Communication and Relationship Management

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Overview

In today's increasingly dynamic health care environment, surgical services are delivered within a complex organizational structure. Within this structure, a surgical services nurse manager must organize and direct the activities of multiple health care workers with various levels of education and training to provide safe and efficient patient care. Therefore, effective communication and relationship management are two vital skills that a surgical services nurse manager should possess. The purpose of this module is to provide a review of the skills related to communication and the relationship management needed by surgical services nurse managers. It reviews negotiation skills for handling conflict in the workplace and the principles of collaborative, multidisciplinary relationships. Key aspects of teamwork, organizational effectiveness, and conflict resolution are also discussed. The importance of information sharing; creating a culture that focuses on patient safety and quality; and technology, related to selecting the appropriate channel for sending a message, is also presented.

TASK STATEMENTS

These task statements were identified from a comprehensive job analysis on the role of perioperative services managers:

1. Utilize negotiation skills in a multidisciplinary environment.
2. Establish and foster a collaborative relationship while understanding the differences among the disciplines (e.g., vendors; ancillary and professional staff; nurses, physicians, and surgeons; anesthesia professionals; finance and senior management).
3. Encourage cooperation, teamwork, and collaboration within the internal perioperative unit and throughout external partnerships.
4. Evaluate the effectiveness of relationship management between perioperative units, both internally and externally, in order to foster continuous improvement.
5. Facilitate the constructive resolution of conflict (e.g., handling disruptive behavior, lateral violence).
6. Communicate organizational mission, vision, values, and goals in a way that clearly links them to the work of perioperative services.
7. Disseminate relevant information about decisions, plans, and activities to people who need the information.
8. Create an environment that encourages a culture of safety, openness, and trust.
9. Use technological communication tools effectively and appropriately (e.g., e-mail, social media, texting, images).

OBJECTIVES

After reading this module, the participant should be able to do the following.

1. Identify effective leader communication skills.
2. Discuss the components of leading teams and relationship building.
3. Determine the relationship between organizational effectiveness and work culture.
4. Describe the process of creating vision and strategic direction.
5. Recognize the importance of a culture of safety in the perioperative environment.
A healthy perioperative work environment is essential for surgical services nurse managers to develop effective leader communication and relationship-building skills. This healthy environment has been positively correlated with staff retention, satisfaction, improved patient outcomes, and organizational performance (Sherman & Pross, 2010). It possesses the following cultural qualities:

- collaborative practice,
- rich communication,
- team member accountability,
- adequate staffing of qualified practitioners,
- shared-decision making,
- expert, credible, and visible nurse leaders,
- encouragement of professional growth/development, and
- recognition of the value of nurses’ contributions to patient care and each other. (AORN, 2009)

Communication and relationship management are indispensable components in a nurse manager’s leadership toolbox. Both facilitate multidisciplinary collaboration among team members in providing high-quality patient care. Knowing how to build and sustain relationships by using solid communication skills leads to motivation and empowerment.

Motivation of others requires a manager to articulate the vision and strategic direction of the organization, to recognize the culture of the organization, and to create and support a healthy work environment conducive of change (Curtis & O’Connell, 2011). In this module, you will identify effective leader communication skills, learn the components of leading teams and relationship building, describe the process of creating vision and strategic direction, relate organizational effectives to work culture, and learn how the personal side of leadership affects the professional side in the workplace.

Although the terms manager and leader are defined differently, similarities exist such as thinking long-term; looking beyond the confines of their practice environment; influencing others beyond their jurisdiction; placing heavy emphasis on the abstract concepts of vision, values, and motivation; and thinking in terms of renewal and revision as it relates to a changing reality (Roussel, 2013). In this module, the terms manager and leader are interchangeable.
Many managers will encounter situations where they will need to negotiate among conflicting team members. These issues may arise out of disrespect among staff or acts that compromise safe, quality patient care.

A manager may be tasked with facilitating the negotiation process if two or more parties have differences of opinion related to patient care services. If the problem is a disagreement between two parties, it should be addressed privately and collaboratively while maintaining confidentiality and avoiding competitiveness. It is important to assume good intent from both sides and to ask the parties to share the event from their perspectives.

Negotiation is an approach to handling conflict in the workplace due to a disagreement regarding the intent of a communication (Roussel, 2013). Its purpose is to engage the two parties in give-and-take discussions when working toward a joint decision acceptable to both sides (Daft, 2011).

Two types of approaches to negotiation are used: integrative or distributive. The integrative approach is based on a win–win perspective, whereby the intent is to satisfy both parties. The distributive approach assumes that both parties will try to apportion as much of the “win” for themselves, creating a win–lose approach (Thompson, Wang, & Gunia, 2010). The principles of negotiation follow.

- Maintain self-identify and insight into your own motives, values, perceptions, and skills.
- Understand others’ values without judging them to be better or worse but only different from your own.
- View issues as potentially solvable.
- Use personal flexibility in analyzing and reacting to issues and behaviors.
- Use skills to repair damaged relationships, allowing the ability to retreat and regroup in a manner that allows for perceptual openness (Roussel, 2013, p. 183).

