Running Head: Prehab

Prehabilitation Program:

Leadership Insights Into The Planning Process

By

Ann Reichert

A practicum project submitted to the Faculty of Graduate Studies

in partial fulfillment of the requirements for the degree

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MASTER OF NURSING

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Abstract

Program planning is an essential part of nursing administration. In a time of rapid change within healthcare, this planning includes an understanding of change management. Strong leadership skills are a requirement to engage others and guide actions that will meet the goals of the new program.

One of the recent challenges for health care administration was to develop strategies that optimize care for patients on the lengthy waitlist for hip and knee replacement surgery. There are currently ongoing efforts to reduce wait times and improve accessibility for clients requiring surgery for advanced arthritis of the hip and knee. However, because of the lengthy wait times and the uniqueness of the individuals waiting for hip and knee replacement surgery, leaders in healthcare realized the need to also focus on ways to transform the current structure of care provision prior to joint replacement surgery. With the goal of optimizing physical functioning and improving quality of life both prior to and following surgery, the Prehab Program was developed to transform health care for clients awaiting lower extremity joint replacement.

The purpose of this clinical practicum was to gain insight into leadership through participating in the planning process of the Prehab Program. This included attendance at regular meetings of the interdisciplinary Prehab Program Steering Committee over a nine month period. In the role of participant observer, there was opportunity to participate in the planning process as well as observe, and later, reflect upon, the leadership required in the creation of a new program.

The Universal Dynamics of Transformation (UDT) model served as the framework for this learning experience. The model considers adaptation and

transformation within the context of the concepts of chaos, loss, new rules, new work, and new script, as well as the driving forces of socio-political, economic, and technical factors. The conceptual framework was utilized in the context of the clinical and administrative challenges associated with transforming health care for a specific sector, namely individuals awaiting hip and knee replacement surgery.

In planning the Prehab Program, a sound knowledge of the business of healthcare, as well as the competencies of leadership was required. This included an understanding of the socio-political, technical, and economic driving forces and attention to their impact on the planning process. The leaders effectively communicated their vision of the future for clients requiring hip and knee joint replacement surgery, and brought energy and commitment to the Prehab Program planning process. In order to create energy within the team, losses were acknowledged and, enthusiasm regarding the new vision was created. This required looking at the planning process, not as an event, but rather a journey that involved accountability, as well as continued learning and flexibility. In order to travel this journey, it was essential that leaders engaged others in moving across the landscape of a preferred and optimistic future for joint replacement clients.

The participant observation experience with the planning of a Prehab Program provided an opportunity to participate in the evolution of a new program and experience the relevance of strong leadership in change management. Using the UDT model as the theoretical foundation and the literature to provide the evidence base, insight was gleaned into leadership techniques that enhance the program planning process.

Chapter 1: Statement of the Problem

According to a report by the Canadian Institute of Health Information (CIHI, 2005) "Canadians wait too long for many scheduled health care services, with none being more notable than the long wait times for joint replacement surgery" (Noseworthy et al., 2005, p. 2). Hence, a major challenge for health care administrators is to develop strategies to optimize the care for these individuals. Accordingly, there are two priorities which require simultaneous consideration. First, it is important to focus on optimizing the quality of life for individuals on the waitlist for joint replacement surgery. Second, acceptable benchmarks must be established and wait times must be reduced to meet these benchmarks.

There are currently ongoing efforts to reduce wait times and improve accessibility for clients requiring surgery for advanced arthritis of the hip and knee. However, because of the particularly lengthy wait times and the uniqueness of the individuals waiting for hip and knee replacement surgery, leaders in health care also realize the need to focus on ways to transform the current structure of care provision prior to joint replacement surgery. With the goal of optimizing physical functioning and improving quality of life both prior to and following surgery, the Prehabilitation (Prehab) Program will transform health care for clients awaiting lower extremity joint replacement. This interdisciplinary program will work with clients to stabilize medical issues, maximize muscular strength, improve joint function, and also encourage weight loss and smoking cessation.

The purpose of this clinical practicum was to gain knowledge and insight into the program planning process, from a leadership perspective. To this end, I immersed myself as a participant observer in the development of the Prehab Program. This report is a synopsis of this learning experience.

Background

The primary objective of Canadian health care policy is to protect, promote, and restore the physical and mental well being of the residents of Canada (Canada Health Act Annual Report, 2001). This objective is fundamental to program planning, in general, and in planning the Prehab Program for joint replacement clients, in particular. The current approach to waitlist management of hip and knee joint replacement clients does not address the "protection and promotion" aspect of physical and mental wellness. Rather the focus is on the restoration of health, or more specifically, getting the surgical procedure completed. The focus of care for this client population needs to be broadened to address, not only accessibility to the operative procedure, but also the protection and promotion of the current health status of the individual in need of a lower extremity joint replacement. According to the Romanow Report (2002), health and wellness is not "simply a responsibility of the state, but something we must work towards, as individuals, families, and communities, and as a nation" (p. 5). The individual, family, community, and the state must be mobilized to work collaboratively in order to achieve the goal of health and well-being for all citizens.

There are several reasons why Canadians must become more accountable for maintaining their health. Canada is faced with an aging population. As the population ages, there will be an increased need for protection, promotion, and restoration of both

mental and physical health. The number of Manitobans aged 65 and older is expected to increase by 43% over the next 20 years. In 2021, it is expected that one-third of Manitobans will be 55 years or older (Manitoba Council on Aging, 2004). In North America, an aging population tends to translate into health cost concerns (Humber & Almeder, 2003). The social, economic, health, and political implications associated with rapid change in a population's age structure are profound. Specific to this project, it is predicted that 57% of Americans will be affected by arthritis in 2020, as compared with 18.2% in 1990 (Walker & Helewa, 2004). The prevalence of arthritis is two and a half times greater than heart disease and more than six times greater than cancer (British Columbia Orthopedic Association, 2004). The incidence of joint deterioration increases with age. Over time, many individuals with arthritis of the knee and hip have disease progression to the extent that a joint replacement is indicated. The average age of clients on the University of Manitoba Joint Replacement Group (UMJRG) knee and hip replacement waitlist is 66.8 years (Bohm, 2004). Hence, the demand for orthopedic care associated with joint disease is exploding.

