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President's Message

I have to admit, I have been struggling with what to write for this particular President's message. Finding inspiration has eluded me. The cold blustery days of winter, the never ending stresses in our health care system, the feeling of never having enough time to complete the work on my desk has taken its toll. That is until my eyes were opened and I was reminded about why I chose not just nursing but specifically perioperative nursing as a career. The source of my new-found inspiration arrived in my Operating Room with enthusiasm, boundless energy, and a notebook full of questions ..... in the form of a 4th year student nurse! The daily grind seems to have an uncanny ability to make us numb or less sensitive to the importance of what we do for our patients. Sometimes we need a reminder of where we all started – if only to snap us out of that numbness – and there is no better reminder than daily contact with a student!

So here is this 4th year student on her first day of her 6 week senior practicum rotation – one that she specifically requested. Little did she know that her presence would both inspire and ignite the staff. She brought with her a desire to learn and an enthusiasm for the profession... and as a result motivated the staff, myself included, to teach and to show off the perioperative world.

The pride and passion of being a perioperative nurse was at an all time high. Even the "old dogs" – the veterans of the OR – perked up and took this young student under their wings. I would even go so far as to say that we all felt possessive of, and responsible for, the goal of providing her with a comprehensive learning opportunity for her. We recognized that we had a potential future perioperative nurse in the making! What better way to pass on the torch than to open our doors and nurture the skills this young nurse was developing.

Certain events happened over the course of her rotation that cemented my faith in my fellow colleagues and my belief that perioperative nursing will always be my first love. Probably the most amusing was the voracity and determination of the staff to not allow any of the surgeons to diminish or deter the student's gusto!! Despite the typical pressures of the operating room environment, there was no chance the staff were going to allow for any bullying or any intimidation. And we realized that we should practice what we preach on a daily basis – we need to advocate for each other as well as for our patients!!! In the end, everyone – nurse, physician, and ancillary staff accepted the assignment of mentoring with the utmost importance. In the end it is possible that we "old dogs" benefited the most!

It's not that we haven't had students in our OR before....we are typically on the radar for student placement for a post basic operating room program in our province. Perhaps we were just due for a reminder that we need to embrace the student nurses... they are our future after all – and it seems they have a lot to teach as well as to learn! ✦

Linda M. Socha

Linda M. Socha, RN, BSN, RNFA, CPN(C), CEBT, CTBS, is President of the Operating Room Nurses Association of Canada. She is Clinical Nurse Educator for the OR at Saskatoon City Hospital and the past Chair of the ORNAC Editorial Committee.

President's Message

Il faut le dire, j'ai eu beaucoup de mal à choisir un sujet pour ce message. L'inspiration ne voulait pas se pointer le nez. Les journées froides d'hiver, le stress interminable existant au sein de notre système de santé et le sentiment de ne jamais avoir assez de temps pour compléter le travail sur mon bureau m'avaient tous sapé le moral. Mais cela a tout changé quand j'ai dû me rouvrir les yeux et me rappeler non seulement pourquoi j'ai choisi la carrière d'infirmière, mais pourquoi j'ai choisi celle d'infirmière périopératoire en particulier. La source de cette nouvelle inspiration est entrée dans ma salle d'opération débordante d'enthousiasme et d'énergie et portant un carnet rempli de questions : une étudiante-infirmière de quatrième année! En faisant la même chose tous les jours, on a la tendance troublante à devenir moins consciente de l'importance de ce que nous faisons pour nos patients. Parfois ça nous prend un petit rappel de notre point de départ, si seulement pour se sortir de sa torpeur, et rien n'est plus efficace pour le faire que le contact quotidien avec une étudiante!

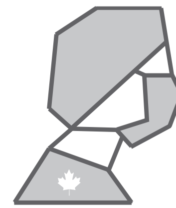
Alors voici cette étudiante-infirmière de quatrième année qui arrive pour la première journée de son stage de 6 semaines, un stage qu'elle a demandé. Elle n'aurait pas pu savoir que sa présence allait à la fois inspirer et motiver le personnel. Elle faisait preuve d'une soif d'apprendre et était prise d'enthousiasme pour la profession. Ce qui a eu comme résultat de motiver le personnel, moi inclus, à l'enseigner et à lui faire connaître le monde des soins périopératoires.

La fierté et la passion pour la carrière des soins périopératoires ont atteint de nouveaux sommets. Même les vétérans se sont ragaillardis et ont pris cette femme sous leurs ailes. Je dirais même que nous nous sentions tous possessifs et responsables de l'expérience complète d'apprentissage que nous voulions lui offrir. Nous nous sommes rendu compte qu'elle était une infirmière périopératoire en herbe! Comment mieux passer le flambeau qu'en ouvrant nos portes et en nourrissant les nouvelles habiletés de cette jeune infirmière.

Plusieurs événements ont eu lieu pendant le stage de l'étudiante-infirmière qui ont confirmé ma confiance dans mes collègues et ma conviction que les soins périopératoires seront toujours ma première passion. La chose la plus amusante était probablement la voracité et la détermination du personnel à bloquer tout effort de la part des chirurgiens à décourager ou diminuer l'enthousiasme de l'étudiante! Malgré les pressions typiques de l'environnement de salle d'opération, le personnel n'allait permettre en aucun cas quelque forme d'intimidation que ce soit. Et nous nous sommes rendu compte que nous devrions suivre quotidiennement nos propres conseils. Nous devons nous défendre les uns les autres ainsi que parler pour nos patients! En fin de compte, tout le monde, personnel infirmier, médecins et personnel auxiliaire, a accepté la tâche de mentorat dans toute son ampleur. Il se peut bien que ce soit les vétérans qui en ont profité le plus!

Ce n'est pas que nous n'avons pas déjà eu d'étudiants-infirmiers dans notre salle d'opération, car nous sommes souvent choisis comme lieu de stage pour les programmes post-scolaires en soins périopératoires de base dans notre province. Peut-être qu'il était tout simplement le temps que quelqu'un nous rappelle qu'il faut accueillir chaleureusement les étudiants-infirmiers, ils représentent l'avenir, après tout, et il me semble qu'ils ont beaucoup à nous enseigner eux aussi!

Linda M. Socha, infirmière autorisée, baccalauréat en sciences infirmières, RNFA, CPN(C), CEBT, CTBS, est la présidente de l'Association des infirmières et infirmiers de salle d'opération du Canada. Elle est infirmière clinique enseignante pour la salle d'opération de Saskatoon City Hospital et présidente sortante du comité de rédaction de l'AIISOC.



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CALL FOR ABSTRACTS AND POSTERS

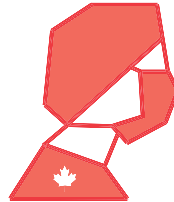
Operating Room Nurses Association of Canada

21ST NATIONAL CONFERENCE

St. John's, NL – June 7th-12th, 2009

Share your accomplishments in the fields of perioperative clinical practice, education, professional development, research, and administration! The 2009 Conference Program Committee is accepting submissions of abstracts for paper or poster presentation at the 21st ORNAC National Conference. The theme of the conference is:

"The Depth of Perioperative Nursing, What Lies Beneath"



Abstracts will be considered for presentation in one of the following forums:
Poster: A visual display. Posters will be displayed at the conference.
Paper: A 15-minute presentation by the author(s) plus 5 minutes for question & answers.

Posters will be selected based on relevance and implications for perioperative nursing and those in keeping with our theme. Criteria are available at www.ORNAC.ca.

Abstract submissions should have a maximum of 150 words on a single-spaced page, typed in a size-12 font. The abstract heading should include: title, author(s) name(s), institution name, city, province, contact information, and specific field of focus.

The deadline is July 31st, 2008. Please send three (3) copies of the abstract, by the deadline, to:

Glenda Tapp, *Program Chair* • 21st National ORNAC Conference • 7 Rosalie Place, CBS, NL A1W 2H4 • Phone: (709) 777-5773 • Fax: (709) 777-5372 Email: glenda.tapp@easternhealth.ca

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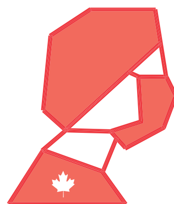
«Les profondeurs des soins périopératoires : Ce qui se cache»



Les résumés seront évalués pour présentation dans une des formes suivantes :
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Discours : Un discours de 15 minutes présenté par son auteur(e) ou auteur(e)s suivi de 5 minutes pour les questions.

Les affiches seront choisies selon leur pertinence et leur application aux soins périopératoires tout en respectant le thème. Les critères détaillés sont disponibles à www.ORNAC.ca.

Les soumissions doivent être d'un maximum de 150 mots dactylographiés dans une police de 12 points à simple interligne sur une page. Le nom du résumé doit inclure le titre, le nom de l'auteur(e) ou les noms des auteur(e)s, le nom de l'institution, la ville, la province, les coordonnées de la personne contact et le domaine spécifique d'intérêt.