GENDER DIFFERENCES

Gender often affects negotiations among perioperative team members. Before trying to facilitate successful negotiations, managers should recognize how society differentiates gender-appropriate roles and how men and women are culturally
conditioned. Although societal gender bias and stereotyping have diminished, or at least changed over the past decade, nursing continues to be predominately female, and physicians are predominately male.

Women are viewed as less assertive and competitive than men, and negotiation is seen as a situation requiring assertive and competitive behavior. This creates a dilemma for women during negotiation as they determine which behavior (either stereotypical or counter-stereotypical) will prove more advantageous (Thompson et al., 2010).

To negotiate successfully, managers must be well versed in the process of negotiation and the differences in how it is approached from male and female perspectives. Negotiation is a skill, and both genders can improve their skills by using the same strategies, such as being prepared, identifying the outcome, staying objective, and focusing on strengths.

**ADDITIONAL CONFLICT RESOLUTION APPROACHES**

In addition to negotiation, other methods exist for handling conflict such as mediation, facilitating communication, and advocacy.

Mediation involves the use of a third party to assist in the negotiation, such as another team member or someone from the human resources department (Daft, 2011).

In smoothing the lines of communication, the negotiator assumes the role of facilitator and assists each party in communicating honestly and openly through dialogue. Dialogue between parties assists in reducing suspicions, leading to more effective teamwork (Daft, 2011).

Using the advocacy approach, the negotiator usually functions as an advocate for one party with the intent of obtaining the most favorable outcome for the party. The negotiator works to determine the minimum outcome the other party is willing to accept. A successful negotiation consists of obtaining all or most of what the advocate’s party wants without causing the other party to break off the negotiation process. This approach is similar to the way lawyers advocate for their clients.

Frequently, this approach results in a short-term gain for one party, not a long-term gain for both. When the goal of negotiation is to create good working relationships, not to advocate for predetermined solutions, everyone benefits. As negotiators and mediators, managers need to focus on meeting the needs and interests of the stakeholders. Doing so requires active listening and creativity on everyone’s part, but especially the manager as the facilitator of negotiation (Eisaguirre, 2002):

Regardless of the chosen process of negotiation, a manager should strive for the best outcomes among the parties including maintenance of self-respect, being sensitive to each other’s needs, meet a majority of each other’s objectives, and encourage future negotiations if necessary (Roussel, 2013, p. 183).
A collaborative practice culture is a key element in support of a healthy work environment. Many organizations, such as The Joint Commission (TJC), have leadership standards specific to collaboration (Schyve, 2009). The American Nurses Association (ANA) and the American Organization of Nurse Executives (AONE) joined to establish the principles of collaborative relationships between clinical nurses and nurse managers, which include effective communication, authentic relationships, and learning environment and culture (ANA & AONE, 2012). Further explanation of the standards follows.

**EFFECTIVE COMMUNICATION**

Effective communication involves giving and receiving accurate information, knowing the context of the situation, and appreciating the intuitive parts of a conversation.

**Principles**

- Engage in active listening to fully understand and contemplate what is being relayed.
- Know the intent of a message, and what is the purpose and expectations of that message.
- Foster an open, safe environment.
- Whether giving or receiving information, be sure it is accurate.
- Have people speak directly to the person they need to speak to, so the right person gets the right information.

**AUTHENTIC RELATIONSHIPS**

Professional nurses should engage in caring relationships with their patients and colleagues. The principles of authentic relationships guide nurses toward developing relationships that grow nurses’ mutual sense of caring.
Principles

- Be true to yourself—be sure actions match words, and those around you are confident that what they see is what they get.
- Empower others to have ideas, to share those ideas, and to participate in projects that leverage or enact those ideas.
- Recognize and leverage each other’s strengths.
- Be honest 100% of the time—with yourself and with others.
- Respect others’ personalities, needs, and wants.
- Ask for what you want, but stay open to negotiating the difference.
- Assume good intent from others’ words and actions, and assume they are doing their best.

LEARNING ENVIRONMENT AND CULTURE

Trust, support, and representation are attributes of a well-developed practice environment. Nurses believe they are valued and that their practice has meaning. The principles related to learning environment and culture promotes success, empowerment, and recognition.

Principles

- Inspire innovative and creative thinking.
- Commit to a cycle of evaluating, improving, and celebrating, and value what is going well.
- Create a culture of safety, both physically and psychologically.
- Share knowledge, and learn from mistakes.
- Question the status quo—ask, “What if...”; do not say, “No way.”

Roussel, in her 2013 book, speaks to the work done jointly by the ANA and the American Association of Colleges of Nursing (AACN) in this area. The ANA, in a joint statement with the AACN, provides examples of core abilities inherent in nurse administrative roles including the ability to use management skills that foster collaborative relationships and team-based learning. “The intent of utilizing the skills is to advocate for patients and community partners, embrace change, manage resources in an effective manner, negotiate and resolve conflict and use information technology as an effective means of communication” (Roussel, 2013, p. 28).

