses with interpretive statements*. American Nurses Association.

American Organization of Nurse Executives. (2015). Nurse manager competencies. http://www.aone.org/resources/nurse-leader-competencies.shtml

Anderson, A., Floegel, T., Hofler, L., & Swanson, M. (2019). Exploring the relationship between contact frequency, leader-member relationships, and patient safety culture. *Journal of Nursing Administration (JONA)*, *49*(9), 441–446. https://doi.org/10.1097/NNA.0000000000000782

Avolio, B. J., Bass, B. M., & Jung, D. I. (1999). Re-examining the components of transformational and transactional leadership using the multifactor leadership questionnaire. *Journal of Occupational and Organizational Psychology*, *72*(4), 441–462. https://doi.org/10.1348/096317999166789

Bass, B. M. (1985). *Leadership and performance beyond expectations*. Free Press.

Boamah, S. A., Laschinger, H. K. S., Wong, C., & Clarke, S. (2018). Effect of transformational leadership on job satisfaction and patient safety outcomes. *Nursing Outlook*, *66*(2), 180–189. https://doi.org/10.1016/j.outlook.2017.10.004

Campbell, A., Kennerly, S., Swanson, M., Forbes, T., & Scott, E. (2021). Manager's influence on the registered nurse and nursing assistant relational quality and patient safety culture. *Journal of Nursing Management*, *29*(6), 2423–2432. https://doi.org/10.1111/jonm.13426

Campione, J., & Famolaro, T. (2018). Promising practices for improving hospital patient safety culture. *The Joint Commission Journal on Quality and Patient Safety*, *44*(1), 23–32. https://doi.org/10.1016/j.jcjq.2017.09.001

Churruca, K., Ellis, L., Pomare, C., Hogden, A., Bierbaum, M., Long, J., Olekalns, A., & Braithwaite, J. (2021). Dimensions of safety culture: A systematic review of quantitative, qualitative and mixed methods for assessing safety culture in hospitals. *BMJ Open*, *11*, e043982. https://doi.org/10.1136/bmjopen-2020-043982

Famolaro, T., Hare, R., Yount, N., Fan, L., Liu, H., & Sorra, J. (2021). Surveys on patient safety CultureTM (SOPS®) hospital survey 1.0: 2021 user database report. (prepared by Westat, Rockville, MD, under contract no. HHSP233201500026I/HHSP23337004T. Rockville, MD: *Agency for Healthcare Research and Quality*. AHRQ Publication No. 21–0016.

Ferreira, T., de Mesquita, G., De Melo, G., De Oliveira, M., Bucci, A., Porcari, T., Teles, M., Altafini, J., Dias, F., & Gasparimo, R. (2022). The influence of nursing leadership styles on the outcomes of patients, professionals and institutions: An integrative review. *Journal of Nursing Management*, *30*(4), 936–953. https://doi.org/10.1111/jonm.13592

Frush, K., Chamness, C., Olson, B., Hyde, S., Nordlund, C., Phillips, H., & Holman, R. (2018). National quality program achieves improvements in safety culture and reduction in preventable harms in community hospitals. *The Joint Commission Journal on Quality and Patient Safety*, *44*(7), 389–400. https://doi.org/10.1016/j.jcjq.2018.04.008

Gandhi, T., Berwick, D., & Shojania, K. (2016). Patient safety at the crossroads. *JAMA*, *315*(17), 1829–1830. https://doi.org/10.1001/jama.2016.1759

Health and Safety Commission Advisory Committee on the Safety of Nuclear Installations. (1993). *Organizing for safety: Third report of the ACSNI study group on human factors*. HSE Books.

Institute of Medicine. (Ed.) (2000). *To err is human: Building a safer health system*. National Academies Press.

Institute of Medicine. (2004). *Keeping patients safe: Transforming the work environment of nurses*. Government Printing Office.

Kanter, R. M. (1993). *Men and women of the corporation* (2nd ed.). Basic Books.

