

values. As a catalyst to initiate changes, nurses will assume more responsibilities and be leaders. It takes only the vision of tomorrow, entrepreneurial spirit and commitment to create the reality from the dream. The future is not something you predict, it is something you invent. It is too important to guess at.

As visionaries, we have an opportunity and should be committed to shaping, as architects, the future of our profession. There are three kinds of people; those that make things happen, those that watch things happen and those that wonder what happened. It isn't the burdens of today that drive us mad, it is the regrets over yesterday and the fear of tomorrow.

Most of all, we must not forget humour in our lives. To know even one life has breathed easier because you have lived - this is to have succeeded, to have had a reason for having once been.

To strengthen your vision, this poem by D. Ritter may be appropriate:

*If you think you are beaten, you are,
If you think you dare not, you don't,
If you like to win, but you think you can't
It is almost certain you won't.
If you think you'll lose, you've lost,
For out of the world we find
Success begins with a fellow's will -
It's all in the state of mind.
If you think you are outclassed, you are.
You've got to be sure of yourself before
You can ever win a prize.
Life's battles don't always go
To the stronger or faster man,
But soon or late the man who wins
Is the man who thinks he can!*

May your vision of nursing, your expectations for your career and your personal life be fulfilled. It's just the beginning!

Measuring Quality: Evaluating Personnel Competencies

By Audrey Macdonald, R.N., Hon.B.A.

When I heard the topic which I was to present to the World Conference, I did two things. First, I reflected on my career as a perioperative nurse and reviewed in my mind how both quality and evaluations had changed throughout those years, as well as how my feelings about them have changed. Second, I began to review the literature on both topics to determine whether we agreed on what the changes were. For the most part, we were in agreement even if my views were expressed in more simplistic terms.

I will briefly review quality and personnel evaluations from the past to the present based on a personal perspective and a literary perspective. However, the main thrust of this article will be my challenge to you for tomorrow. To get to that future, I am asking you to consider the elimination of performance appraisals as they exist today. In their place, each nurse will be

required to develop a continuous improvement plan based on established competencies and quality indicators as they relate to expected internal and external client outcomes.

As you read this article, I would request that you reflect on your personal experiences with respect to quality and evaluations. What have they meant to you and how would you like to see them change or improve?

When I began my operating room nursing career, quality assurance was not in existence. Not until the early 1970s was quality in health care given much emphasis. Since that time, the concept of assuring quality has gained momentum, moving from retrospective audits to the current status of continuous quality improvement (CQI). In essence we have moved quality by inspection (bad apples theory) to quality by process improvement (quality improvement theory). At this time I would like to point out that the word "quality" is really redundant when used with continuous and improvement. If we achieve continuous improvement, we are producing quality as the end result. Also, we have moved from a system which saw quality assurance as a management responsibility to continuous improvement which is everyone's responsibility. These changes have been driven by government agencies, accreditation bodies and a more informed and knowledgeable client (patient).

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Abstract

Historically, quality and performance evaluation have been considered a management responsibility and have been completed retrospectively. In this article, I am proposing a radical shift. Specifically, I am encouraging the elimination of performance appraisals and, in their place, the introduction of continuous progress reviews and competency assessments which are initiated by each individual, not by management. Quality care will continuously improve in direct relationship to improved personnel competence which can be measured by using established quality indicators and expected client outcomes.

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If the continuous improvement process is to succeed, we must change the way we deal with issues.

One of these changes must be the elimination of traditional performance appraisals. Now, this suggestion is downright frightening! How else can we ensure that employees are working according to expectations and requirements? Why are we using them? What purpose do they serve? If considered realistically, the performance appraisal is dangerous and detrimental to performance as well as manipulative and controlling. Think about how you feel when your manager tells you that your performance appraisal is due and to start thinking about it. I can recall shaking in my boots, struggling to recall the positive things that I had done over the last year. In some instances, it may have been more than a year. Frequently, this was the only time that I had any discussion with this individual, and they were telling me what I should do to improve, and where I went wrong. I often wondered where they discovered all this information and whether everyone I worked with were paid spies.

“The performance appraisal is dangerous & detrimental to performance as well as manipulative & controlling.”

In the early days, and indeed even today, performance appraisals were used to determine the amount of the merit increase in salary. They were also used, and still are used, to promote individuals into positions of greater responsibility. As well, they are required by the accreditation bodies. Some of the reasons given for support of the performance appraisal systems are to:

1. Improve communication between the employee and the manager
2. Discipline and take corrective action
3. Develop personal goals
4. Assess competence.

What is wrong with these reasons? Communication should be a daily, on-going process. Discipline and corrective action should be immediate. Goal development should be an on-going process, not just an annual exercise. Competence assessment should be neither subjective, nor based on evaluator bias.

Based on these facts, elimination of performance appraisals must be considered since they are de-

signed to “catch” people, with management placed in the role of cop. The idea of the “trained nurse” comes to mind. “Do as I say and you will get your reward!” They are a yearly ordeal in which both parties get together to dig up the ghosts of past performance.