COLLABORATIVE PARTNERSHIPS

Collaboration within the perioperative team is a process by which interdependent professionals build a collective action to meet the needs of the patient and family.
Team members may include vendors, ancillary and professional staff, nurses, physicians and surgeons, anesthesia care providers, and senior management. Built on a voluntary basis for the most part, this collective action implies an element of negotiation and requires individual professionals and disciplines to forgo autonomy and adopt shared partnership. In perioperative teams, the strong affinity for autonomy along with power differences based on gender stereotypes and the hierarchal nature of health care tend to foster domination and control, rather than collegiality and trust.

Establishing a collegial environment in which all members of the perioperative team are considered equal partners with surgeons is critical to successful collaborative partnerships (San Martín-Rodríguez, Beaulieu, D’Amour, & Ferrada-Videla, 2005). The literature consistently identifies the characteristics that enhance the chances of successful collaborative partnerships as mutual purpose, high stakes, right people, right leadership, strong and balanced relationships, trust and respect, good communication, and formalization (Brown, White, & Leibbrandt, 2006).

Several studies exist on the use of collaboration, both within and among disciplines. For example, nurse managers who perceived their culture to be positive and collaborative used more authentic leadership behaviors while those who perceived a negative culture faced many challenges in participating in authentic leadership behaviors (Shirey, 2009). Another study showed nurses who worked in collaborative environments and had supportive managers were very satisfied in their workplaces (Schmalenberg & Kramer, 2008).

In an effort to document teamwork and collaborative behaviors among various team members, patients, and families while conducting bedside rounds, a checklist was developed as a means to record the behaviors and establish a consistent mode of communication (Henneman, Kleppel, & Hinchey, 2013). The Johns Hopkins Delirium Consortium, composed of physicians, nurses, pharmacists, and others, was developed to foster collaborative work on best practices in the prevention, detection, and treatment of delirium (Neufeld et al., 2011).

After the construction of a new health facility, perioperative nurse leaders developed a multidisciplinary orientation program to introduce team members to the facility and provide education on the newer technology available (Hemingway & Morrissey, 2013).

The previously mentioned studies represent a fraction of the work on teamwork and collaboration. For a collaborative partnership to work, everyone must have compelling reasons to make it work. These reasons, called high stakes, include the partners’ need for each other and their commitment to devoting resources or services to the partnership. In a business partnership, this is usually demonstrated by a shared fiduciary responsibility. The participants must be accountable for the outcome, and they must have assurances that everyone invests in each other and the partnership. Researchers maintain that to provide stakeholders with a voice without responsibility and accountability for the outcome is counterproductive to the best interests of the collaborative process (Brown et al., 2006).
Developing collaborative partnerships requires selecting the best possible people for a situation or process. Having the right people means having the best possible match of individual abilities and expertise as well as adequate representation of disciplines and departments. Carefully identifying all stakeholders is crucial to the success of the collaborative effort. Manager responsibilities to foster collaboration include the following:

- enhance the ability of the partnership to address important issues;
- acquire budgetary allocations, new competencies, and useful information to support the group activities;
- develop new and beneficial relationships; and
- provide sufficient authority and resources, including time, to the participants in the collaborative process. (Brown et al., 2006)

CONFLICT IN THE WORKPLACE

The more diverse the members of a collaborative partnership are, the more perspectives, skills, and ideas they bring to the process, which increases the probability of synergy and improved outcomes. Having diversity also presents a greater risk of tension and conflict. However, if effectively managed, conflict can be good. “If two people on the job agree all the time, then one is useless. If they disagree all the time, then both are useless” (Eisaguirre, 2002, p. 3).

In healthy conflict, team members are comfortable in disagreeing and challenging one another in the interest of seeking the best outcome. “Diversity contributes to the avoidance of groupthink, which alludes to cohesive groups or teams suppressing contrary opinion” (Daft, 2011, p. 305). Team members practice groupthink when they desire harmony and unity as opposed to challenging or questioning the opinions of others.

“The majority opinion of seeking fast solutions with minimal critical thinking and member input inhibits consensus building within the team” (Roussel, 2013, p. 170). Those participating in collaborative partnerships need patience, managerial skill, and goodwill. An effective manager nurtures the team beyond the ongoing storming and norming phases if the partnership is to achieve the collaborative advantage (Brown et al., 2006; Eisaguirre, 2002).

THE LEADER AS RELATIONSHIP BUILDER

Building strong, balanced relationships is one of the most challenging and time-consuming aspects of developing collaborative partnerships. The key to successful collaboration is the quality of the professional and personal relationships. Active collaboration is possible when structures, processes, and skills are developed for resolving personal, professional, organizational, and interpersonal differences.
A leader who encourages an environment whereby team members feel valued is a main tenet of highly motivated people and contributes to relationship building. The prevailing idea is to bring out the best in each other while valuing the impact of what someone does as opposed to the task at hand (Daft, 2011). To motivate people and build relationships, a leader must provide the opportunity for team members, inside and outside the organization, to satisfy their needs, whether internal or external. Examples may include recognizing the effect of a life-saving procedure, comforting a patient or family member, or knowing that an evidence-based practice project led to improved patient outcomes. Other needs include professional growth and fulfillment, career-ladder opportunities, and continuing education to maintain competent practice.