Hip and knee replacement surgeries are two of the most common elective surgical procedures. This type of surgery is a cost effective option for clients suffering from pain and functional impairment related to chronic arthritis conditions (Bozic, Saleh, Rosenberg, & Rubash, 2004). The effectiveness of hip and knee replacement is well documented (Hawker et al., 1998; Jones, Voaklander, Johnston, & Suarez-Almazor, 2000; Laupacis et al., 1993). Low complication rates, improved outcomes, and an aging population have resulted in an 80% increase in lower extremity joint replacements in Manitoba over the past 7 years (Bohm, 2004). This, in part, explains why wait times for

hip and knee replacement surgery are lengthy. Arthroplasty accounts for one-fifth of all long wait outpatients and a third of long wait inpatients (Yates, 2001). Median waiting times, from assessment by a specialist to surgery, range from 11 to 37 weeks across Canada. There are some clients who are outliers and their wait times are longer. In Manitoba, in 2006 there were 3000 people on the waitlist for joint replacement surgery, with an average wait time of 41 weeks. There were approximately 180 arthroplasty procedures performed monthly, while approximately 200 clients were added to the waitlist each month (Sawchuk, 2006). The CIHI data (2004) has shown a compounded yearly increase in arthroplasty volumes since 1994/95. Despite this increased volume of surgery, waitlists between 1999/2000 and 2001/2002 continued to grow at a rate of 8.8% per year. Unfortunately, "the specialty is not amenable to quick fixes" (Yates, 2001, p. 29).

Waitlists are a constant source of public distress and political anxiety. Hence the political interest in waitlists is high. The new Federal Conservative government has identified wait times for hip and knee replacement surgery as one of their five top priorities. Newspaper headlines such as 'Line ups reaching alarming lengths' (Rabson, 2005) and 'System flaws hurt people and society' (West, 2005) represent how emotionally charged this issue has become. For many individuals, this waiting period, as recently described in a Winnipeg Free Press editorial, "is a time of being sentenced to house arrest and punishing pain" (West, 2004, p. A15). Romanow (2002) referred to waitlists as being "a preoccupation for healthcare providers as well as Canadians" (p. 5). Dr. A.J. Burak, the president of the British Columbia Medical Association, referred to waitlists as the "litmus test of whether or not our healthcare system is working" (Harris,

2004, p. 41). While establishing benchmarks and reducing the waitlist is a priority for health care administrators, limiting the waits for joint replacement surgery to less than 6 months is not immediately achievable.

During the prolonged period of waiting, joint dysfunction and pain may increase, resulting in an overall deterioration of functional capacity and quality of life. There is evidence indicating that poor pre-operative functional health status is associated with poor post-operative functional health status (Holtzman, Saleh, & Kane, 2002; Ostendorf et al., 2004). According to the Noseworthy Report (2005), pre-operative health status is a significant predictor of health outcomes; individuals with worse pre-operative pain and function tended to have worse post-operative pain and function. There is also evidence that long waits (i.e. >12 months) result in poorer post-operative outcomes after surgery (Noseworthy et al, 2005). A Canadian study published by Mahon and Associates (2002) reported that clients who wait longer than 6 months for their elective total hip arthroplasty experience increased pain and clinically significant losses in mobility and health related to quality of life during the wait. Therefore, a creative alternative to the 'sit and wait' approach to the care of clients on the waitlist is required.

Wait times also have a negative effect on the economy in terms of lost productivity while clients wait. Eighty percent of working age patients referred to the UMJRG for hip replacement surgery are still in the workforce and nearly 25% of these patients report being off work secondary to their hip condition (Bohm, 2006). Therefore, there is sound rationale for a parallel process of care to protect and promote both physical and mental health during this time.

There are also many bottlenecks within the health care system, which contribute to the long waitlist. Hospital lengths of stay (LOS) need to be reduced in order to increase bed capacity for postoperative clients. Manitoba's average LOS is longer than that of other provinces (Sale, 2006). As well, there is a need for more fellowship trained arthroplasty surgeons. Manitoba has a high rate of joint revision surgery. In revision surgery, some or all of the original joint replacement components are removed and replaced with new ones. Revision surgery uses resources and therefore limits the number of primary joint surgeries that can be slated. Revisions account for 16.5% of total hip arthroplasty and 9.2% of total knee arthroplasty in Manitoba. This is higher than the national average of 11.5% (Bohm, 2006).

Politicians and health care leaders have been challenged to find a solution to the waitlist problem. In Canada, the Alberta Bone and Joint Institute recently initiated a central assessment clinic in which a multidisciplinary team ensures clients are in the best physical and mental condition before surgery. The Institute has found that the program greatly reduces the number of surgery cancellations, and post-operative complications. There are also better outcomes for the clients, including shorter length of hospital stay, thereby increasing the client throughput and shortening the waitlist (Kuyumcu, 2006).

The development of a Prehabilitation or 'Prehab' Program for clients on the waitlist for knee and hip replacement surgery is consistent with the health protection, promotion, and restoration objectives of the Canada Health Act. Waiting times place a huge burden on the health of clients. A Prehab Program with education, exercise, nutritional counseling, and emotional support could optimize the waiting period for knee and hip joint replacement surgery and relieve some of the bottlenecks by reducing the

recovery period and associated stay in hospital. The waiting period could be converted from a 'sit and wait' time to an opportunity to optimize one's overall health in preparation for surgery. Clients with increased muscular strength will rehabilitate more quickly and will have shorter length of hospital stays. Weight loss can also impact the longevity of the new joint and subsequently reduce the revision rates. An active fifty year old male will wear out his total knee arthroplasty faster if he is 225 pounds than if he is 175 pounds. Optimizing the time on the waitlist may ameliorate the 'lineups,' 'system hurting people,' 'pre-occupation,' and the 'litmus test' mentality that currently exists. This would also be consistent with the recommendation of Mike Harris, ex-premier of Ontario, who suggested the best way to manage waitlists would be to have public education about how to get and stay healthy (Harris, 2004).

Research based evidence supports the contention that participation in pre-operative education, counseling, and physical conditioning programs has a positive impact on post-operative complications and LOS (Crowe & Henderson, 2003). Gilbey et al. (2003) concluded that an 8 week exercise program improved strength, reduced stiffness, and improved quality of life for clients with hip disease. The research literature supports that education results in less preoperative anxiety and fear and can decrease postoperative pain (Johansson, Hupli, & Salantera, 2002; McGregor, Rylands, Owen, Dore, & Hughes, 2004; Sjoling, Nordahl, Olofsson, & Asplung, 2003). As well, Hough, Crosat, and Nye (1991) concluded that client education improved outcomes such as fewer hip dislocations, less return calls to surgeons, less medication use, and earlier ability to ambulate postoperatively.