We must move toward a system of progress review and improvement assessments which facilitate learning. How frequently these reviews and assessments are performed must be left to the discretion of each individual, but they must be more frequent than yearly. Management becomes the facilitator, helper and enabler. Individuals should learn about the impact of their performance, where their efforts are making a difference, where they are not and what they can do to improve. In addition, they must be given the freedom to identify barriers to improved performance, to experiment with new approaches and to learn from what did not work so that improvements can be made. When I refer to individuals, I refer to everyone in the organization. Managers must ask their team what is working, what is not and what they can do to help the team and each individual accomplish the desired outcomes. Competency assessment tools enable employees to develop and improve personally and as a team. Managers gain from the employees the knowledge and insight critically needed to improve the processes and systems within which the employees are working.

The foundation for improvement is laid when all employees are encouraged to develop personal leadership skills. This makes a very powerful statement - “We believe in you. You have much to contribute”. Self-improvement is the beginning point to team and organizational improvement.

“Everyone has a responsibility to solve performance problems and initiate improvement.”

Improvement should become a part of our daily routine such that as we work, we develop the discipline and skill to continually look at whether we are doing the right things in the best way. Everyone has a responsibility to solve performance problems and initiate improvement, whether they are personal, team or procedure related. There are leaders in every department and at every level of an organization. A title or position does not a leader make, and we must look at ourselves and realize we have a responsibility to ourselves and our profession as perioperative nurses

to become leaders. We must take the initiative to develop a continuous professional and personal improvement system which will interface with the continuous improvement program within our practice setting.

About now, you are probably saying, “This all sounds great but how can we do it”. I have faith in all of you, but you must be committed and willing to take chances. Our first attempt may not be perfect but that is what continuous improvement is all about. The words “Well done!” should become the most commonly heard in the department.

In Ontario, our credentialing body, the College of Nurses of Ontario, must by law have a quality improvement program in place by 1997. In developing the program, Standard Statement Number 5 states:

“Each nurse assumes the responsibility for maintaining competence while striving for improvement in the quality of service in her/his dimension of practice”.

These dimensions of practice are direct practice, education, administration and research. From this statement, we are made aware of our responsibilities and as never before, competence and quality have been placed under one umbrella. They go hand and hand on parallel tracks. Also, everyone is placed in a leadership role since competence, improvement and quality of service are made a personal responsibility.

Quality Options

To assist us in this endeavour, four quality options are being offered whereby nurses will be able to demonstrate their competence. These options are:

1. Agency assessment
2. Formal education
3. Professional improvement profile
4. Professional portfolio

The agency assessment option must meet the College's quality improvement requirements, based on specific criteria for professional development. My proposal will focus on this particular option.

The formal education could include the pursuit of a degree, post-graduate work or obtaining and maintaining a certification in a specialty.

The professional improvement profile is similar to competency scales and would allow each individual to do a self-assessment, compare yourself to the ideal to identify strengths and potential areas for improvement. (Note the absence of the word “weaknesses”.)

Finally, the professional portfolio is similar to a detailed resume with the addition of a section about on-going professional improvement activities. In Great Britain, the nursing regulatory body is in the process of making a professional portfolio mandatory.

The purpose of these four options is to provide a framework for each individual nurse to evaluate her competence and develop plans for improvement. One must be selected in January, 1997, but over the years, a nurse may find herself using all four as our needs change. Clearly, the emphasis is on personal responsibility for our own performance and maintaining competence as well as accountability for our actions, and resultant consequences of those actions.

In everything we do, every action we take, there will be an outcome for someone. That someone may be the patient, our coworkers, the surgeon, anaesthetist, other nursing units, other departments, the health care facility, or even the community we serve.

Each one of us, as individuals and as team members, will play an important role in whether those outcomes are positive or negative. Our goal as professional perioperative nurses has always been to strive for the positive outcome. To accomplish this goal, our competence must be not only maintained, but continuously improved.

ORNAC 's Definition of Competence

According to the Operating Room Nurses Association of Canada (ORNAC), the definition of competence is “the knowledge, skills and abilities necessary to fulfil the professional role/functions of a registered nurse in the operating room, regardless of the practice setting”. Competencies will range in progression from beginner to expert, which is defined as “requires supervision” to “functions independently”, adapting to changing situations and demands.

Suggested competencies for perioperative nurses as outlined by ORNAC are:

1. Practices professionally
2. Provides physical care
 - circulating role
 - scrub role
3. Provides supportive care
 - to patient and family
 - to team members
4. Provides a safe environment
5. Responds to urgent/emergency situations
6. Manages resources

More detailed statements have been provided to further define each of these competencies, some of which I will be discussing in more detail later.

