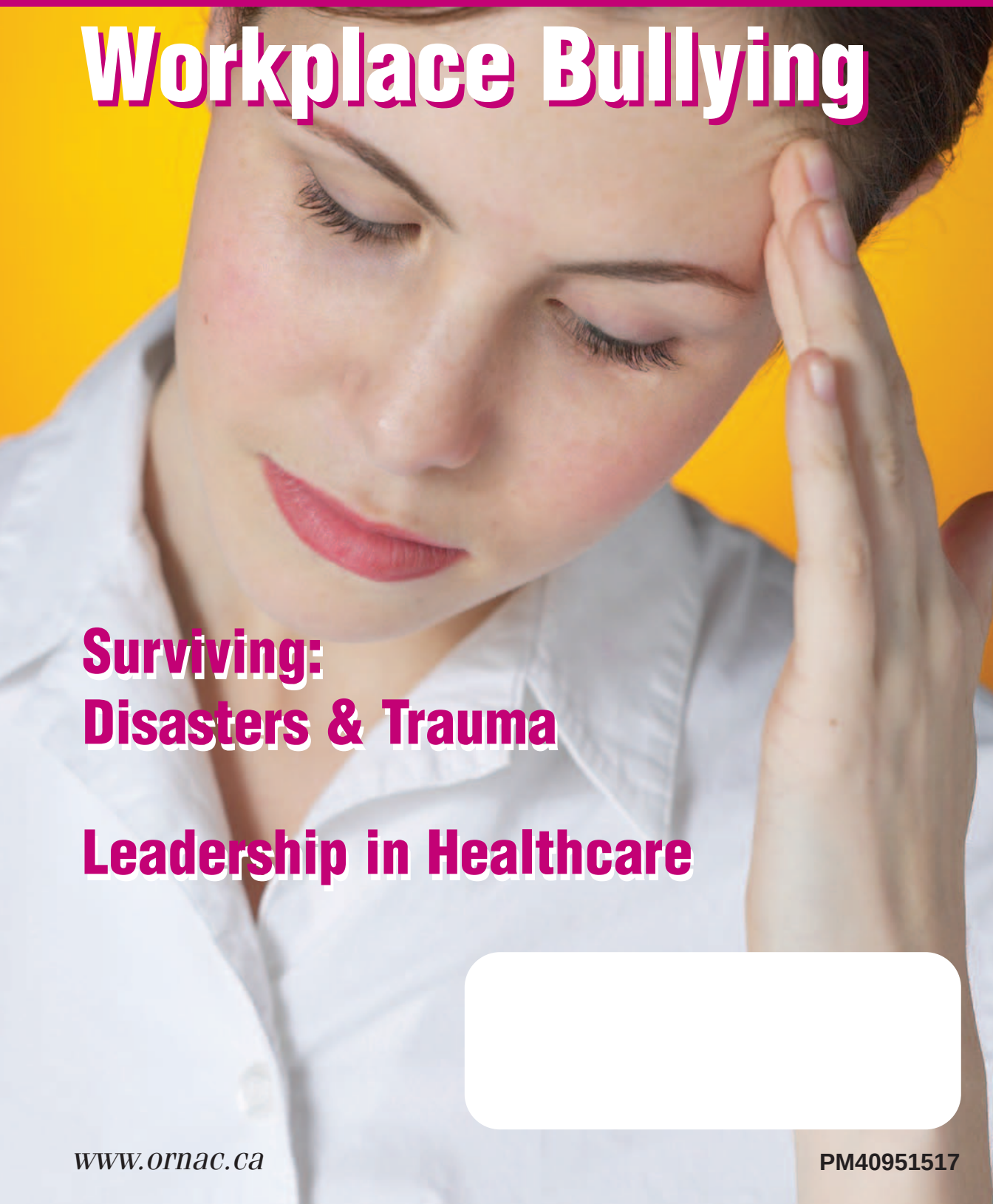
CANADIAN
OPERATING ROOM
NURSING JOURNAL

Volume 23, Issue 2
June 2005



Workplace Bullying

Surviving: Disasters & Trauma

Leadership in Healthcare

www.ornac.ca

PM40951517

President's Message

I did bid farewell in my last President's Message but, due to editorial deadlines, I was still the President when this letter was submitted. I thought I would take the opportunity to introduce the new *ORNAC* President. While Margaret will remain involved with the Executive, it will be in a more advisory role.

As memories of another successful National Conference begin to fade we look to the future. For *ORNAC* it holds much promise under the leadership and guidance of Marcy and with the continued efforts of the volunteer Board and Executive.

What can I tell you about Marcy? We first met in the fall of 1998 when Marcy attended her first Board Meeting as a representative of BC. What a glorious start – in Quebec City, in a board room showcasing the most spectacular view of the Plains of Abraham. Marcy jumped right in… signing on to committees and offering her views.

Tomorrow is a new day with new thoughts and mysteries to be discovered. *ORNAC* is growing and evolving as any "baby" does. With Marcy at the helm the changes will be varied as well as valuable. Please welcome, encourage, and assist her as you did me.

Margaret Farley
Past President, ORNAC

__Margaret Farley__, RN, CPN(C) is Past President of the Operating Room Nurses' Association of Canada. She is the Perioperative Clinical Development Educator at Regina Qu'Appelle Health Region in Regina, SK.

It has been my pleasure to be part of the *ORNAC* team with Margaret Farley at the helm. Margaret has done an admirable job as President. Many of you will recall that she unexpectedly took on the role of President Elect due to a sudden resignation on the executive. She has been a wonderful role model and her easy-going attitude and zest for life has been an asset to this organization. I can't thank her enough for all her guidance and encouragement. *ORNAC*'s bylaws have been changed this year, and the role of Past President has been modified. While Margaret will remain as part of the executive, it will be in a more advisory role.

ORNAC moves forward, and the coming term promises to be one of change and uncertainty. I feel we must be advocating for our patients like never before. I look forward to the challenge, and I take this opportunity to commend all perioperative registered nurses in Canada. You strive everyday, in the face of great adversity, to bring the highest standard of care to your patients.

In today's electronic world I am only an email away (**president@ornac.ca**) and I encourage you to keep in touch. Send me an email with your ideas, concerns or just to say hello. I look forward to the next term with great enthusiasm!

Marcy McKay
President, ORNAC

__Marcy McKay,__ RN CPN(C), is President of the Operating Room Nurses Association of Canada. She is a staff nurse at Victoria, General Hospital, Victoria BC, and is currently the webmaster for __www.ornac.ca__.

Message de la présidente

Il est vrai que je vous ai déjà dit adieu dans mon dernier message, mais en raison des échéances de publication, j'étais toujours présidente lors de la soumission de cette lettre. Je profite alors de cette occasion pour vous présenter la nouvelle présidente de *l'AIISOC*. J'assume maintenant le rôle de présidente sortante, et il me fait plaisir que j'ai l'honneur de présenter la présidente, Marcy McKay de Victoria, C.-B.

Pendant que les souvenirs des succès de la dernière conférence nationale perdent leur vivacité, nous nous tournons vers l'avenir. Pour *l'AIISOC*, l'avenir se montre plein de promesse sous la direction de Marcy et grâce à l'effort continu des conseils administratif et exécutif.

Que puis-je vous dire à propos de Marcy? Je l'ai rencontrée à l'automne de 1998 à l'occasion de sa première réunion de conseil en tant que représentante de la Colombie-Britannique. Quel début fortuné – à Québec dans une salle de réunion donnant sur les magnifiques Plaines d'Abraham. Marcy s'est lancée sans hésitation dans la discussion en offrant ses opinions et en s'inscrivant aux comités.

Demain l'avenir nous attend avec de nouvelles idées et de nouveaux mystères à découvrir. *L'AIISOC* grandit et évolue comme le fait tout nouveau-né. Avec Marcy au gouvernail, les changements seront variés et feront preuve de grande valeur. Veuillez accueillir, encourager et aider Marcy, tout comme vous avez fait avec moi.

Margaret Farley
Présidente sortante, AIISOC

***Margaret Farley**, inf., CSP(C) est présidente sortante de l'Association des infirmières et infirmiers de salles d'opération du Canada. Elle est éducatrice clinique pour le développement des soins périopératoires au Regina Qu'Appelle Health Region à Regina, SK.*

Faire parti de *l'AIISOC* sous la direction de Margaret Farley m'a été un grand plaisir. Elle a fait un excellent travail comme présidente. Plusieurs d'entre vous vous rappellerons qu'elle a entrepris le rôle de présidente désignée dû à une résignation imprévue de la part d'un membre du conseil exécutif. Elle s'est montrée un modèle de rôle de premier ordre et son allure calme et sa passion pour la vie ont été des atouts pour notre association. Je ne peux lui remercier convenablement de tous ses conseils et de son encouragement. Les règlements de *l'AIISOC* ont changés cette année, et le rôle de la présidente sortante a été modifié, quoique Margaret demeurera membre du conseil exécutif, ce sera dans un rôle plutôt consultatif.

L'AIISOC va de l'avant et l'avenir prochain s'avérera sans doute une période de changement et d'incertitude. Je crois que nous devons maintenant être défenseurs de nos patients comme jamais auparavant. J'ai hâte au défi, et je prends cette occasion de féliciter toutes et tous les infirmières et infirmiers de salle d'opération au Canada. Vous œuvrez tous les jours contre des obstacles de taille afin d'apporter à vos patients des soins de plus haute qualité.

Dans le monde électronique d'aujourd'hui je ne suis pas plus loin qu'un courriel (**president@ornac.ca**) et je vous encourage de vous tenir en contact. Envoyez-moi un courriel avec vos idées, vos préoccupations ou tout simplement pour dire bonjour. C'est avec un grand enthousiasme que j'attends l'occasion de vous servir en tant que présidente.

Marcy McKay
Présidente, AIISOC

***Marcy McKay**, infirmière autorisée, CPN(c), est la présidente de l'Association des infirmières et infirmiers de salle d'opération du Canada. Elle est infirmière de soins généraux au Victoria General Hospital, Victoria, C.-B., et est actuellement webmestre du site **www.ornac.ca**.*

CANADIAN
OPERATING ROOM
NURSING JOURNAL

Published Quarterly • Volume 23, Issue 2, June 2005

A peer-reviewed Journal published quarterly for the Operating Room Nurses' Association of Canada by Clockwork Communications Inc.