Lee, S. E., & Dahinten, V. S. (2020). The enabling, enacting, and elaborating factors of safety culture associated with patient safety: A multilevel analysis. *Journal of Nursing Scholarship*, *52*(5), 544–552. https://doi.org/10.1111/jnu.12585

Lincoln, Y., & Guba, E. (1985). *Naturalistic Inquiry* (Vol. 9) (pp. 438–439). Sage Publications. https://doi.org/10.1016/0147-1767(85)90062-8

Miles, M., Huberman, A., & Saldana, J. (2014). *Qualitative data analysis: A methods sourcebook* (3rd ed.). SAGE.

Olds, D., Aiken, L., Cimiotti, J., & Lake, E. (2017). Association of nurse work environment and safety climate on patient mortality: A cross-sectional study. *International Journal of Nursing Studies*, *74*, 155–161. https://doi.org/10.1016/j.ijnurstu.2017.06.004

Panagioti, M., Khan, K., Keers, R., Abuzour, A., Phipps, D., Kontopantelis, E., Bower, P., Campbell, S., Haneef, R., Avery, A. J., & Ashcroft, D. M. (2019). Prevalence, severity, and nature of preventable patient harm across medical care settings: Systematic review and meta-analysis. *BMJ*, *366*, 14185. https://doi.org/10.1136/bmj.14185

Patient Safety Advisory Group. (2017). Sentinel event alert: The essential role of leadership in developing a safety culture. https://www.jointcommission.org/resources/patient-safety-topics/sentinel-event/sentinel-event-alert-newsletters/sentinel-event-alert-57-the-essential-role-of-leadership-in-developing-a-safety-culture/

Reis, C. T., Paiva, S. G., & Sousa, P. (2018). The patient safety culture: A systematic review by characteristics of hospital survey on patient safety culture dimensions. *International Journal for Quality in Health Care*, *30*(9), 660–677. https://doi.org/10.1093/intqhc/mzy080

Sandelowski, M. (2000). Whatever happened to qualitative description? *Research in Nursing & Health*, *23*, 334–340. https://doi.org/10.1002/1098-240X(200008)23:4<334::AID-NUR9>3.0.CO;2-G

Shirey, M., & Hites, L. (2015). Orchestrating energy for shifting busyness to strategic work. *Journal of Nursing Administration*, *45*(3), 124–127. https://doi.org/10.1097/NNA.0000000000000169

Steege, L., Pinekenstein, B., Arsenault Knudsen, E., & Rainbow, J. (2017). Exploring nurse leader fatigue: A mixed methods study. *Journal of Nursing Management*, *25*, 276–286. https://doi.org/10.1111/jonm.12464

Weaver, S., Lindgren, T., Cadmus, E., Flynn, L., & Thomas-Hawkins, C. (2017). Report from the night shift: How administrative supervisors achieve nurse and patient safety. *Nursing Administration Quarterly*, *41*(4), 328–336. https://doi.org/10.1097/NAQ.0000000000000252

How to cite this article: Harton, L., & Skemp, L. (2022). Medical–surgical nurse leaders' experiences with safety culture: An inductive qualitative descriptive study. *Journal of Nursing Management*, 1–10. https://doi.org/10.1111/jonm.13775

LAMPIRAN 3 : LEMBAR KONSUL

UNIVERSITAS dr.SOEBANDI

Program Studi : 1. Ners 2. Ilmu Keperawatan 3. Farmasi 4. Dill Kebidanan
5. Profesi Bidan 6. S1 Kebidanan 7. D IV Teknologi Laboratorium Medis

Jl. DrSoebandi No. 99 Jember, Telp/Fax. (0331) 483536,
E_mail :info@stikesdrsoebandi.ac.id Website: http://www.stikesdrsoebandi.ac.id

LEMBAR KONSULTASI PEMBIMBINGAN PROPOSAL DAN SKRIPSI
PROGRAM STUDI ILMU KEPERAWATAN
UNIVERSITAS dr.SOEBANDI

Judul Skripsi : Pengaruh kepemimpinan transformasional dalam meningkatkan persepsi perawat terhadap handover

