SUSTAINING THE NURSING WORKFORCE through EDUCATION IN HUMAN VALUES

(A Case Study)

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ABSTRACT

A shortage of nursing personnel is currently being experienced globally and Australia is no exception. One of the major contributory causes of nurses abandoning the profession is their dissatisfaction with the management system. A large number of registered nurses are not in the workforce as they are not willing to work under the current adverse conditions created by hospital managers. Other factors identified for the unattractiveness of the nursing profession are the heavy workload, inappropriate skill mix, poor rostering and enforced overtime. These problems that contribute to the shortage of nurses in the workforce are further compounded firstly by an aging workforce and secondly by reduced number of university seats for undergraduate nurses.

The aims of this research were firstly to determine whether managers who incorporate Sathya Sai Education in Human Values (SSEHV) into their management style are able to transform or influence the behavior and attitude of their staff positively. Secondly the aim was to explore how senior management interacts with frontline managers, nursing staff, union members and other support staff with regard to the introduction of SSEHV.

The justification for the research was the high staff turnover in the Critical Care Unit (CCU) and results of a staff opinion survey undertaken in 2003 in a regional hospital. The major issue identified in the survey was the dissatisfaction of the staff with the style of management. This led the nurses to experience high levels of stress, anger, frustration and burnout. As a consequence of the results of the survey dissonant leadership was identified and senior nursing management staff were replaced.

In this research an attempt was made to influence the style of management by introducing the practice of Human Values into the management process by the Frontline Manager (FLM) which in this case is the Nurse Unit Manager (NUM) of the High Dependency Unit (HDU). SSEHV was implemented to heighten the awareness of the nursing staff to the practice of these values. The concept and practice of Emotional Intelligence (EI) were introduced and implemented at the same time, to enhance the capacity of the staff to monitor their own and others feelings and emotions.

Furthermore to discriminate between these emotions and to use the information to guide their thinking and action.

In this research direct observations were made on the interaction between upper management with staff to determine whether staff were consulted in the decision making processes, whether staff were encouraged to undertake professional development internally and externally and whether the nurses Union was involved and to what extent.

The results from this observation were gathered from formal and informal meetings, correspondence and emails. No evidence was found to indicate that upper management consulted with nursing in the decision making processes that affected the working life and personal lives of the nurses.

A performance review was undertaken through an interview process to determine whether any transformation had occurred in the staff attitude and perceptions as a consequence of implementing SSEHV and EI.

The results revealed that all staff (100%) stated that positive transformation had occurred within themselves over the eighteen month period. All staff stated that they had developed a greater awareness of their emotions and gave an example of practicing at least one of the human values (Truth, Love, Peace, Right Conduct and Non-Violence) in their personal and professional lives.

As a consequence a cohesive team emerged resulting in increased staff retention rates and job satisfaction.

A further study with an increased sample size has to be undertaken with the ultimate aim of formally incorporating SSEHV and EI in all future nursing educational programs.

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CHAPTER 1

NURSING SHORTAGE

Introduction

The severe shortage of nurses in Australia is likely to worsen as nearly half of the nursing profession, who are aged over 45, retire in the next 10-15 years (Union News 2005). The problem thus with attracting, maintaining and retaining nursing staff. Predictions are that this nursing shortage will be more severe and of longer duration than has been previously experienced and that traditional strategies implemented by employers will be of limited success (Nevidjon and Erickson 2001). This problem is further compounded by the reduced number of university seats for undergraduate nurses.

1.1 Nursing in the 19th Century

Figure 1: A photo from a scrapbook of yesteryear 1887

Figure 2: Florence Nightingale (1820 to 1910)

Florence Nightingale is widely known as the founder of modern nursing. Single handedly she made history in the 19th century by transforming nursing from a lowly occupation to a noble profession (Schiavenato 2005). Less known is the fact that she had well developed advanced ideas about the spiritual aspects of nursing care. In this she draws her views from both Eastern and Western spiritual traditions. These have had a startling relevance to nursing practice today (Macrae 2001). Nightingale's ideas on spiritual practice included a variety of techniques such as yoga, meditation and relaxation exercises for both nurses and patients which brought about a more spiritual and humane form of nursing care (Dossey 2001).

Florence Nightingale considered her work as a call from God for social action to serve the needy, a vocation that took the work beyond a 'mere job'. She desired that other women would respond to that same calling. She also honored the beliefs, rituals and practices of all cultures and stressed that all the great religions of the world should be united (Dossey 2001). She held the conviction that spirituality was part of the essence of nursing practice and incorporated spirituality into the nursing curriculum (Schmidt 2002).

Furthermore she emphasized that nursing is about environmental manipulation, nutrition and conservation of patient. In order to achieve these the nurses had to be actively involved in change and progress. Their focus had to be on the health and well being of the patient. If this could not be achieved by the nurse, then nursing was certainly 'not her calling' (Schiavenato 2005). Many of the nurses were single women of lower working class who became financially independent until they met their husbands (Norman cited in Schmidt 2002). However a minority of nurses regarded their profession as a life long career and became administrators, leaders and directors of nursing schools.

Early admission booklets identified that the hospitals were very interested in women who had high moral values, came from good families and were physically strong. Florence Nightingale had written that nurses should possess personal and professional integrity, sense of duty, love, kindness and heroism (Dossey 2001). Historically nurses were trained in large numbers with the realization that their departure from the workforce was inevitable due to their female gender.

Nightingale believed that students needed spiritual resources to do their work and student nurses were required to attend chapel and read prayers in the wards. Physical strength was a prerequisite for training. This makes more sense when one has a clearer image of those first

training programs. Student nurses were a source of cheap labour, worked 12 hour shifts, 6 days a week under strenuous conditions and for minimal pay (Schmidt 2002). Nurses honor the memory of this extraordinary human being whose contributions have made a lasting impression. Nightingales example of inner strength, vision and perseverance must be taken into the twenty first century.

1.2 Nursing in the 21st Century

Figure 3: 21st Century Nurse

While the core belief that nursing is about helping and caring for people, it is the fundamental common characteristic during both these periods. Many aspects of education and work settings are very different today when compared with the 19th century example whereby women have more career choices and their knowledge base has increased remarkably. Nurses are now educated together with a strong sense of professionalism and the values of accountability and interdependence strongly cultivated. Today the nurses carry a sense of entitlement to a fulfilling career, have high expectations from their workplace as they focus on labour issues and patient outcomes (Schmidt 2002). Education technology has revolutionized their training. Nurses first turn to the internet source for the latest information and even their classes can be undertaken online.

At the level of practicing their profession nurses are dealing with the challenges of 'do more with less' and ***'improve quality but reduce cost'***. After eight to ten hours spent in the wards, they have little time and are too exhausted for study. Nevertheless, nurses today still have the patient's best interest at heart and would like to do their best in the practice environment. However they are prone to let the emphasis shift to their own labour issues (Potempa cited in Schmidt 2002).

The current working conditions have severely affected the staffing levels and staff morale nationwide which makes it difficult for nurses to focus on the professional issues. The work environment today has led nurses to focus on individual achievement and self actualization as

they seek to be recognised as professionals. For example a nursing professional will generally go above and beyond her duty, to help an accident victim because he or she is a professional with a commitment rather than regard the profession as a mere source of pay cheques (Schmidt 2002).

Nonetheless, nursing as a 'calling' has lost its lustre over time in that it has become more of a socio-economic stepladder. Nurses have stepped away from the spiritual values that under-girded the profession from its inception in the late 19th century (McDonald et al 2002). According to Shelly cited in Schmidt (2002), religion is definitely a no-no in today's nursing, but spirituality is becoming a major focus. This comes from a desire to be inclusive in such a way that the differences between religions tend to be ignored and only the inner spirituality is valued. Tadd (1998) states that nurses everywhere have many shared values in common however by gaining knowledge, understanding and insights they can also learn to respect and value their differences.

Cryer et al (2004) state that nurses need an environment where they have the materials to do their job, have a supervisor concerned about their development, have peers interested in delivering excellent care, have a chance to do their best and lastly for managers to communicate a vision for the organization. Nurses would then have the awareness and understand how they fit in and make a difference. In the absence of the above qualities, stress will continue to harm every facet of the health system, compromising quality of care and inhibiting the very creative energy needed to revitalize the system.

The International Council for Nurses (ICN) Congress was held in Taipei in May 2005, where 4000 nurses from 140 nations gathered to deliberate on knowledge and innovation in nursing. Australia was represented by Coral Levert from the Australian Nurses Federation (ANF). She stated that Australian nurses need to take more notice of global nursing issues and get involved where they can, to improve their own well being. Below are some of the facts disclosed that came to light at this international congress(ANF Report 2005):

- 50% of nurses in Jordan are male
- 80% of nurses in Netherlands work part-time
- The average age of students entering nursing in United Kingdom is 29 years
- The average age of nurses in Taiwan is 29 years
- In Paraguay there are only 1.2 nurses per 100 000 population
- In Australia there are 1106 nurses per 100 000 population
- The average salary for nurses in Latin America is US $400-$500 a month

The Australian Nursing Federation is the national union for nurses in Australia. The Federation was established in 1924 and is comprised of a national office and branches in all states and territories.

1.3 The Nursing Shortage

A shortage of nurses has a significant negative impact on the healthcare system. Studies have demonstrated that this shortage threatens the quality of care an institution can deliver. Healthcare institutions are forced to mandate unsafe nurse overtime, adding excess responsibilities to a nurse's workload and deploying nurses from one unit to another (Cryer et al 2004). This situation not only compromises the quality of care delivered to patients but also decreases the job satisfaction of nurses. Left on the frontline to deal with the chaos of the health system many nurses experience high levels of emotional stress. This manifests as increased absenteeism, high staff turnover, impaired decision making abilities and individuals leaving the field (HeartMath 2004).

Today the focus is on sustaining and retaining human health resources. Health care is fundamentally international and health systems can be strengthened by drawing on a global workforce. In the age of globalization, nation states are becoming increasingly interdependent on the free movement of people in the same way as that of goods and services. It is the combination of the push factors in the home country and pull factors in the recipient country that have resulted in the international migration of professional and technical personnel. The push pull factors derive from the unequal and different development levels of the involved countries. The push factors refer to those conditions in the home country that exert negative or pushing forces while the pull factors in the recipient country refer to those that serve as attracting or pulling forces (Kline DL 2003). In general, the push factors include undesirable socioeconomic status, political instability, poor working conditions, oversupply of professionals in a particular field, and underdevelopment of the home country. The pull factors are generally the opposite that exist in the recipient country. The push and pull factors exert their influences at the individual, institutional, national, and international levels simultaneously (Kline DL 2003)

The primary donor countries are Australia, Canada, the Philippines, South Africa, and the United Kingdom (UK) . The primary receiving countries are Australia, Canada, Ireland, the UK, and the United States (US). The effects of migration on donor countries include the loss of skilled personnel and economic investment whilst receiving countries receive skilled nurses to fill critical shortages with less economic investment. (Chaguturu and Vallabhanei 2005) state that reducing the 'pull' factors at home and 'push' factors abroad that are hastening the migration of nurses will ensure long term stability of health care infrastructures around the world. Ethical concerns include the potential for exploitation of foreign nurses.

The nursing shortage in some of the underdeveloped nations such as African and the Philippines will be discussed first followed by the more developed countries such as America, United Kingdom, and Australia. In reviewing the nursing shortage in the Australian situation a brief

description of South Australia will be given followed by a detailed account of the nursing crisis in New South Wales.

1.3.1 African Nursing Crisis

The nursing shortage in the developing world is being felt more intensely even as increased foreign aid becomes available to provide drugs for millions of people with Auto Immune Deficiency Syndrome (AIDS) (Chaguturu and Vallabhaneni 2005). Therefore more nurses are required to administer drugs, monitor patients, run clinical trials and train new nurses.

The estimates by Harvard University Joint Learning Initiative on Human Resources for Health and Development have stated that in the sub Saharan Africa's low income countries will need more than double the workforce in the coming years. They will need to add another 620 000 nurses, to be able to tackle their severe health emergencies (HRSA 2002).

The United Kingdom relies heavily on direct recruitment of nurses from former British colonies eg Botswana, Ghana, Malawi, Nigeria, Kenya, South Africa, Zambia and Zimbabwe. These are the very countries that have been hardest hit by the AIDS pandemic. It seems ironic that while funds are being provided for AIDS care, simultaneously nurses who give that care being taken away (Chaguturu and Vallabhaneni 2005).

1.3.2 Nursing Crisis in the Philippines

The Philippines is losing its highly skilled nurses to the United States, United Kingdom, Ireland and Netherlands. The Department of Health is offering s no strategic solutions at the worsening health crisis, as a result medical doctors are now enrolling in an abbreviated nursing course (Tan 2004). It is stated that the Filipino nurses are globally competitive in professional nursing standards of care and practice but Filipino salaries can never be competitive.

In the year 2001, 13 536 nurses departed to 31 countries (10 000 were directly hired by United States based hospitals). In 2002, 11 911 nurses departed to 33 countries and in 2003, 8968 nurses left the Phillipines. Some strategies that Tan (2004) proposes are to develop a unified health human resource policy for countries to include in their aid package to the Philippines financial assistance to continuously train globally competitive nurses. Other strategies are financial grant to every nurse recruited and compulsory requirement for all licensed health professionals to serve anywhere in the country for a certain amount of years.

1.3.3 The American Nursing Shortage

A report from the United States by Kimbal and O'Neil (2001) which is also relevant to the Australian context states that the shortage is driven by a broad set of factors namely:

- Fewer workers - fewer younger people are entering the workforce
- An ageing population, as baby boomers age, there is an increased demand for nursing care
- Ageing workforce, the average age of nurses is increasing while physical demands of work remain high. Many nurses will retire in the next decade
- A mismatch on diversity - the racial, ethnic and gender makeup of current workforce does not reflect society
- More options for women, as they are leaving nursing for other career options
- The generation gap, generation X perceives nursing as unappealing
- Work environment with fewer resources, greater demands resulting in disillusionment and dissatisfaction amongst nurses
- Consumer activism in growing consumer empowerment, increasing awareness of medical errors and consequent litigation
- A ballooning health care system with pressures on health care financing and a push for accountability, are putting pressure on the nursing profession which lacks authority to create change

The shortage of nurses in the United States is a serious and growing problem with 126 000 nursing positions currently unfilled in hospitals (Chaguturu and Vallabhaneni 2005). Increasing demands on nurses result in career burnout with 20% of nurses retiring early. It is predicted that by 2020 the shortage of nurses in relation to demand will reach 29% with more than one million nursing positions vacant.

The solution that has been pursued has been to increase flow of nurses into the United States from other countries especially India, Philippines and Canada (Mc Gee 2005). In an attempt to create solutions for the growing threat of nursing shortage and shape the future of healthcare leadership and practice, the American Association of Colleges of Nursing(AACN) developed a working paper in which a new role 'clinical nurse leader' (Drenkard and Cohen 2004). This is not a managerial role but a generalist clinician who will enhance delivery of care, be a resource for the clinical nursing team and bring a high level of clinical competence and knowledge to the point of care. The benefits from the creation of this position are not clearly defined therefore one has to question the wisdom of this action.

Lafer (2004) argues that there is no shortage of qualified personnel as there is simply a shortage of nurses that are willing to work under the current conditions created by hospital managers. Extensive survey data gathered from both the current working nurses and those who have left the

profession indicates a very strong consensus regarding the causes and potential solutions to this problem.

1.3.4 British Nursing Crisis

The British government has launched local and national initiatives to tackle problems of recruiting and retaining staff as the shortage is severely hampering the quality of service and progress towards modernization. Finlayson (2002) considers some of the main initiatives by the National Health Services (NHS) as follows:

PROBLEM	INITIATIVE
Changing Nature of Job Increase in paperwork – regular audit and clinical governance activities Inadequate administrative support and therefore work overtime	Limited paperwork for general practitioners- need to replicate for nurses
Limitations to clinical roles and lack of senior clinical posts	More opportunities to expand nurses clinical roles being developed. Extend nurses prescribing rights. Allow nurses to make and receive referrals. Admit and Discharge patients
Caring for more patients with fewer staff Increased workload, high level of turnover- supervise agency staff who are unfamiliar with wards. Cutback in staff – staff to care for more patients, more acutely ill patients, fewer staff More pressure to take up management responsibility- taken away from patient care	Govt. promises to recruit an extra 20 000 nurses by 2004 thus attracting nurses back into the profession To recruit trained nurses from overseas To increase no of training places

Table 1 : British Initiative

The United Kingdom is drawing heavily from Africa with 7000 African nurses immigrating to the United Kingdom between 2001-2005 (Mc Gee 2005). This practice is in turn contributing to the nursing crisis in the underdeveloped countries.

1.3.5 Australian Nursing Crisis

Nurses comprise 50% of the health workforce. Nearly half the current nursing workforce is over the age of 45 years. With an ageing Australian population requiring more nurses into the future we need to start to build up the nursing workforce to replace those 10000 nurses who will be contemplating retirement over the next 15-20 years. In 2002 a government report predicted that

by 2006 the Australian health system nationwide will be short of 31 000 nurses (ABC Report 2002). The report stated that nurses are leaving in large numbers and increasing the number of training places will not fill the gap.

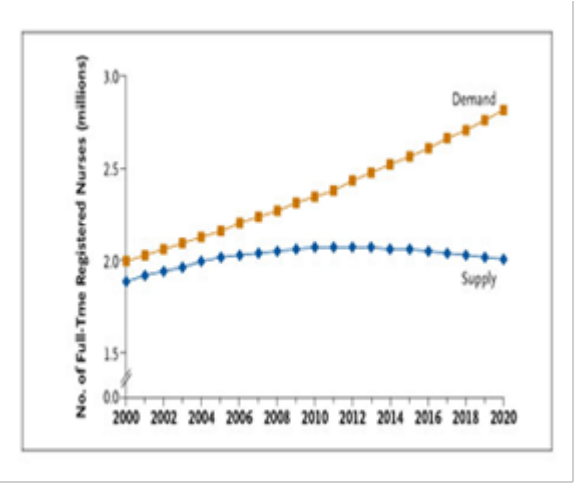


Diagram 1: Registered Nurses Supply and Demand

The hospitals and health care providers are being urged to develop strategies to retain nurses they already have, particularly the young graduates who can quickly become disillusioned. Some comments and concerns from nursing leaders are that not only can they get nurses to work within the specialties, they cannot retain the nurses that they already have. It is known that nursing is an aging workforce, but many are quitting rather than retiring (ABC Report 2002). An analogy given is like trying to pump up a basketball when there is a leak. We have to stop the leak first so that current nurses are retained. In order to ease workplace tensions senior and junior nurses need to understand their conflicting backgrounds and expectations.

The inadequate number of nursing undergraduate and pre enrolment places has been a major focus of the Australian Nursing Federation (ANF). The Australian Health Workforce Advisory Committee (AHWAC) in a report released in August 2004 estimated that for supply to meet demand between 10 182 and 12 270 new graduate nurses are required to enter the workforce in 2006 and 10 712 and 13 483 required in 2010 (Lliffe in ANF Report 2005). The Health and Age Care workforce has become the single most critical issue currently impacting on health care delivery.