Building relationships among members outside the organization (such as vendors) contributes to the success of the team and patient safety. AORN’s position statement, The Role of the Health Care Industry Representative in the Perioperative/Invasive Procedure Setting, recognizes the importance of having a structured process for education and training of these individuals in a supportive and inclusive culture (AORN, 2006). An effective manager uses relationship management to build team engagement toward future accomplishments in the perioperative setting.

GOVERNANCE STRUCTURES

A type of governance that lends itself to multidisciplinary teams is shared governance: “Shared governance is a model that has been used to increase the participation by staff nurses in decision-making and problem-solving” (Roussel, 2013, p. 174). It has been used as a strategy in nurse retention (Twigg & McCullough, 2014); as a structural component in nurse practice environments with Magnet® designations (Clavelle, O’Grady, & Drenkard, 2013; Walker, Esquieres, Fowler, & Tennaro, 2013); in conjunction with evidence-based practice in the perioperative setting (Waddell, 2009), and as a multidisciplinary model in perioperative practice (Hartley, Moss, & Straley, 2008). The following are strategies and tips toward implementing a shared governance model (SGM) in the perioperative environment.

Strategies for Implementing a Shared Governance Model

1. Research types of models.
   a. Literature review
   b. Networking
2. Select one or the best of several to fit your team’s needs.
3. Build relationships and gain buy-in from staff, managers, and physicians.
4. Provide education and encourage team awareness.
   a. Use multiple communication mechanisms to inform others.
b. Find a staff/manager champion who is passionate and can articulate clearly what the benefits of SGM are and make it meaningful to staff.

c. Managers need to be involved and act as role models of the ideals that are presented.

5. Educate and communicate.
6. Start small and build your model.
7. Celebrate achievements frequently.
8. Trial and error may be necessary.
9. Set a clear vision and expectations with target times and dates.
11. Set the tone—council time and work is important, not a burden (Hartley et al., 2008).
“Although teams have been used in nursing since the 1950s, [they have] been implemented at the point of care level instead of at top or middle management” (Roussel, 2013, p. 245). To facilitate the development of team behaviors, a manager must begin with the end in mind (Covey, 1989). If having a collaborative, high-performance team that achieves optimal patient outcomes is the desired end, managers must understand where communication and collaboration breakdowns occur among perioperative team members. Managers should understand the differences in socialization, education, and perceptions of the disciplines that make up the team.

Traditional types of teams include functional, cross-functional, and self-directed, whereas basic teams are management, project, and work. A functional team is hierarchical in nature with the manager at the top and subordinates who follow a formal chain of command. Its members are from one department with specific goals and objectives.

Cross-functional teams are composed of members from different departments within an organization whose specific purpose is to lead projects of special importance such as a Joint Commission accreditation visit or a process improvement project.

A self-directed team may evolve from a cross-functional team and is usually long-term or permanent. It is multidisciplinary with team members empowered to make decisions. It typically has an elected team leader; or it may be decided that leaders may change depending on the circumstances. An example of perioperative self-directed team would be a specific service such as cardiac. Any one member of the team (e.g., surgeon, perfusionist, anesthesia care provider, registered nurse, surgical technologist) could lead the team depending on who is most experienced with the situation at hand (Daft, 2011). It is important to remember that although scope of practice will limit team members’ authority, their particular expertise should be recognized and valued as it contributes to the overall goal of patient safety.

Management teams are led by upper management and address the change inherent in complex health systems. Project teams are similar to ad hoc teams in that each is formed for one purpose or project and once the objectives or charges are met, the team disbands. Work teams are synonymous with self-directed teams and responsibility is shared with each team member. The nine characteristics of a self-directed work team are:

1. bottom up communication,
2. consensus,
3. big picture,
4. ongoing diverse training,
5. mobility,
6. empowerment,
7. challenge/innovation,
8. external competition, and
9. work and celebration (Roussel, 2013, p. 246).

**DIFFERENT PERSPECTIVES**

Multidisciplinary members of the team may perceive teamwork differently. Effective communication goes hand-in-hand with successful teams and a leader conveys expectations through sound communication methods. The perioperative literature is full of information on perceptions of communication, team training, and successful teams due to the reality that communication continues to be one of the most frequently identified root causes of sentinel events as reported by TJC (2013a). For example, in a systematic literature review of team training intervention projects designed to increase communication in the operating room (OR), findings indicated the interventions were purposeful in increasing team communication and cohesion (Gillespie, Chaboyer, & Murray, 2010).

A study examined perceptions of communication and collaboration among OR team members as a focus of a Veterans Health Administration (VHA) quality improvement project to gather preliminary data for implementing a briefing checklist. It was determined that surgeons overall had more favorable perceptions of team communication during procedures and of teamwork effectiveness than did nurses (Carney, West, Neily, Mills, & Bagian, 2010).