When considering each competency statement, we must apply the following characteristics: knowledge, clinical decision-making, team skills, communication skills, organizational skills, teaching and leadership, as well as accountability and responsibility. Knowledge is not enough. Skills come from knowledge and practice. They are learned, practiced, mastered, and reinforced until they become an integral part of the individual who self-evaluates and knows what is needed to reach excellence. Clinical decision-making involves analyzing what is required to perform a procedure, what the outcomes may be, and whether the resources are available to manage the outcomes. A highly effective team is a group of individuals who are committed to one another's personal growth and success, one that is continually learning, growing and developing. Personal leadership is at the core of all of these characteristics. Management's role should be one of servant-leader. Management must guide and direct. Management does not problem-solve, they make sure the right problems are being solved by equipping and supporting the team to solve these problems.

I am now going to take specific competency statements and relate them to who the clients may be, what the expected outcomes may be and suggest indicators whereby one can determine if the outcomes are being achieved. While reading through these statements, think about the characteristics I have just mentioned, and how they impact on each outcome.

1. Practices Professionally

"Recognize self-limitations and expertise in providing patient care."

The potential 'clients' are the patient, the coworkers, the surgeon and anaesthetist, the health care facility and the community.

Expected outcomes are:

- the patient receives the care they expect and deserve.
- the team members and the health care facility provide the assistance needed to increase skills.
- the community recognizes the quality of care available to them.

Indicators of whether the outcomes are being achieved are:

- the nurse knows how and where to find relevant information and invests time and energy in improving knowledge, skill and judgment required for effective practice.
- the nurse is not afraid to ask for help and other nurses are willing to share their experiences for the common good of the patient.
- educational resources are made available to the nurse.

2. Provides supportive care to patient and family

"Provide explanations and demonstrate a caring attitude to the patient."

The potential 'clients' are the patient, family, and the health care facility.

Expected outcomes are:

- the patient and family feel important and can verbalize a basic understanding of the perioperative processes.
- the image of the health care facility is strengthened

Indicators of whether the outcomes are being achieved are:

- the patient and/or family are greeted by name and the nurse introduces herself by name.
- the nurse describes the course of events which will take place, and what role she will perform during the perioperative experience.
- the nurse discusses issues of concern to the patient and answers their questions.
- the health care facility recognizes the importance of patient input and provides the freedom and means whereby the perioperative nurse can alter procedures to meet the patient's needs and expectations.

3. Manages Resources

"Organize and coordinate patient care and the surgical team, maximizing efficient use of energy, safety procedures and time."

The potential 'clients' are the patient, the family, coworkers, the physicians, the other nursing units, the other departments, the health care facility and the community.

Expected outcomes are:

- the anxiety level of the patient and family are kept to a minimum.
- the surgeon and anaesthetist begin the first case of the day at the scheduled time.

- other nursing units and departments can organize their activities based on the operative schedule.
- the health care facility does not incur costly overtime expenses.
- the community views the health care facility as responsible and efficient.

Indicators of whether the outcomes are being achieved are:

- the patient is called and arrives in the operating room just prior to their scheduled time.
- number of delays in starting of the first scheduled case on time.
- interruptions in patient care in other nursing units and other departments due to operating room delays.
- record of overtime and call-backs worked and paid.
- number of cases cancelled due to schedule delays.
- number of patient complaints related to surgical delays or cancellations.
- number of cases cancelled due to unavailability of supplies and/or equipment.

These are but a few examples of how we can do a competency assessment. Utilizing these examples, each statement could be developed as a part of the competency assessment tool. All the perioperative nurses must be involved in the development of the tool as well as other health care workers in the facility, since what we do can directly affect what they do.

I hope I have helped you to see the advantage of continuous competence assessments and how they will lead to continuous improvement personally, professionally and organizationally.

To help us focus on our performance and the effectiveness of our performance, we must continually ask the following questions:

1. **Why do we do what we do?**
2. **How do we know that what we do works?**
3. **How can we improve what we do?**
4. **How do we know we have improved?**

We all must decide which type of person we are and which type of person we want to be. Which one are you? One who makes things improve, one who watches things improve, or one who wonders what is improved. I sincerely hope that all of you fall into the category of making things improve.

In closing, I quote a statement made by Isabel Stewart on the science and art of nursing in 1929:

"The real essence of nursing, as a fine art, lies not in the mechanical details of execution, nor yet in the dexterity of the performer, but in the creative imagination, the sensitive spirit, and the intelligent understanding lying back of these techniques and skill. Without these, nursing may become a highly skilled trade, but it cannot be a profession or a fine art. All the rituals and ceremonials which our modern worship of efficiency may devise, and all our elaborate scientific equipment will not save us if the intellectual and spiritual elements in our art are subordinated to the mechanical, and if the means come to be regarded as more important than the end."

Sixty-six years later, this statement remains pertinent and reflects the importance of continuous improvement through personal improvement. Let us all make our personal commitment to quality, and consider promoting the abolishment of traditional performance appraisals and to move toward continuous progress reviews and competency assessments. Remember, success is never-ending, and failure is never final.

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