Editor: Deborah Murphy
Art Director: Sherri Keenan
Translation: Trina Langille

Canadian Operating Room Nursing Journal

c/o **Clockwork Communications Inc.**
Quinpool RPO #33145
Halifax, NS B3L 4T6
Tel: 902.497.1598
Fax: 902.444.0694
E-Mail: Contact@ClockworkCanada.com

Non-Member Subscription Rates

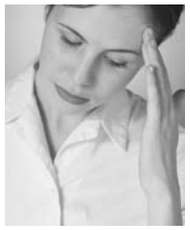
Canada	$30 *plus GST/HST*
Outside Canada	$52
Single Copy Orders	$10 *+ tax in Canada*
	$18 *outside Canada*

GST/HST# (Pending)
I.S.S.N. No. 0712-6778

Indexed in the Cumulative Index to Nursing and Allied Health Literature (CINAHL), ProQuest Information and Learning Company.

Publications Mail Agreement No. 40951517
Return Undeliverable Canadian Addresses to PO Box 33145
Halifax NS B3L 4T6
subscriptions@ClockworkCanada.com

Editorial Contents



After The Flood: Surviving Hurricane Juan

APRÈS L'INONDATION: SURVIVRE À L'OURAGAN JUAN

Auteurs:
***Cynthia Fulmore**, infirmière autorisée, baccalauréat en soins infirmiers, CPN(C), est l'infirmière clinicienne enseignante aux salles d'opération, site Victoria General, QEII Health Services Centre, Halifax, N.-É.*
***Sunny Russell**, infirmière autorisée, baccalauréat en sciences infirmières, PGOR, est l'infirmière gestionnaire aux salles d'opération, site Victoria General, QEII Health Services Centre, Halifax, N.-É.*

RÉSUMÉ

Le centre universitaire des sciences de la santé *Capital Health* est le plus grand district de la santé intégré au Canada atlantique. Il fournit des services médicaux tertiaires aux Canadiens de l'Atlantique ainsi qu'à 40 pour cent de la population de la Nouvelle-Écosse. *Capital Health* comprend neuf établissements médicaux, un desquels s'agit du Queen Elizabeth Health Sciences Centre. Ce dernier est le plus grand centre universitaire des sciences de la santé pour adultes au Canada atlantique; il compte 10 bâtiments sur deux sites, 8500 employés et 1075 lits.

Le Queen Elizabeth Health Sciences Centre a été créé en 1996 lors de la fusion de six hôpitaux : Victoria General, Halifax Infirmary, Abbie J. Lane Memorial, Camp Hill Veterans' Memorial, Nova Scotia Rehabilitation Centre et Nova Scotia Cancer Centre. Il y a 33 salles d'opération aux sites Victoria General et Halifax Infirmary; ensemble, à peu près 29 000 procédures chirurgicales y ont lieu chaque année. Les deux hôpitaux se trouvent à environ 5 pâtés de maisons l'un de l'autre.

Cet article traite de la manière dont ces deux établissements ont fait face aux ravages de l'ouragan Juan en septembre 2003.

AFTER THE FLOOD: SURVIVING HURRICANE JUAN

Authors:
***Cynthia Fulmore**, RN, BN, CPN(C), is the Clinical Nurse Educator for the Operating Rooms, Victoria General Site, QEII Health Sciences Center, Halifax, NS.*

Cynthia Fulmore, RN, BN, CPN(C)

Sunny Russell, RN, BSCN, PGOR

***Sunny Russell**, RN, BSCN, PGOR, is the Nurse Manager, Operating Rooms, Victoria General Site, QEII Health Sciences Center, Halifax, NS.*

ABSTRACT

Capital Health is the largest integrated academic health district in Atlantic Canada. It provides tertiary health services to Atlantic Canadians and to 40 per cent of Nova Scotia's population. Capital Health consists of nine facilities, one of which is the Queen Elizabeth II Health Sciences Centre. The QEII is the largest adult academic health centre in Atlantic Canada, occupying 10 buildings on two sites. It employs 8,500 staff and has 1,075 beds.

The QEII was created in 1996 with the merger of the Victoria General (VG), Halifax Infirmary (HI), Abbie J. Lane Memorial, Camp Hill Veterans' Memorial, Nova Scotia Rehabilitation Centre and the Nova Scotia Cancer Centre. There are 33 operating rooms at the HI and VG sites; together about 29,000 operations are performed there each year. The two hospitals are located about five city blocks away from each other.

This article discusses how the two facilities coped after the devastation of Hurricane Juan in September 2003.

WEEK ONE, DAY ONE

Usually we practice evacuations for fire or other types of disasters thinking it will never happen to us. When the people of Halifax, NS, awoke

Surviving Hurricane Juan (cont.)

Photo by M. MacLeod

Damage to VG Hospital roof

on September 29, 2003, disaster was a reality. Hurricane Juan had arrived during the night with sustained winds of up to 170 km per hour, leaving devastation in its wake. Power was out across the Halifax Regional Municipality and streets were covered with downed electrical lines and debris.

The staff at the QEII made brave efforts to get to work, some walking as much as 12 to 15 km. Many staff members had to leave damaged homes, cars and property. It was hard to leave their families in the dark, with no telephone service and some of them without water. When the VG staff arrived at work, they were greeted by the sight of their hospital's roof lying in pieces in the parking lot among the fallen trees.

For the first time since the Halifax Explosion, in 1917, Halifax declared a state of emergency. Every single transmission line running into Halifax Regional Municipality (HRM), was knocked out. The QEII was operating on auxiliary power, and all scheduled surgeries were cancelled. The situation was tense, but staff tried to keep the atmosphere light. Between 0600 and 0630, a plant engineer came to the OR to tell staff that the roof was gone and asked them to check for water damage. The OR supply technician checked the ORs and the hallway but found no visible signs of damage. The VG OR staff received a call to book an emergency case.

At about 0800, it began to rain heavily. The patient hadn't arrived yet. The anesthesia staff was getting ready when someone noticed that the emergency-evacuation stairwell was a river of water, and the damage went all the way from the 12th floor down to the fourth floor. Water was beginning to leak into the hallway. On the 11th floor, water was running down the OR lights and walls. The hallway was flooded, as were the storage rooms for sterile medical surgical supplies. Staff started moving everything out of the theatres to alternate emergency-evacuation rooms.

Due to the flooding, the emergency case's operation couldn't be done at the VG site. The ceiling tiles by the OR desk and in another room started to drop. Asbestos exposure became a concern. The Engineering Department ordered everyone to evacuate immediately to the ground floor. The power and ventilation were disconnected to the 10th and 11th floor OR theatres. The charge nurses used the daily staff schedule to account for everyone. The Perioperative director told VG staff members to remain on the ground floor in case they were needed to evacuate patients.

The nursing units from the 3rd to the 11th floors of the A wing of the VG site's Centennial Building were evacuated to different facilities around the city. The VG intensive care unit was moved to the HI site in the post-anesthesia-care-unit overflow area. More than 200 patients were moved out of the VG site by 2100h.

Photo by M. MacLeod

Parts of VG roof in the parking lot

The OR staff wasn't needed to evacuate patients, so they were sent home. That night the VG site's OR staff was asked to report to the HI site for life-or-limb emergencies. The VG staff knew that the HI site could supply instrumentation for most emergencies except urology. All of the instrumentation on the 11th floor was contaminated, but the 10th-floor instrumentation, where urology was located, was fine. The charge nurse made arrangements to send instrumentation and equipment to the HI site for urology. The Sterile Processing Department (SPD) worked through the night reprocessing all of the 11th-floor operating rooms' contaminated instruments. For the rest of the week, emergency life-and-limb surgery for all services was done at the HI site.

WEEK ONE, DAY TWO

QEII staff members were saddened by the loss of their colleague, John Rossiter, a paramedic who died instantly when a tree fell on the ambulance he was driving during the storm. VG staff began to make plans for how they would carry on post-disaster. Each day started with a meeting of department chiefs, managers, and the director of Perioperative in order to decide priority cases, modify OR schedules and address concerns.

The SPD manager and Infection Control manager did rounds to inspect the damage to instrumentation and supplies at the VG site. Most of the medical surgical sterile supplies were contaminated, and OR supply technicians had to inventory them before they could be given to insurance adjusters. The VG staff had to move equipment to the HI site. VG nursing staff did this in the dark with flashlights because the power and ventilation weren't working. Necessary equipment was identified and prepared for transportation. Biomedical Engineering at both sites inspected the equipment upon departure and arrival.

A truck was assigned to move equipment, supplies and instruments. The resource nurses in each service from the VG made lists of necessary instrument sets to do emergency

Photo by M. MacLeod

Hundred year old trees knocked to the ground in Public Gardens, downtown Halifax

cases. SPD staff packed carts to transport the sets to the HI. A hospital-wide deployment centre was set up. Daily planning was done to deploy extra staff to areas that were short-staffed or that needed assistance. This process continued until all services moved back to the VG site.

VG site nursing staff needed to be oriented to the HI's 19 operating theatres. There are many differences between the two facilities. For example, the HI works with a sterile core and a case-cart system, while the VG nursing staff picks cases from a sterile room and doesn't have a sterile corridor. The HI nurse educator spent most of the second day helping VG staff become familiar with the HI's physical layout as well as the case-cart system.

WEEK ONE, DAY THREE

HRM residents were still cleaning up and the power remained off in most areas. It was decided that only emergency surgeries would be performed. Engineering and maintenance reports from the repairs at the VG site's ORs were positive, and staff looked forward to returning there the following week. The HI educator continued to orientate staff that had been off or deployed to other areas.

The damp smell in the VG site's ORs was troubling because there was no ventilation, and dampness is an ideal breeding ground for

Surviving Hurricane Juan (cont.)

mould. Maintenance installed large industrial blowers to dry the area, and Maritime Testing checked the air quality. The results indicated that there were no asbestos or other fibre concentrations in the air. Daily newsletters were printed to inform staff of the damage, any repairs and services such as the use of showers for staff with no water or heat at home. Repairs to the VG site Centennial A wing roof began.

WEEK ONE, DAYS FOUR AND FIVE

An OR newsletter was distributed telling staff about changes in the OR schedule and how processes such as callbacks would work. The OR executive made the decision to resume a limited number of day surgeries at the HI site, a maximum of six cases per service for week two. VG services were assigned specific ORs, which were geographically close, to be run separately from HI services.

VG nursing staff was assigned to SPD to pick cases for the VG services on the case cart because HI site SPD staff members weren't familiar with the VG cases. Daily meetings were held with the charge nurses, OR educators, and health services managers to solve problems at the two sites. An HI nurse was assigned to each VG site's OR theatre to locate supplies and help the VG staff become comfortable in their new environment.

WEEK TWO

Engineering Services was planning to complete a damage assessment in the VG site's ORs and patient floors by midweek. The roof at the VG site's A wing was repaired. The ORs appeared to be dry. Infection Control was concerned about the growth of mould and moisture behind the walls.