It has been said, "We are all faced with a series of great opportunities – brilliantly disguised as unsolvable problems." The development of the Prehab Program presents an opportunity to learn about program planning and change management. The administration literature discusses how the significant change that business, as well as health care organizations must face in order to survive, not to mention prosper, can be quite overwhelming. Kotter (2005), a guru in change management, stated that "the trend towards rapid change has grown tremendously in the past two decades, a trend which will likely continue, and demand more of future leaders" (p. 5). Samuel (2001) refers to revolutionary times requiring revolutionary solutions and breakthrough results. Kouzes and Posner (2002) claim that the leadership challenge is to learn how to mobilize others to want to get extraordinary things done.

Purpose of this Practicum

The purpose of this practicum was to gain knowledge and insight into the program planning process from a leadership perspective. This included the management of change. As a participant observer, the development of a new comprehensive, interdisciplinary Prehab Program of assessment and intervention for people awaiting hip and knee replacement surgery was synthesized.

Three goals related to health care administration were identified for this practicum.

1. To describe the evolution (or development) of the Prehab Program in terms of a change/leadership model.
2. To review the existing evidence regarding the role of leaders in guiding change.

3. To observe the leadership techniques used in the development of the Prehab Program and determine how they did or did not concur within the model and/or the existing evidence.

Thus, this practicum provided the opportunity to apply a broad leadership framework to the context of the clinical and administrative challenges of transforming health care for a specific patient population. In this practicum, that sector included individuals with advanced hip and knee arthritis who were awaiting joint replacement surgery.

The unfolding of the Prehab Program was a change within health care delivery and provided a learning opportunity regarding the planning of a program in response to external driving forces in a time of chaos. Losses had to be acknowledged. New rules, work, and scripts were established. This transition and adaptation to a new plan of care for clients awaiting joint-replacement surgery can be compared with experiences described in the management literature. These comparisons assisted in drawing conclusions about effective leadership in program planning. Considering the rapidly changing health care environment, the experience and knowledge gained in planning the Prehab Program can be transferred and applied to new projects that will present in the future.

Chapter 2: Conceptual Framework

Polit and Hungler (1983) define a conceptual framework as an "interrelation of concepts or abstractions that are assembled together in some rational scheme by virtue of their relevance in a common theme" (p. 638). Models are developed to aid our understanding of phenomena, to direct research, and ultimately, to guide practice. They are designed to show the factors and processes involved in the phenomena being investigated in order to reduce conceptual abstraction. The Prehab Project can use the model as a map to provide guidance and direction to all aspects of the implementation process (Hauser, 1980). Models assist in the organization of collected data, as well as analytical techniques. In a time of rapid change in health care, a model can provide the basis for viewing the entire landscape in order to develop a workable vision of the future.

Several models were examined as a potential framework to provide organizational structure for this clinical practicum project. These included Horak's (1997) Model for Quality Based Strategic Planning (see Appendix A), Lewin's Model of Change (Marrow, 1969), Kotter's (1996) Organizational Transformation Model, and the Universal Dynamics of Transformation (UDT) Model (see Figure 1) by Tim Porter-O'Grady and Kathy Malloch. Horak's model was based on organizational development concepts such as assessment, planning, implementation, and evaluation. This model was more linear with defined action plans, timeframes for completion, and internal benchmarks. The Lewin and Kotter models align with the UDT Model, but are less specific to health care. Lewin's 3 step change framework of unfreezing, moving, and refreezing refers to

"locking in new behaviours in the new state." This suggests that change is a one time event and permanent (Marrow, 1969). The Kotter (1996) organizational model is an eight step managerial elaboration of the Lewin model with the first four steps paralleling the unfreezing stage, the next three steps introducing change, and the final step, refreezing, or 'locking in' the change.

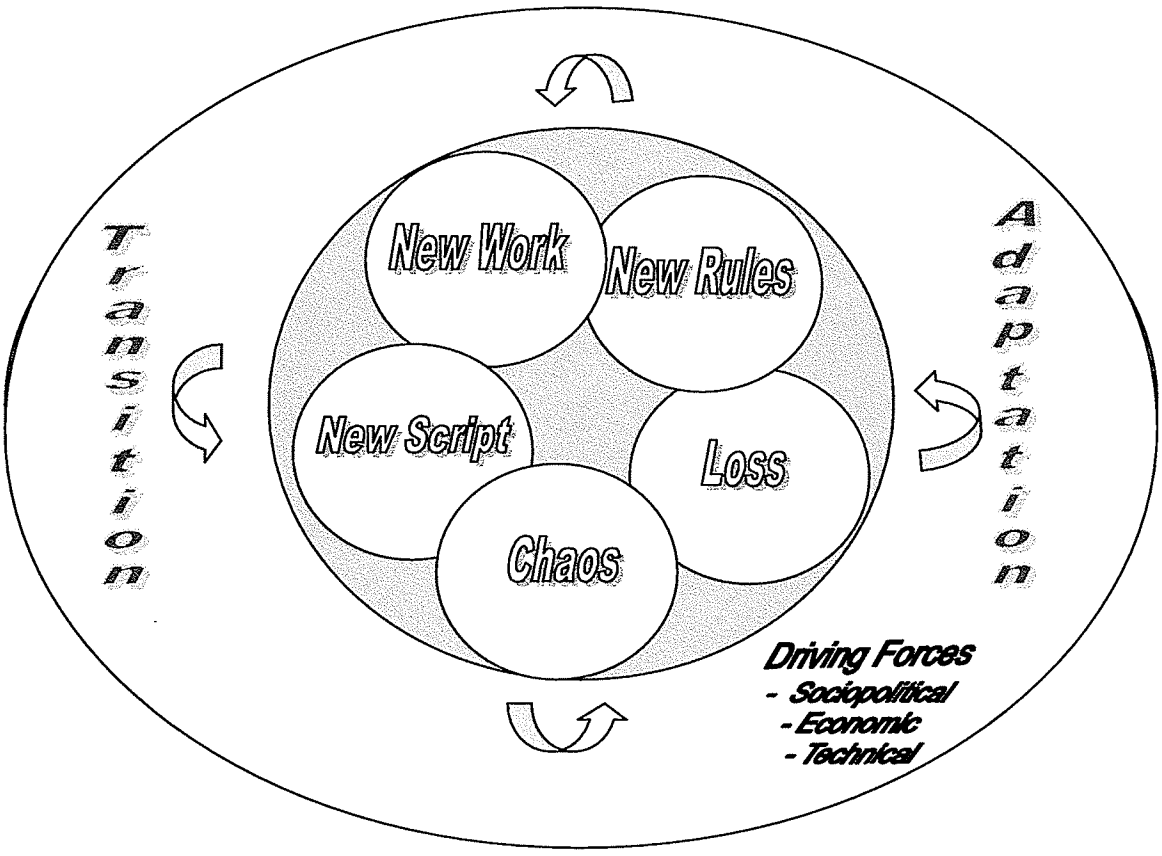


Figure 1. The Universal Dynamics of Transformation Model from "Quantum Leadership – a textbook of new leadership" by T. Porter-O'Grady and K. Malloch, 2003, p. 9.