La date limite est le 31 juillet 2008. Veuillez envoyer trois (3) copies du résumé avant la date limite à l'une des adresses suivantes :

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UTILISATION DE MATERIEL VIDEO COMME OUTIL PEDAGOGIQUE AU SEIN DE LA FORMATION DES INFIRMIERES ET INFIRMIERS PERIOPERATOIRES : ANALYSE DOCUMENTAIRE

Auteures :
Danielle Vigeant, infirmière autorisée, maîtrise en sciences, CPN(C), travaille en tant qu'infirmière de salle d'opération depuis 1990. Elle est actuellement infirmière clinique spécialiste au service périopératoire (préopératoire, salle d'opération et soins post-anesthétiques) aux sites pour soins adultes du Centre universitaire de santé McGill.

Hélène Lefebvre, Ph.D, est professeure à la Faculté des sciences infirmières à l'Université de Montréal.

Mary Reidy, Ph.D, est professeure à la Faculté des sciences infirmières à l'Université de Montréal.

RESUME
Cette analyse documentaire examine l'utilisation de matériel vidéo en tant qu'outil pédagogique lors de la formation d'infirmières et infirmiers périopératoires. L'objectif de cette analyse est de déterminer quelles applications vidéo peuvent être intégrées à la formation périopératoire. Le modèle d'apprentissage par expérience de Kolb, suivant lequel les connaissances sont acquis en transformant ses expériences en nouvelles manières de penser et de se comporter, sert de cadre théorique pour l'analyse des documents pertinents. Les articles sélectionnés ont été identifiés par le biais des moteurs de recherche suivants : CINAHL, ERIC et PSYCH INFO. De plus, certains articles ont été reçus d'experts dans le domaine clinique. Les articles analysés se divisent en trois catégories : l'utilisation de matériel vidéo pour démontrer un contenu; l'utilisation de matériel vidéo pour l'autoévaluation; et l'intégration de matériel vidéo au sein de programmes de formation multimédia.

THE USE OF VIDEO AS A PEDAGOGIC TOOL FOR THE TRAINING OF PERIOPERATIVE NURSES: A LITERATURE REVIEW

Authors:
Danielle Vigeant RN, M Sc. CPN(C), has been an OR nurse since 1990. She is currently the Clinical Nurse Specialist for the Perioperative Services (pre-op clinic, OR and PACU) at the adult sites of the McGill University Health Center.

Hélène Lefebvre, Ph.D, is a professor at the Faculty of Nursing for the Université de Montréal.

Mary Reidy, Ph.D, is a professor at the Faculty of Nursing for the Université de Montréal.

ABSTRACT
This review of the literature considers the use of video as a pedagogic tool (teaching instrument) for the training of new perioperative nurses. The literature review seeks to address the question of which usage of the video medium can be integrated into the education of new OR nurses. Kolb's model of experiential learning, whereby knowledge is acquired by transforming experience into new ways of thinking and behaviours, is the theoretical framework used to analyze the pertinent literature. The selected articles were obtained from the following search engines: CINAHL, ERIC and PSYCH INFO. In addition, articles were obtained from experts in the clinical field. The reviewed literature can be classified into three main categories: the use of video to demonstrate content; the use of video for self-analysis; and the integration of video in to multimedia teaching programs.

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Introduction
Recent high rates of retirement among experienced nurses has contributed to a staffing shortage in both general and specialized nursing. The major impact of this shortage is being felt in the specialties with the highest levels of stress and where the most training is required. These areas include the intensive care, the labour and delivery room, and the operating room[1]. The training of new nurses in to the OR takes, on average, one year and involves a significant investment of time and money.

These in-house, and informal, orientation programs are a factor that Craven and Boyle[2] have identified as a cause of staff turnover, burn out, and dissatisfaction. Because the new nurse's orientation takes place entirely in the operating theatre, her exposure to the surgery varies depending on the scheduled cases. The use of video in a formal orientation program is discussed in this article as an advantageous option for offering a broad and standardized content to the new nurses in the operating room.

This article is a systematic literature review on the use of video as a pedagogic tool for the training of nurses in the operating room. Kolb's model of experiential learning was chosen to direct the analysis of the literature. Kolb explains experiential learning as based on a personal and concrete experience of the learner. Learning occurs through a critical reflection on a particular experience and requires the active participation of the learner to transform his/her experience into knowledge[3]. The structure of the experiential model makes it possible to study and strengthen the links between education, work and personal development. It is also a cognitive, emotive, and behavioural process resulting in a living experience rather than just the knowledge of facts[3,4].

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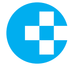
Kolb's Model
Kolb's model is simple and dynamic. It describes the experiential adult learning process in four cyclical phases: concrete experience, reflective observation, abstract conceptualization and active experimentation.

This model can be illustrated with the elements of a typical OR orientation. When the new nurse is sent to an operating theatre to observe the procedure and the role of the nurses and becomes actively involved in the scrub role by double scrubbing, or interacts with the circulating nurse on various aspects of patient care, this would be a concrete experience (CE) in the cycle of learning (fig 1). Upon leaving the theatre, the new nurse will meet the clinical educator and discuss her experience. This discussion should lead to reflection, by the new nurse, on her perception of the role based on her interactions in the operating room, defined in the model as reflective observation (RO). At this point, the new nurse could be presented with the theoretical concepts, for example aseptic technique or principles of electrocautery and link them to what she has already observed by using abstract conceptualization (AC). From there, she would be able to developed her own explanation (concept or model) to be tested in the active experimentation (AE).

The four phases of Kolb's cycle are located on two continuums: apprehension that occurs

Continued on Page 14



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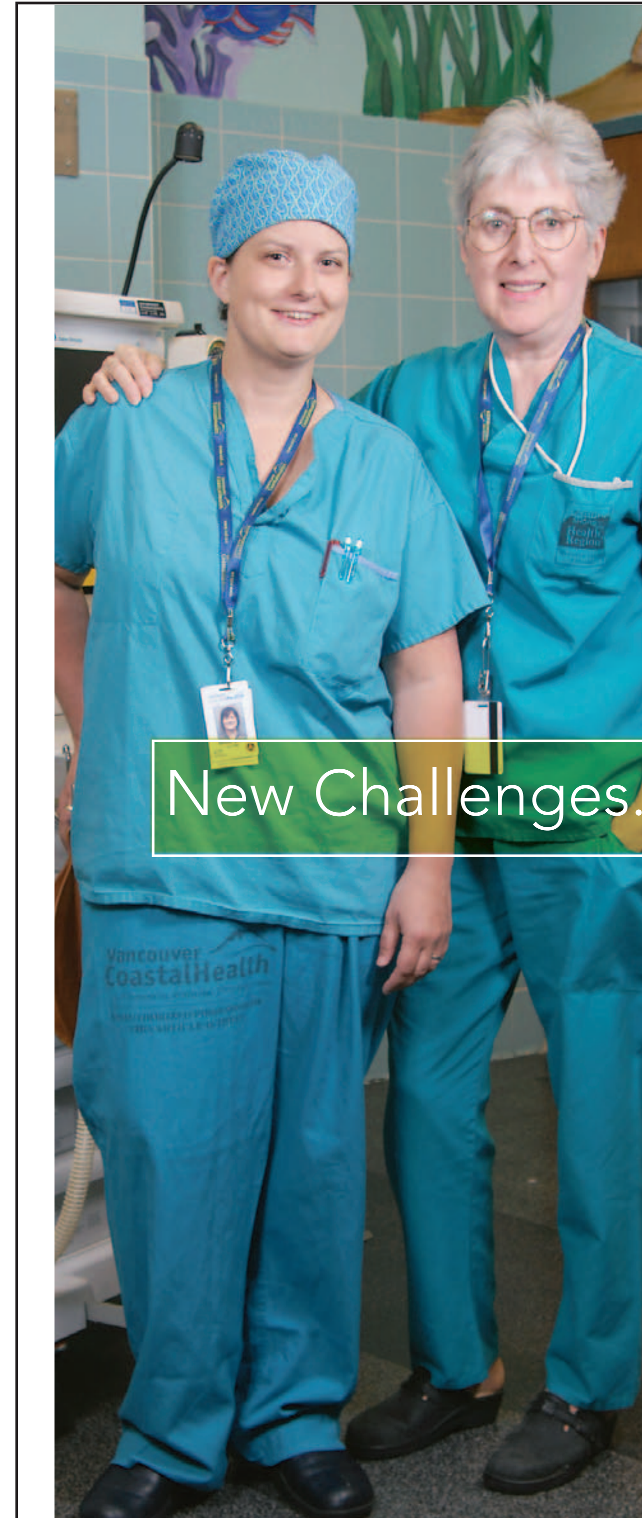

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when the individual participates in actual experience (the learner needs to touch and actually do in order to understand) and comprehension that happens outside of the context of actual experience (i.e. the learner reading an instruction manual before manipulating a machine, learning in a classroom lecture environment, or studying a text book).