Simply stated, nurses and physicians communicate differently. Nurses are trained to tell a story about how things appear. Physicians are trained to communicate succinctly. These differences are rooted in how nurses and physicians are educated and socialized within their schools and professions. Nurses may also have an inherent hesitance to speak up and stand up to surgeons. The traditional hierarchy with the surgeon as the captain of the ship has discouraged effective communication and collaboration.

Other sociological barriers, such as race, gender, education, and socioeconomic status, may contribute to a sense of intimidation. The theme of finding voice is engaging with fellow colleagues, regardless of role or status, in meaningful conversations in a context of respect (Hudek, 2012). As managers begin to understand how various communication methods affect team performance, they will learn to devise processes that meet the needs of the team and patients while respecting the perceptions of others: “Effective teamwork is not a given but a goal that requires training and cultivation” (Clancy, 2007, p. 18).
A relationship exists between organizational effectiveness and organizational performance. “Recognizing the value of nurses and their role as potential sources of partnerships for profit could change the perception of nursing as charitable and idealistic to one of viability and profitability” (Roussel, 2013, p. 279). Cost-effective health care is a goal of all organizations as each competes for growth with limited resources. This way of thinking fits within a synergistic model whereby nursing participates, not only in the unit governance, but also in the overall health of the organization.

Organizational effectiveness is a term used to describe the product or output of an organization and specific indicators exist to monitor organizational effectiveness. These include the following:

- patient satisfaction with care,
- family satisfaction with care,
- staff satisfaction with work,
- staff satisfaction with rewards, intrinsic and extrinsic,
- staff satisfaction with professional development: career, personal, and educational,
- staff satisfaction with the organization,
- management satisfaction with staff,
- community relationships, and
- organizational health. (Roussel, 2013, p. 279)

Various tools have been developed to measure the preceding indicators. In one example, organizational culture, similar to organizational health, has been linked with organizational effectiveness and consists of shared beliefs, assumptions, and values by members of an organization (Casida, 2008). The Denison Organizational Culture Survey (DOC) tool, based on the Denison Organizational Culture Model (DOCM), was proposed to measure a nursing unit’s organizational culture and its relationship to organizational effectiveness (Casida, 2008). The model has four organizational traits—adaptability, mission, involvement, and consistency—that are attributable to organizational effectiveness. In a review of the literature on organizational culture tools, King and Byers (2007) found several instruments nurse
executives may use in measuring organizational culture, organizational effectiveness, patient safety, and quality improvement. The list includes the following.

1. Agency for Health care Research and Quality (AHRQ) Survey on Patient Safety Culture
2. Organization Description Questionnaire
3. Nursing Unit Cultural Assessment tool
4. Team Survey
5. Organizational Culture Inventory
6. Total Quality Management (TQM) Practices and Culture Survey
7. Quality Improvement Implementation Survey

Although limitations exist with each tool, a nurse manager may use the results to begin the process of planning, implementing, and evaluating change in infrastructure. The choice of tool will depend upon it coinciding with the organizational mission, goals, and strategic plan (King & Byers, 2007).

**Baldrige National Quality Program**

The contributions of the OR team related to reducing costs through the reprocessing of single-use items and changing group purchasing organizations assisted a New Jersey hospital in winning the prestigious Malcolm Baldrige National Quality Award (Flowers, 2005). The Baldrige National Quality Program (BNQP) was established by the U.S. Congress in 1987 to support businesses seeking to improve product and service quality, customer and employee satisfaction, efficiency, and financial and overall outcomes. Nurse managers may use the BNQP characteristics of highly effective health care award recipients as a benchmark for organizational self-assessment and leadership practices:

Experience has demonstrated that health care systems’ design and cultural characteristics inhibit the application of evidence-based effectiveness knowledge into clinical practice. For example, delays in adopting and spreading current knowledge regarding patient-focused practice, multidisciplinary teamwork, hazard prevention, process management, routine clinical outcomes measurement, and improvement raise questions about cultural, management, structural, and other barriers to performance excellence in health care. (Goonan & Stoltz, 2004, pp. 31–32)

The BNQP defines performance excellence as the delivery of ever-improving value; continual improvement of overall organizational effectiveness, management capabilities, and outcomes; and individual and organizational learning. For perioperative services, performance excellence involves clinical quality, customer satisfaction, workforce satisfaction, financial performance and growth, organizational effectiveness, and social responsibility. Leadership, management, and operational
practices have been demonstrated by Baldrige Award recipients. In the order of highest ranking, these practices are the following:

1. visionary leadership guidance,
2. focus on customer satisfaction and relationships,
3. high-performance work systems,
4. focus on employee education and professional development,
5. knowledge of the customer and the market,
6. process design and delivery, and
7. strong financial and market results. (Goonan & Stoltz, 2004)

STRATEGIC PLANNING

Highly effective organizations hold strategic planning sessions and set priorities before implementing action plans. For perioperative services, strategic interventions may include the following:

- implementing evidence-based practice to standardize delivery of care, e.g., standardized instrument sets and implants, protocols, and clinical pathways;
- improving patient flow to increase case volume and revenue;
- designing patient–family centered service lines, such as bariatric surgery, to attract new market shares;
- developing state-of-the-art, minimally invasive and robotic-assisted procedures;
- designing education and training to dramatically enhance behavioral competencies of all personnel; and
- improving operational efficiency to increase productivity while cutting cost or at least managing cost and waste.