The AHWAC was set up to assist with a national approach to workforce planning and is in the process of estimating the required health workforce to meet future health service requirements and the development of strategies to meet those requirements (AHWAC 2004). It aims to balance workforce supply with requirements. Measures that have been actively pursued include encouraging non working nurses back into the workforce, recruitment of nurses from other countries and recruiting of school leavers into nursing courses (AHWAC 2004). However it is

widely believed that a national, broad and a long term approach is required to address the core issue of the nursing shortage. It is hard to fix nursing shortages when the federal government is under funding nursing education.

Australia urgently needs additional nursing places in the Universities if we are to meet future needs. More than 7700 prospective student nurses were not able to access a university place in 2002 and 2003 (Australian Democrat Report 2004). The lack of funding and human resources seem to be the leading factor for this current situation. There are at least 23, 000 registered and enrolled nurses who are not working as nurses. There is also little coordination between the university sector who provide the supply of nurses and the health workforce sector who require the nursing workforce.

It is evident that there is a need for new nurses, however it is surprising that universities turned away thousands of qualified applicants for nursing courses. In 2006, 2716 potential students were turned away from nursing courses. There is currently a shortage of 1750 nurses in public hospitals, not including shortages in the private sector (Union 2005).

Registered Nurses currently overseas are not accounted for within the labour force at present and amount to 21%. A competitive market operates to recruit skilled workforce. Within Australia there is a rising dependence on overseas qualified nurses to compensate for the chronic shortage. This is related to a continued exodus of Australian nurses overseas and to emerging opportunities for nurses in other professions (Hawthorne 2001).

Attracting immigrant nurses to Australia will provide a short to medium term alleviation of the shortage however immigrant nurses will eventually experience the same degree of dissatisfaction as their Australian trained counterparts. Economically committing resources to train the required number of nurses in Australia to meet forecast demand, then to spend further resources to recruit and register immigrant nurses to the country from failure to retain Australian nurses seems irrational (Eggert 2005).

The National Health Workforce Strategic Framework has a vision that states:-
“Australia will have a sustainable health workforce that is knowledgeable, skilled and adaptable. The workforce will be distributed to achieve equitable health outcomes, suitably trained and competent. The workforce will be valued and able to work within a supportive environment and culture. This will therefore provide safe, quality, preventative, curative and supportive care, that is population and health consumer focused and capable of meeting the health needs of the Australian community” (AHWMC 2004).

This statement is proving difficult to comprehend. It is unlikely that the States in Australia are responsible for the healthcare system and the issues of the nursing profession will remain unresolved. This is supported by Eggert (2005) who strongly suggests federalizing the Healthcare

system to enable a national approach to solve a national problem. The issues in South Australia and New South Wales will now be discussed revealing the different problems in these states.

South Australia

The Guardian (2002) reported that nurses across South Australia had placed the Government on notice for they no longer accept workloads which compromise patient safety. In addition they highlighted the following issues namely the failure to meet agreed nurse-patient ratios under the Enterprise Bargaining Agreement, in demanding the increase of nursing staffing levels at country hospitals to match that of the Metropolitan hospitals, compensation for the additional non nursing work undertaken in rural hospitals by nurses for example ward clerk, orderlies and administrative work and lastly securing a safe and professional environment for both nurses and patients.

A crisis point was reached when the Royal Adelaide Hospital and had to close 10 beds in an attempt to reduce workloads and cope with nursing shortage (Guardian 2002).

New South Wales

In common with the rest of the country New South Wales (NSW) public hospital system currently faces the challenge of attracting and retaining nurses. Under funding for health, management systems and stagnant pay have been identified as key causes of the nursing crisis in NSW (The Sydney Herald 2003). There are approximately 90,000 registered nurses in NSW, but only about 33,000 working in the NSW public health system. There is a mass exodus of nurses, trained and experienced, from our hospitals and that's the problem the government needs to address.

Faced with insufficient graduate nurses, Premier Bob Carr has promised to recruit 300 interstate and overseas nurses this year. The government has promised a 3% per year wage increase for nurses in NSW public hospitals. However, this is disappointing because it fails to match the pay increases of other public sector employees. The government does not understand why there continues to be a shortage of nurses (The Lamp 2005). The difficulties seem to be associated with maintaining an adequate nursing workforce are ongoing and the struggle is intensified by the aging demographic profile of qualified nurses in this country.

The New South Wales Nurses Association has stated in the April 2005 issue in 'The Lamp' that:

"It is now our challenge and responsibility to convince the government that retaining nurses and attracting new nurses is the key to fixing the problems in our health system. Better pay for nurses is part of the solution to the nurse shortage and the crippling workloads that nurses holding the system together face on a daily basis".

Brett Holmes the president of the New South Wales Nurses Association (NSWNA) stated that nurses now work in an environment that is in perpetual fast forward, where turnover of patients is high and wards are filled with seriously ill patients. He stated that in day surgery the same bed

is used by three or four different people each day. The nurses have to go through the process of admissions and discharges for many patients per day. Ruth Pollard in the same article argued that to shift the focus from hospital funding and waiting lists to concentrate on building a system that meets the needs of the majority of people is vital to fixing an ailing system (Herald 2003).

The New South Wales Nurses Association (NSWNA) commissioned the Australian Centre for Industrial Relations Research and Training (ACIRRT May 2000) to conduct a qualitative research in NSW to identify the barriers and disincentives influencing nurse's decisions to leave the profession. The result revealed that the poor management system is the main reason.

a) Management Systems

The key finding in the above report is that the changes in hospital management systems have had major implications for the nature of nursing work. In combination these changes have led to more stressful and less satisfying work. As a result, many nurses have been induced to leave and many others are seriously considering leaving the profession. (Watson et al 2003) identified reduced levels of support from management and a diminished capacity to provide quality care to patients.

One of the most significant problems facing society today is health related. Therefore healthcare requires leaders who can ensure delivery of quality, effective patient care demands, flexibility and adaptability (Watson et al 2003). This involves inspiring people and organizations to develop the capacity to create the future they desire. Leaders are therefore called upon to stimulate significant changes in individual behaviors (Wood and Hessler-Key 2003). For such changes to be sustainable, individuals must examine the meaning that gives rise to their behavior. In nursing, as in other walks of life, there is a need of leaders with the ability to adapt to the unsteadiness of the emerging new world and to manage under uncertainty.

The poor management in nursing may be improved through extensive management and leadership training to shift the traditional hierarchical style and to implement a more professional model of staff supervision. A hierarchical structure built on a chain of command is not compatible with the professional self-image developed in nursing courses in the universities. Such courses value professional autonomy and responsibility Eggert (2005). Disappointment with the experience is one of the reasons why nurses feel undervalued and lack of support from management in the workplace. Safety, shift work, lack of access to childcare, enforced overtime and stress are other reasons for nurses leaving the workforce.

As a result of this combination, the more stressful and less rewarding profession now lacks the intrinsic rewards that used to attract and retain nurses. As the nursing shortage continues and consumer demands mount, nurses emotional stress intensifies. Research shows that when people are angry, anxious, alienated or depressed their work suffers. They cannot think clearly, cannot absorb or understand information fully. The response will be inadequate resulting in their inability

to effectively process information (Goleman 2002). The shift to a "cost control" approach in managing illness, injury and disease has led to an increased patient turnover and increased load of patients with acute medical problems (ACIRRT 2002).

Health Services today are run as a business. The fundamental goal of the stakeholders is to build wealth and achieve profit by optimizing its human resources. As a consequence of this new approach, there has been a change in the objective nature of the work undertaken by nurses particularly in their work practices and their roles (ACIRRT 2002).

b) Work Practices

There are two problems identified, firstly there is an increase in the intensity of nursing activity with increased severity of patients illness without a matching increase in staffing levels. Secondly there is an increase in the level of responsibility that often arises from reduced levels of support from the managers. Nursing leaders are under intense pressure to ensure safety and quality at every point of service. Therefore their priority is to transform the systems and processes of care to improve the overall healthcare delivery.

(Heath et al 2004) conducted a study on healthy work environments and their findings from the literature review and focus groups indicate that nursing leaders must prioritize efforts to improve the culture in the work environment by effective communication, collaborative relationships and promoting decision making. Evidence indicates that a healthy work environment is at the heart of the solution to significantly affect patient outcomes and professional nursing practice.

Conclusion

The Nursing shortage is a trend that's expected to continue in Australia in particular, the demand for qualified nurses is far exceeding supply. As our population ages, and its needs evolve, the need for specialist nurses is also changing. While demand for nurses overall is expected to rise, there are three key areas of career specialisation that experts believe will be in particular demand in the near future. Aged Care Nursing, which is already experiencing a nursing shortage, and as the population continues to grow older, demand will only increase. Other specialist areas is Mental Health and Critical Care Nursing. As long as workload pressures and staff shortages continue nurses will leave the workforce for other career opportunities. Therefore to attract and retain new nurses to the profession it is crucial that the true value of nurses is made explicit. Nursing needs to be repositioned, with structures and supports that value its contribution, recognising it as a highly versatile profession with enormous diversity and opportunity.

CHAPTER 2

HUMAN VALUES FOR LEADERS

Introduction

One of the great gifts of spiritual knowledge is that it realigns your sense of self to something you may not have even ever imagined was within you. Spirituality says that even if you think you're limited and small, it simply isn't so. You're greater and more powerful than you have ever imagined. A great and divine light exists inside of you. This same light is also in everyone you know and in everyone you will ever know in the future. You may think you're limited to just your physical body and state of affairs — including your gender, race, family, job, and status in life — but spirituality comes in and says "there is more than this". (Janis 2008)

Notice that *spirit* sounds similar to words like *inspire* and *expire*. This is especially appropriate because when you're filled with spiritual energy, you feel great inspiration, and when the spiritual life force leaves your body, your time on this earth expires. These are two of the main themes of the spiritual journey is firstly allowing yourself to be filled with inspiration, which also translates into love, joy, wisdom, peacefulness, and service. Secondly, remembering that an inevitable expiration awaits to take you away from the very circumstances you may think are so very important right now(Janis 2008)

The nursing profession today requires a new breath of life. This can only be done with a revival of spirituality. "Spirituality refers to the state beyond all attachment and hatred and makes you understand the unity and oneness of all mankind" (Lesley-Chaden 2002). Some of the practical tools which nurses can use to help in their self transformation are relaxation techniques such as Silent Sitting, Breath Control, Meditation, Yoga, Affirmations, Self Audit and Self Enquiry.

Today we see the fragmentation of the process of thinking, feeling and action of the Head (thought), Heart (word) and Hands (deed) respectively which has led to the disintegration in human character and moral development in the world. We need to bring about this awareness that once a thought (Head) occurs we must immediately get approval from the conscience (Heart) before putting it into action (Hands) (ISSE 2000). Real learning for man therefore lies in mastering the relationship between the senses and the mind so that the inner consciousness is brought out into the forefront, and the conscience acts as the guiding force in life to monitor the vagaries of the mind (Sri Sathya Sai Educare 2001).

What is the leadership role in the healthcare system today? Can you hear Florence Nightingale's voice saying "Bring back spirituality and Human Values"! Leaders and managers who practice human values using the harmony of head, heart and hands could create a more committed, satisfied and productive workforce and perhaps be instrumental in the retention of nurses.

This Chapter firstly explains the levels and domains of Human Personality then goes on to an explanation of Sathya Sai Education in Human Values (SSEHV). Human Values in research and Human Values practiced in various other situations are touched upon. The Chapter ends with strategies to reprogram the mind and how to cultivate positive emotions.

2.1 Human Personality

The Table below displays a model of the domains of human personality establishing a correspondence between Ideals of Education, Domains of Human Personality and the Five Human Values (Gokak and Rohidekar 2000).

No	Ideals of Education	Domains of Personality	Human Values with Blossoming of Excellence in the 5 Domains
1	Knowledge	Intellectual	Truth
2	Skill	Physical	Righteous Action
3	Balance	Emotional	Peace
4	Vision	Psychic	Love
5	Identity	Spiritual	Non-Violence

Table 2: Domains of Human Personality

The practice of Human Values will help develop excellence in all levels of the human personality in a balanced and integrated manner with the overall aim of perfecting character.

Craxi(1992) explores these different levels and relates them to the corresponding human value:

Physical Aspect: Words and actions are trained to follow informed and unselfish ethical choices in **RIGHT** A**CTION**. *Is it right? or Is it wrong?* The aim of Man is to discriminate utilizing the power of his intelligence and to encourage faultless application of the human will, strengthened by control over selfish, greedy or agitating impulses.

Psychic Aspect: **Love** is a psychic energy present in the heart of Man in the form of a little spark. Man then has the potential to develop this steady selfless spark and love everyone. This attitude is not just an emotional feeling or an intellectual attitude, but is closer to a sense of identity with the object of love. This type of love is independent of circumstances or returns and gets satisfaction from expressing the love in caring actions.

Emotional Aspect: The mind is where a thought is formed and the seat of thousands of thoughts that pass through it daily. Thought is synonymous with desire and desire is synonymous with emotion. The mind has the power to assume the form of the desired object. In this process it provokes emotions which in various which in various degrees disturbs our tranquility and makes us lose our Peace. Therefore the value **PEACE** is directly connected with the Mental aspect of the human personality. We can consider the mind as the commander of our five senses. The mind orders the tongue to taste, the ear to hear, the eyes to see and so on. Therefore by keeping this mental balance both performance and happiness are enhanced.

Intellectual Aspect: The ideal perfection follows the ceaseless quest for **TRUTH** and encourages the enquiring mind. It acknowledges the importance of both rational methods of enquiry using clear reasoning and also intuitive, creative capability.

Spiritual Aspect: Perfection aims at uncovering the potential for steady, selfless **NON VIOLENCE** inherent in everyone. This attitude is not just an emotional feeling or an intellectual attitude, but is closer to a sense of identity with the object of love. This type of love is independent of circumstances or returns and gets satisfaction from expressing the love in caring actions. **Non Violence** becomes a natural, instinctive way of life and there is a feeling of kinship with all of creation.

2.2 Sathya Sai Education in Human Values

The SSEHV teaches that the five Human Values are inherent in the **human personality** and therefore shared by all humanity. It seeks to draw out the universal human values of Love, Truth, Peace, Right Action and Non Violence which are inherent in the fundamental make up of the human personality. Inspired and guided by the founder Sri Sathya Sai Baba, there is a powerful sense of unity in the development and implementation of the curriculum of SSEHV (Shah 2004). SSEHV has been adopted in various countries and is adapted to suit the culture and requirements of the country. Specific components in the curriculum are common to most countries and can apply to both children and adults namely:

- **Divinity** is inherent in all beings
- **Unity of all Faiths:** All religions teach the one Truth and that Human Values cannot be practiced without understanding that Love forms the very foundation of each and every religion.
- **3HV :** It is Sri Sathya Sai Baba who defined and elaborated in a unique way that integrity in character is unity in thought (Head), word (Heart) and deed (Hand) – 3HV.
- **Values:** The Universal HV are inter related, interdependent and inseparable.
- **5 Teaching Techniques:** The curriculum for children/students employs 5 teaching techniques with an integrated approach as a powerful instructional methodology.
- **Role models:** Successful implementation of the program requires a resolve on the part of the entire community to put into practice the values we want children/students/employees to acquire in their own lives.
- **Holistic approach:** It is the first curriculum project in recorded history, complete with all the components of a curriculum which are foundation of educational sciences, course content, activities, techniques, instructional methodology, evaluation procedure and a teacher training module. It suggests and promotes the integration of values with academic subjects and co curricular activities (Shah 2004).

SSEHV is based on Human Values that represent what is noble in spirit, in thoughts and in actions. The primary aim of SSEHV is the inculcation of the five fundamental human values. For example in a classroom situation a teacher employs instructional techniques aimed to promote certain desirable behavioral characteristics in the students. The underlying idea is that good behavior in life is an evidence of blossoming of human excellence (Shah 2004). For the purpose of the study the SSEHV components were adapted to the situation of nurses working in a critical care unit.

2.3 Research and Human Values

Action research conducted by Ritchie (1998) highlights how the ethos of a school can be improved leading to a learning and caring environment that will foster character building thus contributing towards academic excellence through the incorporation of basic universal human values which are fundamental to the SSEHV program. Observations of the Sathya Sai Schools in both Thailand and Zambia were conducted. This paper is an extension of the paper conducted by Majmudar 1998 (cited in Ritchie1998) who emphasized that consideration of values education, needs to be placed in the global context but placed in the national and local cultural needs.

The integration of five human values in the curriculum of Sathya Sai School in Zambia has had a positive impact on the pupils, both spiritually and morally. The findings in a Report of Evaluation of the school were character excellence, academic excellence, and spiritual and moral excellence. An profound example is given in relation to the pupils of the school in the report which stated:

" Grade 7 'failures', that is, pupils who fail to secure places in the public school system in grade 8…these pupils (at the time of recruitment) were bullies, truants, rebellious, and stubborn… Today, these pupils have completely changed for the better. They have become disciplined, and have developed respect for teachers and elders. They also offer voluntary service to the school… I noticed for example that vandalism is non-existent unlike in government schools. The school has for the past five years registered 100 per cent academic success at grades 9 and 12 levels. The school is non-denominational, it accepts all religions and forms of worship as being valid in essence" (McNaughton 2005). Also mentioned in the report was the impact SSEHV had on parents and teachers. Teachers were found to be more caring, punctual, friendly, and committed to duty. One parent said that the type of education the school gives has really made a great impact on the whole household…

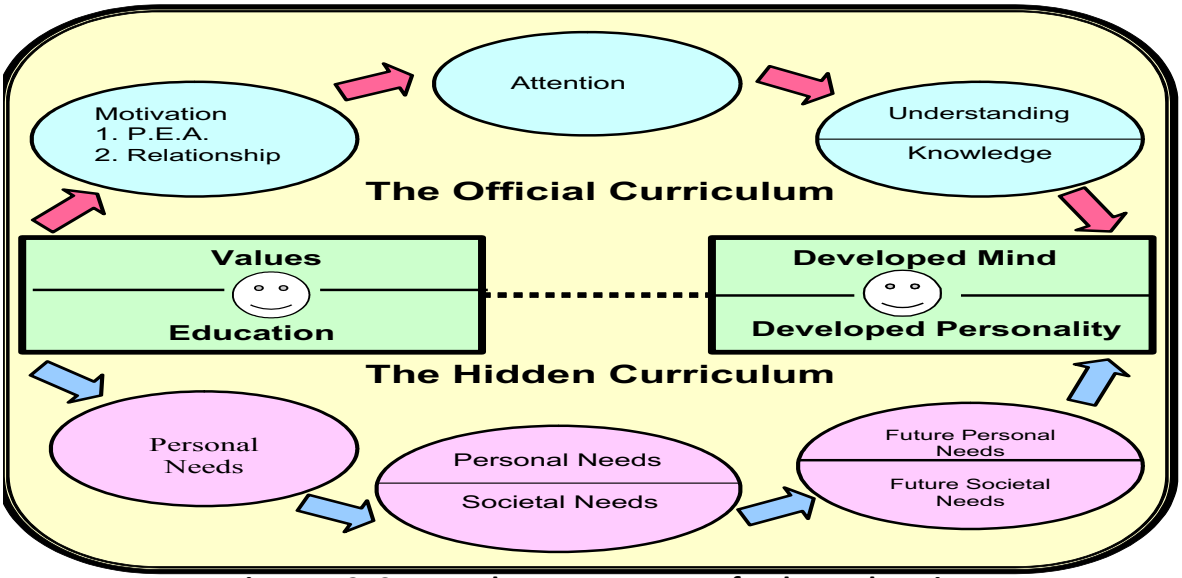


Diagram 2: Seen and Unseen Impact of Values Education

An investigation of a possible link between the emotional intelligence of university educators and the productiveness of the hidden curriculum in the Thai setting was made by Elliot (no date). The diagram below explains how values education seems to play a very important role in the curriculum in the Thai higher educational setting.