On Tuesday limits were set on the number of same-day-admit patients per service that could be handled due to the decreased number of beds. Another concern was that most patients were still without power, telephone or water service, so they couldn't be sent home or contacted. Eight OR theatres were to be functioning at the HI. Nursing staff inspected sterile and non-sterile items stored in the VG site's ORs for water damage.

Nursing staff was asked by Engineering Services to remove everything from the VG theatres in order to repair the plaster, paint and ceiling tiles. These repairs were finished by the end of the second week. Maritime Testing, which was called back to check the dampness, discovered high levels of water behind some walls. Infection Control was concerned about aspergillus, mould and mildew. The OR committee called an emergency meeting to address this. The Infection Control physician and nurse discussed their concerns about opening the ORs with a risk of aspergillus spores in the air. The OR committee accepted infection control recommendations and all of the openings around lights and vents in the OR theatre were sealed to prevent spores from escaping. As added protection an anti-microbial shield was applied to all OR surfaces. This shield is designed to provide control of fungus, bacteria and other single celled organisms and it chemically alters building surfaces to provide long-term protection from regrowth. It is a very thin, clear liquid that can be invisibly applied (sprayed) to most surfaces in buildings including painted drywall, concrete, carpets, HVAC components and furnishings.

The OR Committee suggested the services resume at a 75% activity level at the HI site during week three, using an Ophthalmology theatre at the VG site for general surgery. This meant moving some equipment and instrumentation back to the VG site in a short period of time. The sterile-processing liaison nurse and educator prepared the Ophthalmology suite for general surgery.

WEEK THREE

During the weekend of October 11, 2003, all VG site ORs were resealed using 450 tubes of caulking. An anti-bacterial shield was sprayed on and air samples were taken. Infection Control gave permission to put the VG

Continued on Page 35

ORNAC Executive

PRESIDENT
Marcy McKay
Staff Nurse, OR
Victoria General Hospital
Victoria, BC

PRESIDENT ELECT
Linda Socha
Acting Manager,
Transplant Program,
Saskatoon, SK

SECRETARY
Lynn Anderson
Clinical OR Nurse, Orthopaedics
General Hospital Health
Sciences Site
St. John's, NL

TREASURER
Ray Larkins
Project Systems Coordinator
St Boniface General Hospital
Winnipeg, MB

ORNAC Board Members

BRITISH COLUMBIA

Donna Gramigna
President Elect, BCORNG
Clinical Educator
Victoria General Hospital,
Victoria, BC

Bonnie McLeod
President, BCORNG
Clinical Nurse Educator
Royal Columbian Hospital
Westminister, BC

ALBERTA

Sue Styles
President Elect, ORNAA
Staff RN,
QE II Hospital
Edmonton, AB

Diane Johnson
President, ORNAA
Clinical Nurse Educator
Grey Nuns Community
Hospital, Edmonton, AB

SASKATCHEWAN

Linda Socha
Past President, SORNG
Acting Manager,
Transplant Program,
Saskatoon, SK

Alicia Oucharek Mattheis
President, SORNG
Staff RN, St Paul's Hospital,
Saskatoon, SK

MANITOBA

Audrey Hiebert
President Elect, MORNA
Staff RN
Grace General Hospital,
Winnipeg, MB

Brenda Badger
President, MORNA
Staff RN
Seven Oaks Hospital,
Winnipeg, MB

ONTARIO

Chris Downey
President Elect, ORNAO
OR Manager,
Kingston General Hospital
Kingston, ON

Alaine Young
President, ORNAO
Clinical Practice & Education-
Perioperative Hamilton
Health Sciences - McMaster,
Hamilton, ON

QUEBEC

Line Boucher
President, CIIOQ/CORNQ
Staff RN
Pierre Boucher Hospital,
Longueuil, QC

Francine Cloutier
President Elect,
CIISOQ/CORNQ
Staff RN
Cite De La Sante De Laval,
Lavel, QC

NEW BRUNSWICK

Kim Reese
President Elect, NBORN
Staff RN
Saint John Regional Hospital,
Saint John, NB

Karen Frenette
President, NBORN
Surgical Suite Nurse Manager
Chaleur Regional Hospital,
Bathurst, NB

NOVA SCOTIA

Diana Mabbett
Past President, ORNANS
Staff RN
QE II Infirmary Site
Halifax, NS

Yvonne LeBlanc
President, ORNANS
Staff RN
Valley Regional Hospital,
Kentville, NS

PRINCE EDWARD ISLAND

Dorothy Connor
President, ORNPEI
Staff RN
Queen Elizabeth Hospital
Charlottetown, PE

Catherine MacAulay
President Elect, ORNPEI
Staff RN
Queen Elizabeth Hospital
Charlottetown, PE

NEWFOUNDLAND & LABRADOR

Susan Pardy
President Elect, N&LORNA
Staff RN
Western Health Care Corp.
Corner Brook, NL

Angela Patten
President, N&LORNA
Clinical OR Nurse,
Neurosurgery
Health Sciences Complex,
St. John's, NL

A Night In The Life of an OR Nurse

UNE NUIT DANS LA VIE D'UNE INFIRMIÈRE DE SALLE D'OPÉRATION

Auteure : Cindy Laukkanen *est la directrice des services chirurgicaux à l'Alberta Children's Hospital à Calgary, AB. Originaire de Vancouver, C.-B., mais ayant travaillé aux États-Unis comme au Canada, elle est infirmière de salle d'opération depuis 1990.*

RÉSUMÉ

L'auteure partage une expérience vécue d'une nuit en salle d'opération qui l'a changée à jamais.

En un moment ce traumatisme m'a définie en tant qu'infirmière. Pendant 9 ans j'étais spécialiste en traumatismes dans un grand hôpital aux États-Unis. Chaque soir il y avait des blessures par balle et des patients poignardés. Après avoir fait face à trop de fusillades dans les écoles, je suis revenue au Canada. J'étais fatiguée.

Après ce soir-là, la mort n'était plus jamais une idée, une notion poétique de l'esprit quittant le corps. Elle était froide, elle était sans pouls, elle était sanglante et elle avait une odeur tout à elle. Dès ce jour-là, je sais si un patient va expirer sur la table; l'odeur me le dit. J'avais fait face à la peur et à la mort et j'avais survécu. Je n'étais certes plus « nouvelle »… ni naïve.

A NIGHT IN THE LIFE OF AN OR NURSE

Author: Cindy Laukkanen*, is Manager, Surgical Services, Alberta Children's Hospital, Calgary, AB, and has been an OR nurse since 1990. She is originally from Vancouver, BC, and has worked in both the US and Canada.*

ABSTRACT

The author shares a personal experience, during a night shift in the OR, that changed her forever. I was defined as a nurse by that moment of trauma. I spent 9 years as a trauma specialist in a large US hospital. We did gun shots and stabbings every single night. After facing the results of too many school shootings, I came back to Canada. I was tired.

After that night, death was never again an idea, a poetic notion of the spirit leaving the body. It was cold, it was pulseless, it was bloody, and it has a smell all it's own. To this day I can tell if a patient is going to die on the table, I can smell it. I had faced fear and death, and survived. I was certainly not "new" anymore… nor was I naïve.

I had been a nurse for just one year, and had always been in the operating room. I had first walked into the OR during my third year of nursing school. Until that day I had planned on being a midwife somewhere on the Hopi Reservation trying to balance life and poetry. But I walked into the OR one day during nursing school, in to the sterile, formal, hierarchical, environment and was so purely fascinated that I never walked out.

This fall night, one year in to my career, I was the in charge, night shift, OR nurse. The 3-11 shift cases were done, instruments were cleaned and put away, cases picked for the next day. I looked out the third floor windows to the creek below and lush overgrowth of the Oregon bushes, and in the reflection of the window stared down the night shift. Night shift was hard to predict. I hoped for a quiet one. I didn't have a lot of confidence yet, the unpredictability of nights made me anxious.

I was walking the north hall, securing the hallway doors, when the trauma pager went off. I phoned down to the emergency room (ER), told them I was en route and would be there in two minutes. They asked who the trauma surgeon was, where he was, was my crew in. I asked the patient status. There were two simultaneous traumas, a two car motor vehicle accident (MVA) and a stabbing/ gun shot wound (GSW) to two patients – thoracic, possible heart, possible abdomen.

I arrived in the ER and found the trauma surgeon looking for me. Together we had to triage and decide on the magnitude and case order to the OR. Four trauma rooms were being opened in the ER. Orders were being shouted by the ER charge nurse, the expected times of arrival of the ambulances were being announced on the intercom, x-ray was setting up, the lab technicians were getting ready, everybody was gowning, gloving and talking.

The two MVA patients arrived first. The initial assessment a nurse makes is level of consciousness; yes, they were both breathing unassisted and able to speak. Good.

One patient had a large facial degloving and a good portion of her face and scalp were torn forward and hanging over her eye. She was covered in blood, it was flowing from her open scalp wound, but she had two good IV's going. She had abdominal distention, but was still breathing on her own. We could see facial fractures on exposed bone. I stopped to call the OR, ordered them to prepare for facial degloving, fractures and possible belly trauma. Plastics were called by the trauma surgeon.

The second MVA patient had open, compound femoral fractures of both legs, and the left leg was dislocated at the fractured pelvis, and the ankle shattered. The leg looked twisted as though it had been put on backwards and I quickly grabbed bone fragments from the stretcher. Again, the patient was awake and screaming in spite of massive doses of morphine. He was alternately vomiting in his hair and throwing it at the nurses and trying to strangle the paramedics. He had chest trauma of some sort, shallow, irregular breathing, and a terrible electrocardiogram (EKG).

Both patients were clearly operative. I was anxious. I was overwhelmed. I was dodging vomit and trying to prioritize my patients and organize my crew. I called in additional OR help and ordered the facial degloving first, anticipating blood in the ever distending abdomen. The second patient was being restrained by two security officers, two orderlies, and a resident. His strength in spite of his injuries was remarkable. As I tried, with the trauma surgeon, to evaluate a pelvic dislocation, he began spitting at us with deadly accuracy. This was also bloody. It was very hard to focus. I had to concentrate to keep my voice as calm and even as possible, "Number 2 to the OR, call ortho and for God's sake, knock him out."

Courtesy L. Socha

Ambulance at the ER

Still in trauma 1, Jane Doe 1 (the first patient) had betadine poured over her abdomen. The belly tap kit was quickly opened and the surgeon made a small umbilical cut. I inserted the catheter into the abdomen and drew up fresh, frank blood. OR1. My crew arrived and I gave them a quick report, feeling as though I was somehow talking from outside myself. I was falsely calm. *Jane Doe 1 – OR1* – blood in abdomen, face. *John Doe 1 – OR2* – ortho. Above my own orders were the voices of the ER doctors, residents, charge nurse, lab and x-ray technicians. The second set of ambulances was being announced so the trauma surgeon and I moved to evaluate the next patients.