Strategic planning resulting in organizational effectiveness in perioperative services requires full participation of providers and support personnel. The hallmark of high-performance organizations is a commitment to maintaining a strong work environment that enables staff members to perform their work effectively and efficiently leading to competent practice.

In designing education and training to advance competencies, one must know what constitutes a competent worker: Competency is having the knowledge, skills, and professional attitude to carry out the work of the perioperative team (Goonan & Stoltz, 2004). Strategic planning is a competency of nursing management.

The rationale for strengthening competency in strategic planning skills includes:

- to provide accountability and monitoring of performance,
- to tie merit to performance,
• to think and concentrate more on strategic issues,
• to integrate strategic plans with operational and financial plans,
• to improve communication from top administration and nursing management, and
• to focus on quality outputs that will improve nurse performance and productivity, decrease losses, and increase return on equity (Roussel, 2013, p. 367).
Conflict resolution is a requisite skill and process in building effective teams (Powell & Hill, 2006). “Conflict appears inevitable in teams and is influenced by factors such as scarce resources, incompatible goals, or unclear responsibilities” (Daft, 2011, p. 316).

Some common causes of conflict for nurses include different management styles and staff perceptions, staffing issues, limited support staff or resources resulting in heightened stress levels, and differing objectives and opinions among perioperative team members. Unresolved conflict leads to team feelings such as being overwhelmed or swamped, resulting in an unhealthy work environment (Hocking, 2006). The most recurrent source of conflict is the nurse–physician relationship (Vivar, 2006).

CONFRONTING CONFLICT

Depending on the situation, effective managers and team members use different styles of handling conflict. Regardless of style, the end result should move the team to adopt healthy patterns of conflict (Daft, 2011). Harmonious nursing units and multidisciplinary teams lead to excellent patient care. First and foremost, before conflict resulting from disrespectful behavior can be addressed, respectful behavior should be established.

A code of conduct is a means of educating team members as to what types of behavior are expected in an environment that values a healthy work setting. Managers should be provided educational opportunities on conflict management. An educational program specifically addressing conflict management was developed by a quality-of-life taskforce convened to address concerns of disrespectful behavior in the OR. The program used the teaching strategies of role-play, simulation, and self-assessment and was designed to address the following:

- accountability of leaders in managing conflict,
- analyzing how different individuals resolve conflict,
- approaches to conflict resolution, and
- methods for coaching others to resolve conflict. (Costello, Clarke, Gravely, D’Agostino-Rose, & Puopolo, 2011)

In the presence of conflict, a manager assumes leadership and intent and prepares for disagreement. A manager’s ability to focus on the goals and mission will support
the consistency in daily work that can rise above conflict and see it as opportunity and growth. A manager should determine which of five most common conflict resolution approaches is best suited to successfully address the conflict. The five approaches are avoidance, competition, accommodation, compromise, and collaboration (Vivar, 2006).

**Conflict Resolution Approaches**

*Avoidance* is a form of denial in which a manager ignores the person, issue, or situation and does not acknowledge that a conflict exists. In some instances, using avoidance until more information is available may be appropriate. Avoidance may be effective in the short term; however, in the long term, it may lead to dysfunction.

*Competition* forces a win–lose situation. With this approach, one side endeavors to overpower the other and gain control of the situation. Competition may be appropriate when the stakes are high and there is no time for collaboration and dialogue, for example, in a life- or limb-threatening emergency. The downside of this approach is that it lacks collaboration and results in winners and losers.

*Accommodation*, the opposite of competition, is a lose–win situation. Accommodation occurs when one party is willing to give in to the other party. Cooperation is high, but assertiveness is low. In some situations, accommodation can appear relevant because it can encourage people to express themselves, which can lead to an agreeable relationship at the end of the process.

*Compromise* is characterized as both parties giving a little or negotiating. With this approach, each party gets something and gives up something else in the process. In other words, each party compromises to achieve conflict resolution.

*Collaboration* results in a mutual gain or win-win situation. Each party addresses the conflict with equal interest and identifies areas of agreement and disagreement while creating a resolution that incorporates both parties’ interests. When used to address conflict, collaboration requires more time and energy than the other approaches, but it provides the most meaningful satisfying resolution (Vivar, 2006).

**MUTUAL UNDERSTANDING**

Conflict resolution is reaching a mutual understanding through a process, in which parties share facts, reactions, effects, perceptions, requests, and agreements.