The impact it created went through two different channels but worked complementarily for the same end result and that is, the students development. It indicated that the teaching of values in Thai classrooms seem to create the students motivation, thus effectively getting their attention and subsequently leading to greater learning. On the other hand, when the hidden curriculum is considered, values education appears to satisfy the personal needs of the students, which is essential, especially in maintaining a harmonious collective society (Elliot no date). P.E.A. in the diagram below stands for Positive Emotional Atmosphere.

In another study undertaken by Sharma(2005) the results revealed that Sai Centers do act as agents for transformation. One of the benefits exposed were the practical application of human values both at home and work. Also, the transformation of the inner self which led to the control of negative traits and enhancement of positive ones

2.4 Human Values in Medical Education

The concern has been expressed all over the world that commercialization of medical activities is harming the very fabric of human relationship between doctor and patient. It is now realized that Human Values as a part of medical curriculum could provide the necessary inspiration and direction to future doctors thus sanctifying their profession and work. Human Values inputs in medical courses could provide the essential insights and the motivation for future doctors (Institute of Sathya Sai Education 2004).

The institute has prepared a curriculum module for Human Values inputs for the M.B.B.S. courses in 2002 and has since been implemented in local colleges. The feedback from the students and faculty members have been very encouraging therefore the course has been further refined and two day workshops for the teaching faculty. It is possible for a curriculum module for Human Values to be adapted and implemented in the Nursing Profession in the future.

2.5 Human Values and Nursing Management

The key objective in Nursing Management is to enable nurses to deliver genuine human caring to their fellow beings. Nurse training has to be promoted together with an establishment of an environment where caring is nurtured, rather than having to be fought by a few brave individuals. Management must establish the priorities of the care environment - Is it targets, profit or human caring? One also needs to examine the local and global factors that are obstacles to the delivery of caring such as - are there enough nurses rostered for them to spend the essential time with patients? Are adequate resources present or are the staff spending all their time looking for equipment or working beyond their scope of practice?

The expression of Human Values can make a difference in many ways according to Sri Sathya Sai Baba (Global Dharma Centre 2004). Truth can open lines of communication, leading to more informed and wise decisions. Righteousness or Right Conduct can ensure that agreements are kept, building trustworthiness. Peace can foster proactive thoughts and behavior that focuses on resolving issues rather than reacting(Global Dharma Centre 2004). Love can generate a sense of sincere caring in your work with others. Non-Violence can have an uplifting spirit of collaboration and respect for people, resources and the environment. This can be applied to all other health professions and all other professions where human resources are an asset.

Nurse managers need to create an upward spiral in generating positive emotions thus transforming other individuals and groups (Leahy 2005). Human Values in combination with the harmony of thought, word and action as well as understanding and mastering the senses and the mind will help raise the consciousness of individuals. Thus, the hand should carry out what the heart has approved of the ideas emanating from the head(3HV). One should not act on impulse the moment a thought occurs. The rights and the wrongs of the idea should be examined and only when the heart approves should action follow.

By living these values, we develop an awareness in our behavior and therefore we make a conscious effort in dealing with the environmental pressures and other adversities. Since the dawn of civilization these Human Values have been and will be the guiding principles for humankind. (Mitra 2003) states that developing an understanding of human values will lead to inner as well as outward transformation, resulting in human upliftment at individual, social and global levels.

2.6 Human Values in the Workplace

Values in the workplace imply a particular code of conduct such as equality, freedom, self respect and honesty. This can vary from person to person and not necessarily be consistent from day to day. Firstly you need to understand your own values and how they influence your thought, speech and action. How does it influence your work, decisions and your approach to different situations?

Secondly to be aware that your values an also affect your interaction with others especially members of your team (Martin 2000). One has to also understand others personal values and how it influences particular situations. Creating this awareness will help understand your workmates better. Martin (2000) also states that the lack of consistency between attitudes, values and behaviors results in dissonance and creates discomfort.

Sathya Sai Baba sums up the importance of this wisdom for the workplace:

" If Man is valued at his true worth, and treated as a Divine Spark enclosed in the body, then he will rise to new heights of achievement and produce all the necessities of life in profusion. He will

not grab or cheat, he will be a good worker, a pure person and a sincere spiritual aspirant" (Discourse 1975 cited in Global Dharma Centre 2005).

2.7 Human Values and Business

An American businessman William George, Chairman of Medtronic Incorporated, the worlds largest producer of medical electronics, responded with an open letter to a well known business author and lecturer who once wrote a column advising people to keep their spirituality separate from secular business. William George stated:

" We are all spiritual beings, composed of minds, bodies and a spiritual side. To unleash the whole capability of the individual---mind, body and spirit--- gives enormous power to the organization. It truly empowers members of the organization to devote their entire beings to the ultimate purpose for which the organization exists, which is to serve others" (Global Dharma Centre 2005).

Isaac Tigrett a maverick entrepreneur of The Hard Rock Café and the House of Blues Entertainment had this to say:

" All I did was put spirit and business together in that big mixing bowl and add love. I did not care about anything but people. Just cherish them, look after them and be sensitive to them and their lives" (Leadership and Entrepreneurship 2005).

2.8 Reprogramming the Mind

The development of human values goes hand in hand with the elimination of negative traits that are also inherent in human beings. These negative traits are desires, anger, greed, attachment, conceit and envy thus human values cannot flourish in their presence. To understand this concept further one needs to ask the question as to whether love can be experienced in the presence of anger.

Fear, anger or disgust prepare us mentally and physically to take immediate action against an object or situation that poses a threat. For example, fear prepares us to run away from a ferocious animal. Thus negative emotions protect us from life threatening situations but when used excessively and inappropriately this very life saving emotion can become life threatening and could lead to suppression of our immune system increasing the risks of heart disease (Watkins 1997). Unmanaged negative emotions can cause release of destructive hormones for example cortisone and adrenaline. The effects of negative emotions can also narrow our thinking and actions and accelerate the ageing process.

The negativity which has filled the nursing profession at present has to be replaced with positivity. Therefore the reprogramming of the values and mind set through a transformation process. One of the approaches is to become a witness of thoughts and just watch them. Another is to try and bury bad thoughts under the good ones.

Studies by Goleman (2002) suggest a new learning path called the "5 discoveries", which is a self directed learning process that reflects the way the brain operates. By experimenting with and practicing new behaviors, thoughts and feelings to the point where they become habits from 'rewiring' of the brain.

Sathya Sai Baba (cited in Shah 2004) explains that to attain peace of mind we have to use the intellect to still the emotional outbursts pouring out from the lower mind. Also that emotion is like a wave, it has its periodic ups and downs for example: pleasure and pain, happiness and suffering, elation and depression, alternating all the time. One's effort should be to reduce the peak and the trough of emotional outbursts until the wave no longer exists. This is good practice for intended leaders and managers.

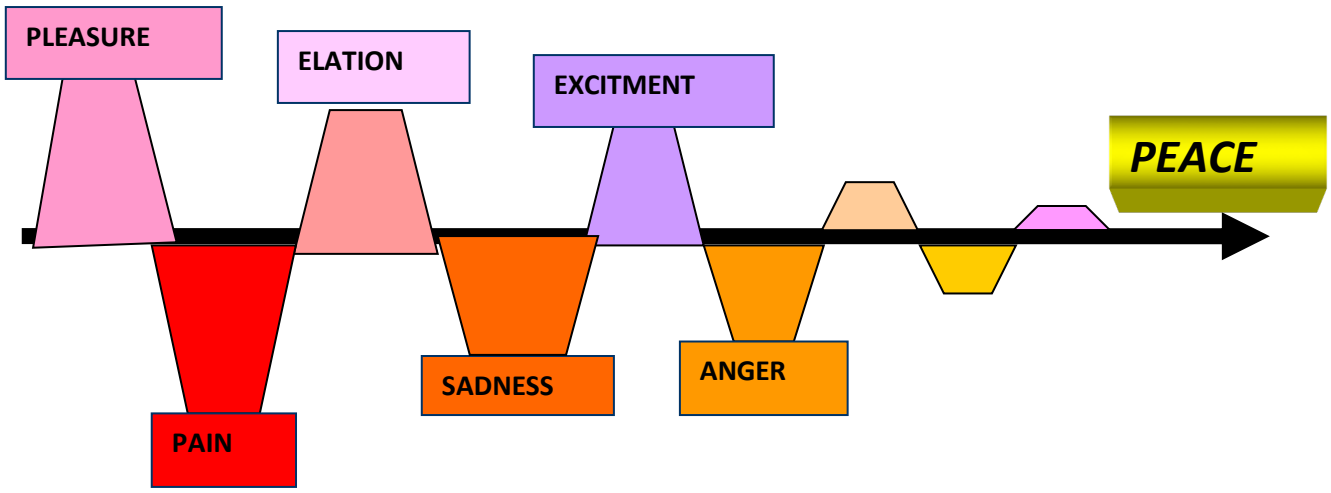


Diagram 3: Direction To Attain Equanimity

Positive emotions such as joy, hope, optimism, love, contentment and gratitude help us to grow as a person, energize us for positive action, solve problems, improve the quality of our relationships and increase our sense of emotional well being (Sharma 1999). When engaged in positive emotions habitually, over time this exercise can become life enhancing. At the same time we must avoid life threatening emotions.

We sometimes encourage one another to be positive, think positive or to engage in positive emotions but just how do we do this. We do realize that emotions have their purpose namely that negative emotions help us survive and positive emotions help us thrive.

Seligman (2002) takes the hopeful message of positive psychology and shows how empirical research supports it and illustrates how one can use simple and life-enhancing self-help techniques. An example of good empirical evidence is that appreciation, non materialistic values,

tolerance, acceptance, forgiveness and gratitude are key factors to a better life and to enhance relationships.

Conclusion

The healthcare environment is directly affected by the values and attitudes of the wider society. Societies that prioritize wealth and power and are uncaring for their weaker or less fortunate members are going to be less conducive to human caring in their health professionals (Schoenhofer 2004). The attitude can become one of just patching people up rather than of truly human healing. It is therefore necessary to question these values and attitudes of society that can lead to negative health outcomes in so many of its citizens and denigrate the humanness in us all.

Human Values helps in the empowerment of a life long commitment to act in accordance with ones conscience. Developing self awareness, self confidence, self regulation, self reliance and self discipline will enhance problem solving and decision making skills. Effective communication and social skills will enable one to resolve conflicts and work cooperatively.

Vitello-Cicciu (2002) state that healthcare is changing so rapidly that leaders can no longer use outmoded ways of leading an organization and consumers are demanding that the Healthcare System become more relationship centered and service orientated. Earlier Kerfoot (1996) contended that successful healthcare leaders are those that lead with their heart and possess what has become to be known as 'soft skills'.

These 'soft skills' are demonstrated as being empathetic to their employees, enhancing individual and group relationships and recognizing the individual contributions to each member of the health care team (Kerfoot 1996). As people become central to organizational performance, the ability to motivate, engage and direct people increases in importance.

This brings us to the next Chapter of Emotional Intelligence(EI) which is the mental ability that one has since birth. It gives one emotional sensitivity and the potential for emotional learning management skills which can help one maximize long term health, happiness and survival (Hein 2004).

CHAPTER 3

EMOTIONAL INTELLIGENCE IN MANAGEMENT

Introduction

Nurses in their professional life work consistently with human emotions, whether dealing with pain, discomfort, sadness, relief or hope. An ability to manage ones own emotional life whilst interpreting others is a prerequisite for any caring profession. From a patient's point of view, the smile and care from the attending nurse restores a sense of humaneness and dignity during hospitalization.

Emotion is an affective state in which joy, sorrow, fear, hate or the like are experienced. It should be distinguished from cognitive and volitional states of consciousness. Intelligence is a set of cognitive abilities which allows us to acquire knowledge, to learn and to solve problems. Therefore Emotional Intelligence (EI) is a combination of two of the three states of the mind namely cognition and affect or intelligence and emotion. EI is the head working with the heart – a unique intersection of both.

Emotions serve as the single most powerful source of human energy, authenticity, drive and offer intuitive wisdom. Learning to recognize, respect and value the inherent wisdom of our feelings is critical to insight, integrity and good judgment (Crone 2002). To be successful we must learn emotional self-awareness and recognize and respect the emotions of others.

This chapter draws from the work of Daniel Goleman on EI. At the beginning of this chapter information on the necessity of EI is given and how this information can be useful to leaders, managers and the workplace. This is followed by the implementation of EI components and competencies in workplace training and skills development. Will managers who develop high EI skills be instrumental in sustaining their nursing staff?

Mayer and Salovey (1997) originally defined EI as the ability to monitor one's own and other's feelings and emotions, to discriminate among them and to use the information to guide one's thinking and actions. People who behave in this manner are referred to as emotionally intelligent.

3.1 Intelligence Quotient (IQ) versus Emotional Intelligence (EI)

For almost 100 years intelligence quotient (IQ) tests were thought to be the most reliable predictor of individual intelligence and performance from school to the workplace. Today high powered jobs require applicants to conduct an EI test as part of the recruitment process. Hammer (2002) states that the singular value of the EI construct is an acknowledgement that there is more to human effectiveness than SAT and IQ scores, and employment tests that focus on cognitive ability.

Intelligent people who perform well are those with high EI as well as IQ. Studies have shown that it is a combination of particular personal and interpersonal skills that make the difference. Freshwater and Stickley (2004) contend that although it is clear that EI works synergistically with IQ to enhance overall performance, EI can be measured and can be learned. It is this ability that differentiates exceptional from mediocre ability and achievement.

In a world of product and services (IQ) is prominent but as the emphasis shifts to people and relationships, (EI) comes to the fore (Lee 2004). For example lawyers are recruited for their IQ but their EI determines 'how far they get'. Lawyers may be valued for their 'head' but they are significantly more effective and successful when they do it in conjunction with their 'heart'(Lee 2004). In other words it is IQ or technical ability which gives the opportunities, but it is EI or relationship skills which determine the extent to which opportunities are realized. This important principle can also be applied to nurse management.

3.2 EI and Leadership

The term Emotional Intelligence (EI) is described as the primal aspect of leadership and refers to the ability to monitor and discriminate among emotions and to use the information to guide thought and action (Herbert 2004).

To become a great leader is not only a challenge but a necessity in managers, as they are sure to influence the mind of the people they lead. When core values and norms are clear to people, a leader does not need to be physically present for the team to run effectively (Goleman et al 2002). Teams are the vehicle of choice in today's organizations.

In a study conducted by Connolly (2002), nurses and business executives were asked to identify desirable management traits and preferred professional and personal characteristics were identified. These were good organizational skills, strong interpersonal skills, risk taking abilities, independent decision making and teamwork orientation

Participants deemed these particular characteristics valuable and exclusive of an applicant's previous managerial experience or advanced education degree. They surveyed executives who specifically preferred applicants who were team oriented, independent, organized and visionaries with strong interpersonal skills. The findings confirm that EI outweighs education level or past managerial experience (Connolly 2002).

Boyatzis and Mc Gee (2003) built on the principles they coauthored with Daniel Goleman in the 2002 bestseller. They explained how managers and executives can employ mindfulness, hope and compassion to create and maintain exceptional business success. Effective teams and powerful, positive organizational cultures do not happen by accident, they are created by resonant leaders who employ EI to motivate and nurture their employees.

The contemporary concept of EI as a critical set of management skills is traced through time to its current application for healthcare administration and management. Freshman and Rubino (2002) state that EI represents proficiencies in intrapersonal and interpersonal skills - in the areas of self awareness, self regulation, self motivation, social awareness and social skills.

Strong, emotionally intelligent and effective nurse leaders are essential to address the many challenges facing practice. The human resource crisis in healthcare requires a coordinated national strategy for the creation of workplace cultures that value and retain employees. Implementation of these strategies necessitates nursing voices at a senior level. (Herbert and Edgar 2004) state that evidence suggests that emotionally intelligent nurse leaders will have a significant impact in addressing these issues and in moving the profession forward.

The ability of nursing leaders to manage their mood so as to display a positive mood may actually enhance work performance. Persistent crises will hopefully not paralyze these leaders or allow them to become emotionally overwrought. With the chaotic nature of healthcare, leaders who possess the abilities of EI may become a valuable resource in healthcare organizations.

The fundamental task of leaders is to prime good feelings in those they lead. In Goleman's Book, Primal Leadership (2002) he shows why understanding the powerful role of emotions in the workplace sets the best leaders apart from the rest. The common thread that holds people together in a team and that commits people to their workplace is the emotions they feel. How well leaders manage and direct those feelings to help a group meets its goals depends on their level of EI (Bort 2003).

The book *Resonant Leadership* by Boyzatzis and McKee(2003) describes the highly stressful conditions in which leaders operate today, and explain sympathetically how many well intentioned people fall into what they call 'dissonance' due to burnout. Managers are required to get their team working together and to pass on the company's goals to the team to inspire them into working enthusiastically towards those goals. They also need to mediate between what they want and what the company wants. Managers require EI to meet their targets and manage their own stress levels.

3.3 EI and the Workplace

Teams, departments and individuals can become locked into conflict very easily in the workplace or they can become disaffected and unmotivated. They all have different needs and aspirations therefore each set can be dealt with using EI effectively. If the EI of the staff can be developed, then the results will be even better.

EI does not and should not be thought of as a replacement or substitute for ability, knowledge or job skills. EI is hypothesized to enhance workplace outcomes but does not guarantee it in the absence of suitable skills. Applications of EI in the workplace may include career development

whereby some careers require a higher level of EI than others. If one has an aptitude for understanding people and oneself perhaps one should consider a 'people–intensive' career such as those in the mental health field. In management development managers who focus on their technical skills do not manage, they are just 'in charge'. Whereas understanding and enhancing EI may enhance certain management skills and styles. In team effectiveness– teams are more than the sum of the individual parts. The cohesiveness of the team may be held together with EI.