As I walked to the next bay, I felt like I was trembling. I told myself to breath slower and try to slow my heart. I wanted to cry so I bit the inside of my cheek to stop it.

The second set of ambulances had 3 patients. One was dead… two patients. One appeared to have knife wounds to his arms, legs, and scalp. I didn't see any frank venous or arterial blood. He was sitting up screaming profanities as we unloaded the other patient. The next patient had 5 visible gun shot entry wounds, was unconscious, intubated and the paramedics had lost his blood pressure. We went stat to the OR, shouting at the ER charge nurse, as we rolled by, to let the OR know we were on our way up.

We arrived in the OR, the other nurse began to cut off his clothes and pour betadine over his abdomen and chest. I gowned and gloved without scrubbing and was setting up my instruments for abdominal and thoracic trauma. My heart was

A Night In The Life (cont.)

Jupiter Images

ER Sign

racing, but finally I could turn away from evaluating trauma, from the ER zoo and set up my case. I was flooded with relief at this small familiarity. I had some relief from the fear.

My back was turned when I heard my other nurse yell "Oh My God". I heard a huge bang, and another. It was so loud my ears hurt and my head hurt from it. I heard metal on metal. I turned around. I saw the other ER patient, the stabbing patient. I saw his gun. I saw our patient on the table looking very, very dead. I felt like I froze, and that time was very slow. But I remember getting to the floor and pulling my back table over me. I remember the sound of my 200 instruments crashing to the floor. I remember screaming at a nurse coming in the back door to get out.

I remember in one moment conversing with God, calmly, as though only God and I were in the room. I thought I might die that night. "Please God, keep my nurses out of the room. Please God, my boy is three, please let me see four, I'm all he has. Please God, help us."

It was quiet for a moment. Then I heard screaming and shouts and looked over my back table to see the ER security and city police tackle and take down the armed patient. There was nothing gentle in what they did. The surgeon was counting his crew… we were all okay. I had pulled my table over, he and the anaesthesiologist and circulating nurse had hidden behind the anaesthesia machine. We were okay, but no one could speak for a moment.

The two patients were in rival gangs. One had followed the other to the OR to finish him off, successfully. We called the morgue to get the patient on the table.

I went home that morning, after having cleared the body to the morgue getting the report on the MVA patients, comforting the other nurses, and telling the police a dozen times what had happened. All the while I felt numb and exhausted. I went home and held my child while he slept.

I was defined as a nurse by that moment of trauma. I spent 9 years as a trauma specialist in a large US hospital. We did gun shots and stabbings every single night. After facing the results of too many school shootings, I came back to Canada. I was tired.

After that night, death was never again an idea, a poetic notion of the spirit leaving the body. It was cold, it was pulseless, it was bloody, and it has a smell all it's own. To this day I can tell if a patient is going to die on the table, I can smell it. I had faced fear and death, and survived. I was certainly not "new" anymore… nor was I naïve.

Bullying and Harassment in Perioperative Settings

L'INTIMIDATION ET LE HARCÈLEMENT EN SITUATIONS PÉRIOPÉRATOIRES

Auteures :
***Diane Gilmour**, infirmière autorisée, baccalauréat en science infirmières, PGCEA, DANS, diplôme en prévention des infections, gestionnaire de projet – améliorations aux salles d'opération, Healthcare NHS Trust de Surrey et Sussex.*
***Lois Hamlin**, infirmière autorisée, baccalauréat en sciences infirmières, certificats OT et IC, maîtrise en soins infirmiers, FRCNA, FCN, infirmière gestionnaire/conférencière principale, University of Technology, Sydney, Australie.*

RÉSUMÉ
Cet article examine les concepts de l'intimidation et du harcèlement, offre une définition de ces termes et de leurs répercussions et explore ce qu'ils partagent et ce qui les diffère. Il analyse également la législation pertinente et identifie les stratégies qui visent la conscientisation ainsi que le développement d'un environnement périopératoire sans intimidation et sans harcèlement. L'intimidation et le harcèlement sur les lieux de travail était le sujet de cette présentation au congrès national de la *NATN* en 2002. Carrière et les comportements difficiles des patients constitue un sujet en soi.

BULLYING AND HARASSMENT IN PERIOPERATIVE SETTINGS

Authors:
***Diane Gilmour** RN, BN, PGCEA, DANS, Dip Infect Control, Project Manager - Theatre Improvements, Surrey and Sussex Healthcare NHS Trust.*
***Lois Hamlin** RN, BN, OT Cert, IC Cert, MN, FRCNA, FCN, Nurse Manager/Senior Lecturer, University of Technology, Sydney, Australia.*

Lois Hamlin

Diane Gilmour

ABSTRACT
This article explores the concepts of bullying and harassment, defines the terms and their implications, and explores similarities and differences between the two. It also examines pertinent legislation and identifies strategies to raise awareness and optimise a bullying and harassment-free perioperative environment. Bullying and harassment in the workplace was the focus of this presentation at NATN Congress 2002. Challenging behaviours involving patients and careers is another topic in itself.

BULLYING - FACT OR FICTION?

A survey by Rayner et al (2002) estimated that of 24 million employees in the UK, 10% have been bullied in the last six months. A Royal College of Nursing survey of 4,500 nurses revealed that one in six had been bullied in the last 12 months, one third of whom were intending to leave as a result (RCN 2002). Can we afford to let this carry on?

Many of you will have experienced the intimidating surgeon - the one who throws equipment across the floor, who shouts and criticises, constantly undermining staff. Many more will give examples of the theatre sister who expects 110% of her staff, but is never in theatre herself. But do we actually do anything about it? Do we constantly moan about their behaviour but inevitably accept and 'put up with it'?

It is not just managers who act like this; it may also be colleagues and peers. Should we tolerate a colleague's behaviour because they are good at their job or because, if we complain, we may create an environment of mistrust or animosity? Examples exist where theatre staff have

complained collectively about a member of staff's intimidating behaviour, resulting in that person leaving their post or being removed from the United Kingdom Central Council (UKCC) register (Castledine 2001).

Bullying may be seen as an umbrella term for behaviour such as intimidation, aggression, harassment and/or violence (Hadikin & O'Driscoll 2000). However, various definitions exist, resulting in a lack of clarity and therefore difficulty in tackling bullying effectively within the workplace. The definition of bullying is dependent on people's ideas and perceptions, and the workplace environment.

A manager may criticise your work and leave you feeling uncomfortable. However, to another person this might be a very negative and humiliating experience, particularly if the criticism occurred in front of colleagues (Hollinghurst 2000). Bullying is negative to the recipient, and is often persistent and long term in nature (Hadikin & O'Driscoll 2000, NATN 2002, Rayner et al 2002).

The Manufacturing, Scientific and Finance Union define bullying as 'Persistent, offensive, abusive, intimidating or insulting behaviour, abuse of power or unfair penal sanctions which makes the recipient feel upset, threatened, humiliated, or vulnerable, which undermines their self-confidence and which can cause them to suffer stress' (MSF 1994 cited by Rayner et al 2002). This is a strong definition, but one which clearly concentrates on the effects to the individual, recipient or victim.

WHO BULLIES WHOM? WHY AND HOW?

In nursing, a female-dominated profession, women are seen to bully more than men. Nationally there is no significant gender difference. Bullies are usually in a position of power, authority, responsibility or trust, and results of surveys echo this: 41% of nurses surveyed said they had been bullied by their manager. Surprisingly, in the same survey, 41% stated that their colleagues were bullying them (RCN 2002).

In the current climate, NHS managers are under pressure to achieve targets, and so may resort to bullying tactics to ensure that this happens. But what about colleagues? Changes within the NHS affect us all and may be uncomfortable for some. Colleagues may feel threatened or insecure, and alter their behaviour to deal with the situation. However, although this behaviour is understandable, if it results in bullying then it should be reported immediately. Such behaviour should not be ignored. It can be more harmful to colleagues and the work environment than abuse from patients.

Bullying manifests itself in many ways (see Hadikin & O'Driscoll 2000, Hollinghurst 2000, NATN 2002, Rayner et al 2002) and may include:

- overruling of decisions
- undervaluing or belittling of staff/colleagues
- lack of recognition for work done/taking credit for him/herself
- giving an unmanageable workload to an individual
- withholding information
- constant criticism
- impeding of progress/development
- lack of autonomy or giving authority to someone else.

Being bullied is unpleasant, yet many are unprepared for the experience as they have never encountered it before. Bullies often, but not exclusively, target those with low self-esteem, those who need to feel valued or who have high levels of dependence. Recipients of bullying may also be popular, committed, successful and competent. Bullies have little regard for their own behaviour and how it affects others; bullying is often seen as a symptom of the bully's own insecurity (Rayner et al 2002).

WHAT IS HARASSMENT?

Harassment, like bullying, is part of a wider issue, that of workplace occupational violence. It is outside the scope of this article to discuss all facets of occupational violence, but it is important to locate bullying and harassment within it.

Increasingly, the issue of occupational violence is being researched, acknowledged and addressed, usually via occupational health and safety legislation (Bowie 2002). Occupational violence research has been ongoing for two or three decades, but it is only in the last five to ten years that bullying and harassment have appeared in the literature and been the subject of research (Department of Health and Human Services 1994).

These challenging behaviours are increasingly being acknowledged as real issues in the workplace (Mayhew & Chappell 2001a&b, Howells-Johnson 2000, NATN 2002) and are significant issues for nurses (Michael & Jenkins 2001, Mayhew & Chappell 2001c). They are associated with wider social changes, such as economic rationalism and market-focused reform agendas (Hancock 1999), downsizing and job insecurity, and the increased use of casual labour. All of these have an acute impact on healthcare and nurses.

One of the frustrating aspects of examining harassment is the lack of clarity and consistency around the meaning of the word. There are similarities with and differences from bullying. The Australian Public Services Commission define workplace harassment as 'behaviour that is unwelcome, unsolicited, usually unreciprocated and usually (but not always) repeated. It makes the workplace or association with work unpleasant, humiliating or intimidating for the people or group targeted by this behaviour. It can make it difficult for effective work to be done' (APSC 1994). However, even this definition makes it difficult to distinguish bullying from harassment and in different cultures, the word harassment has different meanings. For example, in the Unites States of America, the word refers to bullying, just to cause further confusion!

This article explores the different types of harassment, and compares and contrasts it to bullying, but it is important to remember that the issue is not about an absolute or authoritative definition. It is about recognising and responding appropriately to unacceptable behaviours in the workplace.