Kolb identified four learning styles: converging (the learner favours abstract conceptualization and active experimentation); diverging (the learner prefers concrete experience and reflective observation); assimilating (choosing reflective observation and abstract conceptualization); and accommodating (whereby the learner will prefer concrete experience and active experimentation)[3,5,6]. The preferred learning style of an individual is influenced by his/her hereditary background, previous experience, and the demands of the environment. The pedagogic tools (such as case studies, observation grids, simulations, and video) when used within an experiential framework will enable the simulation of specific situations and help create personal experiences for the learner.

Literature Review

The search engines CINAHL, ERIC, PSYCH INFO as well as the publication search of Association of periOperative Registered Nurses (AORN) website were used to gather articles on the use of video as a pedagogic tool for the time period of 1995 to 2005. Only one article was found on the use of video in the operating room setting and so the search was broadened to nursing academic education and nursing continuous education. Using the keywords nursing, audiovisual, video, nurse education, and multimedia in various combinations, 492 articles were discovered and twelve were selected for this literary review. The inclusion criteria for the selected articles were nursing education, availability, and language (either English or French). Of the excluded articles many studied the use of video for patient education. No articles were found discussing the usage of video as a pedagic tool within the 1995 to 2005 time frame. Seven more articles and publications were chosen from the reference lists of the selected articles from an earlier date. Experts in the field of perioperative nursing and education were also consulted.

Three themes emerged from the selected articles: the use of video to demonstrate content, the use of video as a self-analysis tool, and the integration of video in multimedia teaching programs.

The Use of Video to Demonstrate Content

Shortly after video cameras were invented in 1956, academic settings predicted a major upheaval in education, even forecasting the disappearance of teachers and the domination of video. But it did not happen. The height of popularity of video was reached in the 1980s and most publications on the topic are from this decade[7].

Meeker[8] presents the experience of a Louisiana center using video and closed circuit television to provide continuous education to nursing staff. The flexibility of access by staff on all shifts, as well as the savings resulting from the elimination of costly workshops and a decline in staff replacement made this project successful. Unfortunately, the effectiveness of video as a pedagogic tool was not measured. Can you give timelines of this project – the wording project implies it was short term and had a start and finish date. When did it start and is it ongoing?

In the nursing schools, in the 1980s, the use of video was superficial and seemed to be rejected by nursing teachers[7]. This could be explained by several beliefs that govern the choice of teaching strategies and that resulted in a higher value being placed on face-to-face communication, over technological substitutes, at the time[9,10,11]. The single focus approach of the time denied the benefit of a multi modal educational methodology and dismissed the individual, and varied, needs of the learners. Teachers also perceived their profession as an art form and did not see a need for the science and technology of video[7]. Other considerations in the apparent lack of popularity of video are the absence of significant differences, as perceived by the students, in learning achieved through filmed presentations versus live presentations. It was felt that video was developed primarily for purposes other than education. Although the medium has obvious advantages, including the opportunity to view the images, as a group or individual, many times and at different speeds, it did not fully replace the student's involvement in an actual maneuver – video alone could not fully replace the real setting. The cost of equipment and the expertise necessary to develop programs could also have contributed to its lack of popularity[7].

In the 1990s, a study described the frequency of use of video cameras within a college nursing department[12]. Only 3% of the teachers used video cameras, to film and play for the class, more than 6 times a year. The absence of technical abilities and a lack of familiarity with the equipment were given as explanations by the teachers surveyed. They could not readily think of pedagogic applications for the equipment.

Video was used more intensively in European academic systems and Mottet analyses the phenomenon of video-formation that lead to a collective research action (also known as intervention research) in the school system[13]. This type of research looks at the effectiveness of an intervention in the natural setting with the researcher also being one of the participants.

In 2000 Lai[14] published the results of an experimental study demonstrating the learning advantages of using dynamic visual information combined with audio. This experiment was based on the Paivio[15] dual coding theory that assumes that memory and cognition are served by two separate symbolic systems – verbal information and visual images.

The Use of Video for Self-analysis

There are two trends among the articles discussing the use of video as a reflective tool. They are self-analysis of cognitive abilities, such as communication skills[16], or self-analysis of psychomotor abilities (muscular movement that is a direct result of mental activity)[17]. In both areas an observation tool is necessary to guide the learner and provide opportunities for reflection. This application of video is currently being used in the skill lab of an operating room formation program to assist with the acquisition of psychomotor skills. Graling and Rusynko[17] maintain that being filmed while performing a skill introduces a level of stress that can be beneficial to the learner by giving them an opportunity to learn to deal with a stress level similar to that of real life while still in the relative comfort of the skill lab.

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The Use of Video in Multimedia Teaching Programs

In the last 20 years, technology has been increasingly used in nursing practice and academia. The expectations of a "learning revolution" that were placed upon video in the '80s have now been transferred to informatics (the science concerned with gathering, manipulating, storing, retrieving and classifying recorded information) and multimedia (information transmission that combines various communication media such as text, graphics, video, sound etc.). While some studies have shown that computer-assisted programs are an effective tool for learning facts and concepts[18,19], the actual context of accessibility should be different since technologies are now part of the learner's environment. Most students are familiar with computers and use Internet, which was not the case of the preceding generation[20].

When planning to use multimedia technologies in teaching programs it is important to evaluate the pertinence of the program prior to the utilization. Criteria have been established to guide the user in assessing such programs and it is recommended that the user evaluate and classify the nursing programs available on CD-ROM and websites[21,22]. The multimedia technologies can be integrated into a teaching program as a topic, a communication mode or

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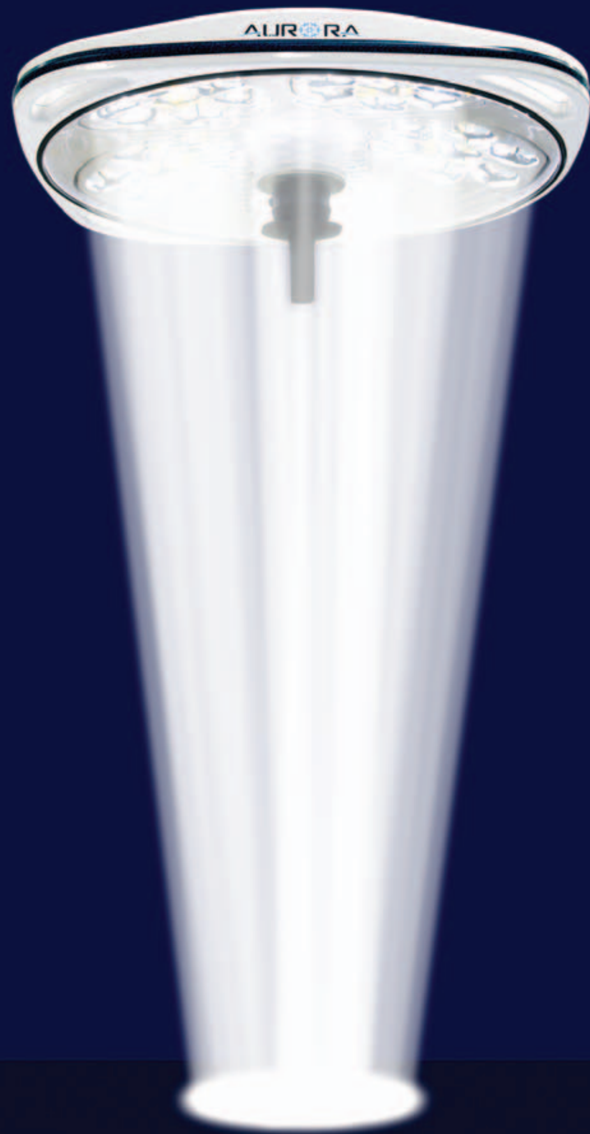

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as a pedagogic tool. It is important to note that using them does not in itself guarantee learning. They must carry an adequate pedagogic content[23]. Multimedia can facilitate the collaboration between students and teachers as well as stimulate reflection and problem resolution[24]. In the hospital setting, a potential use for multimedia programs is for general orientation of new employees. The advantages are seen as reducing the demands placed on the clinical educators, offering flexibility in the timing and place of the formation and an increase in time devoted to direct patient care. Barriers are perceived in the initial investment necessary for computer equipment, the few programs available in health care, and the lack of technical support and related expertise within the teaching institutions[25].

Three concrete applications have emerged among the literature on the use of multimedia. They are interactive video, distance education, and simulation.