EI measurement and development is a practical method to build teams that work cooperatively and productively. Since EI encompasses the capacities involved with maintaining good relationships it makes sense to focus it on teams (EI Skills Group 2005). The benefits are when the team members learn how to communicate with each other so that the task is not slowed down by misunderstandings or they learn how to support one another in order to accomplish the task in the least stressful manner.

3.4 EI And Gender

A study conducted by Rivera and Beatrix (2004) documented peoples differences in the display of emotional intelligence competencies at home and at work. The findings were that the gender role dynamics affect EI behavior differently for men and woman and that the degree and features of the difference is affected by cultural factors primarily.

A correlation analysis revealed that the difference in behavior is related to the masculinity/femininity dimension of culture and human values in the case of women. Men however show a difference in display at the personal competence level of the model. This has implications for today's organizations in terms of training, retention, practices and policies.

3.5 TRAINING FOCUSING ON DIMENSIONS OF PEOPLE

I. **Intellectual Dimension** –This is the logical aspect for ***thinking***, learning facts and information, making choices and solving problems. In healthcare this is crucial, however simply having technical skills does not guarantee effectiveness when interacting with people (Freshman and Rubino 2002).

II. **Emotional Dimension** – This is the ***feeling*** aspect-this is usually more influential. Feelings drive most choices and decisions. Studies have shown that up to 85% of job success is based on feelings, attitudes and emotions (Esterday 2004). In difficult situations people often know what to do but they may not always feel comfortable with the situation.

III. **Unconscious Dimension** – This is a profound level that houses values, feelings of worth and self esteem. Silently but powerfully it controls all actions, feelings, behavior and ability. It is unfortunate at present that most of the training is directed only at the intellectual dimension through presentation and information. Attitudes, values and motivation come from ***within*** oneself.

Integration of the three dimensions is required for long term behavior change, customer service training and interactions with others (Esterday 2004). One needs to help staff understand the purpose of their job and how it relates to the purpose of the organization. In the nursing profession staff can be enhanced by focusing on their strengths instead of their weaknesses. Recognise their potential and value them for who they are as individuals and also their ability. Leaders as role models can teach how to connect with others emotionally with the Head and Heart. One needs to understand that great service often involves much more than words. This can be delivered with a genuine smile, a touch or taking a moment to truly care (Freshman and Rubino 2002)

3.6 EI Components

Four Areas Identified by Mayer and Salovey (1997): One of the most powerful and unique aspects of this four-branch model is its simplicity to understand and apply. People can be taught to employ this model to assist them in integrating emotion and thinking.

IDENTIFYING EMOTIONS	The ability to recognize how you and those around you are feeling
USING EMOTIONS TO FACILITATE THOUGHT	The ability to generate an emotion, and then reason with this emotion
UNDERSTANDING EMOTIONS	The ability to understand complex emotions and emotional 'chains', how emotions transition from one stage to another
MANAGING EMOTIONS	The ability which allows you to manage emotions in yourself and others

Table 3: Four Branch Model

Nurse leaders and managers can use the following cues to add or improve their leadership or management skills in the following table:

Identifying Emotions	How do I feel? How does the other person feel?	*Actively observe facial expressions and note the congruency with spoken words*
Using Emotions to facilitate thoughts	Is the mood helpful? Does it focus our attention, motivate us or blind us?	*Try to remain in the present and reflect on upsetting situations after the fact and try to learn from the situation.* *Active listening and inquiry will help develop this ability*
Understanding Emotions	Why do I feel this way? Why does the other person feel this way? How are the feeling changing?	*Can be fostered by learning that emotions convey meaning about relationships and to learn the transition of emotions from one state to another. For example annoyance and irritation can lead to rage*
Managing Emotions	Do the decisions and actions include emotional and logical data to achieve an adaptive outcome?	*Generating an emotion to help solve a problem, energizing a group or calming oneself prior to an emotional event are learned skills to help one manage one's emotions as well as others*

Table 4: Cues for Leaders (Mayor and Salovey 1997)

3.7 EI Competency Framework

Mixed Model of EI by Goleman 1998: This model has initially had 5 broad domains namely self-awareness, self- regulation, motivation, empathy and social skills. It has been further expanded to include several competencies including personal and social. Goleman contends that outstanding work performance requires only that we have strengths in a small number of these competencies.

PERSONAL COMPETENCE	
SELF –AWARENESS *(This is having insight into one's own emotions, drives, strengths, weaknesses and needs. Those who possess a high degree of self awareness know how their feelings affect themselves, others and their performance)*	**Emotional awareness:** Recognizing one's emotions and their effect **Accurate self assessment:** Knowing one's strengths and limits **Self Confidence:** A strong sense of one's self worth and capabilities
SELF-REGULATION *(It is the ability to control one's impulses and to channel one's moods constructively. It enables an individual to withhold judgment until information is gathered*	**Self –Control:** Keeping disruptive emotions and impulses in check **Trustworthiness:** Maintaining standards of honesty and integrity **Conscientiousness:** Taking responsibility for personal performance **Adaptability:** Flexibility in handling change **Innovation:** Being comfortable with novel ideas, approaches and new information
MOTIVATION *(This is an innate drive to achieve for the pure joy of achievement. Motivated people are energetic and creative actively seeking solutions to solve problems. They seek new challenges and want to stretch their capabilities)*	**Achievement drive:** Striving to improve or meet a standard of excellence **Commitment:** Aligning with the goals of the group or organization **Initiative:** Readiness to act on opportunities **Optimism:** Persistence in pursuing goals despite obstacles and setbacks

SOCIAL COMPETENCE	
EMPATHY *(This is the ability to consider thoughtfully another persons feeling whilst making intelligent decisions. It is a step in creating trust and cohesion and is essential to building effective teams, leading change, retaining skilled employees and creating loyalty that transcends job description)*	**Understanding others:** Sensing others feelings and perspectives, taking an active interest in their concerns **Developing others:** Sensing others development needs and bolstering their abilities **Service orientation:** Anticipating, recognizing and meeting customers needs **Leveraging diversity:** Cultivating opportunities through different kinds of people **Political Awareness:** Reading a groups emotional currents and power relationships
SOCIAL SKILLS *(This is the ability to manage relationships with others.It is also the aptitude to find commonality and move people forward towards their vision and goal which can build networks, bridge differences and make those around them feel at ease)*	**Influence:** Wielding effective tactics for persuasion **Communication:** Listening opening and sending convincing messages **Conflict Management:** Negotiating and resolving disagreements **Leadership:** Inspiring and guiding individuals and groups **Change Catalyst:** Initiating or managing change **Building bonds:** Nurturing instrumental relationships **Collaboration and cooperation:** Working with others toward shared goals **Team capabilities:** Creating group synergy in pursuing collective goals

Table 5: Mixed Model (Daniel Goldman 1997)

These competencies are increasingly seen as indicators of how well individuals will work in teams and who is best suited to lead and follow and who may have difficulty in belonging in a team (Newby 2002). Developing these skills is an asset to human resource management especially in the retention of nurses.

3.8 LEADERSHIP

3.8.1 Leadership Model 4 Domains

Four Domains of EI (Goleman 2002): In Goleman's updated model of EI the domains are simplified into 4 instead of 5 namely self awareness, self management, social awareness and relationship management and the competencies have been reduced to 18 from 25. The result is an EI model that more clearly links specific clusters of competencies to the underlying brain dynamics that drive them.

The four domains and clusters of competencies that are linked to the underlying neurology are listed below. Self Awareness is no different to the earlier model however the other 3 domains/ competencies are different.

SELF AWARENESS	**Emotional self awareness:** reading ones own emotions and recognizing their 'gut sense' to guide decision **Accurate self-assessment**, knowing ones strengths and limitations **Self-confidence**, a sound sense of ones self worth and capabilities
SELF MANAGEMENT	**Emotional self control:** keeping disruptive emotions and impulses under control **Transparency:** Displaying honesty and integrity **Adaptability:** Flexibility to changing situations or overcoming obstacles **Initiative:** readiness to act and seize opportunities **Optimism:** seeing the upside in events
SOCIAL AWARENESSS	**Empathy:** sensing others emotions, understanding their perspective and taking in their concerns **Organizational awareness:** reading the currents, decision networks
RELATIONSHIP MANAGEMENT	**Inspirational leadership:** guiding and motivating with a compelling vision **Influence:** wielding a range of tactics and persuasion **Developing others:** bolstering others abilities through feedback and guidance **Change catalyst:** initiating, managing and leading in a new direction **Conflict management:** resolving disagreements **Building bonds:** cultivating and maintaining a web of relationships **Teamwork and collaboration:** cooperation and team building

Table 6: Four Domains of EI (Goleman 2002)

The resonant leader is one who can inspire, motivate, arouse commitment, strengthen and fine tune one's EI competencies and move fluidly to meet the needs of the situation (Dearborn 2003). The different models of EI competencies depicted can be used by leaders and managers.

Golemans book *Primal Leadership* extends his work on Emotional Intelligence and focuses on the initial ingredients for leadership effectiveness. Their fundamental argument is that primal (the first and most basic) task of any leader is to drive the emotions of the follower group in the right direction.

The message of the book is that primal leadership operates at its best through emotionally intelligent leaders who create resonance. Goleman et al 2003) states that:

"Today's complex social realities are being responded to with a brain designed for physical emergencies. The thinking brain evolves from the limbic brain. When we are under stress the amygala provides the impulse response sending a signal to the brain's prefrontal area, which rationalizes the impulse to a 'thought' response. The prefrontal area has two zones: the left is associated with positive emotions and the right with negative. Without this neuro-circuitry, impulses would be acted upon without the veto or rationalization provided in the pre-frontal zones. Thus EI competencies are neurologically separate from cognitive abilities, but intelligence and emotion fit and work well together in resonant leadership."

3.8.2 Characteristics of a Leader

Leadership is a process by which a person influences others to accomplish an objective and directs the organization in a way that makes it more cohesive and coherent. Leaders carry out this process by applying their leadership attributes such as beliefs, values, ethics, character, knowledge and skills (Clark 1997).

Considering the impact of a variety of leaders ranging from Nelson Mandela, Mother Theresa, Yitzhak Rabin, the Dalai Lama, Martin Luther King, Mahatma Gandhi to hundreds of other great leaders, all these great hero's of the last century have been deeply authentic people who have transcended their own life situations to inspire others and change the world in some profound way.

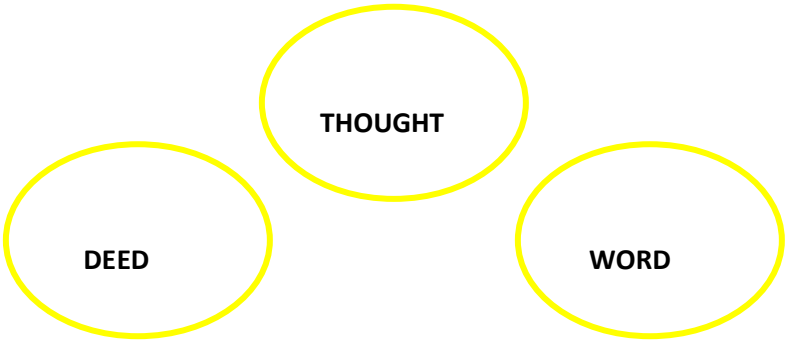
Wood and Hessler-Key (2003) state that these types of leaders have one essential quality and that is they resonate with people from all walks of life in many different ways. This resonance or way of 'striking a cord' with a significant population of people is an essential dimension of leadership.

3.8.3 Types of Leaders

Bhushan (1992) has used the teachings of Sathya Sai Baba to illustrate that a man whose thoughts, words and deeds are in harmony can become a good and effective leader. These thoughts need to be pure – their source not related to lust, anger, greed, attachment, egotism or

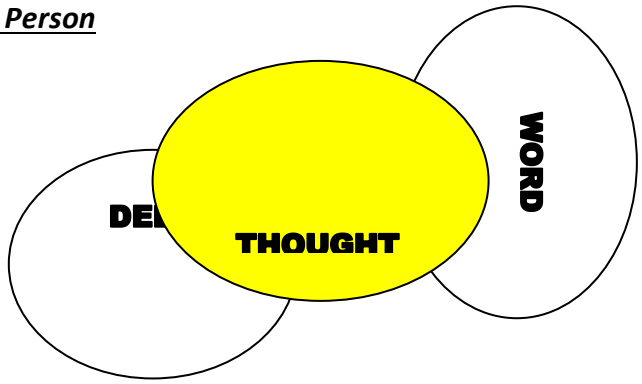
jealously. In other words it has to be transparent and straightforward in word and conduct. Two types of Leaders are depicted below:

a) ***Clever Person***



This is a worldly person whose thoughts are related to self interest. He thinks one thing and says another. He seldom does what he says.

b) ***Trustworthy Person***



This person has harmony in thought, word and deed and can therefore be trusted. It is this type of person that has the potential of becoming a good leader.

3.8.4 The Leadership Process

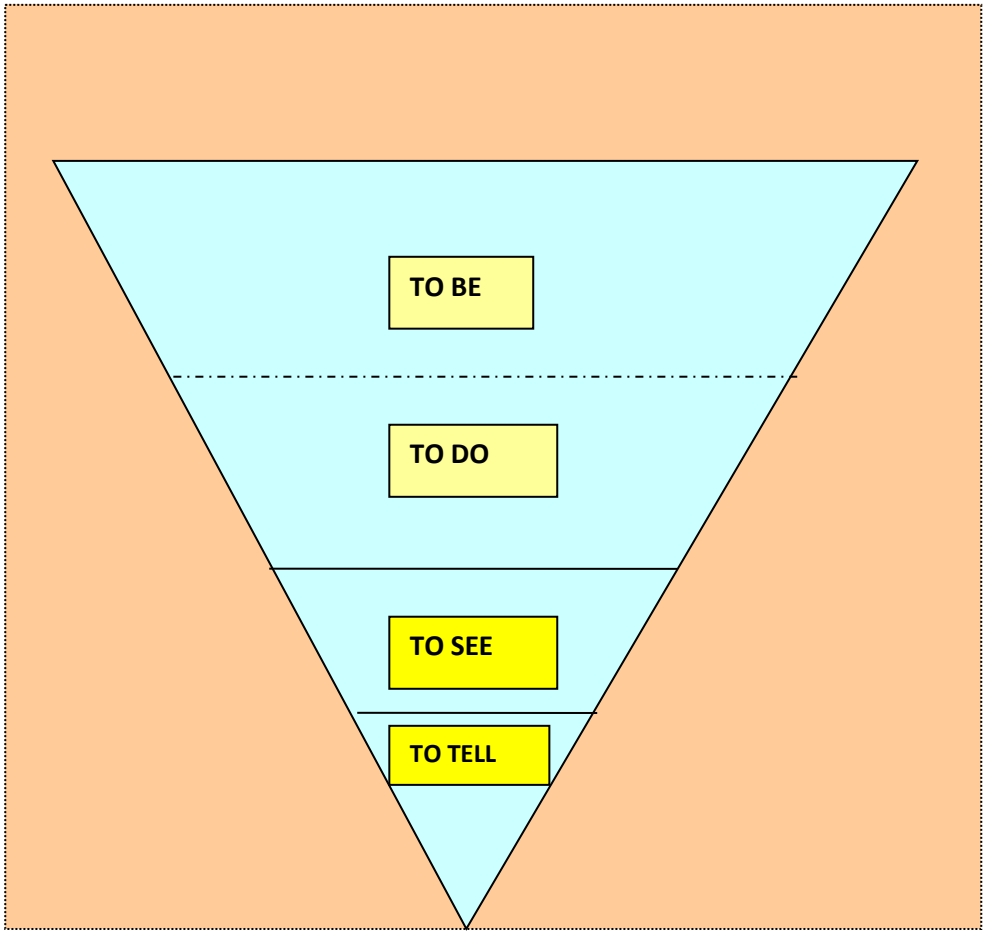


Diagram 4: Leadership Process (Mahavakya 1992)

The Chancellor at the Sathya Sai University had a discussion on Leadership articulating what has come to known as the 'Mahavakaya' (the Great Utterance) cited in Bhushan (1993). He very simply summed up the entire distillate of the leadership process as follows:

TO BE ; TO DO; TO SEE; TO TELL

TO BE: *is the source of Leadership.*

- is the beginning and the end of Leadership
- is shown diagrammatically as the largest component in the leadership process
- 90% of a leader is character

It is composed of a persons values, qualities and knowledge - practically the 'total being'. Emphasis is placed on the Macro and practical approach to leadership.

TO DO: *is the style of Leadership*

- best style of leadership is by personal example
- to practice what we preach
- reflects the substance of a person

TO SEE and TO TELL**:** *are the functions, tools and techniques of Leadership*

TO SEE:

- Implies that a leader must be in complete touch with the realities of the environment in which he works.
- Required to have all the information prior to task commencement
- In decision making goals have to be clear, collecting information, evaluating data, crystallizing options, selecting an option and lastly formulating a plan for implementation.

TO TELL:

- Conveying to others the task
- Instruction of leader must be clearly understood
- Channel of communication through the hearts and depends entirely on the strength of ***TO BE*** and ***TO DO*** of the leader.

Bhushan (1993)

People want to be guided by those they respect and who have a clear sense of direction. To gain respect leaders must be ethical and a sense of direction is achieved by conveying a strong vision for the future. Clark (1997) has reinforced the above in stating that respected leaders concentrate on:

- what they **are [be]** such as beliefs and character.
- what they **know** such as the job, tasks and human nature
- what they **do** such as implementing, motivating and providing direction.

3.8.5 LEADERSHIP STYLES

Resonance releases energy in people and it increases the amount of energy available to the team, which in turn puts people in a state where they can work at their best (Goleman et al 2003). The authors call on further research findings from a global database of executives, which determine these six different styles of leadership and how these styles influenced the working environment and affected financial results.

Six different leadership styles and their impact on a group in terms of creating resonance and dissonance are displayed in the table below.

LEADERSHIP STYLE	HOW IT BUILDS RESONANCE	IMPACT ON CLIMATE	WHEN APPROPRIATE
VISIONARY	Moves people toward shared dreams	Most strongly positive	When change requires a new vision or when a clear direction is needed
COACHING	Connects what a person wants with the teams goals	Highly positive	To help a person contribute more effectively to the team
AFFILIATIVE	Creates harmony by connecting people to each other	Positive	To heal rifts in a team, motivate during stressful times or strengthen connections
DEMOCRATIC	Values peoples input and gets commitment through participation	Positive	To build buy-in or consensus or get valuable input from team members
PACESETTING	Sets challenging and exciting goals	Frequently Highly negative because poorly executed	To get high quality results from a motivated and competent team
COMMANDING	Soothes fears by giving clear direction in an emergency	Often negatively because misused	In a crises, to kick start a turn around

Table 7: Leadership Styles and Resonant Teams

When leaders display emotions positively they bring out the best in all. This is termed 'resonance' by Goleman et al (2003). He states that resonance comes naturally to EI leaders, their passion and enthusiastic energy resounds throughout the group. The opposite occurs with 'dissonance'.