Harassment can be verbal, physical or sexual and it can have a racial or disability overlay, that is the physically or mentally disabled or those of minority races (compared to the dominant culture) are targeted more than others. The different types of harassment will be explored in this article.

Why do we not hear more about the occurrence of challenging behaviours? Why do they continue to occur and why don't nurses, including perioperative nurses, complain more? There are a number of reasons for this.

Anecdotally, harassment, like bullying and horizontal violence, are prevalent in nursing, although they are under-reported and frequently surrounded by a culture of silence. This failure openly to acknowledge unacceptable behaviours is either because victims do not realise they are being bullied or harassed, do not know what to do about it, or believe that nothing can be done to improve the situation.

Previously, nurses were more obedient and tolerated it because 'that's how it is around here' or 'it's part of the job'. One colleague was told on entering the operating room 'if you can't stand the heat get out of the kitchen.' Additionally, nurses think they will not be believed or taken seriously, and they fear retaliation (Birman 1999) or, when they have complained, it has not been dealt with properly (NATN 2002).

A hierarchical organisational culture, which can be oppressive, can result in non-reporting of challenging behaviours (Mayhew 2002). Most hospitals are organised in this way. In times of economic restraint or downsizing (rightsizing!), or when an organisation is under pressure to improve its performance, bullying and harassment increase (Braverman 2002). As in other occupations, it is difficult to estimate their incidence or severity.

INCIDENCE IN PERIOPERATIVE SETTINGS

Some authors believe that bullying and harassment are prevalent within perioperative settings (Shibe 1991, Tyler & Ellison 1994, Kaye 1996), attributing this variously to the geographic isolation of the operating suite, the high stress experienced, the familiarity and bonding that develops between staff, and the persistent belief that nurses act only as handmaidens to surgeons and anaesthetists.

The issue of harassment of perioperative nurses is not new (Wry 1986, Cox 1987, Buchanan & Considine 2002, NATN 2002). Research over

Bullying and Harassment (cont.)

two decades has identified that perioperative nurses are bullied and harassed. Wry (1986), Cox (1987) and Tyler & Ellison (1994) describe a range of stressors experienced by perioperative nurses, including conflict, abuse, emotional manipulation, personality conflict and lack of support. When their results are examined more closely, it is evident that bullying and harassment are being described.

More recently, the work of Santamaria & O'Sullivan (1998) and Michael (2001a&b) in Australia have highlighted various stressors among perioperative nurses. Interpersonal conflict was identified as the leading stressor among the group of perioperative nurses they surveyed (Santamaria & O'Sullivan 1998). However, in exploring traumatic events experienced by perioperative nurses, abuse was the predominant finding, accounting for 45% of reported major types of trauma (Michael 2001a&b). This included verbal abuse, sexual harassment, sexual intimidation and physical assault. The main perpetrators were medical staff (78%). However, supervisors (11%) and colleagues (11%) were also implicated.

To put this into context, 69% of Michael's respondents had experienced workplace trauma. Of those, nearly three quarters had experienced more than one episode in the previous 12 months and more than 25% had experienced more than five episodes. The other major categories of traumatic events were: practice issues which affected the quality of care, such as perceived unsafe or inappropriate activities, due to lack of staff or being inexperienced conflict due to lack of communication or co-operation among team members death of a patient on the table.

Verbal abuse from doctors was the most frequently occurring event. Respondents were: humiliated or spoken to inappropriately, often in front of colleagues or awake patients made to suffer the temper tantrums of surgeons and anaesthetists, who yelled, intimidated, acted obnoxiously or made nurses feel inadequate or stupid.

One respondent revealed that surgeons constantly have the attitude that nurses are there to serve them, rather than to work as a team to provide the best care for patients. Another noted how sarcastic surgeons can be, and difficult to converse with, and how some do not remember your name even after months of working closely with them. Some respondents complained of experiencing various acts of physical abuse, such as having a dirty surgical gown thrown at them, surgeons throwing instruments, or being hit on the arm or chest. One nurse commented 'A registrar stapled my shoulder with a used skin staple gun'.

Cases of sexual harassment and intimidation highlighted that the perpetrators were mostly surgeons or anaesthetists. In other studies, other staff members perpetrate these behaviours. Behaviours include demeaning statements and sexually explicit jokes about other staff members, being slapped on the bottom, and a doctor exposing his genitals through an opening in his overalls whilst talking to a nurse.

One surgeon asked a nurse if she was there to get more exposure in theatre and then suggested she remove her clothes. One nurse complained of the arrogance of a surgeon because he was sexually harassing her. The surgeon was spoken to by management and subsequently he refused to work with the nurse, because he could not believe she had complained! Another nurse was scrubbed and assisting the registrar when the surgeon, who was supervising but not scrubbed, crawled around her feet and pulled her pants down. These are all examples from Rene Michael's research, which she published in 2001.

LEGISLATION

In Australia, there are various acts and policies at both state and federal level that aim to deal with all forms of harassment. For example, most states have occupational health and safety acts which note that all employers must provide a safe work environment, both physically and psychologically. There is also a Sexual Harassment Code of Practice (2001) produced by the Australian Human Rights and Equal Opportunity Commission, which applies nationally.

In the UK there are various pieces of legislation and the Department of Health (DoH) policy. While there is little specific law, the issues are dealt with under Sex Discrimination, Race Relations or Disability Discrimination Acts. The DoH has issued a policy statement advocating zero tolerance (DoH 1999).

DEALING WITH UNACCEPTABLE BEHAVIOURS

When being harassed or bullied, the recipient can suffer a range of symptoms described in Figure 2. The degree of suffering differs, depending on the recipient's awareness of the problem (Hadikin & O'Driscoll 2000, NATN 2002, Rayner et al 2002).

The Royal College of Nursing (RCN) acknowledges that nurses who report bullying by colleagues can experience symptoms similar to post-traumatic stress disorder. This could occur in as many as one in ten recipients (White 2002).

WHAT CAN BE DONE?

Many recipients of unacceptable behaviours may be unaware that there is a problem and try to correct their behaviour in response to the criticism. Others may recognise that they are being bullied but not have the confidence to override the criticism or behaviour directed towards them, particularly if they are being bullied by a senior colleague or manager. Some may even attempt to 'keep their head down' hoping that it will go away if they ignore it.

Another tactic adopted by the recipient may be to put a brave face on the situation, to carry on as if nothing is wrong, and to keep the situation to themselves even when colleagues ask them if there is a problem. However the recipient will gradually lose confidence to deal with the situation (Hadikin & O'Driscoll 2000, Hollinghurst 2000, NATN 2002, Rayner et al 2002).

In 1997, a Unison survey revealed that people who were being bullied took fewer actions than those who were not being bullied but imagined what they would do in the same situation (Rayner et al 2002). It is easy for someone outside to suggest plans of action, offer advice and counselling. But when you are the recipient, you question whether action would make things worse, or create a situation that you consider your fault, and alienate you from colleagues as you perhaps ask them to become involved as witnesses.

Bullying can wreck people's lives and careers, can affect job satisfaction, increase stress and anxiety. But it is important that recipients overcome those fears and tackle the problem. Why should we allow such behaviour to continue? If we do not do something then who will be their next victim - doing nothing will make it harder in the future, but 23% of the nurses responding to the RCN survey did nothing (RCN 2002). That means that a lot of bullying behaviour is being allowed to happen unchecked and unreported.

THE FORMAL OR INFORMAL ROUTE

If you are being bullied, you have a formal and informal route for taking action. Informally you should talk to colleagues - you may not be the only one that this is happening to. Keep a diary of events, times, places and witnesses, find out the local policies/ procedures and legislation, and try to avoid being alone with the bully.

Once you have the evidence, the hardest and most confrontational route is to confront the bully directly with support from colleagues or your manager. The RCN survey revealed that 51% were not satisfied with their employer's handling of the situation. This can be very demoralising, as employees deserve to be heard and positive action taken if their case is proved.

A more formal approach would be to approach your manager, personnel department or occupational health department directly. Some Trusts now have a bullying and harassment advice service. Such departments must ensure that the complaint is made without fear of reprisal, victimisation, further distress and embarrassment to the complainant. Organisations outside the NHS, such as the Andrea Adams Trust and many on the Internet, are available to offer advice, although they cannot take on individual cases.

Healthcare organisations can no longer afford to ignore the issues around bullying and harassment, as employers have a duty of care to their employees. Organisations need to assess the extent of the problem by first clearly defining 'workplace bullying' separately from

Continued on Page 30

Auteure: *Muriel Shewchuk*

TRAUMATISME INTERACTIF EN MILIEU DE TRAVAIL (TIMT)

« Une condition médicale envahissante nécessitant isolement et traitement immédiats »

Jusqu'à quel point le traumatisme interactif en milieu de travail, ou TIMT*, a-t-il envahi votre milieu péri-opératoire ? Se cache-t-il dans les coins, les salons et les salles d'opération…ou peut-être même dans votre propre bureau ? Qui y est impliqué ? Le personnel infirmier ou de soutien, les médecins, les leaders ? Une combinaison de ceux-ci ? tes-vous au courant ? Pratiquez-vous une politique d'autruche en vous cachant la tête dans le sable du déni ? Le déni et les rêves en couleur à eux seuls ne sauront vous en sortir !

* Le traumatisme interactif en milieu de travail (TIMT) est un néologisme proposé par l'auteure dans le contexte de cet article.

Author: *Muriel Shewchuk*

INTERACTIVE WORK PLACE TRAUMA (IWPT)

"A Pervasive Condition Requiring Immediate Isolation and Treatment"

How much Interactive Work Place Trauma, or IWPT*, has invaded your perioperative environment and is lurking in the corners, lounges, and theatres… or even exuding from your office? Who is involved? Nurses, support staff, physicians, or leaders? Or a combination of all? Do you know about it? Are you demonstrating ostrich characteristics by "sticking your head in the sands of denial"? Denial and wishful thinking will not cut-it!

Whether the IWPT is horizontal violence (co-worker to co-worker), bullying, hostile aggressive behaviour or any other form of disruptive activity, it is totally unacceptable. A number of key leaders are themselves a major part of the demoralizing IWPT. Where and why do you have IWPT occurring? What strategies can be put in place to identify, isolate and successfully treat the condition?

Most workplaces generate policies, programs and signage related to "abuse in the workplace". Legislation has been developed on many fronts. Schools, communities and towns are developing "bully free" concepts, practices and education programs. We only have to reflect on the mass shootings in workplaces and schools to fully recognize the magnitude, seriousness, and full impact of IWPT. What recognition strategies, educational elements, proactive plans, and treatment measures have you established?