Interactive Video

Interactive video is presented as a technology that requires the active participation of the learner and offers a simulation with a high degree of transferability towards reality. It is possible to represent the reality on film and, as a result, the knowledge acquired can be used in the real clinical setting. Ward recommends using a program created specifically for nursing rather than adapting another discipline's program[21]. Very few example of nursing programs are found in the literature; amongst them there is a cardio-pulmonary resuscitation program on CD-Rom, developed by Moule, Gilbert & Chalk[26].The authors explain in details the process of realizing their project, from content determination to filming, including the addition of a pre-test and post-test for the learner. The availability of

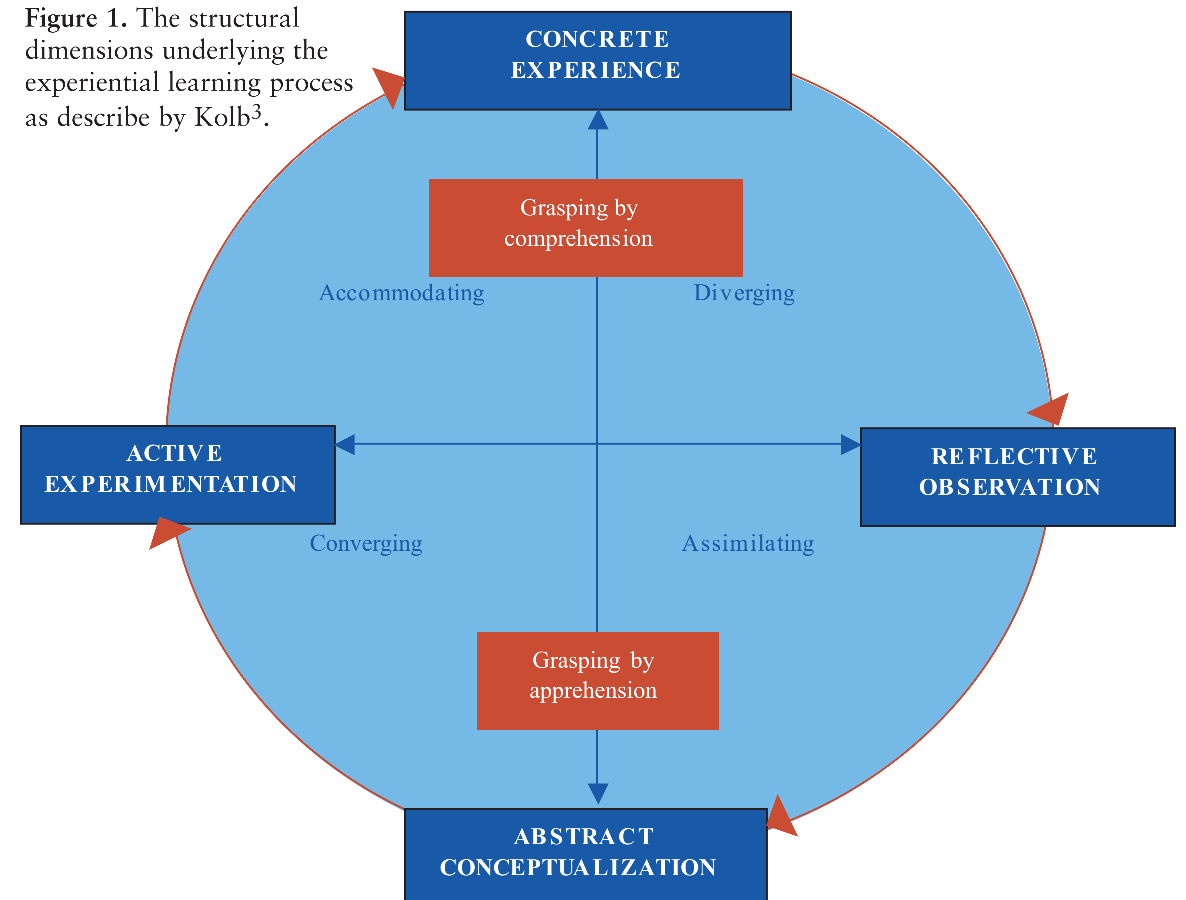

Figure 1. The structural dimensions underlying the experiential learning process as describe by Kolb[3].

digital video camera makes it easier to insert video streaming segments in to programs, web sites and digital audiovisual presentations[19].

Distance Education

Online education in nursing is progressively more available and it increases the accessibility to courses and the number of students. At the Faculty of Nursing of Université de Montréal, a research project was done when the same course, Health Assessment in Emergency Situations was offered both on-line and in a classroom setting. The web version used video to teach the health assessment that was traditionally demonstrated in skill labs. The study was conducted on the satisfaction of the students and success rates were compared and found to be similar[27].

Simulation

In simulations, video images occupy an important place in representing a realistic environment during the teaching process. The objective of a simulation is to reproduce an acute, or infrequent, situation with no risk to actual patients. It can also become a simplified model whereby interactions of filmed real events can be emphasized by the filming technique such as enlarging, focusing or slowing down the image[28,29].

A study was conducted in order to determine the skills that nurses in critical care, Emergency Room (ER), and anesthesia perceived to be difficult to learn and where nurses could benefit from a video simulation. They were also asked about their perception of the usefulness of the simulation. The advantages identified by the nurses of the simulation technology were the possibility of representing a vast array of interventions, their process and consequences. Simulations were also identified as an opportunity to improve the performance of complex procedures[28]. The nursing faculties perceive simulations as an alternative to traditional teaching methods that decrease the need for teacher hours and can also be integrated in to distance education programs[29].

A simulation program was produced in 2001 using digitalized video images, and titled "The clinical decision simulator"[29]. This tutorial combines filmed images of clinical situations and an animated tutor giving feedback to the learner after a decision has been made. For example, after the student assesses a patient and decides which interventions are necessary, the simulator will point out interventions that she did not use, their impact, which of her actions were right in the circumstances, and the rationale behind each option. This type of program is complex, is costly, requires computer expertise, and is mostly being produced at the experimental level. It is difficult to produce such a program in the clinical or academic setting and usually requires the use of external computer firms to program the content of a simulation that has been developed internally[29]. The simulations that are currently being developed and commercialized involve three-dimensional models such as the sim-man mannequin. Those simulation programs have been evaluated in quasi-experimental studies with second year nursing students comparing the skill acquisition of two groups (one group having used the simulation, the other learning without it). In this study, video was used as a self-analysis tool. While the use of the simulation improved learning significantly it did not change the confidence level of the students[30].

Discussion

The literature review suggests that video can be used as a pedagogic tool in nursing but it would find its relevance in the operating room mostly within the context of experiential learning (using Kolb's model and Paivio's theory as theoretical frameworks).

When Lai[14] validated Paivio's theory, she demonstrated that students assimilated abstract concepts better when they were presented with dynamic images and sound. Due to video's advantages of offering multiple viewings and the opportunity to rewind and pause the image, it can be perceived as a superior representation of reality and a concrete learning experience for the student[7,8,13]. As such, video can be used as a demonstration tool for students who favour a diverging learning mode.

When used as a self-analysis tool, video becomes an instrument used to induce reflective observation. The learner revisits his/her performance on video and, through the use of an evaluation grid, can structure the process of reflection and the integration of concepts. This application can be useful in the training of an OR nurse and in the setting of the skills laboratory.

The most recent articles on this topic discuss the use of multimedia in education, whereby video is a component of the three major themes: interactive video; distance education; and simulation. In some instances, the video image is digitalized and integrated in to an on-line program[27] or on to a CD-ROM[26] where the learner is an observer and integrates the concepts by observing and reflecting. This would be quite different than the use of a simulation or an interactive video where the learner becomes an active participant and lives a concrete experience as describe by Kolb[3].

A learner whose dominating learning mode is diverging, or assimilating, could benefit from using video as a concrete experience, during a simulation, or as a reflective observation tool. A learner whose dominating learning mode is convergent, or accommodating, will prefer the active experimentation. They would not benefit as much from the use of video since their integration of concepts would occur during the experimentation. Fortunately, active experimentation is already an obligatory component of the operating room formation and therefore tools are in place to appeal to learners who respond better to that form of learning. The addition of video would help appeal to the other style of learner.

Many authors cited by Garrett & Callear[29] doubt the efficacy of video in education and justify it by the lack of studies comparing video or multimedia with traditional teaching methods. AORN's clinical education department has been producing perioperative teaching videos since 1987, but has not conducted any studies in to the efficacy of, and value of, video as a pedagogic tool. In order for a change to occur in the culture surrounding video in education it will be important to obtain empiric results proving the pedagogic value of video and multimedia.

