DNP Essential II-Organizational and Systems Leadership for Quality Improvement and Systems Thinking

The American Association of Colleges of Nursing (AACN) second foundational competency for Doctorate of Nursing Practice (DNP) graduates has a lengthy title (AACN, 2006). Essential II outlines a conceptual framework for advanced nurses to utilize system thinking and leadership skills to impact healthcare reform and quality improvement. DNP practitioners are able to approach complex situations with deep insight and innovation (Zaccagnini & Waud White, 2011).

Michelle Riley, a nurse educator, addressed role expansion strategies for DNPs, and the parity with other professionals like pharmacists, psychologists, physical therapists, and medical doctors that the clinical doctorate for nursing provides (Riley, 2011). Riley summarizes the importance of experts in clinical practice, academia, and research collaborating to facilitate complex systems changes to improve patient and societal outcomes; the essence of DNP Essential II (Riley, 2011).

I was most inspired by the examples of DNP roles and innovations of advanced practice nurse achievements in leadership and systems change, Essential II. According to Hirschman, the DNP degree allows us to “be all that we can be” like the Army slogan (2011). Any nursing leader who quotes Bob Dylan is ok in my book, and indeed; the times they are a-changin’ in healthcare and nursing leadership. Hirschman described how his doctorate study on whether discontinuing anticoagulants decreased complications in cataract surgery made a practice change. It helped him get a higher education position but did not earn him more money, vacation, or promotion (Hirschman, 2011.) Many people ask me why I am going after my DNP, why I put so much time and effort into a degree that won’t reap financial rewards or lead me to a
new position anytime soon; I have finally started replying that the DNP degree “completes me” (think of the Jerry Maguire movie line!)

My dissertation project examines a nontraditional intervention to improve quality of life and resilience in breast cancer survivors. The literature shows mixed results from individual therapy and traditional group therapy, sometimes it helps, and sometimes it doesn’t. My hypothesis is that innovative interventions like therapeutic “Casting for Recovery” (CFR) retreats can make more of an impact than other lengthier traditional psychotherapy treatment modalities. If my hypothesis is correct, therapeutic retreats may be more effective in improving mental health in other groups and may be more cost effective as well. For example, I think that a therapeutic retreat for nursing burnout and compassion fatigue can have more impact than dry, classroom groups held in clinical sites. My committee chair (and probably other more traditional nurses) begs to differ, and would rather attend a class in a facility than go on a weekend retreat in a relaxed nature setting. (I think she would change her mind if I could get her to attend a nursing leadership retreat at Camp Joy some weekend!)

I related even more to the nurse entrepreneurs and their leadership skills and work outside traditional systems. I am happy to work in a small private practice setting where I can focus on my clinical practice, not on systems issues, though I have had my day in nursing administration and leadership and will probably return to larger systems work in the future.

I am also happy to have been part of a Forensic ACT team (Assertive Community Team), mentioned by Sgro (2011) as an innovative practice in public health. I worked on the Mental Health Access Point (MHAP) FACT team at the Hamilton County Justice Center assessing incarcerated mental health patients and prescribing psychiatric medication and linking to community support to prevent unnecessary incarceration and/or hospitalization. I also worked
with the Alternative Interventions for Women (AIW) program at Court Clinic for women with mental illness and addictions. AIW is a diversion program to get women treatment rather than sending them to prison; our re-arrest rate was very low the first year after treatment. These were tough populations that challenged my clinical skills and systems thinking. They were programs I had the privilege of being a part of in my position at Central Clinic, another tough system to survive and thrive in for 5 years or more. As I complete my DNP portfolio, I am reminded of the leadership positions and systems I have dealt with in the first 30+ years of my career and get excited about what’s to come in my next 30 years!

I would like also like to expand my knowledge and roles in future DNP practice to include integrative practice areas like those described by Elwell and White (2011). Psychotherapy and counseling are already considered integrative practices. I have also done some work with art and relaxation therapy. I have practiced Yoga and Qi Gong personally and often help patients with simply taking three deep breaths when anxious, something I do before I have to give a talk and on the way to work and home. Mind body and energy therapies have shown efficacy and DNP’s need to expand our knowledge of complementary/integrative therapies that 38% of our patients already use (Elwell & White, 2011). The websites for Integrative Health found on page 435 are already saved in my favorites (Zaccagnini & White, 2011).

References