3.9 The Five Discoveries

The limbic (emotional) brain which has a more primitive organization of cells and therefore the learning process is slower than in the neo-cortex where the cognitive abilities are learned. Repeated and sustained learning over a period of time develops deeply ingrained habits centered in the limbic area, the area most suited to learning the EI competencies (Goleman et al 2003). A process of self directed learning is prescribed, based on the five discoveries which are:

- Discovering the vision of yourself
- Discovering your real self: from the difference between the vision and reality a list is made of the strengths and gaps
- From these strengths and gaps: identifying an agenda to improve on strengths and close the gaps
- Practicing the new competencies required
- Developing a trusting relationship with others who can provide feedback, through all the stages 1-4

This process can also be applied to groups which the authors maintain, will generate and develop a resonant group.

3.10 Developing Emotional Intelligence

As with all personal change a heightened level of consciousness and vigilance to implement new changes. It begins with self awareness where you become more observant of yourself, your emotions and feelings, the reactions of others, your body and your thoughts. The more you practice the closer you will get to becoming more conscious of the energy behind your words and interactions. Recent neurobehavioral research on the limbic system shows that EI can be learned through motivated and extended practice and feedback (Vitello-Cicciu 2002).

Emotion is energy in the body, so by increasing your awareness of the energy changes within you and the energy changes you have with others, you will become more effective at managing emotions (Fuimano 2004). To gain awareness about how you are received and perceived observe how your staff respond to your presence. Are they too intimidated to speak their mind or do they speak freely? When they have concerns do they seek out someone else? Do they pay attention to how you feel after conversations rather than just what you think?

You need to listen to what staff members say about you. What have you been told in your evaluations? What compliments do you receive?

The best way for you to know the impact you have on your staff is to ask them. However if you feel that there is something having an alienating effect on the staff that decreases productivity, then it is your responsibility to identify the issue and find the solution. Try and see this as an opportunity for personal improvement rather than criticism. There are probably few employees anywhere who could not name someone in their organization, at just about any level, whose seeming blindness to their own emotions and motives, has been disruptive to team or organizational functioning.

3.11 Integration of Human Values And Emotional Intelligence

More than anyone else it is the team leader who has the power to establish human values and model behavior that encompasses the above concepts to maximize harmony and collaboration in a team. Speaking the truth and honestly assessing both the behavioral and emotional aspects of the team will help create new habits and so optimize the teams effectiveness.

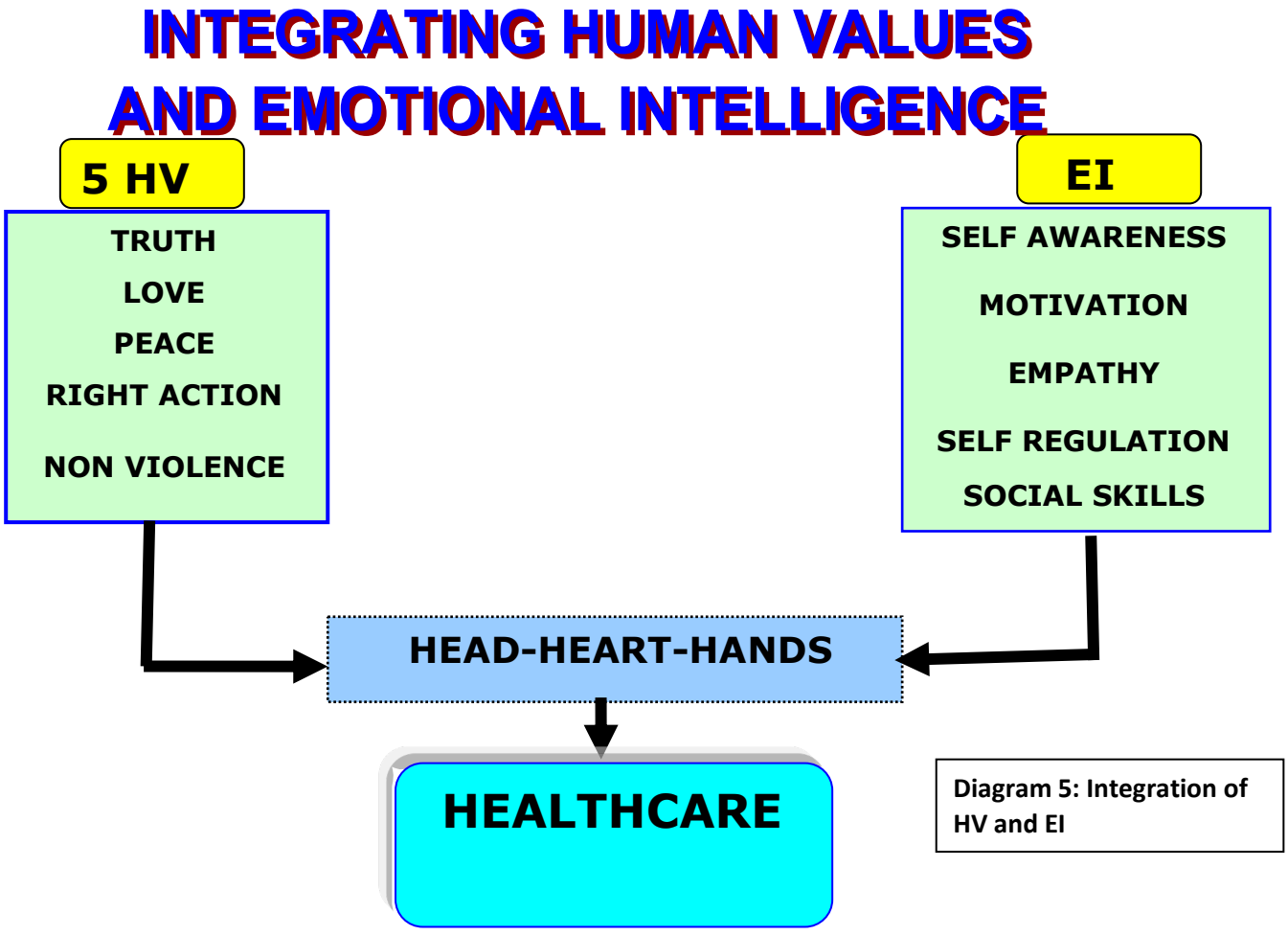


Diagram 5: Integration of HV and EI

Conclusion

Goleman et al (2002) identifies three key findings to create a resonant and effective EI culture in an organization. Firstly discovering the emotional reality in an organization, secondly visualizing the ideal and attuning to peoples hopes, beliefs and values and thirdly sustaining EI, turning the vision into action, creating EI practices and EI leadership.

Nursing leaders who can address the emotional side of their staff, patients and families can develop the highly energized and synergized teams necessary for the survival during this ever changing landscape of healthcare. Raising the EI in our managers and them creating resonant teams can become the solution to the current problems that the nursing workforce is facing today. However understanding and practicing Human Values will enhance this concept of EI.

Healthcare institutions that wish to thrive into the next millennium cannot do so without leaders who have high EI. Strickland (2000) stated that what has long been called 'soft skills' is now the key to achieving results and not just technical skills and a bag of brains. The question is whether organizations are willing to examine their own EI with the same gusto as they do with academic credentials and technical competencies.

Relaxation techniques, breathing exercises, meditation, visualization and self help books can assist to enhance awareness of emotions.

Of the 5 Human Values Truth and Right Conduct virtually contain the distillate of all morality. Honesty, integrity and loyalty are inherent in these two values. There is an ancient Indian edict based on this and it translates:

"***Speak the Truth and act as appropriate to the duties and obligations of your position whatever it may be. When one acts with unselfish love, then there is perfect peace and equanimity in success or failure, pleasure or pain, joy or grief'*** (Bhushan 1993).

CHAPTER 4

THE CHALLENGE

Introduction

The question arises as to whether the staff of the High Dependency Unit(HDU) would have taken to task Senior Management in the Intensive Care Unit(ICU) which includes medical and nursing management teams had the Sathya Sai Education in Human Values(SSEHV) program not been implemented in the HDU. A chapter has been dedicated to the challenges the HDU staff have had to encounter and the relevant action that had to be undertaken. It was a very difficult period for all concerned however the unity of the team would be tested during this time.

The cohesive HDU team worked very effectively and efficiently. However the ICU medical team together with ICU management began admitting patients with higher acuity. This placed greater pressure on staff who had to cope with the increased activity resulting in high turnover of patients being admitted.

The background of the establishment of the HDU will be related. This is followed by the specific issues that were being experienced. How ICU management addressed these issues and their interaction with various team members will be highlighted. The HDU Nurse Unit Manager(NUM) role change, the involvement of the workload committee and Nurses Union is highlighted.

4.1 Background

The government had given the ICU a sum of $600 000 to open an eight bed HDU. A ward was used for the new HDU which was geographically distant from the Intensive Care Unit (ICU). A Steering Committee was formed and the official opening of the HDU took place. The funds were sufficient only for the salaries of the nursing personnel. No funds were allocated for cleaners, wards-persons, equipment, pharmacy, clerical, doctor etc. The HDU was established in two specialized four bedded rooms within the ward area. As a result the specialist function of the ward was abandoned. There was no consultation with Occupational Health and Safety(OH&S) officers nor the committee with regard to the feasibility and safety of transforming two 4 bed ward rooms into an 8 bed HDU.

HDU acts as both as a ‘’step down’’ unit for ICU patients and a ‘’step up’’ from the general wards. The diverse workload within HDU provided an intensive learning environment for nurses. The majority of the nurses were from the pre existing ward and had to be educated and up skilled in HDU type nursing. The balance of the staff had been recruited from other wards within the

hospital and some staff from outside the hospital. The In-Charge of shift positions were mainly filled by ICU staff and so too was the medical support.

The immediate past Nurse Unit Manager (NUM) had no patient load and was responsible for the overall day to day running of the unit. The ratio for nursing staff to patients had been 1 nurse to 2 patients. The medical staff comprised mostly of the pre existing ward specialists in (facio-maxillary, burns-plastics, ophthalmology and ENT). Both medical and nursing staff were not involved in the consultation process nor had they any choice about their future in the institution.

This fragmented group displayed feelings of anger, hurt, mood swings and disillusionment. The situation unfortunately led some nurses to engage in 'horizontal hostility'. This is a destructive phenomenon that contributed significantly to stress and burnout resulting in adversely affecting the role, health and well-being of the nurses in the ward as well their working environment. The immediate past NUM had resigned officially due to the escalating pressures from managing the HDU and the staff.

One of the senior registered nurses(the researcher) stepped into an Acting NUM position and later secured the NUM position officially in Oct 2003. The ICU department then decided that the newly appointed NUM must also take the clinical load of two patients as there insufficient funding to perform in a supervisory capacity. This NUM was expected to work four ten hour shifts per week from 0700-1730. During the period between 0700-1500 the NUM was expected to have a full clinical load(2 patients) and manage clinical and staffing issues. The period from 1500-1730 was allocated for administrative work. The role of the NUM in the HDU now became challenging with continual interruptions occurring during clinical delivery. These interruptions included decision making and problem solving issues. There was a directive that 'In charge' shifts must be allocated to the ICU registered nurse.

The NUM for the past six months had constant interaction with the nursing staff whilst working with them as a registered nurse. This had presented an opportunity for the NUM to observe the group dynamics in the HDU and furthermore to understand the processes leading to group development. It became apparent that staff were unhappy. The reasons being that their specialized Ears Nose & Throat (ENT)/ Burns Unit was now the new HDU. They felt that their expertise in this area was now irrelevant as they now had to upskill to HDU Nursing. The NUM had to set boundaries in regard to acceptable behavior. Two important ground rules amongst others were established early within the group; the first was 'no inappropriate language' (swear words) to be used and the second 'inappropriate behavior unacceptable' (moody).

The group members were given a clear understanding of what was expected of them. Problems were addressed as they occurred and plans to resolve them were immediately put into place. As individual strengths and weaknesses emerged support and guidance were given appropriately. However colleagues in the group gradually started to believe that they could rely on the support

and assistance of other colleagues in the group. HDU meetings were held fortnightly and were conducted democratically. Opinions and suggestions by all staff were considered and plans of action formulated . Through such encouragement gradually a high performing team displaying commitment and ownership emerged .

4.2 HDU and NUM Issues

4.2.1 HDU Issues

HDU issues are demonstrated below by a fishbone map. Greater detail is illustrated in Table 8 portraying issues and effects on environment, nursing staff, medical staff and patients. Table 9 portrays separately the NUM's issues and effects.

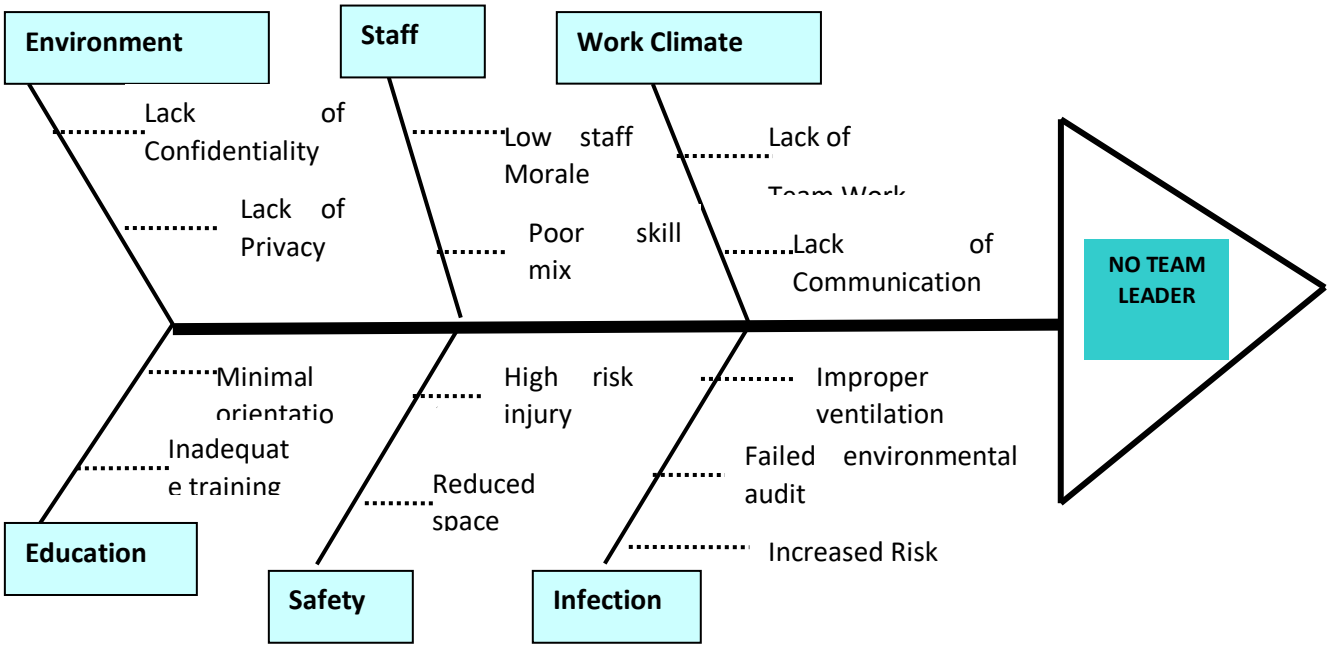


Diagram 6: Fishbone Map depicting The Issues.

ISSUES IN HDU

ENVIRONMENTAL	Geographically distant from ICU Activity of unit increasing –for the year 2003 Total admissions 815 and began increasing in the following years Acuity of patients increasing – high turnover of patients Space per room too small for four beds, equipment, computer etc At times there are up to fifteen extra people in room including doctors, allied health and other personnel

	More equipment in the 2 four bedded ward causing OH&S problems for staff, patients and visitors Faulty air conditioner-leaks onto floor in humid conditions-safety issue Inadequate suction and oxygen outlets therefore portable equipment used adding to clutter Beds continually moved into corridor to make room for recliner chairs No ward clerk-multiple telephone calls, filing etc Lack of confidentiality and privacy in rooms HDU meeting held in corridor outside both 4 bedded rooms-corridor a thoroughfare Toilets and especially bathrooms small – difficult to maneuver shower chairs No blood gas machine-need to go to ICU Computer frequently not printing out handover sheets – multiple calls for service Failed infection control audit
NURSING	The In-Charge persons from ICU rely heavily upon HDU staff as they had no official orientation to the HDU Diluting skill mix in rostering: Junior staff left to look after 4 patients during breaks, transfers Lack of supervision, support and education for all junior staff new to the unit Lack off leadership and management especially morning and afternoon shifts Burden of entire shift falling on HDU senior staff No bed maker services to help with cleaning and making of beds-stating HDU not a priority Lack of support from wardsperson – too busy in other wards, insufficient wardspersons Problems transferring patients to X Ray and CT scans Injuries to staff and visitors– cluttered rooms Inadequate linen and stores Pharmacy only on Mon, Wed and Fri – scheduled drugs to be collected by staff. Daily procuring of drugs, chairs, stores and other equipment mainly from ICU or other ward areas Daily checking of emergency trolley, intubation tray and emergency drugs and the replacement of used items
MEDICAL	No HDU doctor initially then junior doctors placed in HDU-orientation by nursing staff HDU doctor rostered on a patchy basis Staff relying on ICU doctor input and ICU In charge person alls shifts

	Sometimes difficult to contact HDU doctor-attending to procedures in ICU or medical emergencies in the ward. Difficulty in contacting 'consulting team doctors' A doctor who experienced the difficulties in the HDU wrote a letter to the Director of Nursing stating his findings.
PATIENT	Decrease in the quality of care Clinical duties not attended eg. Evidence that medications not given, intravenous fluids not changed Not a conducive environment for resting as corridor used as a thoroughfare Lack of privacy and confidentiality-beds too close and room too small Restricted number of visitors due to space constraints

Table 8: HDU Issues

4.2.2 NURSE UNIT MANAGER ISSUES

The following Data has been taken from NUM diary and tasks have been categorized. The amount of time spent on the tasks and issues has been converted to percentages. Note that

TOTAL 65% tasks undertaken whist allocated a clinical load

Clinical Tasks **0700 – 1500**	***Supervision 10%*** Orientation of new and unfamiliar staff to HDU Infection control eg wearing of personal protective equipment during procedures Manual handling procedures eg use of equipment Clinical practice –eg removing bellovac Monitor the knowledge, skill and performance of all staff ***Planning 8%*** Defining and allocating tasks Bed management issues- admissions/transfers/discharges Recording data of above in book and database Managing doctors and HDU staff plan of care Print updated handover sheets for next shift

	Coordinating 10% Teabreaks Educational sessions Staff to attend various meetings eg Occupational Heralth and Safety (OHS) Receiving and communicating information continually ***Evaluating 5%*** Safety walks for OHS purposes Chart audits Emergency equipment Ensure documentation of incidents and recording on database Giving feedback to nursing staff, patients, allied health Critical thinking and clinical decision making ***Investigating 10%*** Linen shortage- prompted linen audit Inadequate stores- prompted stores audit Nursing staff emptying linen bags – audit attended Replace empty oxygen bottles Report broken equipment Drug audit Managing conflict Lost property ***Negotiating 8%*** Faulty equip for example beds, ECG cables Restock respiratory stock from ICU equip officer Inservice with specialist personnel for example the stoma therapist Cleaner role –leakage water in corridor, Changing of curtains