The literature reviewed offers no recommendations for the making of a specifically perioperative teaching video but some of the general suggestions can be applied to the perioperative setting. Initially, the clinical experts of the setting and the novice nurses, as potential users, should be consulted to determine the concepts and techniques where it is difficult to acquire actual workplace experience and for which a video representation would be advantageous[28,31]. Following this process, the content should be validated and a script and storyboard developed[26]. Participation by the audio-visual department of the institution would help with the feasibility of the project.

The use of video as a tool for self-analysis could also prove very enriching in the acquisition of specific skills to the different surgical specialties in a skills lab[17]. But the use of a teaching video does not, in itself, guarantee a faster and more complete training. Video needs to be integrated in to an educational program where the role of the clinical educator and the preceptor assures this experiential learning approach.

Conclusion

A video educational program for perioperative nursing, based on Kolb's experiential learning framework and Paivio's theory, could contribute to a training program for operating room nurses. Video appears to be an interesting medium to demonstrate the reality, and thus the details of surgical procedure, as well as the use of equipment and instruments. Once introduced as part of a training program in the operating room, further research, in a comparative or experimental study in measuring learning and staff satisfaction, would be of interest.

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ENTEROCOQUES RESISTANTS A LA VANCOMYCINE ET LE ROLE DU TRAVAILLEUR DE SANTE

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RESUME
Depuis la dernière décennie, la croissance de la résistance aux antibiotiques est fulgurante, et la propagation de souches résistantes aux antibiotiques est maintenant devenue une menace dans les hôpitaux. Les entérocoques résistants à la vancomycine (ERV) se sont révélés une de ces souches. Le ERV est un micro-organisme robuste capable de survivre longtemps sur les surfaces. Ils sont rapidement transmis de patient à patient par le contact avec les travailleurs de santé. Cette souche peut croître le taux de mortalité des patients dont le système immunitaire est affaibli. Les travailleurs de santé dans les hôpitaux ont un rôle primordial à jouer dans la prévention et le contrôle du ERV. Se laver fréquemment les mains en employant une bonne technique est une manière efficace de prévenir et à contrôler la propagation du ERV. Fournir une formation et des ressources aux travailleurs de santé est aussi un facteur important. La théorie des croyances aide à expliquer comment approcher et appliquer les changements à la pratique.

VANCOMYCIN-RESISTANT ENTEROCOCCI (VRE) AND THE ROLE OF THE HEALTHCARE WORKER

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ABSTRACT
Antibiotic resistance has increased dramatically within the last decade. The spread of antibiotic resistant strains of bacteria has become a threat within hospitals. Vancomycin-resistant enterococci (VRE) has emerged as one of these strains. VRE is a robust microorganism and can survive for long periods of time on environmental surfaces. VRE spreads quickly from patient to patient through contact with health care workers. This strain can increase the mortality rate in immuno-compromised patients. Hospital health care workers have an important role to play in the prevention and control of VRE. Proper, and frequent, hand-washing significantly contribute to preventing and controlling the spread of VRE. Providing health care workers with education and resources is also a key factor. The health belief model helps to explain how to approach and implement changes to practice.

There has been a dramatic increase in antibiotic resistance in the last decade and, as a result, the control of infectious diseases has become a major challenge. Antibiotic resistance is one of the most dangerous threats to the treatment of infectious diseases[1]. It has been estimated that thirty to forty percent of endemic institutional antibiotic resistance is caused by the unwashed hands of hospital personnel[2]. One of these antibiotic resistant strains of bacteria is vancomycin-resistant enterococci (VRE). The first isolated incident of VRE was detected in Canada in 1993, with the first outbreak in 1995[3]. VRE has developed into an important nosocomial pathogen and is linked both with mortality and the potential to transfer resistance to other virulent bacteria[4]. Health care workers, especially operating room nurses, recovery room nurses and the surgical floor nurses can play an integral part in the control and prevention of VRE.

In order to understand how to prevent the spread of VRE, and how to control it once it has been detected on a fomite surface in a hospital, it is necessary to further examine the role of health care workers in the transmission of infection. This article will discuss recommendations and barriers to maintaining patient safety when

preventing and controlling the spread of VRE. The health belief model will be used to explain how change in the behaviour of health care workers could be implemented among the staff of an acute care hospital to achieve this goal.

What is VRE?

Enterococci are gram-positive bacterium and are a part of the normal flora of the gastrointestinal tract[5]. The bacteria can, however, cause serious infections such as those of the urinary tract and even endocarditis[6]. Studies have also demonstrated a significant relationship between VRE bacteremia (presence of bacteria in the bloodstream that has been proven through laboratory account (7)) and mortality[5]. VRE can also result in sepsis, multisystem dysfunction, and death in immunocompromised patients[8]. Patients with VRE are often resistant to all other antimicrobial agents[7]. This makes it very difficult for patients who have a bacterial infection to recover as there are no pharmacological therapies available to them. As a patient's immune system is compromised it is important to limit his/her exposure to microbial agents. For this reason it is very important for all health care personnel to wash their hands, before and after patient contact, in order to prevent the spread of microbial agents.

There are many risk factors that predispose individuals to acquiring VRE. One major risk factor is vancomycin use as it prevents the growth of the normal flora in the gastro-intestinal tract, thus predisposing patients to colonization and infection by VRE[9]. Other risk factors include prolonged hospitalization (especially when in the ICU), immunosuppression (as occurs with bone marrow transplant, renal deficiency, neutropenia and chemotherapy), abdominal or thoracic surgery, and urinary catheterization[6]. For these reasons surgical suites and wards are particularly susceptible to nosocomial infection by VRE. It has also been shown that patients who are older than 55 years, neonates and infants are at greatest risk for contracting a VRE infection[10,11]. Mechanical ventilation, use of total parenteral nutrition and use of histamine receptor blockers are all risk factors for nosocomial infections[11].

Despite the proximity of Canada to the United States, the reports from the two countries regarding VRE cases are slightly different. According to Conly et al., the prevalence of nosocomial VRE within the United States in 1989 was 0.3% and increased to 23% in 1999[2]. The first reported incident of VRE in Canada was not until 1993, with the first outbreak in 1995[2]. However in 1996 a survey of VRE in Canada found prevalence rates in Canada of 0.1% among high-risk patients, no outbreaks in 1996, and a 3.7% prevalence rate among high-risk patients with endemic VRE within the same year[2].

VRE has been shown to move very quickly among patients. Wenzel & Edmond found that in San Antonio, Texas, over a 19-month period of time, the introduction and transmission of a single strain of VRE transferred to 32 patients in five hospitals in the area[12]. In Ontario in 1996, there were 167 people who were colonized or infected with VRE and an increase in 1998 to 718 reported incidences[13]. However with prevention and control measures in practice in Ontario, the reported incidences of VRE were decreased in 2001 to 237 people[13]. Therefore it is important to examine how VRE is spread in order to prevent higher prevalence rates in the future.

Although there has been a decrease in the incidence of VRE, most people will contract VRE within a hospital setting. In 2001 in Ontario, 91% of the cases with VRE were deemed to be acquired within acute care hospitals[13]. This is dangerous since the organism can survive for long periods of time on environmental surfaces and the immune system of a hospitalized patient has been compromised, making them more susceptible to infection.

Enterococci are robust organisms that are able to survive on inorganic and organic objects for quite extensive periods of time[6]. Sample et al. found that after a patient, infected with VRE, left the hospital, the environmental cultures of the patient's room remained positive for two weeks[4]. Therefore, standard cleaning procedures were deemed to be inadequate and enhanced infection control practices were engaged through monitored cleaning using 0.5% sodium hypochlorite solution and repeating environmental cultures. According to a study, conducted by Bonten et al, urine containers were the main environmental area upon which VRE was the most persistent[10]. The importance of proper cleaning of environmentally contaminated areas within the hospital setting cannot be stressed enough. This includes environmental factors such as bed rails, telephone, and the toilet. It is important for nurses and other health care provides to be aware of how long VRE can survive. These areas need to be disinfected thoroughly.

Screening for VRE:

It is important that those responsible for writing hospital policy require that patients at risk of developing VRE are effectively screened in order in order to allow the healthcare team to respond quickly and appropriately to positive results. Screening patients early on, and isolating those who are found to carry vancomycin resistant organisms, appears to decrease the spread of the microorganisms[14].

It is difficult to strike the correct balance between the cost of VRE screening and the potential health care costs that result from failure to screen for VRE. It is therefore necessary to establish the cost advantage in terms of the amount of screening to control and prevent the spread, compared with the cost of controlling VRE after an outbreak has occurred.