The UDT Model was the model of choice as it is based on the quantum theory that tells us the world is not only unpredictable, but fundamentally unknowable. The UDT Model focuses on systems learning rather than knowing and can facilitate an understanding about health care leadership from the macro to the micro level. The UDT Model can create an awareness of the linkages and intersections between the various processes that are the focus of the transforming work of leadership. This understanding results in the replacement of linear thinking with relational and whole systems thinking (Porter-O'Grady & Malloch, 2003). Therefore, this model was deemed to be a good fit for this practicum project as it facilitated the synthesis of the Prehab Program planning process, and the achievement of the project goals.

The Universal Dynamics of Transformation Model

The Universal Dynamics of Transformation (UDT) Model can be adapted as a framework for gaining insight into the program planning process, with the development of the Prehab Program as the exemplar. It also can be used as the basis to view the current sociopolitical, economic, and technical landscape which, in turn, will provide the impetus for new rules, new work, and a new script for adaptation and transition from the current chaotic state of care for individuals with advanced joint disease to a new and exciting model of care.

The UDT Model (Porter-O'Grady & Malloch, 2003) is composed of five circles representing concepts that interact with each other and are placed within a larger circle that represents the progression from adaptation to transition. The larger circle is surrounded by arrows that suggest rapid movement and continually shifting foundations. The sociopolitical, economic, and technical driving forces are on the outside of the larger

circle. These driving forces influence leaders to transition rapidly to a new way of living and acting.

The terms assigned to the five circles are chaos, loss, new rules, new work, and new script. The UDT Model suggests that leaders must move with their followers through a complex system of chaos, acknowledging feelings of loss, and establishing new way of doing things with new rules, new work, and a new script. The circles display relational and whole systems thinking rather than the usual linear thinking of the 20th century. For example, chaos has some overlap with loss, and also overlaps with the new script. However, even with a new script, chaos will continue as there is always change. There is no longer time for one portion to be completed before the next begins. The circles encroach upon each other, which represents the interdependency of the various structures and systems. For example, government funding which is a driving force, and personal accountability, the new rule, will influence the new script, which in turn determines the new work.

Chaos

In the UDT Model, the circle representing chaos is most prominent; this suggests that understanding the chaos in the larger system is of paramount importance when transitioning to new rules and new work. It is this chaos that influences the system to change. Leaders need a clear understanding of the sociopolitical, technical, and economic forces that are driving the change. A recent report concluded that the management of waitlists across Canada is, in general, "chaotic, non-standardized, capriciously organized, poorly monitored and in grave need of retooling" (Arnett & Hadorn, 2003, p. 291). Iglehart (2000) reports that the healthcare system remains shaken

by the decline in public support, reduced morale among physicians and nurses, and increased tension between the Federal Government in Ottawa and Canada's disparate provinces and territories. The public will need to be engaged to build a new future for health care. However, Romanow (2002) acknowledges that "providing leadership against a backdrop of turbulent change is never easy" (p. 5). Leaders must be passionate about the need and committed to the journey and hard work ahead.

Driving Forces

The three driving forces for change as identified by Porter O'Grady and Malloch (2003), (i.e., sociopolitical, economic, and technical forces) are applicable to the Prehab Program. Waitlists cause significant distress for the public which, in turn, is anxiety producing for politicians. As well, there are many economic drivers, including escalating health care costs, length of stay issues, and loss of income. There are also many technical drivers, from the availability of information for the consumer via the Internet, to the selection of new and improved implants that will drastically change the quality of life for individuals with joint disease. The improved technology has also provided opportunity for surgeons to expand the indications for surgery to include younger patients. Samuel (2001) reinforces that understanding the external drivers impacting the organization is necessary in establishing a clear direction. This understanding involves convincing others and may require a level of honesty and directness that could, at times, appear confrontational.

Loss

The second circle is loss. It is anticipated that many health care leaders and care providers will experience loss due to change. The UDT Model provides opportunity for

discussion of the loss that will be attached to the new vision. The Prehab Program will be community based, with the primary goals of improving health and shortening hospital length of stay (LOS). The program will be a move away from the current hospital based, sickness oriented model of service delivery. Every stakeholder must continually examine the appropriateness of current work rituals and routines and determine what should be retained and what should be left behind as no longer relevant.

Diminished health care paternalism also will be perceived as a loss for some clients. Some accountability for personal health will shift from professional caregivers to the clients and their significant others. In order to transform or lead change, leaders must engage their followers (Gryskiewicz, 2005). This engagement requires an acknowledgment of the past and associated losses. The need for employees, care providers, and the clients to mourn these losses must be respected. They need to know where they will fit with the change, and that their past contributions will be acknowledged.

New Rules

The first two circles in UDT Model initiate the adaptation process. The chaos has been confronted, the losses have been acknowledged. The next three interacting circles identify the transition to new rules, new work, and new script. There will be several driving forces in this adaptation to new rules. In the Prehab Program, the new rules will center on the need for accountability from both the care provider and the client. Issues such as accessibility to services, cost containment, and waitlist reduction will need to be addressed by the care providers. As well, there must be a commitment from clients to optimize their physical functioning prior to surgery. The new rules need to be clearly

outlined. Leaders need to communicate their vision and the associated new rules through their own behavior in order to engage others to do the new work.

New Work

The new work begins with the development of a vision of seamless care delivery for clients across the continuum from community to hospital, and back to community. The exemplar for this practicum is the development of the Prehab Program. This program will be offered in the community, prior to hospitalization, and will be closely linked with the acute care sector.