	Allied health workers for example radiographers, physiotherapists ***Staffing 10%*** Replacement of sick leave Requests for annual leave Reporting injuries, near miss, unsafe work practices Roster adjustments Refer human resource queries to appropriate staff Deploy excessive staff to other wards ***Representing 4%*** Meetings: Executive, NUM's and wardpersons Networking with wards, ICU, Information technology and bio medical engineering Relocation meeting
Non Clinical Tasks 0700 – 1500	Arrange each days tasks in order of priority ie, most important issues are attended to immediately, less important tasks left for managerial time Attempt to follow systematic and rational procedures however frequent interruption causing fragmentation of activities Problems within HDU need to be broken down into its components, analyzed and a feasible solution sought. HDU can be a turbulent environment. To check that equipment adequate and in good working condition for next 2 shifts and the weekend. Reporting faulty equipment to biomedical engineering and trying desperately to obtain a replacement in the interim Take on the role of mediator with staffing issues Developing a network of mutual obligation with other NUM's –for support of decisions Represent HDU in all matters-to be the spokesperson Change roles regularly from leader to motivator to manager. Continual improvement –initiate change with consensus from staff

	Be able to predict and control situations (skill mix) Coping with the dynamic parade of challenges and surprises Advocating being a role model by practicing human values and upholding the unity between thought, word and deed Constant Integrated Awareness especially in managing ones own emotions and that of the staff Showing empathy and concern to all health personnel, patients and visitors at all times
Non Clinical Tasks 1500 -1730	Processing paperwork eg new grads and 2nd year RN's Performance appraisals, responding to reference checks Emails- receiving and responding. Printing and displaying emails. Recording appropriate data in communication book Gathering Agenda for HDU meetings Updating: Staff Phone Lists, HDU Phone numbers, HDU Doctors rosters, Medicine and Surgery roster Australian Incident Monitoring System(AIMS): filling form, entering into database, investigating problem, forwarding to senior management Follow up with Staff, visitors and patients complaints Follow up on Stationery, Default Equip and Appointments Telephoning of staff members to fill in shifts, Patient relatives making, confirmation and receiving calls Filing in of allocation sheets, Roster sheets All correspondence eg. Education, incidents, appreciation, cards and letters

Table 9: NUM Issues

4.3 SENIOR MANAGEMENT MEETINGS

The following will demonstrate the lack of integrity which is disharmony between thought, word and deed following meetings at all levels. Issues illustrated in the Table 8 and 9 were continually addressed at HDU Meetings, NUM Meeting and ICU Executive meetings. Other issues of importance that were stressed by the NUM at meetings were:

- NUM reiterated the urgency to maintain and retain the staff by practicing the human values such as love, truth, right conduct, peace and non violence.
- NUM brought to the attention that values were part of the Area Health Service 'Code of Conduct' Policy
- To maintain consistency between what management thinks, says and does so as to build trust amongst staff
- The vital qualities of managers were repeatedly stressed eg the ability to identify and control one's own emotions, to be able to identify and manage emotions of others and to demonstrate empathy towards staff members.
- Attracting nurses and retaining them in HDU can only occur with putting the above suggestions into practice
- No evidence of incidents reported and recorded on data base affecting staff, patients, visitors and the environment were visibly addressed.

Although plans of action were documented at the meetings there has been no evidence to show whether these plans eventuated. This inconsistency from senior management spread mistrust within staff members which affected the team and delivery of care. During the weekend ICU staff were In-Charge of shifts in HDU and were also allocated a patient load. Therefore ICU staff experienced the same problems that HDU staff faced. The ICU in-charge persons also relied heavily on HDU staff for 'routine' advice and they frequently supported the HDU by submitting letters of complaint to management in regard to staffing and environmental issues.

SENIOR Management Response

A resonant leader is one who can inspire, motivate, arouse commitment, strengthen and move fluidly to meet the needs of the situation. The following statements will demonstrate the absence of resonant leadership when answers were demanded from senior management.

a) **"**The previous NUM of HDU also had a patient load and coped"

(this is untrue as the reason for leaving HDU was the inability to cope with the demands of senior management)

b) " the HDU senior staff are requesting too many weekends on the roster therefore the HDU is left with too many junior staff *"*

(found to be an untrue statement as rostering requests checked)

c) "HDU has always had junior staff "*(True but there is an increase in junior staff)*

d) "the HDU NUM needs to find a tool to measure the workload as the wards are worse off *"*

(this statement was in response to the NUM undertaking 65% of other tasks whilst having a clinical load)

e) "NUM needs to manage time more effectively"

(in response to HDU NUM requesting for 1 day a month for catching up with administrative tasks as current administrative time inadequate)

f) "If HDU predict a busy shift, then they can firstly request nurse bank for help or secondly telephone a staff member from HDU to commence the shift earlier

(It is difficult to 'predict' a busy shift in an acute setting. HDU staff did contact nurse bank however could not help due to unavailability of staff. Thereafter HDU staff contacted a staff member who did come in earlier however after the crisis period)

After continual pressure from HDU Staff the following proposal was suggested.

4.4 INITIATIVES

INITIATIVE 1: **Proposed Relocation to Isolation unit in ICU**

The Director of ICU suggested moving the HDU to four single rooms within the isolation unit. This meant having two patients to a room. Occupational Health and Safety (OH & S) officers were asked twice to check if this was a feasible idea. Their overall report did not favour this idea and modification of the rooms and bathrooms would be required. However there was tremendous pressure from Senior Management for this relocation despite of all the adverse reports from the OH &S Committee.

HDU staff had undertaken two mock trials trying to envisage two patients in one room. Moving equipment and patients in and out of the room proved a difficult task. HDU staff had made a joint decision and declined the offer . They were also supported by the Executive Council. Moving from one problem area to another did not make sense as it would not solve the OH & S issues. Problems continued over the next few months and now spread across the ICU

Escalation of Problems within both ICU/HDU

The results of a s Staff Opinion Survey 2003 conducted by the Empower Group validated the issues faced by both HDU and ICU staff. Below is a table of the results of the key performance indicators(KPI) and an explanation of these KPI.

	FAVOURABLE	UNFAVOURABLE
Satisfaction - Job Satisfaction	20%	44%
- Overall satisfaction	20%	50%
Motivation	20%	55%
Commitment	28%	32%
Advocacy - Services	43%	29%
- Employer	24%	48%
OVERALL ENGAGEMENT	8%	14%

Table 10: Key Performance Indicators

Satisfaction measures the extent to which employees feel satisfied with their job as well as their overall satisfaction with the Hospital/Service

Motivation measures the extent to which employees feel motivated in their current job

Commitment measures the degree to which employees feel committed to contributing to the success of the Hospital/Service

Advocacy measures the desire of employees to talk positively about Hospital/Service in terms of its services as well as about Hospital/Service as an employer

Overall Engagement is the proportion of employees who indicated high performance for satisfaction, plus motivation, plus commitment, plus advocacy (The Empower Group 2003)

Results of the survey included poor communication; favoritism; lack of clear leadership and direction; bullying and harassment; lack of professional development opportunities; refusal of staff to take annual leave; high staff turnover; lack of respect and poor 'values' These issues were now leading to poor staff satisfaction and staff morale. All staff including doctors, nurses, housekeeping and ancillary staff were being affected negatively. This was demonstrated by their words and actions. The problems within the ICU and HDU were now escalating beyond control and was clearly visible throughout the institution. This escalation led to a 2nd Initiative of Senior Management.

INITIATIVE 2: Formation of Steering Committee

An urgent meeting was called by the Executive and Area Health representatives for the staff of ICU and HDU. Initiatives were undertaken by the Executive to establish a process of 'rebuilding' the Intensive Care Unit and HDU over the next 6 months. The main initiatives were to establish a Steering Committee to oversee the issues within the ICU and HDU, an interim ICU/HDU Management Team(IMT), access to annual leave and emphasis on Code of Conduct.

INITIATIVE 3: Recommendations by Executive and Area Health Service

1st Recommendation

A high performing ICU requires 4 basic components namely leadership, teamwork, planning and communication thus the removal of the The Director of ICU, The Divisional Service Manager and the ICU Nurse manager from their current positions. New appointments were made temporarily and the above positions advertised internally(within the area health service) and externally (outside the area health service).

2nd Recommendation

Formation of an Interim Management Team(IMT) to rectify the major issues within ICU and HDU. A proposal was submitted to the Treasury of the Department of Health for additional funded beds in ICU, integration of HDU into the current ICU, an independent retrieval service for the Hunter and for the refurbishment of ICU.

The IMT had informed the Area Health Service that from a given period the ICU would no longer be able to provide medical and nursing staff for the Retrieval services. An immediate response was received stating that funding would be made available in February 2005.

The question of the relocation of the HDU had been asked repeatedly at the IMT meetings, ICU Executive Meeting and the NUM's Meeting with the response that HDU was next on the list. It was evident that other matters were being addressed prior to the HDU, such as the procedural service. In the meantime research was conducted in regard to minimum standards for HDUs, guidelines and recommendations.

INITIATIVE 3: NUM PORTFOLIO CHANGE

The HDU NUM's working hours was changed to Mon - Fri from 0700 – 1530 with one day in the week allocated for administration. This change further exacerbated the problems for the staff in HDU. It now meant that the HDU staff had to restock, locate and retrieve equipment during office hours. Instead of ICU staff being in charge of shifts (with 2 patient allocation) it was now decided for senior HDU staff to be In Charge of the shift (with 2 patient allocation). The withdrawal of the ICU staff member left the HDU short staffed. The staff deficits were replaced with nurse bank and casual staff. This resulted in HDU staff having to do more overtime shifts to replace sick leave and rostering deficits.

4.5 RESEARCH ON HDU

*(*indicating failure of HDU in this study to comply)*

4.5.1 Minimum Standards for Metropolitan HDU's. Only relevant guidelines mentioned below:

- Nurse staffing equivalent to at least 1 nurse to 2 patients for designated HDU beds. Dependency must be related to patient requirements.
- *A qualified supernumerary team leader on each shift
- A designated NUM
- *A skill mix compatible with case load
- *24 hour access to a blood gas machine
- *Educational programs as well as orientation programs for medical and nursing staff
- *24 hour access to pharmacy, pathology, operating theatres, imaging services, physiotherapy and other allied health services

b) Australian and New Zealand College of Anaesthetics (1997)

The above institution defines HDU as a discrete unit within the hospital which is able to supply critical care expertise at less intensive resource levels, providing a level of care that falls between a general ward and the ICU.*(only relevant material mentioned below)*

Patients: *Need to be cared for in a specifically staffed and equipped section of the ICU. They require immediate level of clinical care between a general ward and ICU and *require frequent specialist nursing intervention.

Classification as Level 2: Patients at this level require more detailed observation or intervention. It requires support for single organ failing system or post operative care. Makes provision for patients stepping down from higher levels of care.

HDU independent unit:

*Morning Shift - 1 staff : 2 patients + In Charge,

*Afternoon shift - 1 staff : 2 patients + In Charge and

Night Duty - 1 staff : 2 patients.

Safe Staffing Model with 4 Components: Nurse to patient ratios. The establishment of associate charge nurse position to support nurses providing direct nursing care; assisting complex nursing needs; establishes stable nursing environment; dedicated time for professional education and development and the evaluation of patient outcomes.

4.5.3 Recommendations on Standards for High Dependency Units seeking Accreditation in ICU (2003) Recommended guidelines *(only relevant material included)*

Operational: The HDU must *be geographically part of the intensive care complex of that hospital; *be operationally linked to ICU; *have support services eg. technical and clerical and *24 access to pharmacy, pathology, operating theatres, imaging services, physiotherapy and allied health services

Staffing: A Medical director who is a fellow of the Joint Faculty of Intensive Care Medicine; At least one registered medical practitioner with suitable level of experience immediately available at all times; *a nurse in charge of the HDU who has post registration qualification in intensive care; *all nursing staff in HDU responsible for direct nursing care being registered nurses, and the nurse to have a post registration qualification in intensive care or high dependency; a nursing staff to patient ratio of 1:2 and *a minimum of 2 registered nurses present in the unit at all times when there is a patient present.

Structure: *The patient area must be at least 16 square meters floor area for each bed space in an open area exclusive of service areas; *a typical HDU will require at least two oxygen, one air and two suction outlets and at least 8 power points for each bed space.

Clearly it can be deduced from the above information that the HDU is not adhering to the minimum standards as portrayed by the three governing bodies.

4.6 THE CHALLENGE BEGINS

Developing unity between the HDU staff, demonstrating integrity, practicing the human values and being a role model in the depth of adversity within the unit has been very challenging.

Staff had told the NUM that they cannot cope with the demands of nursing in an inadequately staffed and sub standard HDU. They were tiring of the NUM's 'motivational cries' and this became the turning point for the future of the HDU. The NUM then took the initiative to contact the Nurses Union Representative urgently for advice on this matter. The NUM made a decision to present the case to the Nurses Union and Industrial Commission.

Senior Management in ICU, Divisional Service Manager, Representative from Reasonable Workload Committee and Union Representative were invited to attend HDU meeting. HDU issues were addressed and interim plans were put in place. For example the promise of clerical support, negotiation of extra hours for wardsperson.

4.6.1 Union and Reasonable Workload Committee

A workload document from HDU staff was presented to the Reasonable Workload Committee. The role of this committee is to facilitate consultation on reasonable workloads for nurses, together with the provision of advice and recommendations to management. Five major issues were discussed namely the In Charge role, patient load responsibilities, staff skill mix, environmental issues and the HDU NUM role and responsibilities.

Their recommendations were for an additional In Charge Nurse position to be appointed on the morning and afternoon shifts on all days of the week. This recommendation was to take effect the next morning and would be trialed for 8 weeks. The purpose of this trial is to immediately alleviate the very unsafe and unreasonable workload in the HDU. A Consultative process commenced informing staff of restructuring proposal. The plan was to open four HDU beds in ICU and leave 4 beds in the current location.

4.6.2 Teleconference with Area Health Service

A Teleconference was held with the Area Health Director, Executive Director of Nursing and Clinical Services, Service Manager for Division of Surgery, CEO of Area

Health Service, Nurse Manager of ICU, Industrial Relation Officer, Union Representative and NUM of HDU. The NUM on behalf of HDU accepted the restructured proposal highlighting two concerns namely the nursing and medical support for the remaining HDU beds

NUM of HDU was immediately directed to move to ICU. There was no time for consultation with HDU staff nor adequate preparation for the move. However the next day four beds were moved to ICU and four beds were left in the current location in the ward area. All HDU staff were transferred over to ICU location

Conclusion

One can conclude that changes implemented by management were due more to the pressure enforced by the Nurses Union, Industrial Relations and Workload Committee.

Despite the problems in HDU, the team remained cohesive and tried their level best to deliver care to patients in the most efficient and effective manner. To reiterate the unity of this team the new graduate nurses and the 2nd year nurses who worked in HDU applied for positions in HDU. The main reason stated for their decision was the quality and unity of the HDU staff members including the NUM. Other reasons were to advance their clinical skills and knowledge.

The Unity of HDU staff also had an impact on ICU staff. They enjoyed working with the staff although the environment and lack of resources were challenging. They also 'wished' that the ICU management would learn from the leadership and management of the HDU.

The cards and letters from patients, visitors and former doctors, nurses and ex staff expressing their appreciation of HDU staff have been enormous. All this has been filed and stored. An ex patient of the HDU has written an article to this effect. Coming back to the question of whether this challenge would have been undertaken prior to the introduction of SSEHV into the personal and professional lives of HDU staff.

CHAPTER 5

METHODOLOGY OF RESEARCH

Introduction

This Chapter will review the methodology that the research will adopt. The research will be conducted in two parts. Initially a case study approach will be used at a micro level to determine whether transformation had occurred amongst the nursing staff since the introduction of HV and emotional intelligence concepts by the NUM.

To enhance the purpose of the research the effects of dissonant leadership on the staff in HDU will be studied and the transformation of the staff through resonant leadership will also be observed and discussed. A Macro approach will be adopted to determine the interaction of upper management with frontline managers, nursing staff, the Union and support staff. The exploratory research will initially adopt a macro approach to determine the interaction between the various parties.

The respondents under study comprised a total of eighteen nursing staff in the HDU. The NUM of HDU integrated the practical concepts of SSEHV and EI within the unit. Through a consultative process clear boundaries were established in respect to behavioral issues. The research will monitor any individual and/or team transformation as a consequence of the introduction of the above concepts over an eighteen month period.

5.1. MICRO APPROACH

An HDU in a regional hospital will be selected for a detailed study relating to the impact with the introduction of HV and EI.

