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Excellence in oncology nursing: Creating the vision and making it a reality

by Leslee J. Thompson & Holly Krol

Behold the future, it is coming whether we like it or not, and we had better be ready. Yes, we could ignore it, forget it, try to change it, resist it or simply respond to it. Or, we could design it according to the very shape, texture, style and image that we want it to be. Acting on George Bernard Shaw's maxim is good advice as we prepare for the future: "Get what you want, or get to like what you get".

Excellence is a value shared by many in oncology nursing today. It is something towards which many people strive, and is held out as the gold standard in all areas of practice, education, research and administration. Given the current stresses within our health care setting, however, just getting through the day can seem like a challenge. Thinking about the future and how to set the stage for achieving excellence requires dedicated time, planning, creativity and lots of dialogue among all members of the team or department that is involved. Building a work environment that truly fosters excellence can be an exciting process, however, one that infuses energy, growth and vitality into an organization.

This paper describes a "stepping into the future" program that was designed to help map out the future of nursing within the Toronto Bayview Regional Cancer Centre. The challenges in building an environment of excellence will be highlighted as will a model of leadership that can be used to help create the necessary energy within an organization to move it forward. Many of the program elements could be applied or adapted in other settings, as we do hope that others will learn from our experience and test out some of these ideas in their own work environment. A general discussion about the concept of excellence and change will preface the presentation of our model, as we found attention to these concepts extremely helpful in the development of our own work.

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Table One: Criteria for corporate excellence: The eight basic principles

1. A bias for action
2. Staying close to the customer
3. Autonomy and entrepreneurship
4. Productivity through people
5. Hands-on value driven
6. Stick to the knitting
7. Simple form, lean staff
8. Simultaneous loose-tight properties

Source: Peters & Waterman 1982

Excellence: The corporate perspective

The 1982 publication of the book *In Search of Excellence*² and its 1989 sequel *Passion for Excellence*³ focused in on what many people call common sense - or "a blinding flash of the obvious". However, if achieving excellence is nothing more than application of simple common sense, then why aren't more people doing it? Perhaps it is because the obvious is not really that obvious at all. Peters and Waterman proposed eight basic principles for creating corporate excellence (Table One). Examples of how these principles were

BOURSE DE CONFERENCE SCHERING: EXCELLENCE IN ONCOLOGY NURSING: A MODEL FOR CREATING THE VISION AND MAKING IT A REALITY

ABRÉGÉ

Nombreuses sont les infirmières en oncologie qui partagent de nos jours la même vision de leur environnement, un environnement qui favoriserait réellement l'excellence dans la pratique, l'éducation, les recherches et l'administration. Existera-t-il un jour? Comment y parviendrons-nous? Quels sont les "facteurs critiques" de réussite et les défis subtils qui accompagnent la construction d'un tel environnement? Que se passe-t-il une fois que l'on a rassemblé un personnel énergétique, innovateur et hautement qualifié? Cet article répond aux questions ci-dessus et à d'autres questions du même genre en se servant d'un modèle de leadership qui peut servir à créer, au sein de l'organisme, l'énergie nécessaire à le faire aller de l'avant. Les politiques de règlements, les hiérarchies administratives et "la gestion par objectifs" de la vieille école peuvent toutes bloquer la croissance des gens au sein de l'organisme.

Il faut utiliser une approche très différente pour encourager la croissance à partir des valeurs et de la vision et les résultats en valent bien la peine. Les auteures de l'article y décrivent leur propre programme intitulé "Stepping Into The Future" pour montrer comment on peut créer une vision au sein d'un département de nursing, développer cette vision et la transformer en plans d'action.

brought to life in different companies are detailed in both books, and the leadership styles of people who helped make it happen are profiled. Although the corporate environment is quite different than that of health care, there is certainly a lot we can learn by examining some of the strategies for building energy, productivity and client satisfaction.

The eighth principle, simultaneous loose-tight properties is, in our minds, one of the most fundamental components of excellence. Knowing when to apply the different approaches is often the key to success. In his classic article "Of boxes, bubbles and effective management", Hurst⁴ proposes the following. Organizations need to learn how to blend the highly structured, more traditional, task-oriented or "box like" approaches to doing things with the softer, more creative and process-oriented "bubble type" approach. Both are required, and both can be learned. Yes, some people are more inclined to that box-type, sequential thinking guided by left brain activity, and others to that lateral, right brain, more creative and exploratory thought process. These different ways of thinking obviously influence our approaches to things, and our interpretation of situations. Neither approach works really well on its own, all the time. We need to learn how to apply both, and when to do so. The two approaches can be applied simultaneously if you combine people in teams who complement one another's thinking. Similarly, each individual can learn to understand and use the opposite perspective as a way of enhancing his understanding of a situation. As Hurst points out, "Sometimes you have to find the bubble in the box and put the box in the bubble".