A recent study by Lee et al., cultured stool of inpatients for VRE testing using specimens submitted already for *Clostridium difficile* at a 688 bed tertiary care facility in Chicago[15]. The study used the findings to determine risk factors of those cultured for VRE and a cost-effectiveness evaluation was conducted[15]. They identified five patients with VRE from the specimens collected and all of these patients had been hospitalized within the last two years[15]. The results found that the total cost per patient admitted to the hospital were lowest in the strategy that included screening patients hospitalized in the previous 2 years[15]. The main limitations of this study relate to the small sample size from the same hospital and surveillance cultures were only conducted once from the patients upon arrival at the hospital[15]. This study does however help to promote the use of VRE screening for all patients who have been hospitalized within the last two years in order to provide the most cost-effective screening strategy for hospitals compared with screening only high risk groups or units.

As mentioned above the screening for VRE is accomplished through peri-rectal/anal swabs or stool specimens and it is necessary to know which isolate of enterococci a patient may have. Therefore the clinical laboratory is a crucial part of prevention.

There are two isolates of enterococci that have been found to be resistant to vancomycin. They are *Enterococcus faecalis* and *Enterococcus faecium*[16]. Infected patients carry VRE and present with clinical signs and symptoms. However, patients who are colonized with VRE may not have clinical signs or symptoms of infection.

The goal of screening, therefore, is to identify colonized and infected patients so that infection control measures may be initiated to decrease the spread of VRE[17]. This allows for the early detection of those who may be colonized with VRE, even though they may not present with the clinical symptoms, so that they can be placed under contact precautions to prevent the spread of infection. These contact precautions for the operating room, the recovery room and the surgical unit are of paramount importance.

Infection Control Practices:

It is a common and good procedure to isolate patients who are positive for VRE in order to help prevent the spread of infection to other patients.

Hand washing is considered the most important measure of infection control[11]. The Centres for Disease Control and Prevention recommends the use of alcohol-based hand rubs in addition to traditional hand washing with soap and water (CDC, 2002)[21]. Although the importance of hand hygiene is well known, compliance with hand washing for health care workers has been found to be conflicting. Many studies have found that health care workers neglect to wash their hands before and after patient contact[2]. Gould, Wilson-Barnett and Ream (1996) conducted a study of nurses and hand washing practices that found hands were only cleaned roughly thirty percent of the time after patient contact and only fifty percent of the time after being in contact

with heavy contamination[22]. Nurses cited the top reason for neglecting to wash their hands as heavy workloads and becoming too busy[22].

Another study found doctors estimated that they washed their hands at a perceived rate of seventy-three percent, but this contrasted sharply with the actual observed frequency of only nine percent[23]. Health care workers often only washed their hands for an average of about 8.5 to 9.5 seconds at a time[24]. This is compared to the recommended vigorous rubbing of hands and fingers for at least 10 seconds[25]. Therefore it is a major responsibility of nurses and doctors to monitor their hand washing frequency and duration.

Other protective barriers include the use of gloves and gowns. Hand washing does not replace the use of gloves, and gloves do not replace the need for proper hand washing. It is necessary to wash hands after wearing gloves. During direct contact with blood or body fluids it is recommended that gloves also be worn[25]. Gloves should be changed between patients and between tasks when contamination has occurred. Contamination takes place during contact with blood, secretions, or body fluids (25). Gowns should be used, and changed between patients, to protect the skin or clothing from gross contamination[26] and to prevent transmission to the next patient.

There is contradictory evidence for the mandatory use of gown and gloves for those treating patients with VRE. In a prospective study by Srinivasan et al. conducted in Baltimore, Maryland, during a three month period, all new admissions to a 16 bed adult intensive care unit at John Hopkins Hospital were isolated as if they had VRE and gown and gloves were worn when giving care[27]. Rectal swabs were taken for the detection of VRE. Patients enrolled in the study were separated into two groups slotted into two separate periods of time, one where gloves and gowns were worn and another where only gloves were worn. In the gown and gloves period, the VRE acquisition rate was 1.80 cases per 100 days at risk. The gloves only period resulted in 3.78 cases per 100 days at risk[27]. Therefore, it was established that patients admitted during the gown and gloves period had roughly half the rate of VRE acquisition of those who were admitted during the gloves only period[27].

Table 1: Health Belief Model – Six Concepts[33]

CONCEPT	DEFINITION	APPLICATION
PERCEIVED SUSCEPTIBILITY	One's opinion of chances of getting a condition	Define population(s) at risk, risk levels; personalize risk based on a person's features or behavior; heighten perceived susceptibility if too low.
PERCEIVED SEVERITY	One's opinion of how serious a condition and its consequences are	Specify consequences of the risk and the condition
PERCEIVED BENEFITS	One's belief in the efficacy of the advised action to reduce risk or seriousness of impact	Define action to take; how, where, when; clarify the positive effects to be expected.
PERCEIVED BARRIERS	One's opinion of the tangible and psychological costs of the advised action	Identify and reduce barriers through reassurance, incentives, assistance.
CUES TO ACTION	Strategies to activate "readiness"	Provide how-to information, promote awareness, reminders
SELF-EFFICACY	Confidence in one's ability to take action	Provide training, guidance in performing action.

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In comparison, a study was designed by Slaughter et al. in which hospital employees used gloves and gowns when attending 93 people in a medical intensive care unit, while for another 88 people, employees used only gloves[28]. Slaughter et al. found no added benefit for universal use of both gloves and gowns compared with the universal use of gloves only in preventing colonization of VRE[28]. One significant difference in the two studies was that the two populations were studied at the same time in the study by Slaughter et al., unlike the study by Srinivasan et al. in which two separate periods of time were used when studying the two groups. This, therefore, may have influenced the results. Further research in this area is necessary.

In addition to wearing gloves and gowns during direct patient contact, preventative measures include removing healthcare workers' rings and regularly cleaning stethoscopes. Higher microbial counts after washing are found on hands of health care workers who wear rings[11]. Also, stethoscopes can be a reservoir of bacteria if they are not cleaned on a regular basis. In a study of 150 health care providers, 48% cleaned their stethoscopes daily or weekly, 37% cleaned monthly, 7% yearly and 7% had never cleaned their stethoscopes[29]. As a result of cleaning the diaphragm of the stethoscope, there was an immediate reduction in the bacterial count by 94% when cleaned with alcohol swabs and a 75% reduction when cleaned with antiseptic soap[29]. It is suggested that all care providers clean their stethoscopes daily with isopropyl alcohol swabs.

There are several reasons why health care workers neglect to follow the recommended practices, including insufficient knowledge regarding when to wash hands as well as personal or organizational beliefs about hand washing[24]. Other factors are skin irritation, dryness and being too busy[24].

Patient safety has become a major priority in Canada, and it is the responsibility of all health care providers, health care organizations and governments to create a healthcare culture that is supportive of safe practices for the patient and staff[30]. The Canadian Nurses Association (CNA) suggests that a culture of safety in the workplace is necessary before quality improvement changes will be made within an organization[31].

Compliance and the Health Belief Model:
Nosocomial infections are a threat to patient safety and therefore it is imperative that infection control measures are effectively managed. The health belief model can be used to help implement changes among staff regarding infection control measures.

Curry and Cole applied the health belief model in collaboration with other social and behavioral theories in a study focused on implementing change of practice within medical and surgical intensive care units (ICU) through educational in-services, policies and programs designed to decrease the incidence of VRE[32]. This study was conducted over a six month period of time. Prior to the implementation of the program in July 1996, twenty percent of the patients in the surgical and medical ICU's were colonized with VRE[32]. After the program had been started, the number of positive VRE surveillance cultures decreased to less than thirteen percent between January 1996 and March 1997 and to less than six percent between April and December 1997[32]. Part of the success of the program is attributed to using the Health Belief Model for changing individual behaviour since there is a focus on both the perceived threat and the net benefits[32].

'The health belief model is a psychological model that helps predict health behaviours by focusing on the attitudes and beliefs of individuals. The health belief model has some key components (see Table 1)[32] of perceived susceptibility, perceived severity, perceived benefits and perceived barriers[34].

The model can be used to understand how staff and patients may view and act toward infection control practices in response to prevention and control of VRE.

Perceived susceptibility is explained as a person's perception of the risk of contracting VRE. A person's knowledge regarding the length of time enterococci can survive on surfaces may influence his/her perceived risk of contracting and spreading VRE.

Perceived severity results from the feelings an individual has regarding the seriousness of VRE in terms of the medical and social consequences.

Perceived benefits refer to a person's beliefs regarding the effectiveness of the infection control actions when it comes to reducing the threat of VRE. If proper practice results in lowering patient infection or colonization and thereby decreasing the time health care workers would have to spend per patient, this would influence an individual's perceived benefit[32].

Perceived barriers are associated with weighing out the challenges or cost of the actions. In the case of VRE, a cost could be the amount of time and extra work that is involved in implementing control measures such as the time involved in gowning and gloving[32].