- **Facts** are information and knowledge based on observed behaviors.
- **Reactions** are thoughts, feelings, and emotions that have been acted on.
- **Effects** are the meaning, significance, or consequences the conflict holds for an individual or a team.
- **Perceptions** are beliefs held by the involved individuals about the conflict and the other people involved.
- **Requests** are details of the expected behaviors and outcomes.
- **Agreements** are common ground for understanding and resolution.
Active listening and paraphrasing are characteristic of the agreement stage of conflict resolution. The mutual understanding should be made public, for example, in a revised or newly developed policy, procedure, or other sort of formal agreement that spells out the expectations (Powell & Hill, 2006).

**Abuse and Intimidation**

Abuse of any kind, including intimidation and lateral violence, has no place in a healthy work environment. Over the past several years, lateral violence in the perioperative setting has gained more attention. *Lateral violence* is considered disruptive, bullying, intimidating, or unsettling behavior that occurs between health care professionals (Bigony et al., 2009).

Lateral violence erodes collaboration, teamwork, and effective communication and affects employees’ well-being and their ability to provide quality, safe patient care. The resultant psychosocial impact may be similar to chemical impairment and may be just as serious in its consequences on personal and professional performance. In a survey by TJC, 77% of participants observed disruptive behavior in physicians whereas 67% witnessed similar behavior in nurses (Rosenstein & O’Daniel, 2008).

Findings from the survey indicated nurses were most likely bullied by physicians; however, nurse-to-nurse hostility was not uncommon. In a study by Saxton (2012) on disruptive physician behavior, results showed a communication skills training program intervention increased perioperative nurses’ perceived self-efficacy to address disruptive behavior (Saxton, 2012). The intervention was based on the Crucial Conversations® Health care Training Track, designed with content specific to the perioperative nurse and setting. Several organizations have resources on lateral violence including TJC (2008), the AACN (2005), and the Council on Surgical and Perioperative Safety (2007).

To prevent and contend with lateral violence, facilities need the following:

- organizational and departmental policies of zero tolerance with clearly defined behaviors,
- human resource procedures for addressing the defined behaviors,
- nursing self-governance models,
- multidisciplinary task forces,
- employee assistance programs,
- sufficient orientation and mentoring programs,
- safe staffing and on-call parameters, and
- protection from reprisal for reported infractions (Bigony et al., 2009).
Unit 7

Information Sharing

Each unit contributes to the collective whole of the strategic vision and mission of an organization. It is a leader’s responsibility to assist in creating the future of the organization by setting a direction for where an organization may be in the next 5 to 10 years. Equally important is for the leader to communicate the strategic vision and mission to the immediate team and connect it to the work being done at the point of care. Simply having the vision and mission on placards and name badges is not adequate. Living the vision and mission by setting an example for the team via open lines of communication is needed.

Why an organization exists is the purpose of creating a mission. “Embedded in the mission of a health care organization is the purpose of providing services to maintain health, cure illness, and allay pain and suffering” (Roussel, 2013, p. 343). Different from the vision, which grows and changes, the mission is at the core of the organization and persists throughout a changing environment. The mission and the vision at the unit level are derived from and support the overall organizational purpose. The vision is an ideal future that all team members can participate, believe in, and work to attain: “A vision can link the present to the future, energize people, secure commitment, give meaning to work, and bring about a standard of excellence and integrity” (Daft, 2011, pp. 400–401). AORN’s 2013–2014 Strategic Plan included many of the characteristics inherent in an organization’s purpose (AORN, 2013a). Its vision and mission are as follows.

**Vision**

AORN will be the indispensable resource for evidence-based practice and education that establishes the standards of excellence in the delivery of perioperative nursing care.

**Mission**

The Association of periOperative Registered Nurses (AORN) mission is to promote safety and optimal outcomes for patients undergoing operative and other invasive procedures by providing practice support and professional development opportunities to perioperative nurses. AORN will collaborate with professional and regulatory organizations, industry leaders, and other health care partners who support the mission (AORN, 2013b).

One leadership style that stresses the importance of information sharing is the transformational leadership model. Components of this model include
idealized influence, inspirational motivation, intellectual stimulation, and individual consideration (Burns, 1978; Bass, 1985). Attitudes and behaviors exhibited by transformational leaders include articulating a clear vision, providing a set of values and collective sense of mission, and supporting goal achievement (Schwartz, Spencer, Wilson, & Wood, 2011). A main feature of transformational leadership is to create considerable change in the organization and its employees. These leaders are able to lead the charge to changes in the organization’s vision, culture, and strategy (Daft, 2011, p. 362).

**Information Management**

“The health care environment contains huge amounts of information that is collected, managed, reviewed, processed, mined, and used” (Roussel, 2013, p. 500). The field of informatics prepares nurses in the integration of data, information, and knowledge to support all aspects of nursing practice and patient care. A nurse manager assists in this process by identifying meaningful uses for data, such as identifying trends in patient outcomes, monitoring communication breakdowns, and evaluating turnover times. Intranets are available in many organizations to support evidence-based practices and information sharing. The Institute of Medicine (IOM, 2003) has advocated for the inclusion of informatics as a core competency for nursing and other health care professions.
Unit 8

Culture of Safety

The seminal report of the Institute Of Medicine (1999) *To Err is Human: Building a Safer Health System* was the catalyst for the present health care focus on patient safety and quality. “Nursing’s contribution to building a culture of safety was clearly articulated because nurses are closest to the patient and can readily attend to problems at the front line of care” (Roussel, 2013, p. 261). In an extensive review of the literature on patient safety culture, Sammer, Lykens, Singh, Mains, and Lackan, (2010) sought to develop a conceptual culture of safety model.