The UDT Model also acknowledges that the value of work is a function of the outcome, not the process. The process of new work was focused on the development of the Prehab Program, but outcome measures for the individuals with joint disease are the most significant aspect. There must, however, be a connection between the process and the end product. While the Prehab Program must improve client outcomes, such as shortened LOS, and improved pain management, it must also respond to the waitlist by increasing client throughput as well as clients' accountability for their own health.

New Script

From the new work, a new script for future efforts will evolve. These three stages, new rules, new work and new script, require leaders to move from their past successes and view the present landscape, noting intersections, relationships, and themes, and thereby, develop a workable vision for the future.

The fifth circle is the new script – the new way of doing things. In the practicum exemplar, this is reflected by the implementation of the Prehab Program. Ideally, client education will be more accessible, surgery slates more appropriately booked, and the

focus will be more on primary care. Clients will be provided with the tools to be more accountable for their well-being up to the time of surgery. An ongoing process of program evaluation will be an essential part of the new script. This will require flexibility on the part of leaders to respond promptly to evaluation results and refocus programs to adapt to the demands of the changing environment.

Summary

The circular model emphasizes movement, inter-dependency, complexity, and non-linear thinking. According to Porter-O'Grady and Malloch (2003), detailing the specifics of some future state is no longer a viable means of planning, but rather discernment and sign post reading are better skills. Change is rapid and often unpredictable. The administrative focus needs to move from concentrating on process to focusing on outcomes. Lichtenstein (2000) proposes that the root of much of the failure in change is that managers are trained to solve complicated problems rather than complex ones. Managers tend to view change as a problem which can be analyzed and then solved in a linear or sequential manner. However, complex problems require managers to cope with dilemmas in the system, rather than to arrive at definitive solutions.

In planning the Prehab Program, leaders needed insight about contextual themes, rather than step by step guidance on how to implement a minutely defined vision. This UDT Model provides a panoramic view of the transformation, which in turn provides direction for the adaptation/transition process. Leaders need to recognize that the organization is on a journey which requires continuous learning. The various structures and influences must be weighed and the right balance for moving forward must be found.

Good leaders know that a complex system works well when the simple systems work, and maintain the focus of change on outcomes for the clients of the health care system.

The following review of the related literature illustrates that the components of the UDT Model will facilitate an understanding of the phenomena associated with the program planning process. The research literature provided the foundation for the participant observation of the development of a Prehab Program and will ultimately provide guidance for leaders in future program planning.

Chapter 3: Literature Review

A literature search in MEDLINE, CINAHL, PubMed, Web of Science, ABI/InformGlobal, and the Cochrane Library was implemented to locate the most current information. Key words used in the search included accountability, change, health care planning, leadership, and resource allocation. A search of the Grey literature was also conducted, which included Canadian and international government and organization websites. The literature was reviewed in regards to application of Porter-O'Grady Model of Transformation and the relevance of each of the five described concepts. The literature was applied to the transformation process. This included a general discussion of the chaos, and associated loss in the adaptation to new rules. The transition to new work and a new script for planning of future programs was reviewed.

The literature is replete with discussions regarding the complexity of the current healthcare system, accessibility and accountability issues, and the need for new approaches to clinical care and system management. The application of the UDT Model in other projects was not found in the literature. The literature review was a means of assessing the evidence in the literature to support / refute the usefulness of this model. Using the UDT Model as an organizational framework, this section offers a review of the literature related to each component of the UDT Model and the basis for the application of these findings in the subsequent chapters.

Chaos

Chaos will be discussed within the context of the three driving forces for change, namely sociopolitical, economic, and technical factors. This section will begin with the broader administration/leadership literature, and will then focus on the healthcare system.

The administration literature is robust with articles on change and 'the state of flux' to which organizations, ranging from car manufacturers and engineering firms to symphony orchestras find themselves responding. Tan, Wen, and Awad (2005) equate change with chaos. Chaos implies unpredictability. A chaotic system operates in an unstable combination of randomness and order, and continually changes and evolves. Phrases and terms such as "change that has been buffeting us all" (Gryskiewicz, 2005, p. 8), turbulence, volatility, and ambiguity are abundant. Kotter (2005) contends that no organization is immune to change. Fisher (2001) refers to an organization as a "living entity" (p. 34). Peter Drucker (1998) notes a fast changing world where what worked yesterday probably does not work today. Drucker is described as one of the fathers of modern management theory. He explains the current system complexity and chaos by arguing that much of what is taught and believed about the practice of management is either wrong or seriously out of date.

Driving Forces

The influence of sociopolitical, technical, and economic driving forces is apparent. Higgs and Rowland (2005) declare that 70% of change initiatives fail as a result of lack of attention to the driving forces at the time. They interviewed 40 informants from seven organizations ranging from financial, high-tech, and service sectors to a small English professional sports club. These interviews generated 70 change

stories. Their findings revealed that change approaches based on linearity were unsuccessful, while those built on assumptions of complexity were most successful. This is further supported by Stacey (1996) who argues that current theoretical paradigms are wrongly based on the assumptions that 1) managers can plan projects in advance of environmental changes, 2) change is a linear process, and 3) organizations are systems tending to states of stable equilibrium.

Drucker (1998) refers to management as a social discipline that deals with the behavior of people and human institutions. The social universe has no 'natural laws' as the physical sciences do, and thus is subject to continuous change. The chaos occurs when assumptions that were valid become invalid, and indeed totally misleading in no time at all.

Sociopolitical

Within the healthcare administration context, there is considerable chaos in the sociopolitical arena. Medicare has been an important part of Canadian federalism for more than 40 years. For a long time, Canadians were among the most satisfied people in the world with how they received health care. Glouberman (2005) contends that satisfaction declined in the late 1980's when health care inflation and fear about the sustainability of the current health care system started to escalate. In the 1990s, Wilson and Rosenberg (2004) noted that the Canadian health care system, which had often been held up as a model of a public, universal, and comprehensive system in international comparisons, went through an unprecedented series of changes. The federal government reduced its financial support to the provinces and the provincial governments responded by restructuring health care delivery. Since then, there has been increasing chaos in

health care, as competing views developed among policy makers and consumers regarding how the Canada Health Act's principle of accessibility should be defined, interpreted, and used in delivering health care.