Assessing the environment for excellence

Metaphors are often useful in helping to describe a situation, and the image of a hurricane is one that seems to capture the whirlwind of activity and change sweeping through the lives of each and every one of us in health care today. Getting caught in the turbulence is easy, and finding a way out sometimes seems impossible. Many of us struggle to get on top of things, to have just one normal day, and to finally get a handle on things before they change again. But change may be the only constant we see for a while, and consequently we need to understand the dynamics of our environment so that we can read and understand the forces affecting it. We need to know where we should be best positioned so that we can capitalize on the energy within that hurricane, and use it to our advantage. A hurricane is unlike other general weather systems in that it is internally motivated to produce tremendous amounts of energy. The central sources of water and warmth cause winds and rain to revolve around a central core (the eye) of low pressure and calm. If the hurricane moves across the land away from its source, then it peters out and dissolves, because the "eye" of the hurricane is the focus around which everything else revolves. McNeil⁵ uses the hurricane metaphor and notes that:

Values and vision are to the organization what water and warmth are to hurricanes. They are the elements that leaders use to create energy. Once you lose touch with the vision and values, your organization's energy will dissipate and you'll gradually recede back into becoming part of the world's general weather pattern, reacting to the environment rather than having the capacity to select a direction all your own (pg. 51).

Understanding environmental trends is an important part of setting the direction for one's future. The external social, political and economic forces affecting the internal environment of the organization need to be identified. Naisbitt and Aburdene⁶ in their 1982 book *Megatrends*, described 10 trends that were shaping the 1980s. These included the shifts from centralization to decentralization, hierarchies to networking, industrial society to information society. We have seen some of the effects of these societal trends in health care agencies over the past few years, especially in relation to the shifts in organization structures and decision-making processes.

As we enter this new decade, Naisbitt and Aburdene⁷ have predicted another 10 trends that they believe will guide our steps into

Table Two: Megatrends for the 1990s

1. The booming global economy of the 1990s
2. A renaissance in the arts
3. The emergence of free market socialism
4. Global lifestyles and cultural nationalism
5. The privatization of the welfare state
6. The rise of the Pacific Rim
7. The decade of women in leadership
8. The age of biology
9. The religious revival of the new millennium
10. The triumph of the individual

Source: Naisbitt & Aburdene 1990.

the 21st century. (Table Two). Two of these have particular significance for nursing. First is the decade of women in leadership and secondly, the triumph of the individual. Given that "individuals today can leverage change far more effectively than most institutions" (p. 298), and that the collection of individuals in nursing is primarily composed of women, the 21st century should be an exciting period! A focus on individuality and what it means to be human is the very essence of oncology nursing, so we are well positioned to provide leadership as we move into the 1990s.

Baumgart and Larsen⁸ in their classic text *Canadian Nursing Faces The Future*, identify three things that are necessary for shaping the future of nursing; vision, conviction and will. Vision is that image of what you want the future to be, conviction is the personal belief that it will happen, and will is the translation of one's conviction from a private to a public forum. Having the will to stand up for what you believe takes confidence, courage and determination. Furthermore, the clearer that vision is, the easier it will be to communicate. The more it is communicated, the more support for it may be gained, and as a result of that increased support, more energy is generated.

Creating the vision

So where do you start? How is vision created, nurtured and then translated into plans of action? The first phase of our stepping into the future project was a data collection phase involving each member of the nursing department. The timing of this was right in that the nursing director was new, and needed to learn about the people and their environment. The organization, a moderately-sized ambulatory care facility, had been through a period of some very solid growth and development over the previous five years, and the stage was well set for re-examining the strengths, weaknesses and future directions. One of the early objectives was to release people from their "day-to-day" perspective of nursing practice, and help them think about things in a more global sense. Our first step was a departmental brainstorming session. An overhead was put up with the words "I have a dream..." across the top of the page. People were asked to let their imaginations and fantasies about the ideal world of nursing loose, and to share those with the group, with no judgments on the ideas allowed. At first people were a little hesitant to speak out, but after the first few ideas were brought forward, some really terrific notions came alive. Everything from being world leaders in oncology care to having someone screen our calls and getting to lunch on time was identified. A long "dream" list was generated and this helped us start to create a picture of what nursing at the TBRCC could look like.