The authors identified seven subcultures of safety culture properties integral to an organization’s culture of safety:

1. leadership,
2. teamwork,
3. evidence-based,
4. communication,
5. learning,
6. just, and
7. patient-centered.

McCarthy and Blumenthal (2006) advocated the creation of a culture of safety as part of any organization’s safety improvement initiatives. In regard to policy implications, they concluded that “. . . policymakers could help stimulate a culture of safety by linking regulatory goals to safety culture expectations, sponsoring voluntary learning collaborations, rewarding safety improvements, better using publicly reported data, encouraging consumer involvement, and supporting research and education” (McCarthy & Blumenthal, 2006, p. 165).

From a leadership perspective, AONE (2007) developed a toolkit, including a patient safety competency model, to assist nurse leaders in guiding best practices for patient safety. The following guiding principles may assist the surgical services nurse leader in creating and sustaining a culture of safety:

- lead cultural change,
- provide shared leadership,
- build external partnerships, and
- develop leadership competencies (AONE, 2007).
Additional resources for nurse leaders include those from the Institute for Health care Improvement (2011), the AHRQ (2013), and TJC (2013b). AORN (2013c) has several resources including a Just Culture toolkit. A culture of safety provides team members with a sense of identity while building commitment to the organization's values and direction in quality patient care.
“Selecting the right channel for sending a message is a key to effective communication” (Daft, 2011, p. 277). A channel becomes a medium through which the message is carried and can be in the form of face-to-face, text or e-mail message, telephone, or printed materials. According to Daft (2011, p. 277), the richness of the information channel is influenced by three characteristics:

1. the ability to handle multiple cues simultaneously,
2. the ability to facilitate rapid, two-way feedback, and
3. the ability to establish a personal focus for communication.

Some channels may be more appropriate than others and are dependent on the fit between the mode and the message. Electronic communication is a mainstay in today’s organizations with advantages and disadvantages. Electronic communication may promote impersonal messaging leading to decreased human interaction. Choosing the best mode of communication by the manager will set the tone for the encounter. The following are effective tips for electronic communication.

- Combine high tech and high touch. Prevent electronic communication from replacing human integrations.
- Consider the circumstances. Teams that will only be working together for a short time will benefit from face-to-face communication rather than electronic.
- Think twice and read twice before hitting the send button. Do not send an electronic message if you are angry or upset. Give as much consideration to electronic messages as you would a printed memo or telephone call (Hallowell, 1999).
This module addressed the many components of communication and relationship management for the surgical services manager. Effective managers lead though a climate of change, not stability. To survive in today’s health care arena, managers serve as role models for change and motivate and empower others to keep the change efforts going (Daft, 2011). Collaborating, an open culture for communication, encouraging creativity, transforming the work environment, and living the strategic mission and vision are evidence-based methods for creating the context in which quality patient care is realized and celebrated.
**Glossary**

*Accommodation:* Opposite of competition—is a lose–win situation.

*Advocacy approach:* The negotiator usually functions as an advocate for one party with the intent of obtaining the most favorable outcome for the party.

*Agreement:* The common ground for understanding and resolution.

*Collaboration:* Interdependent professionals build a collective action to meet the needs of the patient and family. Results in a mutual gain or a win–win situation.

*Competition:* Forces a win–lose situation.

*Compromise:* Both parties giving a little or negotiating.

*Cross-functional teams:* Composed of members from different departments within an organization whose specific purpose is to lead projects of special importance.

*Distributive:* Approach to negotiation—assumes both parties will try and apportion as much of the “win” to themselves, creating a win–lose approach.

*Effects:* The meaning, significance, or consequences the conflict holds for an individual or team.

*Facilitator:* Assists each party to communicate honestly and openly through dialogue.

*Finding voice:* Engaging with fellow colleagues, regardless of role or status, in meaningful conversations in a context of respect.

*Integrative:* Approach to negotiation—based on a win–win perspective whereby the intent is to satisfy both parties.

*Management teams:* Led by upper management and address the change inherent in complex health systems.
**Negotiation:** An approach to handling conflict in the workplace due to a disagreement regarding the intent of a communication.

**Mediation:** Involves the use of a third party to assist in the negotiation, such as another team member or someone from the human resources department.

**Project teams:** Teams that are formed for one purpose, and once the objectives are met, the teams are disbanded.

**Self-directed team:** May evolve from a cross-functional team and is usually long term or permanent.

**Shared governance:** A model that has been used to increase the participation by staff nurses in decision making and problem solving.

**Work teams:** Synonymous with self-directed teams, and responsibility is shared with each team member.
Suggested Reading


References