The public outcry about lengthy waitlists is also adding political pressure in regards to accessibility to care for all Canadians. Issues surrounding the feasibility for private medicine become open for discussion. Some individuals believe that, if we restrict ourselves to a system where all the funding comes from provincial and federal taxes, there will be little choice but to ration services (Mazankowski, 2001). Other political office holders believe that salvation lies in lifting the ban on private insurance as a means of increasing access to hospital and physicians' services for people who can afford such coverage. Iglehart (2000) cites a public opinion survey conducted by M. Kennedy, a journalist for the Ottawa Citizen, which suggested that many people are prepared to support a multi-tiered system if it would lead to more timely access to care. Arnett and Hadorn (2003) state that the Supreme Court decision in the case of Chaoulli v. Quebec (2005) gave "reason for hope that the court may have resuscitated Canada's long moribund discussion on the proper limits of publicly funded health care" (p. 271). On July 9, 2005, the Supreme Court ruled in favor of Mr. Chaoulli using private health insurance to have a hip replacement, rather than remain on the waitlist for the public healthcare system. Many perceived this court ruling as the first step toward two-tiered medicine and the solution to more timely access to care.

According to a recent article in the Winnipeg Free Press, Necheff (2006) reported that the Alberta government is moving ahead with its long stated intention to allow more private health care. This was to have become legislation as early as the spring 2006.

While the Alberta government had planned other changes, Premier Ralph Klein admitted that some of these changes might violate the Canada Health Act. Klein's provincial initiatives were not palatable to many people and are no longer being pursued. In his final report of the commission on the future of health care in Canada, Romanow (2002) stated:

> Forty years ago, when visionary men and women came together to create Medicare, we had private medicine in Canada. You paid out of pocket to receive medical services if you could afford them, or relied on the dole if you couldn't. If you needed an operation, you cashed in your savings, mortgaged your home or sold your farm so you could pay, or you simply did without. If you had the resources or good fortune, you were able to pay your way to the front of the line; if you didn't, you waited and prayed for the best. Many of the so-called "new solutions" being proposed for health care – pay-as-you-go, user and facility fees, fast-track treatment for the lucky few, and wait-lists for everyone else – are not new at all. We've been there. They are old solutions that didn't work then, and were discarded for that reason. And the preponderance of evidence is that they will not work today. (p. 7)

Public discontent with the current health care system, in spite of past history, results in restlessness, the pursuit of different options, and in so doing, the creation of confusion or chaos. This unrest is supported by Storch (2005) who declares that, despite evidence that health markets are not like other markets and that single payer and publicly administered health systems are optimal both on efficiency and equity grounds, Medicare "faces political assaults" (p. 416). She attributes this unrest to a time when the public is

critical and considers governments to be wasteful and inefficient. There is also a fascination with competitive global markets, which then gets transferred to healthcare. Iglehart (2000) notes the growing concern among Canadians regarding their "beloved health care system" (p. 2012). Storch (2005) suggests that the assets of the Canadian system should not be forfeited lightly: "It is a system too good to lose" (p. 416). She expresses bewilderment that so few non-Canadians are aware of this 'fine jewel.'

In spite of such endearing terms regarding the Canadian Health Care system, public unrest is growing, which subsequently creates chaos. While in 1991 over 60% of Canadians surveyed rated the health care system as excellent, in 2000 this figure decreased to 26% (Wilson & Rosenberg, 2004). Further, results from the 2000 survey revealed that almost 80% of Canadians felt that the health care system was in a state of crisis (Wilson & Rosenberg, 2004). These opinions were based on issues such as increased public expectation of timely and appropriate care, quality, the latest in technology, as well as remaining cognizant of funding pressures. A poll on health care policy conducted by Compas in October of 2001 reported that the health care system had worsened in the previous decade (Wilson & Rosenberg, 2004). This public unrest causes discord as individuals become frustrated by delays in health care and look for other options, such as a private clinic, or surgery outside the country. This creates further chaos.

In response to this unrest by the public, politicians become actively involved. There are conflicting right and left wing points of view, which influence and further confuse the electorate. Election promises are made, but not always carried out. In an attempt to remain in power, politicians meddle in the planning and orchestration of health

care system solutions. Control is exerted upon the system through the allocation of health care dollars.

Economics

Economics is the second driving force for transformation and a contributor to the chaos and complexity of the system. Politicians attribute the deterioration in public satisfaction to the lack of a coordinated plan between the federal and provincial governments in regards to transfer payments. At the first minister's conference in March 2003, Canada's ten premiers told former Prime Minister Chrétien:

> We strongly believe that the federal government is underestimating the scope of the difficulties provinces and territories face in maintaining the integrity and stability of the health care system. Doctors, nurses and other health care providers need to know there will be adequate and predictable funding to deliver the services Canadians require (Iglehart, 2000, p. 2011).

The complexity of funding is magnified by the fact that health care spending is estimated to have grown at an annual rate of more than 6.5% over the past 5 years (Province of Manitoba, 2006; see Figure 2).