What is IWPT?

Interactive Work Place Trauma may be defined as the impact, outcome or result of patho-psycho-social activities conducted by an individual, group of individuals, or "gang", who choose subversive, destructive, and demoralizing tactics to gain power and take control of a work environment. Yes, there are many perioperative environments with this type of culture and behaviour firmly entrenched and out of control. The intensity of activity will vary

Jupiter Images

** Interactive Workplace Trauma (IWPT) is a term coined by the author for purpose of this article.*

from time to time, as will the impact, depending on the players and their participation at any given moment. There are perpetrators, victims, knowing bystanders or "fence-sitters", as well as the abdicators of responsibility, all playing a key role in the continuation of IWPT. Generally IWPT is not physical in nature; however, the impact on the victim can readily lead to work dysfunction and mental or physical breakdown.

Common terms used to describe IWPT are horizontal violence and bullying. It is often excused with statements like "Oh, that's just her way…" The Internet and book stores all have extensive information on the subject – from grade school up through the workplace, including nursing behaviour. Everyone needs to pay attention and stop the ruthless attack on fellow colleagues, subordinates, bystanders and persons in senior positions of power.

IWPT severely inhibits the development of a trusting, positive, learning culture. Defense mechanisms become the order of the day for coping with intimidation, verbal abuse and negative body language. Patients can also be at risk when the staff is in "survival mode" – busy protecting themselves against a bully and perhaps dealing with daily fear, anxiety, depression and a lack of focus. Efficiency, effectiveness and progressive performance only occur in a safe, cooperative, trusting and supportive environment – not under a reign of terror.

Perpetrators and their Actions

Bullies are very clever, they excel at manipulation and deny any wrong doing, playing people off against each other, often with great satisfaction as others get destroyed. The manager, or other leaders, may be the target of the action and having no understanding of what is really happening to them.

Perpetrators may present a domineering, superior presence with the intent of assuming power over the victims. Attitude and arrogance will be observed through both body language and verbal expression. To many, the perpetrators appear to be very friendly, charming, helpful, and competent. They are very clever and avoid

Jupiter Images

being pinpointed as the source of the problem. Body language is one of the common forms of discriminating actions. The perpetrator uses such actions as rolling of eyes in disgust for many to see (implying stupidity), aggressive folding of arms in a "refusal to help" posture, or huffing and stomping around the room. Verbal abuse comes with ease to these individuals. Criticism of others (in an effort to make themselves look superior), nitpicking, hurtful sarcasm, and negative gossip or name calling are some of the tactics used. Undermining of instructions, processes, threats, slurs and jokes of a discriminatory nature further attack the vulnerable victim. Actions of isolating, or "freezing out", individuals occur frequently in staff lounges and lunchrooms. In its more serious form IWPT surfaces as threats that extend to an individual's family and property. Perpetrators work to increase the size of the "in group", through peer pressure, thus increasing the victim's isolation. The outcome can be a toxic environment that is emotionally oppressive, demoralizing, and stressful… with threads of fear woven through it.

Victims

Victims of bullying, or horizontal violence, will quickly become more insecure, may blame themselves for errors or incompetence, lose self-esteem, and frequently question their personal abilities. Sleep patterns are the first to be

Pearls of Wisdom (cont.)

disrupted by the stress. Victims also experience a "fear of facing Monday", first calling in to see who they are working with, or just calling in sick to avoid going to work. Visible responses may show up as anger, crying, sitting alone withdrawn, and signs of nervousness. Physical problems may include hypertension and sleep deprivation right up to more serious psychological problems such as depression and even suicidal tendencies. Remaining in a position that involves constant abuse will ultimately have long-lasting negative results for the victim. The victim may just leave the job, without identifying the real reason, and leave the power brokers with another success. Tackling the bully is a highly threatening and dangerous tactic.

Dealing with the Bully - When you are the Victim

- Educate yourself on bullying, recognize it for what it is, know it and name it. It is important to realize that it is not about you or you can be taken over by the "victim mentality". Be very clear that you are dealing with a bully and that it is their problem – NOT yours- do not let the transfer of responsibility occur. Do a thorough reading of abuse and harassment policies. Research on the Internet and read appropriate books.
- Document, document, document. Be very specific in your recording: names, dates, situation, exact words, actions and observers' names. Be very objective and try to keep the emotion out of your records. Protect your documentation; keep it at home with only today's notes in your pocket. Add to your permanent documentation as soon as possible to maintain facts and accuracy. Record detailed observations when others are being attacked or treated inappropriately. You need to establish and to document the pattern of behaviour.
- Use extreme caution when responding to questions or commands that can progress to making the bully right. Siding with them on an issue is very high risk. Evasive, non-committal, non-confrontational, brief answers are best for keeping you outside their control. Use straight facts and truth when responding. Keep unrelated information and opinions out of the conversation.
- Obtain counseling and medical attention that is appropriate to your needs so that you can effectively manage your situation. Maintain good health and plenty of restful sleep.
- Complaints, grievances and lawsuits can be filed. If going down this road you need to be sure your documentation is extensive, that the correct process is used, and that you have the strength to see it through. Make sure you have plenty of emotional support as it can be very stressful. This is NOT an easy option!
- Once you have educated yourself about bullying, use you knowledge help others and to stop this outrageous social abuse.
- Ask yourself if the job is worth it. If after thorough examination you decide it is not, then make sure you give the appropriate management effective and truthful notice. Make sure you have a good reference, insist on an exit interview with the manager and with Human Resources. File a letter stating the real reason for your departure and identify the facts of the situation. Keep opinion and emotion out of it.

Jupiter Images

Continued on Page 29

UPCOMING EVENTS

For details visit www.ornac.ca

PROVINCIAL & REGIONAL CONFERENCES

British Columbia	Harrison Hot Springs	April 19-22, 2006
Alberta	Red Deer	October 26-29, 2005
Saskatchewan	Saskatoon	September 24, 2005
Ontario	Ottawa	April 23-26, 2006
Atlantic Conference	Halifax	October 4-7, 2005
Newfoundland & Labrador	St. John's	September 22-24, 2005

ORNAC CONFERENCES

www.ornac.ca

20th National	Victoria, BC	April 23-27, 2007
21st National	St. John's, NL	June 7-12, 2009

INTERNATIONAL CONFERENCES

NATN (www.natn.org)	Harrogate, UK	October 10-13, 2005
EORNA (www.eornac.com)	Dublin, Ireland	May 2-6, 2005
WORLD	Barcelona, Spain	September 25-29, 2005

ANAESTHESIA CONFERENCES

CAS (www.cas.ca)	Vancouver, BC	June 17-21, 2005

Pearls of Wisdom (cont.)

REMEMBER:

You have done nothing wrong.

The bully is the one with the problem.

You do not have to take it and suffer in silence.

You have options.

You have tools to protect you.

There is nothing wrong with you.

You have been unfortunate enough to fall under the influence of a workplace bully.

You are not powerless.

It is not about you.

It is about the bully.

Things to **NOT** do with a Workplace Bully!

- Do not try to appeal to his/her better nature.
- Do not plead with them to stop bullying. Do not negotiate or mediate.
- Do not try to disarm with a joke, sarcasm, wit or amusement.
- Do not try to get even or to "give them what they have coming".
- Do not allow yourself to feel small, inadequate, timid or incompetent.
- Do not expect coworkers to come to your defense (sad, but true).
- Do not spend hours of conversation dwelling on what happened and what was said. Do everything you can to stay out of the "victim mode" and build an appropriate support network in order to effectively strategize.

Management Strategies for IWPT

Look in the mirror, read between the lines and have a clear understanding of your own reputation before you set out to deal with issues. Make sure you are not a part of the intimidation. Do not listen to or support the bullies. Also, remember to deal effectively with messages and behaviour being brought forth. Check with honest outside sources about the reputation of your environment, whether or not you like the answers. Be sure that you have a thorough understanding of the workplace you are leading. In addition:

- Recognize and accept that bullying and horizontal violence exist, even in your department;
- Assess the culture and the practices that allow disruptive behaviour to exist. Take the temperature of your environment, or have a professional assess it through confidential surveys and job satisfaction ratings. Determine if your workplace is happy and how staff members view your workplace morale;
- Provide education sessions. Define what acceptable professional conduct is. Ensure policies, procedures and support resources are publicly known and readily accessible;
- Ensure staff feel safe in the workplace and can thrive and develop to their full potential;
- Provide opportunities for staff to develop skills and strategies to deal with bullying behaviour and to prevent the victim mentality; and
- Document, document, document. Record dates, details, facts and names. This way you are well prepared, and successful, when discipline becomes the necessary action. You cannot afford to fall victim at the hands of a manipulating bully due to lack of, or incomplete, information and documentation.

Summary

Tragically, horizontal violence and bullying behaviour being master minded by nursing colleagues is firmly entrenched in many perioperative environments – just like a serious pathological bacteria. Interactive Workplace Trauma (IWPT) is ugly, mean, destructive, demoralizing and counterproductive to efficient, effective patient care and positive staff performance. Get educated and use astute observations to ensure you clearly understand what is occurring. Make sure the staff feel safe and have the appropriate, necessary protection to deal with unacceptable conduct. Deal effectively with the bullies. Remember if it is not documented, it didn't happen!

WEB SITES

http://2bebullyfree.com

www.bullyfreeworkplace.com

www.bullyonline.org/workbully

http://adultbully.com

'workplace harassment'. Bullying and harassment should be erased and disapproval of such behaviours made explicit. If proved, they should classify as gross misconduct offences.

Healthcare organisations need to foster a positive working environment, but they cannot do this alone. As managers, practitioners and colleagues we need to respect and listen to others, have time out with each other and foster a sense of belonging (Hadikin & O'Driscoll 2000). As practitioners we also owe a 'duty of care' to our colleagues, to work with them collaboratively and co-operatively in a reasonable manner (NMC 2002).

Bullying and harassment at work can damage employees' health and should be viewed and treated as a psychological hazard under the Health and Safety at Work Act 1974 (NATN 2002, Rayner et al 2002). People are healthcare organisations' prime asset and a healthy organisation has healthy assets.

Bullying and harassment is on the increase but together we can do something about it.

POSTSCRIPT

Incidences of bullying and harassment are reported in the nursing press on an almost monthly basis, and most of these reflect on the negative outcome from such behaviour on the recipient. As authors, we would like to hear from anyone who has been a recipient but has emerged with a positive outcome/result following their actions to address the issue. Please write to us via NATN HQ.

Reprinted with permission, British Journal of Perioperative Nursing, (*Vol 13, No 2 Feb 2003*) pp 79-85.