Nama Mahasiswa : Vikki Lesmana
NIM : 18010019
Pembimbing I : Luluf Sasmito, S.Kep.,Ns.,M.Kep
Pembimbing II : Akhmad Efrizal Amrullah, S.Kep.,Ns.,M.Si

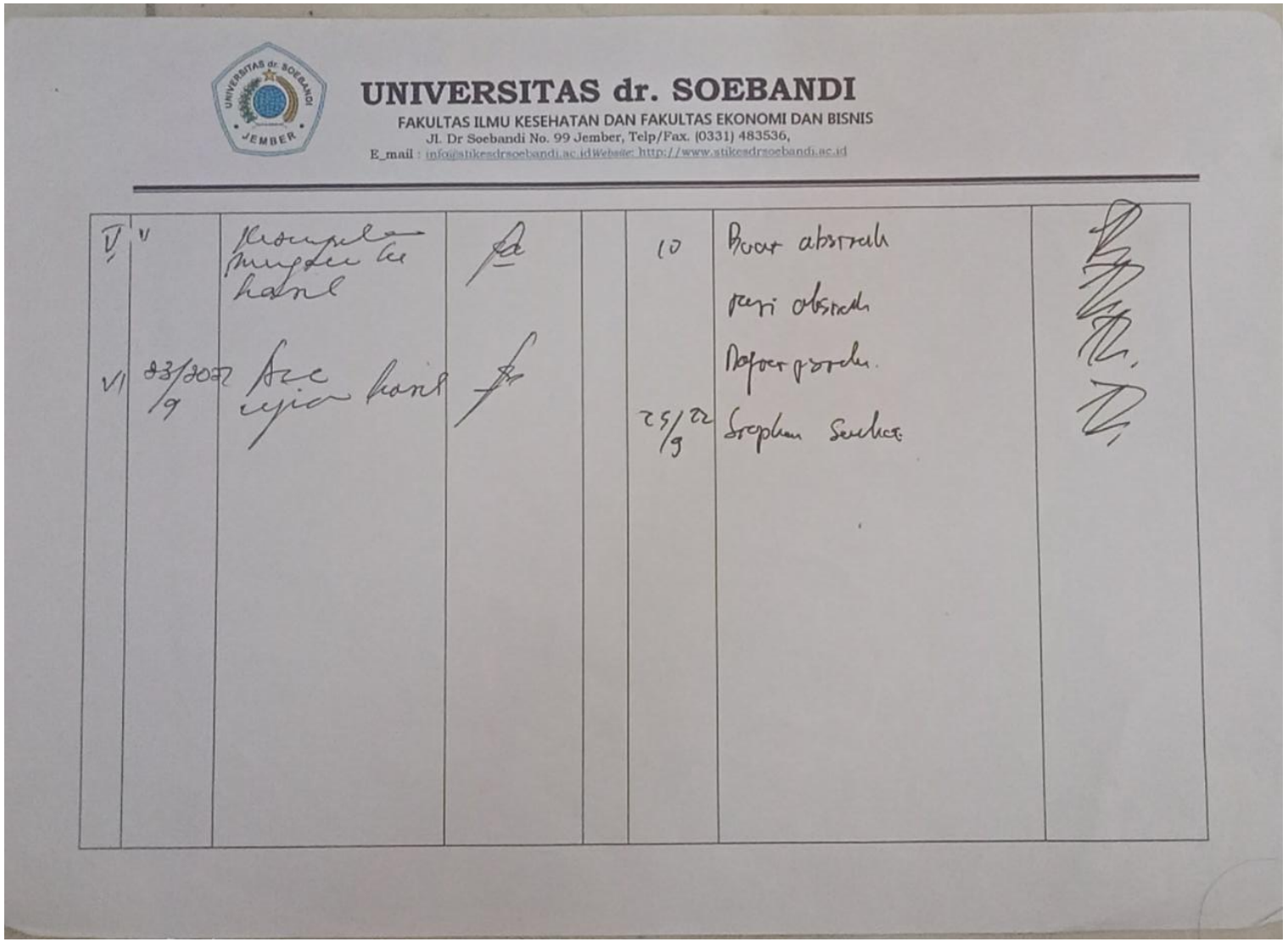
Pembimbing I				Pembimbing II			
No.	Tanggal	Materi yang dikonsulkan dan masukan pembimbing	TTD DPU	No.	Tanggal	Materi yang dikonsulkan dan masukan pembimbing	TTD DPA
1	11/2021	Konfirmasi Topik		1		Konsul judul, Sertakan literaturnya.	
2	30/2021	Acc Judul Proposal Bab 1		2		Acc judul Lanjut Bab 2	
3	23/2021	Konsul Revisi Bab 1, 2, 3		3		Konsul cari judul yg spesifik	