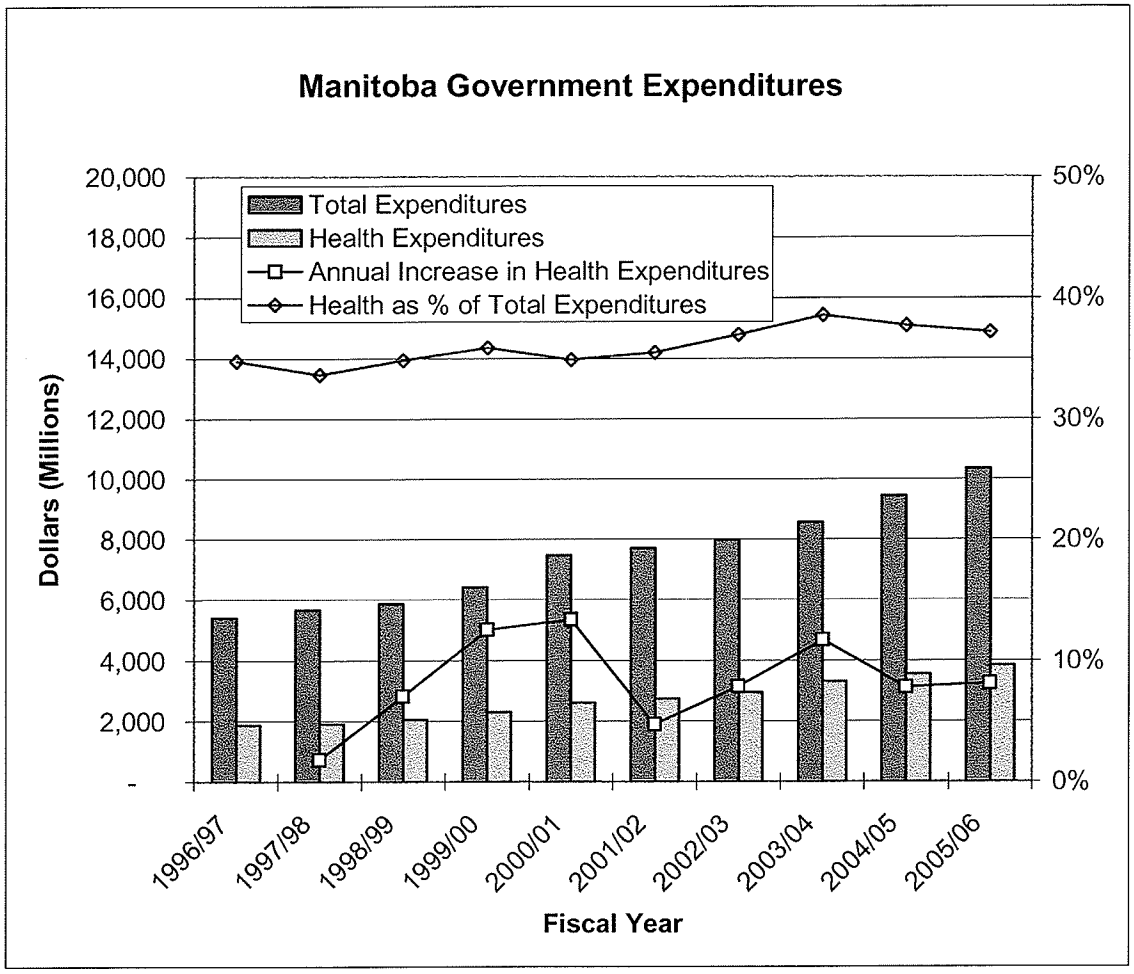


Figure 2. Manitoba Government Expenditures compiled from the Auditor General's annual reports retrieved Nov 15, 2006 from http://www.gov.mb.ca/finance/financialreports.html.

These increases in health costs, as well as the aging of the baby boomers, create anxiety in the political community. This initiates sudden cost constraint directives. Some commentators have concluded that without fundamental changes in how the delivery of care services are financed and delivered, Canada's publicly funded universal health care system is too expensive and unsustainable (Sepehri & Chernomas, 2005).

These economic driving forces contribute to the chaos within the system. As technology advances and surgical techniques are improved, surgeons are restricted in the use of expensive implants, in spite of improved outcomes and longevity.

Technology

Sociopolitics and economy are two driving forces, for the transformation of the health care system; the third is technology. With access to the Internet, the public is more informed about health care options. This information raises public expectations for accessible, high standards of care. Accessibility includes timeliness and the appropriate location of health care services. Fisher (2001) claims that the redistribution of knowledge due to the explosion in information and electronic technology is the single most dynamic change in the past half century. Clancy (2004) concurs that each new innovation acts as a building block for later innovations.

Although new technology streamlines processes, the additive effect of combining older technology to create new technical innovation actually increases complexity. The complexity also is increased by the sheer scope of new information. On the World Wide Web, the information available doubles every 2.8 years (Clancy, 2004). As a result, information is now more widely accessible and dispersed among the population than ever

before. This availability of information to the public was recently illustrated in a Globe and Mail cover story. Margaret Wente (2006) wrote:

> But access to the system was only half the battle. The other half was deciding what kind of procedure I wanted done. Thanks to Google, I quickly learned a whole lot of stuff that doctors don't tell you. For example, I learned that the type of hip replacement you usually get in Toronto is not the only or even the best one, especially for someone youngish like me. (p. F6)

This awareness of different types of surgery is fundamental to the need for change within the system and a contributor to the chaos. The web has introduced patients to new techniques such as computer navigated surgery and minimally invasive techniques. Some patients are questioning the benefits of a total hip arthroplasty compared with a Birmingham procedure. These procedures are available from some surgeons in some hospitals, but not others. The public has also learned about different implant designs such as ceramic versus metal on metal. The increased knowledge diffused through the web as well as the inconsistency and availability of different procedures and implants contributes to the chaos.

The literature is replete with articles on leadership required to manage the three driving forces, namely, sociopolitical, economic, and technical, that create chaos within the system. Sammut-Bonnice and Wensley (2002) propose, that while complex systems are rich in structure, complicated systems are rich in detail. This level of detail has resulted in ineffective rigidity in program planning. This rigidity in response to a complicated system can result in chaos when the system is not responsive to the rapid rate of change. Fisher (2001) advocates that the authoritarian model of command and control

leadership must be replaced by relational leadership in which managers and workers perform as partners, and mutual supporters of the same objective, rather than adversaries. He cautions that if this administrative rigidity is not altered, organizational progress will be blocked.

Brousseau, Driver, Hourihan, and Larsson (2006) conducted a review of the Korn/Ferry International database of detailed information on more than 200,000 predominately North American executives, managers, and business professionals. The authors reviewed the educational background, career histories, and income, as well as standardized assessment profiles of each individual. In the analysis of the decision making profiles, this research showed that senior managers analyze and act on problems far differently than their junior colleagues. Their research identified four leadership styles, namely, decisive, flexible, hierarchic, and integrative. It reported senior executives were highly integrative, whereas junior supervisors displayed a decisive decision making style. The integrative style is less rigid, frames problems broadly, uses input from many sources and makes decisions involving multiple courses of action that evolve over time, as circumstances change. However, the junior supervisors displayed a decisive style, direct, efficient, fast, and firm. This study also confirmed that successful managers and executives tend to become more open and interactive in their leadership styles as they progress in their careers and subsequently deal more effectively with chaos. As executives become more removed from the day to day activities, a flexible and integrative leadership style is needed that will keep the information pipeline open and data moving freely.

The ability to frame problems broadly is an important leadership quality. Gryskiewicz (2005) recommends that leaders must understand the multitude of forces to which the organization is subject, decide which forces to bring in, then gauge (characteristics) the turbulence that is brought on so the forces may be kept positive. She emphasizes the importance of leaders being able to read turbulence and respond to it. She admits that chaos makes all administrators nervous and there is a tendency to impose order, thereby closing boundaries and containing ambiguity.