Figure 1

How to distinguish bullying from harassment

BULLYING OR HARASSMENT?
There are similarities between bullying and harassment, but there are also differences:
Harassment can be a one-off event, whereas bullying tends to be repeated over time, often escalating in intensity.
Harassment can have a physical component or a sexual connotation; this includes sexual intimidation, sexual harassment or actual assault. Bullying is primarily psychological in nature, at least initially.
There is controversy over whether bullying is related to gender. Some are of the opinion that it occurs equally between men and women, however, the actual number of women victims is greater.
Women also experience greater rates of sexual harassment.
Harassment, particularly when associated with assault or sexual harassment, can have a criminal element; this tends not be the case with bullying.
Harassment and bullying are similar concepts - both are an abuse of power in the workplace.
There tends to be an aspect to both bullying and harassment which is linked with gender, with women being victims more often than men. However, women are also perpetrators of these unacceptable behaviours.
'Cyber violence' is being reported now, with people being harassed and/or bullied via telephone and email.

Figure 2

Some of the symptoms experienced by victims of bullying or harassment

SYMPTOMS EXPERIENCED	
Physical	**Psychological**
Disturbed sleep	Withdrawal/isolation
Loss of appetite	Tearfulness
Headaches	Loss of confidence
Sickness	Irritability
Inability to relax	Self doubt
Loss of libido	Depression

REFERENCES

Australian Human Rights and Equal Opportunity Commission 2001 Sexual Harassment Code of Practice

Australian Public Service Commission 1994 Eliminating Workplace Harassment: guidelines Canberra, Australian Government Printing Service (AGPS)

Birman J 1999 Covert Violence in Nursing Australian National Safety Journal 7 (2) 17-21

Bowie V 2002 Defining Violence at Work: a new typology. In M Gill, B Fisher, V Bowie (eds) Violence at Work: causes, patterns and prevention Devon, Willan

Braverman M 2002 The Prevention of Violence Affecting Workers: a systems perspective. In M Gill, B Fisher, V Bowie (eds) Violence at Work: causes, patterns and prevention Devon, Willan

Buchanan J, Considine G 2002 Stop Telling us to Cope! NSW nurses explain why they are leaving the profession A report for the NSW

Nurses' Association Sydney, Australian Centre for Industrial Relations Research and Training (ACIRRT), University of Sydney

Castledine G 2001 Professional Misconduct Case Studies - case 56: intimidating behaviour British Journal of Nursing 10 (17) 1103

Cox H 1987 Verbal Abuse in Nursing: report of a study Nursing Management 18 (11) 47-50

Department of Health 1999 We Don't Have to Take This - NHS/zero tolerance zone London, DoH

Department of Health and Human Services 1994 Injury in Australia: an epidemiological review Canberra, AGPS

Hadikin R, O'Driscoll M 2000 The Bullying Culture Oxford, Butterworth Heinemann

Hancock L 1999 Policy, Power and Interests. In L Hancock (ed) Health Policy and the Market State Sydney, Allen & Unwin

Hollinghurst A 2000 Bullying in the Workplace Nurse 2 Nurse 1 (8) 34-35

Howells-Johnson J 2000 Verbal Abuse British Journal of Perioperative Nursing 10 (10) 508-511

Kaye J 1996 Sexual Harassment and Hostile Environments in the Perioperative Area AORN Journal 63 (2) 443-449

Mayhew C 2002 Occupational Violence in Industrialized Countries: types, incidence patterns and 'at risk' groups of workers. In M Gill, B Fisher, V Bowie (eds) Violence at Work: causes, patterns and prevention Devon, Willan

Mayhew C, Chappell D 2001a Occupational Violence: types, reporting patterns, and variation between health sectors (Discussion paper No 1) Sydney, University of New South Wales, School of Industrial Relations and Organisational Behaviour and Industrial Relations Research Centre

Mayhew C, Chappell D 2001b Prevention of Occupational Violence in the Health Workplace (Discussion paper No 2) Sydney, University of New South Wales, School of Industrial Relations and Organisational Behaviour and Industrial Relations Research Centre

Mayhew C, Chappell D 2001c 'Internal' Violence (or Bullying) and the Health Workforce (Discussion paper No 3) Sydney, University of New South Wales, School of Industrial Relations and Organisational Behaviour and Industrial Relations Research Centre.

Michael R 2001a When the Specialty becomes a Nightmare: workplace traumatic experiences amongst perioperative nurses ACORN Journal 14 (3) 11-15

Michael R 2001b Survive or Thrive? The impact of workplace trauma on perioperative nurses: part 2 ACORN Journal 14 (4) 10-14

Michael R, Jenkins H 2001 Work Related Trauma: the experiences of perioperative nurses Collegian, Journal of the Royal College of Nursing Australia 8 (1) 19-25

National Association of Theatre Nurses 2002 Challenging Behaviours in the Perioperative Environment: dealing with bullying, violence and harassment Harrogate, NATN

Nursing and Midwifery Council 2002 Code of Professional Conduct London, NMC Rayner C et al 2002 Workplace Bullying London, Taylor and Francis Royal College of Nursing 2002 Working Well Initiative London, RCN

Santamaria N, O'Sullivan S 1998 Stress in Perioperative Nursing: sources, frequency and correlations to personality factors Collegian, Journal of the Royal College of Nursing Australia 5 (3) 10-15.

Shibe J 1991 Harassment Comes in Assorted Flavours Today's OR Nurse 13 (9) 3 Tyler P, Ellison R 1994 Sources of Stress and Psychological Well-being in High-dependency Nursing Journal of Advanced Nursing 19 469-476

White C 2002 The Enemy Within Nursing Times 98 (44) 12-13

Wry 1986 The Perception of Stress in the Operating Room: a research study Canadian Operating Room Nursing Journal 4 (5) 14-18

Surviving Hurricane Juan (cont.)

equipment, supplies and furniture in all OR theatres but instructed staff not to move in any patients until the results of the air testing arrived on Oct. 17. If the results were negative, the ORs were expected to operate at 100% on Oct. 20. If the results were positive, a long-term plan was to be discussed.

The VG site's OR manager, VG staff and HI staff who hadn't been assigned to theatres worked together to prepare the VG's 16 OR theatres by cleaning the cupboards and returning equipment. Nurses worked in teams of two to clean and return furniture, set up the rooms and restock supplies. This was done by mid-week. A plan was developed to move sterile supplies, instruments and equipment from the HI site and Ophthalmology back to the VG OR's.

At 1200, on October 17, Infection Control had the air-quality test results. They showed no mould growth, so the VG OR was able to accept patients. The first van was loaded and equipment transferred by 1230. The VG Perioperative educator organized the move back to the VG, deciding which equipment and instruments could move in a particular order because surgeries were still being done at the HI site. She also arranged for Biomedical Engineering to check the equipment after its return, because it would be required for October 20 when surgeries resumed at 100%.

The charge nurses discussed with the VG educator which items were needed for the scheduled cases and what could be moved when. A designated patient attendant, OR supplies technicians, health services manager and two nursing staff met the van at the VG site and delivered carts, equipment and instrumentation. What took one week to move to the other site was returned in 12 hours. Biomedical Engineering worked until after midnight to ensure that equipment needed for Monday morning was both safe and functional.

At 1800 on October 17, the last case was completed at the HI site and the final load was delivered. The VG evening staff members moved back with the last load. Emergency cases were ready to be booked at the VG site.

WEEK FOUR

The ORs at both sites resumed normal activity. The number of booked surgeries that had been cancelled due to Juan was 370 out of 437 scheduled cases. The OR Committee felt that, with its current resources, the system couldn't catch up with all the cases that were cancelled. The only option was to rebook cancelled surgeries and consequently increase the surgical wait lists.

Normally in a hurricane, flood or tornado, the health care system is there to help victims. During Hurricane Juan, the health care system was a victim, which radically affected its ability to deliver patient-care services to Atlantic Canadians.

LESSONS LEARNED

- Verbal and written communication is vital and should be repeated frequently. Any changes should be relayed to staff as soon as possible;
- Leaders need to be visible and to offer frequent support;
- Everyone needs to feel useful. Assign and delegate jobs accordingly. Staff resentment at being relocated was heightened by the fact that there was not enough work for everyone;
- People should be selected and designated at each site to be responsible for sending and receiving equipment. Ensure they receive direct and accurate communication;

Photo by M. MacLeod

Entire streets of trees were down in many areas inlcluding this suburb of Halifax

Surviving Hurricane Juan (cont.)

- Biomedical Engineering needs to be informed directly of equipment priorities in order to ensure priority checks are done as quickly as possible;
- An inventory should be kept to document equipment and instruments along with their current location;
- Priority lists should be quickly developed to document equipment and instrumentation requirements. Resource nurses should identify these lists for various services;
- Regular management visits to the damaged site will help ensure repair and maintenance updates;
- A familiar educator, charge nurse or manager should be appointed to be available to staff, at all times, when they're placed in a new environment;
- A local staff nurse assigned to finding items and getting staff comfortable in the unfamiliar surroundings is very helpful;
- Electrical engineers should regularly communicate with staff to explain the damage and its consequences;
- Staff should be assigned to both sites to work together as one "moving team"; and
- Strong teamwork will strengthen the bonds between two groups and help remind us that regardless of our location we are all part of the same team.

Photo by M. MacLeod

Repair crews working hard to clear the roads and restore power near downtown Halifax

STEPS TAKEN TO DATE:

During Juan, HRM declared a state of emergency and wanted only essential staff to be on the roads. A great deal of time has been taken since Juan, to ensure staff understand that everyone who works in healthcare is considered essential – for example administrative staff can be deployed to answer phones on nursing units;

A toll free phone number has been set up to provide hospital staff with up-to-date, accurate information during an emergency situation;

In recognition of the efforts made, hurricane hero stories were distributed on our intranet site as well as to the local papers;

Halifax and Dartmouth have now established web technology and internal email communication tools;

Display boards for bed status and major event status, providing space for the display of ongoing, changing information, are being considered;

Access to alternate satellite feed for TV coverage or digital access via the internet is being explored to allow for communication to the public about resource changes at the hospital due to an emergency situation;

An emergency contact list of internal and external resources is now available on the web;

A recognized training program is being developed to address the need for a Duty Officer and Duty Administrator in emergency response situations;

The District Emergency Response Center is in the process of being relocated due to the lack of emergency power at its current location.