Roden notes that the health belief model can be further explained through 'cues to action' and 'modifying factors' [34] (see Figure 1). Cues to action refer to additional variables that stimulate preventative activity[34]. Cues to action could be addressed through the training and education of staff. This may involve site-specific in-services relating to increasing awareness of the significance of VRE and the extent of environmental contamination as it relates to the operating room, the recovery room and the surgical floors[32]. A specific in-service should also be provided to housekeeping staff.

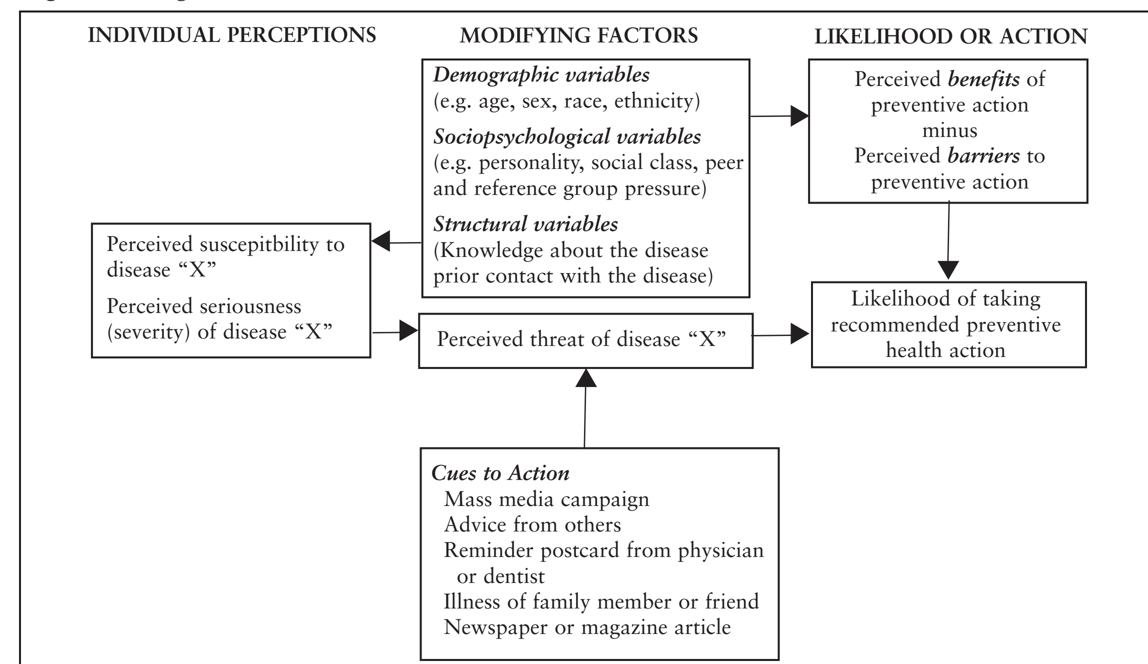
Finally, **self-efficacy** relates to the confidence in one's ability to take action[34] or how confident one is in their ability to appropriately perform the tasks in VRE prevention. This can be addressed through regular feedback from health care workers[32]. This can help to inform management of possible barriers to be able address these concerns.

The Ecological Model of Behaviour Change, the Health Belief Model, and Social Cognitive Theory can be applied to, and are consistent with, successful interventions. This multifaceted approach to intervening consists of five levels of influence:

- Intrapersonal or individual factors;
- Interpersonal factors;
- Institutional factors;
- Community factors; and
- Public factors.

The Health Belief model was employed for the interventions and behaviour change was based

Figure 1: Diagram of Health Belief Model[34]



on modeling, observational learning, and vicarious reinforcement.

Changing Practice:
In order for staff to recognize the perceived threat, it is necessary for them to be educated about VRE and how it is transmitted. Since infection control requires a multi-disciplinary approach, the education should include nurses, physicians, and environmental services personnel[32]. It is clear in the study quoted earlier that while doctors perceived themselves to be washing hands at an appropriate frequency, the reality was quite below appropriate levels. Therefore it is recommended that periodic monitoring of changes in infection control practices among staff be put into place. Providing feedback to the staff regarding actual hand-washing frequency has been shown to improve compliance[11].

There are many barriers to following infection control procedures. However, cleaning the diaphragm of the stethoscope daily and limiting jewelry on the hands are simple ways to prevent microbial growth. Not moving equipment from room to room also helps limit the spread of bacteria. Remembering to wash hands before and after patient contact, or after contact with a contaminated object, carrying gloves and donning a new pair with each patient are key factors in the reduction of the transmission of bacteria. Surgical team members who will have direct contact with sterile equipment should scrub their hands thoroughly for at least 2 minutes and a thorough cleaning underneath the fingernails should be done on the first scrub of the day[35]. Keeping fingernails trimmed and skin smoothened with an antibacterial lotion, will also help to reduce the spread of bacteria. It is also recommended for surgical team members to restrain from wearing artificial nails, since this can increase the bacterial and fungal colonization on hands even with sufficient hand scrubbing[35].

Posting instructional signs around the hospital will encourage patients and visitors to wash hands properly. Asking staff about hand washing compliance may help ensure compliance. Having visitors fill out a survey to see if staff washed their hands may also help compliance.

The health care facility's administration can encourage staff compliance as part of health and safety meetings. At these meetings, rates of infection should be reported. These statistics should be relayed back to the staff on a monthly basis. Positive results should be reinforced. Health and safety staff should be regularly sourcing the newest, and best, cleaning products available.

Conclusion:
The benefit to proper hand washing frequency and technique can help to prevent the spread of VRE and the extra work of trying to contain an outbreak of VRE. The Health Belief Model can be used as a tool to successfully implement change in practice. These measures will help to ensure that the decrease of incidence in Canada of VRE will continue.

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LE LEADERSHIP DESTRUCTEUR

SI VOUS PRENIEZ LE TEMPS D'EVALUER HONNETEMENT LA PERSONNALITE DE PATRON DE VOUS-MEME ET DE VOS COLLEGUES GESTIONNAIRES, QUELLE SERAIT VOTRE CONCLUSION?

« STAR », « SATISFAISANT », « LOIN DE PARFAIT », « INUTILE » ou encore pire?

À la table de souper, qu'est-ce que vos employés disent de vous? Combien de vos employés disent qu'ils haïssent leur emploi et leur patron aussi? La porte d'entrée claque-t-elle bien trop fort quand ils rentrent après le travail? Vos employés crient-ils après leurs enfants de frustration? Combien de larmes sont le résultat d'actions de vous et de vos collègues? Combien d'heures de sommeil perdues? L'absentéisme est-il le résultat d'un environnement de travail toxique?

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BOSSONOMICS DESTRUCTIVE LEADERSHIP

IF YOU RATED YOURSELF AND THE MANAGEMENT COLLEAGUES YOU WORK WITH WHAT WOULD BE YOUR HONEST ASSESSMENT?

"STAR", "OKAY", "JERK", "USELESS"… or worse names?

What are you called at the dinner table of your employees? How many of your employees say "I hate my job and my boss"? How hard is the door slammed when your employee arrives home? Were the children screamed at? How much crying goes on at home because of you and your colleagues? How much do you contribute to the insomnia of your staff? How much absenteeism is related to your workplace's toxic environment?

INTRODUCTION

The sentiments above use shocking words that make some people cringe. Some readers are saying to themselves "No, that's not happening with my staff." Others are getting defensive that this author would suggest OR leaders are anything but perfect… or at least doing their best in a difficult environment." Others will say "That couldn't happen in nursing". Those rejecting the idea are wrong – for the sake of your employees, please read on!

It's true, "bossonomics" is not a word. But for the purpose of this article it seemed necessary to coin a new phrase. Bossosnomics may be defined as reflection of the impact had by, and outcomes created by, the person who is providing direction, establishing authority and control over employees.

The modern manager, director, or supervisor may want to be seen, and referred to, as the "leader". But in truth, the staff will always see that person as "the boss" The boss may be referred to in kindly manner or, at the other end of the spectrum, in very derogatory terms. So, is being the boss a bad thing? That all depends what category of bossonomics you fall into. Using the four choices at the introduction of the article, where would you place yourself? What about the other leadership personnel you are responsible for? This is not an exact science, just based on years and years of hearing employees voice the same type of opinions.

One would wonder how many of those "destructive leaders" believe they can only control if they are viewed as "tough and in control." Distancing themselves from employees with their feelings, demands and needs may be a coping mechanism. Low self esteem, insecurity, incompetence and lack of direction may also add to the negative behavior. There may also be a belief that not being liked by the employees is a sign of a good leader.