People were then asked to fill out a special form which was creatively laid out on bright yellow coloured paper, asking them to identify the following:

- (1) things we do well here are...
- (2) things we would like to do better are...
- (3) words I would like to hear describe nursing at TBRCC...
- (4) if I were in control, my top priorities over the next three to five years would be...

Everyone had two weeks to work on their responses before the papers were returned. Then the nursing director met with small focus

groups and discussed how people felt filling out the sheets, and what their perspectives on the questions were in relation to the functional area they worked in i.e. the chemotherapy area. All group responses were recorded, and added to our data bank.

At the following staff meeting, the group then examined the philosophy statement, goals and objectives of the department and we evaluated whether the current reality reflected these. We had some preliminary discussion as to the role of a philosophy or vision within an organization, as we tried to turn this traditional "accreditation exercise" into a meaningful and useful opportunity to learn more about what was important to people.

Stepping into the future: Phase two

The second phase of our project was to review all of the raw data, interpret it, and figure out how to use it. Recognising that we needed "a centre of calm" away from the day-to-day turbulence to complete this next phase, the senior nursing team set off for a two-day retreat.

When we examined the data, we focused on identifying trends in people's response to the "yellow sheets", and grouped data accordingly. Responses from the "I have a dream" and the "words I'd like to hear describe nursing at TBRCC" were most interesting, as they each painted a similar picture or image of professional nursing practice. The "preferred future" of nursing at TBRCC was taking shape. We knew from the data that people wanted to be and be seen as leaders in oncology nursing who were knowledgeable, caring, creative, innovative, research based, and truly multidisciplinary. Areas of excellence were identified in the "things we do well here are..." list. These included patient assessment, patient teaching, implementation of new ideas, team work, and team support.

The issue identified most strongly in the "things we could do better are..." and in the "priorities over the next three to five years are..." was interdepartmental communication. People were consistently identifying this as an area for improvement that needed attention. Other items from the future priorities list were grouped into the areas of practice, education, research and administration. We learned that people wanted to focus on the development of accessible continuing education programs, strategies for coping with growth and change, research knowledge and leadership skills. Each of these developments could augment and strengthen the previously identified areas of excellence.

A framework for planning was taking shape. Priority issues were identified and some important questions were posed to help us figure out where to go from here. We will use the example of the "communication" issue to illustrate this process. Good communication was clearly a value shared by all members of our department, and yet it was also identified as an area of weakness. We asked ourselves the following series of questions: What would be happening within the department if communication was the way it should be i.e. open, honest, timely, relevant and complete? What is expected of people in various roles for fostering this type of communication? What types of programs or structures could be developed to help improve communication, and what type of leadership is required to make this happen? Finally, what other resources (people, time, equipment) are needed to put these plans into action?

One of the concrete plans we came up with was to develop a nursing newsletter. This was seen as an opportunity to have a creative vehicle for information transfer within our own department, the organization and with other institutions as well. Like all of the other plans proposed at the retreat, this was taken back to the staff to see if they wanted to see this happen, and if so, who wanted to be involved in it. There was

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Hydromorphone is approximately 8 times more potent on a milligram basis than morphine. In addition, hydromorphone is better absorbed orally than is morphine, the former approximately 20 to 25% as active orally as i.m. Hydromorphone has greater antitussive potency than codeine on a weight basis; however, its dependence liability is also greater than that of codeine.

After absorption hydromorphone is metabolized by the liver to the glucuronide conjugate which is then excreted in the urine.

INDICATIONS: DILAUDID is indicated for the relief of moderate to severe pain. DILAUDID HP used without dilution is indicated exclusively for the relief of severe pain in patients who require parenteral narcotics in doses higher than those usually needed. For the relief of severe pain, DILAUDID HP may also be diluted in most common large volume parenteral solutions as required and administered by i.v. infusion.

CONTRAINDICATIONS: Intracranial lesions associated with increased intracranial pressure, status asthmaticus, pulmonary edema. Known hypersensitivity to the drug.

PRECAUTIONS: May be habit-forming. Hydromorphone is a narcotic with an addiction liability similar to that of morphine and for this reason the same precautions should be taken in administering the drug as with morphine. As with all narcotics, hydromorphone should be used in early pregnancy only when expected benefits outweigh risks.

If necessary, hydromorphone may be given i.v. but the injection should be given very slowly. Rapid i.v. injection of narcotic analgesic agents, including hydromorphone, increases the possibility of adverse effects, such as hypotension and respiratory depression. As with any narcotic analgesic agent, the usual precautions should be observed and the possibility of respiratory depression should be kept in mind. If a patient shows signs of hypersensitivity to hydromorphone, the treatment must be stopped.