Leadership in Health Care – Orchestrating Change

LE LEADERSHIP EN SOINS DE SANTÉ – ORCHESTRER LE CHANGEMENT

***Auteure : Cindy Laukkanen**, infirmière autorisée, baccalauréat en sciences infirmières, infirmière autorisée en salle d'opération (CNOR), est la directrice des services chirurgicaux à l'Alberta Children's Hospital à Calgary, AB.*

RÉSUMÉ

De nos jours les soins de santé sont un orchestre. Les patients arrivent quelques heures avant la chirurgie et partent quelques heures après. Ils arrivent avec une chemise de classement pleine d'information téléchargée et de listes de questions. Ils naviguent des systèmes complexes; ils sont indispensables à la coordination de leurs soins et de leurs propres besoins.

Les fournisseurs des soins de santé sont les sections de l'orchestre – chirurgie, radiographie, soins préopératoires, soins cliniques, cardiologie, et plus encore. De plus, l'âge moyen des travailleurs de la santé nous apprend que la majorité ont reçu leur formation au moment où le système hiérarchique était le plus répandu. Le leadership est fondamental. Nous avons changé de lieu, et les leaders doivent fermer la porte et aller vers l'avant. En tant que leader en soins de santé, comment puis-je aller vers l'avant quand nous vivons une période de changement presque chaotique? Il y a plus d'information disponible au simple clic d'une souris qu'une seule personne ne pourrait comprendre. L'heure actuelle nécessite une vision de l'avenir. Cette vision demande la compréhension. La compréhension exige l'intuition, et l'intuition commence à l'intérieur de soi. Le trajet vers l'avant débute par le trajet vers l'intérieur.

Le leadership est une chanson. Elle commence par l'âme et, avec de la formation, de l'aide et une forte équipe, elle peut être entendue de Helsinki à Vancouver.

LEADERSHIP IN HEALTH CARE – ORCHESTRATING CHANGE

***Author: Cindy Laukkanen**, (RN, BScN, CNOR) is Manager, Surgical Services, Alberta Children's Hospital, Calgary, AB.*

ABSTRACT:

Today health care is an orchestra. Patients arrive hours before surgery and leave hours afterward. They bring manila folders full of downloaded information and question lists. They maneuver themselves through complex systems; they are instrumental in coordinating their own needs and care.

The health care providers are the sections of the orchestra – surgery, x-ray, pre-op, clinics, cardiology and so on. Furthermore, the average age of the health care worker lands them at having trained directly at the height of the hierarchical system. Leadership is crucial. We have changed venue, and leadership needs to close the door and look forward. As a Health Care leader, how do I move forward at such a time of almost chaotic change? There is more information available with the click of a mouse than any one person could assimilate. These times require vision. Vision takes understanding. Understanding takes insight, and insight begins within. The journey forward starts with the journey within.

Leadership is a song. It starts in the soul and, with training and help and a strong team, it can be heard from Helsinki to Vancouver.

When an Orchestra finishes playing, the final note hangs in the air for a moment, suspended. Then there is the sound of cases gently closing as instruments are put away. There is the leaving of the orchestra and the closing of the door. They will play again in another venue. This metaphor is an image of sound, movement, change and teamwork. It is a metaphor for our work, our culture, and the change of era we are experiencing at this moment in time. It is a metaphor of leadership. We are no longer

isolated in our jobs, our company, and our practice. We are nothing short of global. A surgeon can sit in Germany and operate on a patient in Baghdad. A singer can sing a note in Helsinki heard clearly in Vancouver. Where is the leadership, then? It is in the orchestra, in the movement of sound, and in the changing of the venue.

Jupiter Images

Although change is a constant factor in life, if we look at the relative speed of change in this information age, we clearly see great acceleration. Change happens today at the speed of the Internet. Old hierarchies are falling because they simply cannot keep pace with the speed of information and change. One of the hierarchical houses struggling with this is *health care*. Health care was established on old hierarchical principles and with simple rules. In previous generations the doctor was always, unquestionably, right. Patients came in for surgery the day before and stayed for a few weeks after. Nurses were "in charge" of their patients and directed their care. Patients got well when the nursing department told them it was time. Nursing told people when they were well and recovery/discharge was best if designed to suit the nursing schedule — the belief was that if a nurse was truly efficient then all patients would "get well" immediately after a shift change. *"Forms such as symbols, slogans and rituals create culture"*.[1] Nursing culture was symbolically identified and nursing leaders were managers with task-oriented thinking.

Today health care is an orchestra. Patients arrive mere hours before surgery and leave just hours afterward. They bring manila folders full of downloaded information and lists of questions. They maneuver themselves through our complex systems; they are instrumental in coordinating their own needs and care. The health care providers operate as sections of the orchestra – surgery, x-ray, pre-op, clinics, cardiology and so on. Furthermore, the average age of the health care worker lands them as having trained directly at the height of the hierarchical system. To this training leadership dominance is crucial. But we have changed venue, and leadership needs to close the door on this way of thinking and look forward.

As someone who considers myself a health care leader how do I move forward at such a time of almost chaotic change? There is more information available with the click of a mouse than any one person could assimilate. These times require vision. Vision takes understanding. Understanding takes insight, and insight begins within. The journey forward starts with the journey within.

The reason that change must start within the leader is very simple. It is the leader who must maintain the big picture vision of all issues at all times. He/she must recognize the needs of all staff and be integrative in nature. In order to do that, the leader must be aware of his/her own biases, tendencies, preferences, and personality. None of these things disappear in the face of leadership. But if you know yourself, you can invite your preferences and opinions into the room of your mind without being ruled by them. It fosters wisdom, and gives rise to integrity. *"The quest for leadership is first an inner quest to discover who you are"*.[2]

It is impossible to build trust without personal authenticity. If you try to, everyone you work with will see through you immediately. In health care, the providers (nursing or otherwise) are

highly trained to read and evaluate people. Their emotional/intuitive knowledge is very high. They will see if you are who you say you are. So there must be a personal willingness to self-evaluate and put energy and spirit into self-knowledge and self-wisdom. *"Find your voice, your authentic self grounded in a set of values and ideals"*.[2]

This authenticity may begin within but it must also turn into action that is visible by staff. For myself, I make rounds through six units, usually at least twice a day, in order to be visible. This allows me to address issues as they come up. I work to state my truth, as diplomatically as I can when it is not the answer someone may want. I make promises carefully, and I keep the ones I make. I work to listen attentively and not let my mind wander when someone is speaking to me. I advocate for respectful treatment of my staff by all medical groups. I want people to dream, so I ask them about their dreams and vision. I work to develop my own integrity by listening to others. Kouzes and Posner suggest even more actions to build relationships. They include carefully watching your time and allocating it to "front line" workers on a regular basis, and remembering to "hang out" over lunch. Say thank you often. Observe yourself.

Health Care leadership also needs to be transformational. Bass (1985, 1996) identified three aspects of the transformational leader. The leader is able to motivate people by *"(1) making them more aware of task outcomes, (2) inducing them to transcend their own self-interest for the sake of the organization or team and (3) order needs"* [1]. In nursing leadership, these are accomplished through education, role modeling, and supporting expanding roles. Nursing education, which is so often cut back in times of fiscal crisis, builds the foundation of evidence-based practice and critical thinking. It must be encouraged. Education transforms the individual, and the individual transforms the team.

To transcend self-interest, you have to model your own ethics. Max Depree said, *"the best way to communicate values is through behavior"*. (RRU course book, 3-6) You have to step up to challenges, bravely take on the conflict that work brings, and communicate back to the group on outcomes. It is also important to be seen in both your successes and failures. The team celebrates the successes together, and in the times I have failed I have found support and, sometimes, a good laugh about it within a strong team. *"Without these experiences (failures), we would be unable to achieve our aspirations"* [2]. Expanded roles for nursing, such as nurse practitioners, executives and first assists in the operating room all develop higher order thinking. These things bring about transformation and evolution to the group and the leader.

If we think again of the metaphor of the orchestra with its different sections of strings, woodwind, brass and percussion, we can see the variety of sections and number of players, of practitioners, involved in Health Care. It is truly an orchestra of specialists that need to work within their own teams and also be connected with each other. A leader, like a conductor of the orchestra, has to keep the connections open, the communications clear, and the practices, policies and structures all focused on the best possible patient outcome. *"It is quite clear that leaders must be innovators to navigate their organizations into and through the New Economy[2]"*. There are ways to support this. The first step is to be clear on vision, to understand yourself and your group. Involve stakeholders, identify strategic objectives, and when looking for change, remember to identify and honour relevant elements in the old ideology.[1] Never let yourself be done; continually assess where you are and where you are going. Continually check in on your own vision and goals.

As leaders in Health Care, we are doing a remarkable job of dealing with these challenges. We are witnessing a change of era and we are in a position of leading our orchestras into unknown venues with completely new music. We conduct teams that are integrative, changing and expanding. We address a deluge of information, legislation, fiscal realities and seas

Leadership (cont.)

of expectations. Is it easy to be a leader in Health Care? Never. What would make us stay? For myself, the opportunity to make a difference has never been greater than now. I have never forgotten that it is an honour to have a job of service. No two days have ever been the same and somewhere, there is laughter. Leadership is a song. It starts in the soul and, with training and help and a strong team, it can be heard from Helsinki to Vancouver.


Jupiter Images

REFERENCES:

1. Yukl, G. (2002) *Leadership in Organizations Fifth Edition*. Englewood Cliffs, New Jersey: Prentice-Hall

2. Kouzes, J & Posner, B. (2002). *The Leadership Challenge*. Third edition. San Francisco: Jossey-Bass. (First Edition 1987).

GENERAL RESOURCES:

O'Toole, J (1996) *Leading Change: the argument for values-based leadership*. New York: Ballantine Books.

Porter-O'Grady, T & Malloch, K (2003) *Quantum Leadership, a textbook of New Leadership*. Mississauga, Ontario: Jones and Bartlett.

With her help, we're providing more solutions than ever before

Across our nation, from Newfoundland to British Columbia, Lac-Mac Limited stands out above the rest. Since 1920, Lac-Mac has provided quality reusable linen solutions for Canadian health care providers coast-to-coast.

Joan E. Thompson, R.N., B.A., O.R. Nurse Consultant, and her colleagues at Lac-Mac are continually finding new and ever more innovative solutions for Canadian hospitals. As Joan admits, "While there is a place for a small percentage of disposable items, reusable is the right choice for the vast majority of procedures". Thanks to the work of Joan and the dedicated team at Lac-Mac, the unmatched value of quality reusable textiles, service and support is proven in case after case across the country.

Want to find out more?
Call us to arrange a free consultation with Joan.

Lac-Mac Limited is Canadian owned and operated with over 95% of all our textile products manufactured here in Canada.

Lac-Mac

London, Canada
519.432.2616
Fax: 519.432.6096
www.lac-mac.com

85
Lac-Mac Limited 1920-2005

Because the Future is not Disposable™