Frontline Management consists of the Nurse Unit Manager(NUM) who is responsible for :-

- Effective operation of the unit on a daily basis
- Patients to receive safe and appropriate care
- Patient movement through the system safely and to enjoy a quality experience
- Patients and their carers to be satisfied with the care provided
- Staff to feel valued and to have the skills and resources to do their work
- Notifying facilities and teams to receive patients
- Patients, staff, carers and visitors safety during the process

- Resources to be used wisely and efficiently
- Provision of high quality care

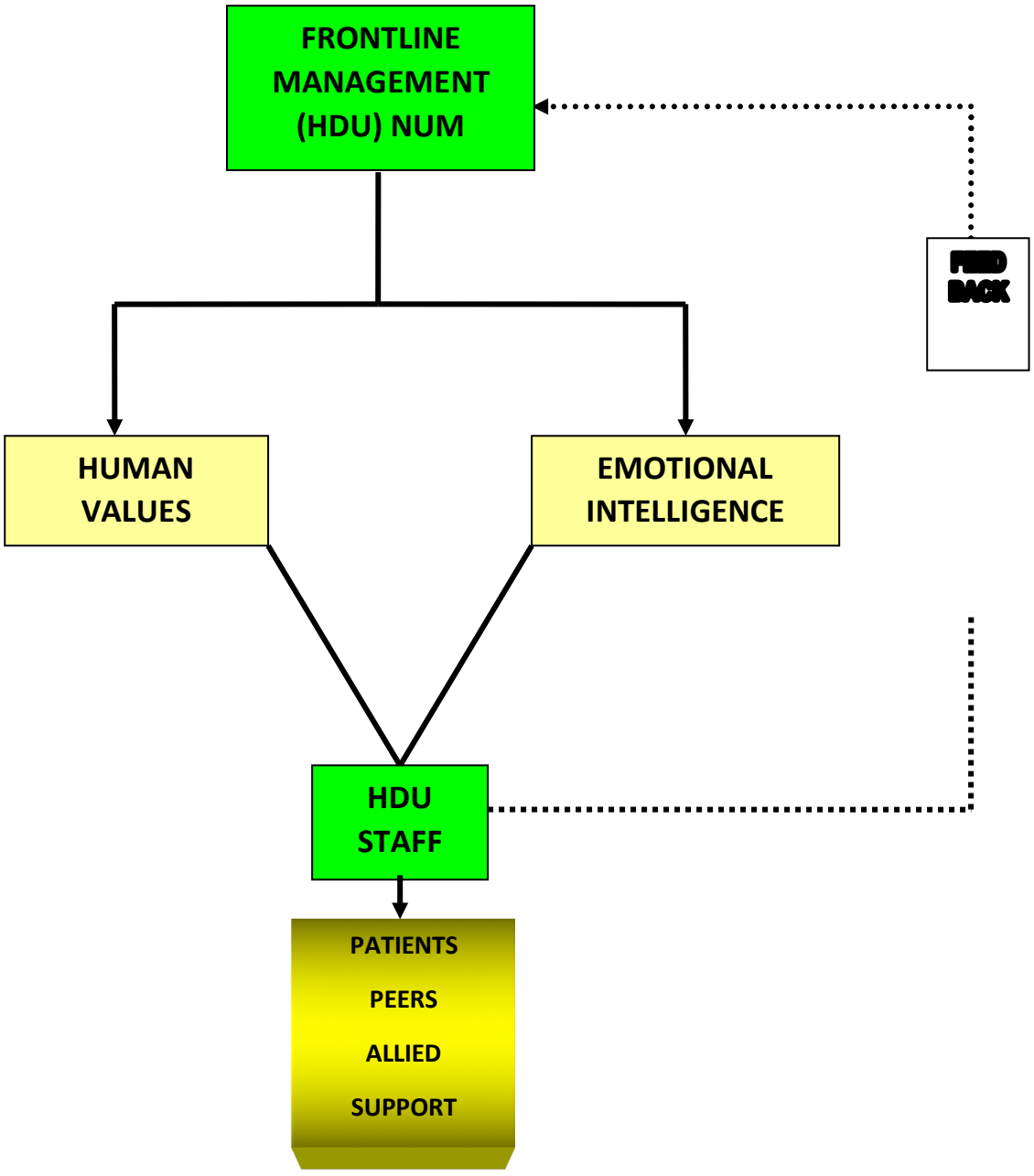


Diagram 7: Illustrating Introduction Human Values and Emotional Intelligence

The diagram above depicts the NUM introducing HV and EI to HDU staff. When the NUM is not rostered, Registered nurses are delegated the position of Team Leader with limited responsibilities. The nurses are selected from either ICU personnel or HDU personnel. HDU Nursing Staff consists of Registered Nurses, Enrolled Nurses, Junior Registered Nurses and a Clinical Nurse Specialist.

5.1.1 MICRO APPROACH: THE CASE STUDY

The scope of the research will be limited to a case study approach, selecting HDU staff members for the in depth study. Case study methods involve systematically gathering enough information about a particular person, social setting event or group to permit the researcher to effectively understand how the subject operates or functions (Berg 2004)

The research related directly to the NUM of the High Dependency Unit (HDU) having introduced Sathya Sai Education in Human Values Program(SSEHV) into the management process namely:

- Role modeling by being supportive, non judgmental, exhibiting confidence
- Human Values by practicing truth, love, peace, right action and non violence
- 3HV congruency between thought (Heads), word(Heart) and deed(Hand)
- Holistic approach with awareness of all levels of human personality
- Unity of all Faiths to accept differences and embrace similarities
- Divinity in all beings by creating a 'Photo Pet Corner' and fish tank
- Teaching Techniques:
    - Silent Sitting- 'Time Out' period to calm the mind thus attaining inner peace
    - Quotation- thought for the week posted at strategic points
    - Story-inspirational stories from all faiths weekly through group emails
    - Singing- In the form of relaxation music being played during 'rest periods'
    - Group Activities-fortnightly social meetings outside of work

5.1.2. HOLISTIC APPROACH UNDERTAKEN BY RESEARCHER (HDU NUM)

Altruistic Level: Expressing love in caring actions **(LOVE)**

Displayed love, care and empathy and became a role model in different spheres of the units activities. An opportunity to improve communication and develop trust by adopting an open door office policy for staff. Group email created and all upline information filtered to staff. Inspirational stories, personal development advice and value based quotation sent regularly to the group via email.

- *Staff over a period of time developed self awareness and self confidence and began reciprocating this Love to their fellow colleagues and patients.*
- *Staff were happier- sick leave reduced dramatically.*

- *Staff would visit the NUMs office at anytime to talk about personal and professional issues.*
- *Letters were pushed under the door if NUM unavailable.*
- *Staff stated that they enjoyed the inspirational emails and forwarded them to friends and family*
- *Undergraduate nurses enjoyed working in the HDU and made application to work in their post graduate year*
- *Four post graduate nurses moved on from HDU into the more acute areas of Critical Care*
- *By promoting compassion and better understanding three staff members overcame their sense of fear and apprehension. They were now active and responsive at meetings, making suggestions and giving their opinions.*
- *A Pet Corner was created where staff members photographs of their pets are displayed.*

Empathy Level: (an extension of altruism)- sense of identity with all beings
(NON VIOLENCE)

NUM encouraged unity amongst colleagues and other health professionals by celebrating birthdays, weddings and births. Each member of staff was treated as a unique being. Social meetings were organized fortnightly by staff members themselves at the local pub. A social director was selected from the team.

- *A cohesive team emerged- team approach to patient care therefore improving quality care for patients.*
- *Staff displayed a willingness to work overtime to help colleagues and provide high quality care for patients*
- *Supported a colleague though marital problems. Babysat children whilst couple attended counseling sessions-kinship extended outside work environment*
- *Changed behavior and attitude(tolerance) was observed during staff interaction with management, patients, visitors, support services and other health professionals. Letters and cards of appreciation poured in from families*
- *A prestigious event at the trots was attended by majority of HDU staff. A private 'box' was donated to the unit by a ex patient for this special event*
- *A sense of kinship, uplifting spirit of collaboration and respect for patients, unit resources and the work environment developed*
- *Reducing waste-unwanted paper cut up and used as message pads. Switching off lights that have been left on unnecessarily*.

Physical Level: To identify whether words and actions are trained to follow informed and unselfish ethical choices **(RIGHT ACTION)**

NUM together with staff approval set ground rules to cease swearing and inappropriate behavior in the unit. Healthy habits were encouraged for optimum physical and mental health eg balanced diet, pilates, attending gym sessions, yoga and meditation classes**.**

- *Encourage a high standard of fairness, ethics and consideration in everyday behavior including matching thought, word and deed. Staff observe the actions of the leader and personality traits and evidence suggests that a few staff members have adopted these traits*
- *Portraying the right attitude therefore the staff wanting to provide high quality nursing care for the patients*
- *staff at a later stage were informing patients returning from the operating theatre (in pain and groggy) that no inappropriate language/swearing was allowed in the unit. They were seen to encourage patients to use the words such as 'far out', 'sugar' instead of swear words.*
- *Reforming individuals to take care of their body, mind and heart. Discouraging smoking, reducing stress, encouraging good habits. Smoke breaks lessened – five staff out of the six staff ceased smoking during this two year period*
- *one staff member refused to administer a medication that was not properly prescribed to a patient despite ongoing pressure from the doctor. The staff member said to the doctor "We do the right thing in this unit"*
- *Mood swings amongst staff decreased steadily ever since one staff member was sent home by the NUM. Verified by comments from kitchen and laundry staff*
- *Providing opportunities in career development and promoting perseverance in completing studies and difficult tasks*
- *Ward meetings are based on the democratic style whereby each person's opinion is considered and open also to feedback. Decision making is usually by consensus where shared decision making prevailed therefore the occurrence of a shared responsibility therefore all staff have ownership over the decisions whether it is a clinical or social decision.*
- *Communication to the staff through emails, the communication book, ward meetings or by printed matter placed on the notice board.*
- *Computer pads displaying this Human Value sign and Unity of Faiths were a constant reminder to staff of the expectations of the NUM*

Emotional Level: To instill a sense of calm and equipoise thus handling any situation. Focused on resolving issues rather than reacting **(PEACE)**

Taught 'not to react' to negative circumstances by ignoring and not identifying with the situation or person. 'Thought for the day' posted daily on notice board. Soft, calm music played during rest periods. Team decision to conduct handover sessions and ward meetings in the corridor of the unit instead of within the unit.

- *If there was difficulty being experienced in controlling emotions staff were given the option of leaving the unit and to sit in the NUMs office for a '5min Timeout' period – silent sitting or reflection time*
- *Conflict resolved through arbitration as soon as possible to prevent escalation of problems. Self regulation, self reliance and self discipline enhanced their problem solving and decision making skills*
- *Patients rested quietly in unit whilst confidentiality maintained by staff*
- *Cordial relationships between patient support services eg wardspersons (previously very strained relationship)*
- *A critical care nurse from Argentina worked as a Volunteer in HDU. HDU staff displayed patience by supporting and helped with linguistic and cultural issues. Today this volunteer is a full time staff member in the Critical care unit*
- *Demonstrate patience by asking for the procedure to be repeated so that competencies can be achieved*
- *Encourage emotional tranquility and content state of mind by promoting concentration during important tasks.*
- *Encourage staff to do good deeds thereby promoting self satisfaction*
- *Sending value based stories, poems via emails on a regular basis to all HDU staff.*
- *Hanging up 'Thought of the Day' quotations eg. 'Anger cannot be subdued by anger, but with forbearance ' or 'You do not always have to oblige, but you can speak obliging' on a weekly basis.*
- *Staff seek out NUM with concerns whether personal or professional*
- *Staff speak freely and do not feel intimidated*

Intellectual Level: Encouraged the enquiring mind to acknowledge the importance of both rational methods of enquiry using clear reasoning and also intuitive, creative capability **(TRUTH)**

Unit meetings were conducted using democratic consultation with staff. The agenda was addressed, action undertaken and feedback given honestly and timely. This demonstration of harmony between thought, word and action developed trust and confidence for the HDU NUM.

- *opened the line of communication leading to more informed and wise decisions thus developing loyalty and honesty amongst individuals*
- *an open door policy whereby staff members could come in and discuss any personal and professional issues in confidentiality. This created trustworthiness between staff and NUM*
- *Staff felt that they contributed in the decision making processes therefore felt ownership of the unit*
- *Evidence based practice encouraged and implemented therefore best practice maintained*
- *Surgeons and anaesthetists refusing to operate on patients if a HDU bed was not available- staff were trusted to provide high quality care*
- *Policies and protocols of the unit followed diligently -staff member refused admission of a patient (did not meet admission criteria) despite pressure from upper management*
- *Demonstrated reliability and sincerity – issues brought up at meetings were followed through by action and results brought to the attention of staff.*

5.1.3 INTERACTIONS WITHIN HDU

Interaction between HDU staff and patients

- *When the staff care for one another they work well together and patients sense this and feel more at ease.*
- *Carry out physical, social and mental activities in a loving, controlled professional manner*
- *Have seen staff buy the newspaper for patients in the event of the patient not having any money*
- *Able to control their emotions with an irritating and annoying visitor*
- *A staff member baked a birthday cake for a patient who 'had no family'*

- *Staff are known to go to great lengths to provide comfort and satisfaction to patients - organized a special recliner from another area.*
- *Developing tolerance by showing love and understanding despite cultural differences*
- *Being sensitive to the needs of others-feeling others pain and help relieve their suffering*

Interaction between HDU staff and support staff

- *At the physical level right action manifests as doing the 'right thing'.*
- *Helpful to allied health staff with positioning of patients prior to commencement of treatment*
- *When cleaning services short staffed staff offer help*
- *A staff member walked to kitchen area for the correct meal when there was a mix up with the meals. The catering staff member very appreciative*
- *Teaching forgiveness by refraining from retaliation – well demonstrated with ward persons*
- *Action is prompted by conscience thus actions here are guided by morality and ethics*

5.1.4 RESEARCHER(NUM) USING THE 3HV CONCEPT IN HDU

The message below has been communicated to HDU Staff on many occasions.

The tongue may be considered as an ambassador of the Heart communicating the message, which originates from a Thought. The message should pass through 3 checkpoints before communicated to others by word Mouth (Shah 2004).

1st It should answer the question: ***Is it the Truth?*** If the answer is approved, the message should proceed to the second checkpoint
2nd ***Is it necessary?*** On receiving an affirmative answer, the message reaches the third checkpoint
3rd It scrutinizes the answer to the third question. ***Is it kind and pleasing?*** Upon a satisfactory reply, the tongue should utter the message.

Thus, harmony between thought(Head), word (Heart) and deeds (Hand) would be established.

This is no doubt an easy concept to understand however a difficult concept to put into practice. However two examples of the 3 HV concept had been put into practice in HDU:

- A staff member found every opportunity to criticize and ridicule another not considering the feelings of others. Had become increasingly unpopular with all health professionals. When confronted about this behavior it was stated that the remarks were said in jest. Some weak areas were discovered in the personality of the person. After 15 minute meeting the staff member left with a copy of the above piece(3HV) of advice. After some months many healthcare professionals had commented on the change in behavior in the staff member.

- A senior HDU staff member refused to admit a patient with an arterial line into HDU despite pressure from ICU Management and Hospital Bed Manager. The incident occurred after hours and the Admission policy for HDU stated that HDU does not accept patients with arterial lines. The HDU staff member stated that the staff in HDU had no education with regard to arterial monitoring besides a bed was available in ICU if admission urgently required. Upper Management would have allowed this admission into HDU had it not been for the integrity of the staff member. She later told other staff that she would never have stood up to her 'superiors' if this incident had occurred a year ago.

- During the performance review of one of the senior HDU staff it had been indicated that the staff member would meet the criteria for the Clinical Nurse Specialist (CNS) Status. The NUM of HDU promised the staff member assistance for this career development however the staff member had been declined this opportunity by upper management. After months of deliberation and perseverance overcoming the barriers the proposition was finally granted. Today the CNS is conducting various projects within the HDU

5.1.5 Researcher using EI in the HDU

- The researcher is able to identify the emotions in one self and is able to control impulses, recognises strengths and weakness and displays confidence when making important clinical decisions.

- The staff of HDU are also encouraged to show initiative, adaptability and optimism when confronted with the use of new equipment to improve clinical practice.

- It has also been stated elsewhere in this research, the researchers ability in sensing others emotions and understanding their perspective and taking in their concerns.
- Leave made available to staff member when experiencing personal problems. Constant guidance and motivation given to all staff when required.
- Conflict resolved as soon as possible to prevent escalation of problem. A personality clash occurred between a staff member and a wardsperson. Both personnel were called to attend a meeting regarding this matter, strategies were then initiated to resolve the conflict.
- Two enrolled nurses were persuaded to attend the medication course under much duress. However after a difficult six month period with attending classes and studying both had passed and were thankful to have been given this opportunity.
- There is evidence of the researcher initiating and managing change through consultation and feedback . Managers and staff from other wards comment about the cooperation and team spirit of the HDU staff.

5.1.6 BLOSSOMING RELATIONSHIPS *(post introduction of HV and EI)*

- Lollies, cakes and other goodies are brought to the unit by members of staff to share as recognition of their tireless efforts
- Freely displaying of hugs and kisses are not an unusual sight especially after individuals have returned to work after sick leave or annual leave, birthdays or any other happy occasion.
- Engagements, wedding, babies and graduations celebrated by having dinner at restaurant on suitable evening.
- Love encourages unselfishness and helpfulness. HDU staff supported two of the staff members through illness and operations. Visits to homes and the hospital
- Socializing outside work, celebrating birthdays, acknowledging achievements, new staff made to feel welcome, this demonstrated that cohesion of the group has a strong influence on job satisfaction.
- Support one another during studying and exams. Willing to teach one another,
- Very supportive to new and junior staff - providing learning material, use of computer, guiding through the routine tasks in the unit

- Staff working overtime to help cover the shift so as not to compromise patient care. Helping one another during unforeseen circumstances by swapping shifts. Selfless action in the spirit of service
- Staff report mishaps honestly and timely
- All staff began to communicate more freely and the loyalty for each other became evident. A negative rumor had been spreading throughout the ICU about a particular staff member. Another colleague investigated the rumor, found the source, confronted the issue and brought closure to the rumor.
- Creating a friendly environment and a family atmosphere has seen relationships blossom between co workers.
- Demonstration of empathy and support when personal problems were divulged by staff. An example is when a staff member had been on the verge of a divorce the roster was adjusted, leave granted and counseling was provided.
- Created harmony by connecting staff within the workplace.
- Demonstrating justice by being fair and judicious. In the case of overstaffing staff take turns to be sent to other wards.
- Demonstrating not to hurt anyone with thoughts, words or deeds – promote 'wishing for the good of all' at all times.
- Encouraged the quest for knowledge by sending staff members to relevant courses and in service. This promoted self confidence and self esteem amongst all staff.

5.2 MACRO APPROACH

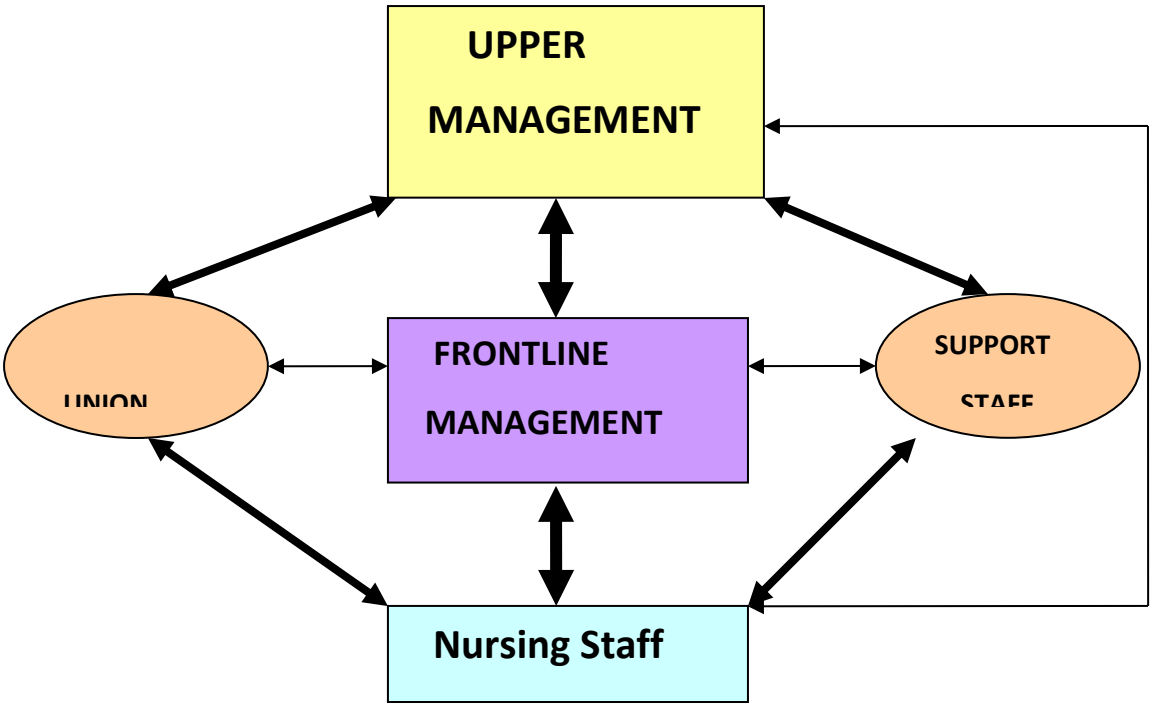


Diagram 8: Conceptual Model of the Exploratory Research

Upper Management consisted of the following levels of management:

Nurse Unit Manager 2, Nurse Manager 4, Divisional Service Manager, ICU Director, Business Manager, Operational Manager.