DILAUDID injection has been reported to be physically or chemically incompatible with solutions containing sodium bicarbonate and thiopental sodium.

Hydromorphone suppositories are not recommended for use in children.

ADVERSE EFFECTS: Nausea, vomiting, dizziness, somnolence, anorexia and constipation may occur. Hydromorphone seldom produces drowsiness. Pain at injection site, local tissue irritation and induration following s.c. injection, particularly when repeated in the same area.

OVERDOSAGE SYMPTOMS: Serious overdosage with hydromorphone may be characterized by respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. In severe overdosage, apnea, circulatory collapse, cardiac arrest and death may occur.

TREATMENT: If significant respiratory depression occurs, it may be antagonized by naloxone or levallorphan tartrate as recommended by the manufacturer. Employ other supportive measures as indicated.

DOSEAGE: Orally for adults, 2 to 4 mg every 4 to 6 hours as required. The usual adult parenteral dose for pain relief is 2 mg by s.c. or i.m. routes every 4 to 6 hours as necessary. If necessary, hydromorphone may be given i.v., but the injection should be given very slowly. Severe pain can be controlled with 3 to 4 mg every 4 to 6 hours as necessary. For post-operative relief of pain, early ambulation is encouraged because of the minimal sedative effect of hydromorphone. Rectal suppositories (3 mg) provide long-lasting relief and are especially useful at night. The oral liquid may be diluted in fruit juice or other beverage, if desired. Continuous subcutaneous infusions of DILAUDID HP have been shown to be well tolerated.

DILAUDID HP used without dilution is not to be given to patients who are not already receiving large doses of narcotics. If the patient is being changed from regular DILAUDID to DILAUDID HP, similar doses would be used. If DILAUDID-HP is substituted for a different narcotic analgesic, the following equivalency table should be used.

Analgesic Non-proprietary (trade) name	IM or SC administration	
	Dose, mg equivalent to 10 mg of IM morphine †	Duration compared with morphine
Morphine sulfate	10	Same
Papaveretum	20	Same
Hydromorphone hydrochloride (DILAUDID)	1.3	Slightly shorter
Oxymorphone hydrochloride	1.1	Slightly shorter
Nalbuphine hydrochloride	12	Same
Heroin, diacetylmorphine hydrochloride	4-5	Slightly shorter
Levorphanol tartrate	2.3	Longer
Butorphanol tartrate (NA in Canada)	1.5-2.5	Same
Pentazocine lactate or hydrochloride	60	Same
Meperidine (pethidine) hydrochloride	80	Shorter
Anileridine	25	Same
Methadone hydrochloride	10	Longer

Adapted from references 1 and 2 below. † In terms of the area under the analgesic time-effect curve.

AVAILABILITY:

Tablets: Each tablet contains hydromorphone HCl 1 mg (green), 2 mg (orange), 4 mg (yellow) or 8 mg (white, scored, triangular). Bottles of 100 tablets.

Oral Liquid: Each mL of unflavoured (clear) alcohol-free syrupy liquid contains hydromorphone hydrochloride 1 mg. Sucrose: 0.5 g/mL. Energy: 8.4 kJ (2 kcal)/mL. Amber glass bottles of 450 mL.

Suppositories: Each suppository contains hydromorphone HCl 3 mg in a cocoa butter base with 1% colloidal silica. Boxes of 6 suppositories.

Ampoules: Each mL of sterile solution contains: hydromorphone HCl 2 mg, sodium citrate 2 mg, citric acid 2 mg and no preservatives. Available in 1 mL clear ampoules, boxes of 25.

DILAUDID-HP ampoules contain 10 mg hydromorphone hydrochloride per mL with 0.2% sodium citrate and 0.2% citric acid solution. No added preservative. Note: DILAUDID HP ampoules are amber in colour with a distinctive identification colour band. Ampoules of 1 mL (violet band) and 5 mL (peach band). Boxes of 10 ampoules.

WARNING: DILAUDID HP is highly concentrated and should be used undiluted only in narcotic-tolerant patients. Do not confuse with the standard strength of DILAUDID; overdose and death could result.

Product Monograph available upon request.

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considerable support for the idea, and to build more energy about participating in its development we held a "name the newsletter" contest, complete with a prize and awards celebration! Volunteers came forward, and our first issue of the "Primary Nurseletter" was launched three months later.