UNIVERSITAS dr.SOEBANDI
Program Studi : 1. Ners 2. Ilmu Keperawatan 3. Farmasi 4. DIII Kebidanan
5. Profesi Bidan 6. S1 Kebidanan 7. D IV Teknologi Laboratorium Medis
Jl. DrSoebandi No. 99 Jember, Telp/Fax. (0331) 483536,
E_mail :info@stikesdrsoebandi.ac.id Website: http://www.stikesdrsoebandi.ac.id

4	6/12/22	Koreksi judul. Statement dalam tujuan khusus. Buat Bab 2		4	7/1/22	Konsultasi BAB 2 & Revisi bab 2	
5	21/1/22	Revisi bab 1, 2, 3		5	19/1/22	Acc bab 2 lanjut bab 3	
6	25/1/22	Acc bab 1 dan 2 Revisi bab 3		6	22/1/22	Konsul bab 3 dan Revisi bab 3	
7	1/4/22	Konsul bab 3 Revisi bab 3		7	25/1/22	Konsul bab 3 dan Revisi	
8	8/9/22	Acc bab 3 lanjut Seminar		8	3/2	Acc bab 3 dan lanjut Seminar	

UNIVERSITAS dr.SOEBANDI
Program Studi : 1. Ners 2. Ilmu Keperawatan 3. Farmasi 4. DIII Kebidanan
5. Profesi Bidan 6. S1 Kebidanan 7. D IV Teknologi Laboratorium Medis
Jl. DrSoebandi No. 99 Jember, Telp/Fax. (0331) 483536,
E_mail : info@stikesdrsoebandi.ac.id Website: http://www.stikesdrsoebandi.ac.id

		HASIL					
9		Koreksi kasio artikel (kelurusan		9		Bab 1 → pilihan pd variabel yg diteliti	
10		Arahkan penyajian gn tujuan khusus!		10		Bab 5 → Fokus pembahasan ke aspek variabel.	
11		Abstrak Bahasa Inggris		11		Bab 6 → revisi kesimpulan.	
12		Daftar Pustaka jurnal → ditambahkan direview—.		12		Defenisi perlu tambahkan sumber² terkait + sesuai ejaan disempurnakan	



UNIVERSITAS dr. SOEBANDI

FAKULTAS ILMU KESEHATAN DAN FAKULTAS EKONOMI DAN BISNIS

Jl. Dr Soebandi No. 99 Jember, Telp/Fax. (0331) 483536,

E_mail : info@stikesdrsoebandi.ac.id Website: http://www.stikesdrsoebandi.ac.id

V	V	Konsultasi mundur ke hasil	✓		10	Buat abstrak perbaiki abstrak	
VI	23/2022 9	Acc lanjut hasil	✓		25/9 22	Daftar pustaka. Seminar Sempro	

LAMPIRAN 4 : CURRICULUM VITAE

A. Biodata Penelitian

Nama	: Vikki Lesmana
NIM	: 18010019
Tempat, Tanggal Lahir	: Kebumen, 09 September 1999
Alamat	: Bangsalsari
Jenis Kelamin	: laki-laki
Agama	: Islam
Nomer Telepon	: 081946349371
E-mail	: vikilesmana@gmail.com
Status	: Mahasiswa

B. Riwayat Pendidikan

1. TK (2004-2006)
2. SDN (2006-2012)
3. SMP (2012-2015)
4. SMA (2015-2018)
5. S1 Keperawatan Universitas dr. Soebandi (2018-2022)