Nursing Staff refers to staff from HDU, Agency staff and Casual staff

Union refers to the Nurses Union. The Union is represented by an ICU union representative, hospital union representatives, Area Union coordinator, Industrial Relations Officers.

S**upport Staff** consist of Nurse Educators, Medical Officers, Workload Committee Members, Allied health, Support Services, OH & S officers and administrative support.

The research intends to explore the type of relationship that existed between the various participants. The core issue is whether Upper Management had been receptive to suggestions from the HDU NUM, the Union and Support Staff or are they dictatorial in their approach.

MACRO APPROACH: OBSERVATION:

An Analyses Of The Interaction Between Participants:-

Upper Management and Frontline Nurse Managers: Authoritarian in the leadership style. Filters information and preferring to make their own decisions. The listed problems were documented and delivered to the Executive Offices of the Department. There was also an opportunity to discuss these current issues at an executive level however this opportunity was declined. The problems remained unresolved and spread throughout the Department.

Upper Management and Nursing Staff: Partly dictatorial and authoritarian. Results gained short term however the quality, quantity and motivation of the team does not remain long term. Nursing staff not included in consultation process. Nurses feel intimidated and undervalued.

Upper Management and the Union: Provide Union with information however with minimal direction – Laissez-faire style. Relationship is strained. Make promises to the Union which were not fulfilled.

Upper Management and Support Staff: Able to influence OH & S in their decision making. Not able to influence Workload Committee. Authoritarian style exercising strong control.

HDU NUM and Nursing Staff: Democratic leadership style focusing on staff by encouraging participation and involvement in the decision making process. Able to understand group dynamics therefore active in directing new staff and coaching with the already established group.

HDU NUM and the Union: Open, honest, respectful relationship with union members. Willing to take risks to uphold principles relating to quality of care and safety.

HDU NUM and Support Staff: Cordial, professional relationship.
Communication with Head of support services through emails and formal meetings.

HDU Nursing Staff and Union: Capacity to trust and have total confidence in the union members. Nursing staff appear very relaxed when in contact with Union members.

HDU Nursing Staff and Support Staff: Respectful towards one another. Display of empathy and open-mindedness during interaction.

5.3 PRIMARY DATA

5.3.1 Performance Review

The staff in the High Dependency Unit (HDU) was selected using the convenience sample method. A convenience sampling method relies on available subjects, those who are close at hand or easily accessible (Berg 2004). A performance appraisal was undertaken through an interview process to determine whether any transformation had occurred in the staff attitude and perception as a consequence of implementing SSEHV and EI over the eighteen month period.

A Performance Review tool is usually used by the institution to review workplace performance. The staff are given feedback on their performance within their position, their achievements formally recognized and the problem areas acknowledged. This tool also identifies ways in which managers can improve the workplace performance. During this review managers are able to receive feedback from their staff member on communication skills, conflict resolution skills, professional development, personal conduct and team membership.

The performance review tool is given to each staff member two weeks prior to the interview dates to fill in as much information as possible. The researcher had taken this opportunity to attach two questions to the tool namely:

Do you believe that to some degree(on a scale o 1-5) **personal transformation** has occurred within you during the past 18 months?

If Yes, can you give me examples on what aspect of change occurred in your personal life.

Do you believe that to some degree(on a scale o 1-5) **professional transformation** has occurred during the past 18 months?

If Yes, can you give me examples on what aspect of change occurred in your professional life.

5.3.2 Results from Performance Review

The researcher conducted a Performance Review with 18 HDU (100%) staff members. All staff felt that some degree of transformation had occurred within themselves during this 18 month period both personally and professionally. Examples stated that approx:-

- 60% have now become more self aware of their emotions and are able to control their anger and impatience.
- 60% stated that they have changed their attitude towards problems that are beyond their control therefore less agitation
- 100% of staff said that they enjoy being part of the HDU team and pledge their loyalty to their peers
- 80% have the confidence and are not afraid of doing the 'right thing'
- 70% now understand each other in the team therefore they are more respectful to one another and at times will make sacrifices to make one another happy
- 100% enjoy the value based emails sent by NUM on a regular basis stating that it gives 'them peace of mind'
- 45% of spouses and partners have commented on how staff are now more happier at home and 'do not whinge as much' when leaving for work.
- 60% have learnt to deal with stressful situations more efficiently eg use relaxation techniques such as breathing exercises, silent sitting during 'Time out' period.

All staff are happy with the HDU NUM's leadership and management however they did feel with the NUM having a patient load and having to do non clinical work impacted even more on their workload. In spite of the situation, the NUM was still able to set an example and act in the role model capacity to the rest of the team. They however did comment on the NUM's belief in the practice of human values which had "rubbed off onto us". Other areas commented on were the NUM's ability in being trusting and approachable, caring about staff both personally and professionally and the calmness in handling difficult situations.

5.4 SECONDARY DATA

5.4.1 Direct Observation

Direct observation was conducted on upper managements interaction with staff to determine:

(1) whether staff were consulted in the decision making process,

(2) whether staff were encouraged to undertake professional development whether internally and externally
(3) the extent of union involvement
(4) if upper management supported frontline management in the clinical setting

The results from this observation were gathered from formal and informal meetings and correspondence/emails. No evidence was found indicating that upper management consulted with staff in the decision making processes.

5.4.2 Acknowledgements

1. A Doctor sent a letter to the NUM of HDU and ICU Management stating the admiration for the quality and attitude of the nurses working under difficult circumstances in the HDU and also comment about the NUM doing a great job with the staffs morale. Many doctors and consultants have a high regard for the HDU Unit and the staff. One consultant will operate on a patient only if an HDU bed is available. The same with anaesthetists who prefer the complicated cases return to HDU post operatively.

2. An article written in the editorial section of the local newspaper by a patient, who also happens to be the journalist, highlighting the difficulties experienced in the HDU and the commitment of the nurses.

3. Other ward staff including managers have asked the question: "How is that the staff in HDU work so well together and seem so close despite working under such unfavorable conditions?"

4. Multiple letters, cards and tokens were given to HDU in appreciation of the caring, hard working and professionalism of the HDU staff. One particular letter had been sent directly to the Premier of NSW, Mr Bob Carr.

5. Student and new graduate nurses requesting to work in HDU in the future stating there are numerous opportunities to pick up clinical skills and knowledge and more importantly a supportive team.

5.5 Implementation of Integrated Model

Traditional approaches to managing the workforce have been shown to be inadequate in optimizing successful recruitment and retention of staff. Therefore contemporary workforce management strategies can assist managers to address their workforce requirements now and for the future. If the findings of the proposed research proves significant then there is a possibility to develop and transform the character of the individuals by creating a balance in their body, mind, emotion and conscience.

INTEGRATED MODEL

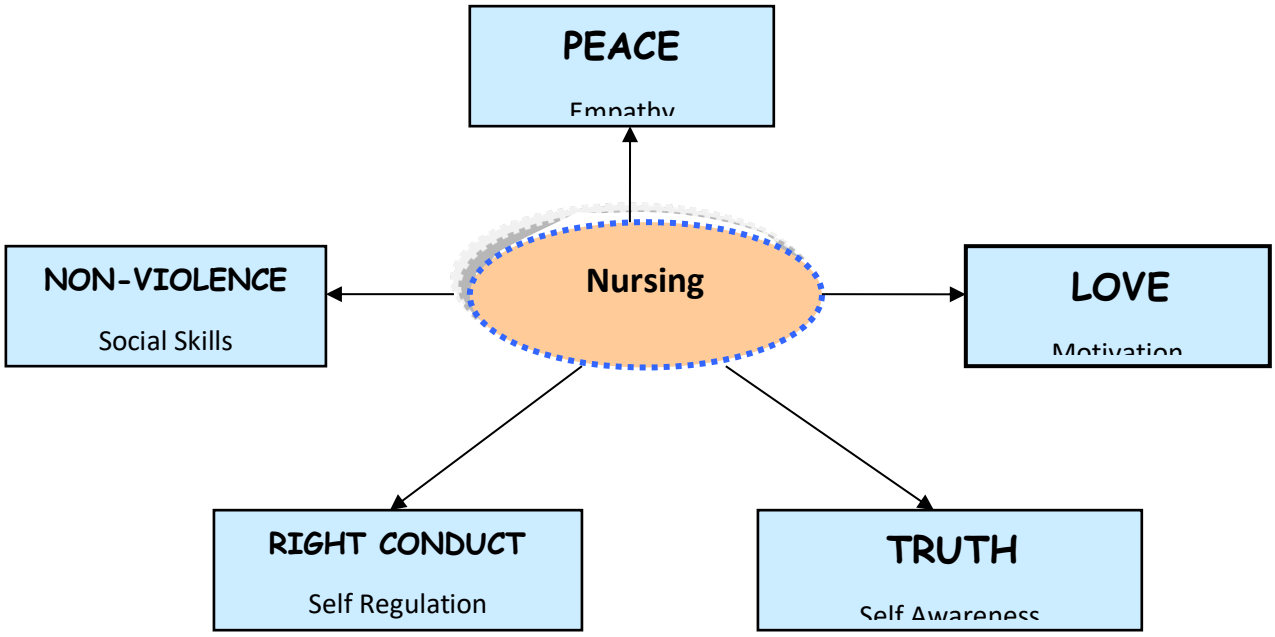


Diagram 9: Integrated Model Nursing Management and EI and HV

Conclusion

Values in the workplace implies a particular code of conduct such as equality, freedom, self respect and honesty; however this varied from person to person and not necessarily consistent from day to day. Therefore strategies for the different levels of character development were implemented by the NUM to establish a change in the group dynamics and to nurture the workplace environment.

The case study demonstrated that 100% of HDU staff members experienced personal and professional transformation over the eighteen month period. The interaction between the various health professionals highlighted positive behavioral changes within the HDU staff. They were certainly much happier and this was exhibited in the workplace performance.

Advice given by the founder of the SSEHV Program which has been shared with staff and has assisted in the transformation process are the following:

"Start early"
by focusing on your own inner development

"Drive slowly"
by sharing your insights with supportive people and creating a nurturing environment

"Arrive safely"
by continuing to build your confidence and strength, noticing how the quality of your work life is shifting, slowly but surely, week after week.

CHAPTER 6

RECOMMENDATIONS

Introduction

Curriculum designers have the task of developing educational strategies that promote stronger links between EI and rational intelligence. To address the quality of life, education must promote emotional, moral and spiritual growth along with professional development (Mitra 2003). It must provide insight into the nature of the human value system so that noble individuals are developed. Therefore the inclusion of the integrated model of Human Values and Emotional Intelligence would certainly be beneficial in improving the quality of life of health managers and undergraduate health professionals.

The first step in the process is to develop awareness, the second is to bring about inner transformation and finally to put them into practice. The inclusion of EI in the curriculum will empower students to manage situations that may be highly emotionally charged. If they are able to deal with their own feelings and emotions adequately, then they will certainly be able to deal with other situations in the future more confidently, competently and safely.

6.1 "HUMAN VALUES AT WORK PROGRAM" *(Highly Recommended)*

Human Values at Work has been developed by the Global Dharma Centre, in partnership with Dr. Peter Pruzan, professor emeritus at the Copenhagen Business School, and his wife, Kirsten Pruzan Mikkelsen, a journalist and former editor who worked for almost 30 years at *Det Berlingske Hus*, a major publishing house in Denmark.

It is a self-guided workbook programme that focuses on how you can work in accord with your own spiritual view of life and five human values that are found cross-culturally in all spiritual traditions: Truth, Righteousness, Peace, Love and Non-violence.

6.1.1 Program Design

This programme has been designed for you to take on your own and/or in a group setting. This is a self guided workbook obtained Online.

Available : http://www.globaldharma.org/hvw-home.htm.

The program focuses on how you can work in accord with your own spiritual view of life and the five human values that are found cross culturally in all spiritual traditions. The program draws

from spiritual texts found throughout the world, inspirational people and practical experiences of business people who are making spirituality the inner context for their work.

In addition, your expression of the Human Values can make a difference in many ways:

- Truthfulness fosters trust and honest communication
- Righteousness fosters high quality work
- Peace fosters wise decisions
- Love fosters service based on caring for others' well being
- Non-violence fosters win-win collaboration

6.1.2 Examples from Modules 1, 2, 3

Here is an example of various modules that can be adapted and used for the nursing context.

Introduction

Creating What You Want From This Programme

The Learning Opportunity

- To identify your own spiritual view of life from which you work
- To unfold your natural ability to express each Human Value
- To integrate what you think, say and do
- To make your work an arena for spiritual growth

Key Concepts

- Bringing out your own inner wisdom
- Taking charge of what you learn
- Learning in different ways
- Using the self-guided workbook
- Participating in a group

MODULE 1

You and Your Spirituality

Key Theme – *We are spiritual beings, first and foremost*

Purpose – To establish a foundation for the journey of making spirituality the inner context for your work

Key Concepts

- Recognising spiritual qualities in others
- Identifying your spiritual view of life
- Discovering creative solutions
- Developing Wonder Questions

- Building strengths
- Creating a *LiveWith* theme

MODULE 2

The Spiritual Basis of Human Values

Key Theme – *Spiritual Values are Human Values*

Purpose – To understand the spiritual essence of each Human Value and its cross cultural and individual expression

Key Concepts

- Defining the spiritual essence of the Human Values
- Expressing the Human Values crossculturally
- Expressing the Human Values individually
- Defining the spiritual basis of success
- Discovering your Human Value strengths

MODULE 3

Developing Spiritual Integrity

Key Theme – *Spiritual integrity is purity and unity of thought, word and deed*

Purpose – To purify and unify thought, word and deed as a consistent practice of spiritual integrity

Key Concepts

- Recognising purity
- Tuning in to your conscience
- Being a positive influence at work
- Having unity of thought, word and deed
- Putting what you've learned into practice

6.2 OTHER RECOMMENDED PROGRAMS

6.2.1 HEARTHMATH HEALTHCARE PROGRAM

HeartMath's research has shown when you learn how to intentionally shift to a positive emotion, heart rhythms immediately change. A shift in heart rhythms may not seem important but in fact it creates a favorable cascade of neural, hormonal and biochemical events that benefit the entire body. The stress-reducing effects are both immediate and long lasting. By practicing HeartMath tools and techniques you can learn how to create a shift in perception and feeling that can have a dynamic effect on your overall health.

The institution could organize for Hospital Programs to be initiated by Healthmath who offers:

- Staff Retention and Development Program
- One day Workshop for Stress management
- Leadership Development

6.2.2 EMOTIONAL INTELLIGENCE TRAINING PROGRAMS

The Optimal Process for Developing EI in Organizations

Once the healthcare worker understands the value of EI and how it can be developed within the organization a training program can be initiated. This program was developed by 'The Consortium for Research on Emotional Intelligence' and involves four basic phases namely:

- Preparation- Increase motivation through assessment and involvement
- Training- Involves building positive rapport between trainer and participants and other activities)
- Transfer and maintenance- Involves confronting the cures so that old habits do not resurface
- Evaluation- Conducting continual evolution of the processes and providing effective feedback (Freshman and Rubino 2002)

6.3 LIMITATIONS

A Case Study approach cannot be used to generalize about the nursing workforce and furthermore the small sample size. There could be bias in the research in that the NUM of HDU had conducted this research. The performance review tool could not be exposed due to confidentiality purposes

6.4 FUTURE RESEARCH

1. The study could be extended to other departments within the institution and also other institutions within the Area Health Service.

2. Future research can be undertaken to include other Healthcare Systems for example the Sathya Sai Healthcare System which firmly believes in blending technology and medical excellence with love and compassion. *Source:* Healthcare Management Express(2001)

6.5 CURRENT IMPLEMENTATION OF INTEGRATED MODEL

6.5.1 August 2007

As part of the Cert IV in Training and Assessment the Researcher delivered a Session on

" Promoting Human Values and Emotional Intelligence in the Workplace" as part of the topic Essential Management Skills. There were 15 managers in the group excluding the program facilitator and one observer. 8 managers were from the health sector, 2 from aviation, 2 from marine and 3 from steel companies. At the end of the session participants were able to:

- Define HV and EI
- Identify components of EI and link them to HV
- Acquire knowledge and skills to strengthen 'soft skills'
- Demonstrate a meditation technique
- Identify strategies to control anger

Feedback from the assessor and participants were very positive. Questions were answered confidently. Participants stated that they will use the information and skills at a personal level and will also apply some strategies in the workplace.

6.5.2 September 2007

An educational session was conducted in a Health Institution on 'Personal Development'. The participants consisted of 15 nursing staff (all levels), 3 activity officers, 1 social worker and 1 staff from the patient support services. At the end of the session participants were able to:

- Identify the difference between character and personality
- Identify the various levels of personality and relate this to HV
- Describe the 3 levels of consciousness
- List strategies to reprogram the mind 'negativity to positivity'
- Describe the 3HV concept (Head, Heart, Hands)
- Demonstrate a meditation technique

There was positive feedback from session from participants. Researcher will need to conduct repeated sessions for remaining staff members at a later date

CONCLUSION

The HDU has a common purpose through which its members develop mutual relationships for the achievement of the common goal and that is to deliver quality care effectively and efficiently to society. The staff are constantly reminded of this statement and have unselfishly committed themselves for this purpose. It has also been demonstrated that the cohesion of the group has a strong influence on job satisfaction among nurses. Reduced turnover of staff in HDU, increase in staff morale and increase in educational opportunities have been demonstrated to have improved. Over the eighteen month period only two staff had left the unit. One member moved interstate and the other felt the pressure of work affected her personal life.

From the evidence portrayed one cannot conclude that the adoption of integrated model of HV and EI by nursing management, does not positively influence the decision making process. One also cannot conclude that transformation did not occur in the behavioral character of the HDU staff. A healthcare leader who can be a role model by practicing HV and high EI will have the confidence to calm and strengthen the organization during difficult times thus stabilizing the workforce.

One is not condemned to be eternal slaves to our ill paced, seemingly unpredictable emotions or those of others. Basic skills related to handling emotions, settling disagreements peacefully and just plain getting along can be learnt or improved. One can develop human competencies such as self awareness, self control and empathy and the art of listening, resolving conflicts and cooperation. Not only is our ability at work and the quality of our life at home is at stake but more importantly the cohesion of society at large.

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