Bossonomics requires that you really look in the mirror for a critical review and to determine what your staff are really saying and how you are viewed. You also need to take a look at the other management team members – bad managers reflect on the boss and other colleagues. It does not end there – what about the staff? If the boss has blinders on to staff behaviour it can create a toxic environment that may be driving the keen, young staff – the staff of the future – away. A boss who is seen to do nothing about bad behaviour will not have the respect of the staff.

The challenge is for every leader to know him or herself, know their own management style, and to recognize its impact on everyone

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What Type of Boss Are You?

including on the boss' personal reputation. It is the staff that make the productive world go round – not the bosses. The bosses, however, have the potential to destroy work environments, and employees, for a very long time. The characteristics and impact of the destructive boss are being widely discussed in books, newspapers, blogs, web sites and, most importantly, in the kitchens, living rooms and bedrooms of the employees. Books with such a title as "Monster Manager" the website www.badbossology.com provide an introduction to the magnitude of the problem. Why is there such a large market for authors of books about the phenomenon of "bad bosses"? "Bad boss" activity unfortunately must be prevalent or no one would be reading about it – it is time to wake up, recognize and take action.

DESTRUCTIVE CHARACTERISTICS

Beverly Kaye and Sharon Jordan-Evans describe many of the characteristics in "Are You The Jerk at Work" (www.fastcompany.com)? Some of the terms describing the "jerk" or the destructive boss' behaviours include rude behaviour, yelling at staff, telling lies and half-truths, humiliation, intimidation, sarcasm, belittling staff in front of colleagues, swearing, and inappropriate humor. Arrogance, negative feedback, withholding recognition, slamming doors, and losing their temper at meetings all create poor moral. Some bosses will withhold information, micromanage, take credit for work done by others, frequently

Continued on Page 36

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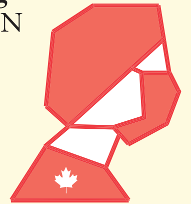

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remind everyone who is the boss and exude an "I am above it all" attitude. Bullying, racism, and sexism add frost to the toxic waters. Equally disturbing negative adjectives that are frequently added to the word boss include: evil, psycho, pig, monster, idiot and jerk. Do you see any of these characteristics, even periodically, in yourself, or in other managers, physicians and staff? If you are saying "no" you have your head in the sand. Even showing only one or two of the above behaviours on a periodic basis can be enough to ruin a boss' reputation. Leaders often have no idea of the impact of actions that the leader views as trivial. But the staff grapevine is long, sour, and a little bit rotten – word will travel and memories are long. By being honest about his or her behaviour a leader can do something about it!

IMPACT OF DESTRUCTIVE LEADERS

The staff are the critical "production" part of an organization. In toxic, unhappy, or abusive work environments productivity will suffer. Disgruntled, non-valued personnel will take back some control by reducing productivity – or just plain QUITTING! A large portion of our current staffing shortage, and lack of retention, is the result of poor work environments, bad bosses, and colleagues that behave in a similar manner.

Conversations with hundreds of nurses over the years confirm that they place a high value on educational opportunities and career development. Disrespecting the priority, or denying attention to the educational component, is one of the most common characteristics of a destructive leader. Combining this disrespect or denial with feeble excuses does not fly – staff don't buy it and believe that if there was respect, and a will, there would be a way! Disinterest in, and disregard for, professional opportunities, personal values, and daily work needs can be very demoralizing.

It is important to believe that the destructive person does not get out of bed in the morning with a "whose life can I ruin today" attitude. Does it just happen or has something pushed this person's buttons and resulted in a loss of integrity, trust and compassion? I doubt many destructive leaders have any idea of how they behave or of the impact of their behaviour. If they truly are vindictive, mean, power mongers then there is no way to change them – an "exit strategy" is the only way to maintain the integrity of the workplace in protecting and retaining the employees. Strong senior leaders and human resources personnel should carry out policies, toward this end, before too much collateral damage is done.

CONSIDERATIONS IN CHANGING DESTRUCTIVE ACTIVITIES

I have long since learned that you likely cannot change an individual's basic personality, mode of operation, leadership style, or attitudes. Having an awareness, however, of unacceptable action and the impact on the staff and putting in place a specific plan of action, with consistent follow up, may change the outcome. Recommendations for managing toxic situations include:

Live by your motto - Print your less than 5 word motto on a small card – have it in front of your face as a frequent reminder. Every day ask yourself "am I living up to it. Sample mottos could be "a positive image", "smile and listen", "professional interest", "lower my voice", "look in their eyes", "don't presume-investigate". Take five minutes to reflect three or four times a day and ask yourself "what just happened?".

Know your staff - It is important to have good communication links and to LISTEN, and pay attention to, what they are saying through words and actions. Do not be an "absentee landlord". Recognize your staff as people with important lives and be aware of how they describe their job to others. What is the morale in the work place? Take ownership – usually the staff will tell you, as long as they are not incriminated – if not, that is a message for you. Request an unbiased human resource expert find our for you, pay attention and start changing the destructive factors for your employees. Remember the employees are the ones that do the work for you and in spite of you.

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Pearls of Wisdom (cont.)

Know your personal reputation - what does your conversation with the mirror tell you? What do you see when you step back and evaluate yourself as the staff see you? Read between the lines of what people are telling you. Carefully reflect on how the staff react to your words, presence and direction. No news is not necessarily good news – if staff aren't talking to you there could be a problem.

Face, and accept, the facts - Fear, denial, and avoidance create an environment where the employees can be destroyed. The toxicity only increases for those who stay, while many excellent, and often young, staff may suffer long-term impact… and may quit, just as you have them fully trained! Don't stick your head in the sand – leaders who do not deal effectively with a "bad boss" also lose their own credibility.

Leadership crisis - Accept the fact that there is a leadership crisis both in quality and quantity. Don't be fooled by the assumption that you are desperate – often a bad manager is worse than no manager at all. Recruitment of the right people, rather than just filling a position in haste, is critical. Many employers do not check references that could have provided warnings. Are you asking the right questions during interviews? Are the candidate's responses giving you the information you need and not just what the candidate thinks you want to hear?

Demonstrate consistent role model behaviours - Good leaders attract more good leaders. Bad leaders, however, drive away good leaders. Good leaders are more likely to choose to work in a positive, supportive, environment where initiative can thrive and people are happy.

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A good leader means a happy and productive team

Read the "bad boss", "jerk boss" literature, web sites, and blogs to gain insight into what to look for and how staff respond to it. Information will help create insight and lead to action.

Development Training - attend training sessions yourself and make sure problem leaders attend. Have a follow up plan in place to determine what they have learned, how they will incorporate it, and how they will report ongoing progress.

Performance Management - Be alert and document unacceptable interactions, with precise words, tone and responses. Coach leaders and monitor their progress. Establish a code of conduct with the parameters by which to measure behaviour. Use highly skilled human resource consultants to assist with complex issues. Outside consultants may be useful. If you are unable to deal with the issues and effect change then be prepared to "adjust the employment status" – whether it is your own or that of someone else. Do not leave your staff hostage to bad bosses.

CONCLUSION

Be alert to the reputation, conduct, and communication patterns of those you supervise as well as those you report to. Do not excuse unacceptable behaviour with statements like "that is just the work culture". Leaders who do not deal with destructive staff will lose their credibility and reputation.

Know what is being said about you in the locker room. Know what your reputation really is. The truth may hurt, but consider if you, or some other supervisor, are the reason you are short of staff. Behave in a manner that has everyone saying "I love my job". Be one of those "magnet departments" where there is a waiting list to join. Create a three to five work personal motto and remind yourself at all times what it is. Your obligation is pursuit of professional excellence – nothing less will do!

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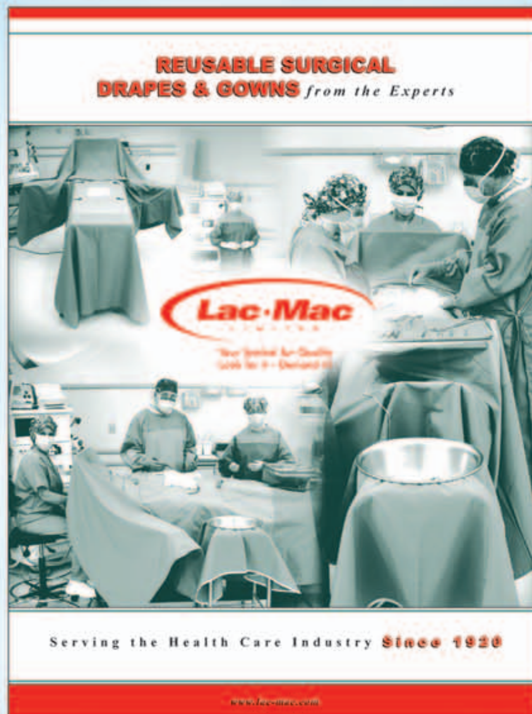

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