Phase three: The transition phase

The next phase of the stepping into the future project was probably the most important. It began when we returned from the retreat and communicated our work to the staff. The process of how we examined the data they had given us was shared, and the thinking that led up to our proposals for action was described. Excellence was put forward as the hallmark for all project planning, and that framework was validated by the staff. We were all wary of setting standards of excellence for ourselves that seemed unrealistic or unmanageable in the current climate. By the same token, we did not want to compromise on our vision of the future. At this stage of our planning, it was the affirmation of our general direction that was most important, and although we knew that it might take us a while to get where we wanted to go, we still wanted to get there!

We also worked hard to link current strengths with the opportunities for development that we were proposing. People needed to feel as if we were building on the existing foundation, not demolishing and rebuilding something, or simply repackaging things. There is nothing more frustrating than to feel as if one is beginning a "new" project that is simply a revised version of something that had been tried unsuccessfully in the past. It was also very important to propose the "new initiatives" as an integrated package. Again, it is very frustrating for people to feel as if their attention and energy is being pulled in 50 different directions. There must be some sort of interconnection among the parts or, like the hurricane, ideas will dissolve and peter out.

One of the other issues that is important to recognize in this transition phase is that the people who have been away immersed in all of these wonderful plans and ideas for two whole days have had a lot of time to get used to different ways of thinking. They have worked through their own feelings of initial ambivalence, being overwhelmed and, then, very excited about "getting on with things". The staff, however, are hearing all of this for the first time when you get back, and need the chance to reflect, adjust, question, and then get on line themselves. As we learned, you can't expect a swell of excitement right away, but you can gradually build support by providing lots of opportunity for dialogue. We used a strategy called "spotlight on success". With this approach, we tried to highlight everything we were doing well as we moved along, and celebrated the steps we were taking along the way. The launching of the newsletter, our new ET (Education in Transit) Program, our full department development proposal, and the securing of additional resources so that we could meet our defined goals, were all profiled at departmental and unit based staff meetings. The informal communication network was also used to its full advantage so that the achievements we were making were visible on a broader scale.

Evolution, not revolution, is the pace of change we set for ourselves. Sometimes, however, we lapse into a flurry of activity, and other times we feel as if we are moving nowhere at all. The vision of what we were setting out to do in the first place is important to revisit on a regular basis. The vision, and the leaders helping to keep it alive,

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must be visible as much as possible. This can be a challenge at the best of times, however, its importance should never be underestimated. Keeping a handle on people's response to the new directions, and on how people are feeling as we move forward, is just as important or even more so than the outcome or the achievement itself. Think about what signals you are sending off in relation to that process; people need to feel some consistency with the message and the methods. If there is a sense that one thing is being advocated and another exemplified, then energy can quickly dissolve.

Another leadership strategy for building energy in this transition phase is to promote teamwork as much as possible. Simply creating committee structures will not achieve this end, however. Energy comes from the positive dynamics among group members, and the process of working through a challenge together. By paying some attention to the different box- and bubble-like characteristics of people, and putting work groups together accordingly, there is even higher potential for productive and positive team work to occur. The paths of communication and decision-making should be clear to the team, however, so that ideas can be processed in a timely fashion, and energy is not lost on "getting things through the system". With the involvement of as many staff members as possible in working groups, committees and general discussion forums, ownership for the new direction is fostered. One of the interesting things about our work environment is that it is characterized by a large number of highly experienced oncology nurses, many of whom are, and are seen as leaders within their own subspecialty areas. With our stepping into the future program we are offering opportunities for these people to share that expertise in a way that can benefit the whole department, and hence the impact of their expertise is broadened.

Stepping into the future: The sequel

Over the past year, we have all been working hard to advance our movement toward that vision of excellence. Many of the resources that we identified as necessary for moving forward have been secured, and hence there has been a lot of learning and adjustment to new roles and responsibilities that various people have assumed. The people are now in place, and the time has come for more focused operational planning. We are in the midst of the second cycle of our departmental development which we have called: Stepping into the Future: The Sequel. We are checking to see where we are at and how we are feeling. Then we can reaffirm our direction and develop specific project plans so the individual components of our vision could come alive. Goals and objectives to help guide our movement into the future are being set. We know that the steps we are choosing along the way may change, given different circumstances within the organization. However, our commitment to the direction we are taking is strong.

A colleague sent us a greeting card recently which said "Just when you get it all figured out...somebody changes the rules". Well, this time WE are the ones changing the rules, and making things happen. Our vision is becoming our reality. Yours can too.

Acknowledgements

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