Drucker (1998) cites Mary Parker Follett, as an insightful management scholar from the early 1900's, who never differentiated between business management and non-business management. Unfortunately her work was ignored for decades. Drucker (1998) claims that most people still believe management refers to business management. He does not share this opinion and believes that the differences between business and non-business management apply to only 10% of the work, and are determined by the organization's specific mission, culture, history, and vocabulary. These differences are mainly in application, rather than in principles. Drucker declares that the executives of business, as well as health care organizations, spend about the same amount of their time on people problems, and the chaos related to the people problems is almost always the same.

The health care system is complex and diverse. Public expectations are high, both in regards to health care, but also in having a government that is fiscally responsible. The sociopolitical, economical, and technical driving forces contribute to the chaos. It is an interwoven web where decisions or actions in one part of the bigger system have a profound effect on others. The commitment of health care professionals also is shaken as

large systemic changes are being imposed on their practices. Mazankowski (2001) acknowledges this chaos and refers to health care as being "wrapped up with emotional debates, dedicated professionals, long standing traditions, and old biases clashing with new ideas" (p. 4).

In order to transition from this state of chaos, there will be many leadership challenges. These challenges will involve significant change in order to adapt to new rules, new work and the new script. Jooste (2003) defines these adaptations as the essence of leadership, whereby through communication, a leader exerts influence on others, and modifies attitudes and behavior in order to reach group goals and needs. In doing so, he differentiates between management and leadership: Managers rely on systems, while leaders rely on their people. This reliance on people includes acknowledging their losses as part of the adaptation process.

Loss

The dedicated professionals, long-standing traditions, and old biases referred to by Mazankowski (2001) result in mourning the loss of what is passing away (Porter O'Grady, 2001). Some of the factors that attracted individuals to the health care profession are vanishing because of the changes within the healthcare system. The second circle in the UDT model acknowledges this sense of loss in the process of transformation.

The business literature also makes reference to loss in relation to change. Bridges and Mitchell (2000) differentiate between change and transition. They define transition as the state into which change puts people. Change is external – as in policy, practice and structure. However, transition is internal – a psychological reorientation that people have

to accept before the change can work. Bridges and Mitchell (2000) identify three phases of transition, all of which are associated with loss. The first requires that people have to let go of the way that things, and more importantly, the way that they themselves, used to be. The relationships that hospital staff prided themselves on developing with their patients are altered as the hospital LOS shortens and care is managed more in the community. Healthcare providers are being asked to alter the way of engaging or accomplishing tasks that made them feel successful in the past.

Stern (2005) advises that the roots of resistance may be found in fear and survival, and need to be understood and re-interpreted. Nurses have been taught to advocate for their patients and may fear that outcomes will be compromised if they are discharged from hospital too soon. This fear will lead to resistance to change. According to Bridges and Mitchell (2000), individuals then transition into a neutral zone where they find themselves unable to start anew. Eventually these individuals are able to move into the third, forward phase.

Wren and Dulewicz (2005) stress the importance of leaders addressing the loss. They attribute many failed transformations to the fact that managers treat the challenges as "technical problems" and ignore the emotional aspect. This contention was based on the results of a survey they conducted in the British Royal Air Force in which a leadership dimensions questionnaire was used to measure the dimensions of leadership associated with positive change. A 360^{o} feedback questionnaire gathered data on leader activities and the success of change programs. The analysis of 90 questionnaires revealed three dimensions that contribute most towards successful change, namely: managing resources, engaging communication, and empowering staff. The engaging

communication allows for the emotional aspect of the associated losses to be discussed. Chatman and Cha (2003) suggest that the way with which loss is dealt will create an organizational culture that will either help or hinder the ability of leaders to execute the strategic objectives. Drucker (1998) reinforces the need for transparency within an organization in order to deal with loss. He refers to a universal principal of organization that ensures people know and understand the organizational structure in which they work.

The concept of loss is also prevalent in the healthcare literature and relates to both the consumer and care provider. One loss for consumers may be the transition from a medical model to a wellness model. The loss of endless free medical services may also be inevitable. At the first ministers' conference on healthcare, Murray Bryant, an expert on healthcare management, noted that individuals' demands for healthcare are 'boundless' (2004). The health system user has a notion that the cost of care is zero; thereby the demand is potentially infinite. Consumers are frequently requesting diagnostic tests, such at CT scans and MRIs. The internet is providing health related information, which is leading to a demand for more health services (Porter O'Grady, 2001). The wellness model will require more accountability on the part of the consumer to optimize their health through health promotion strategies such as exercise, good nutrition, and the absence of smoking.

Shorter hospital stays may result in a sense of loss as clients and their significant others are required to take more responsibility in the recovery phase of illness. Strategies, such as those undertaken by the Largo Medical Clinic in Florida, where spouses/significant others are encouraged to act as coach from the pre-op to post-op phases of recovery may be adopted. The wellness philosophy of the Largo Medical

Clinic promotes that there are no sick people, only "guests who need orthopedic surgery" (Field, 2005, p. 2). This philosophy may be perceived as a loss of the traditional paternalistic approach to care for consumers and their families.

Health care providers also experience loss during periods of transition. Aikman, Andress, Goodfellow, LaBelle, and Porter-O'Grady (1998) contend that physicians have a long history of independence, which has made the formation of integrated systems difficult. The traditional medical model focuses on diagnosis and treatment, and relies heavily on the physician for treatment options (Ashton, 2005). Aikman and associates (1998) conclude that current political activities are aimed at shifting the thinking and behavior patterns of physicians. For example, strategies such as the centralized surgical slating of clients are aimed at increasing system efficiencies. Such an action may be perceived by doctors as a loss of autonomy. LeTourneau (2005), a physician, concedes the following:

> Although physicians work as individuals and have different perspectives, they tend to think and talk as a group. Those who act positively are willing to become actively involved in planning for change. Those who resist will display anger and frustration about the inevitable implementation, thus undermining the plans. (p. 6)

LeTourneau advises administrators to listen to physician concerns, manage the flow of misinformation, and acknowledge their losses.

Other healthcare providers, including nurses, also will experience loss. Healthcare is moving from residency-based delivery models of health service to mobility-based approaches. The emerging care models emphasize reduced hospital LOS, but Porter-O'Grady and Malloch (2003) note that much of nursing education is still based on

learning and practices that require clients to stay in hospital long enough for nurses to do the work they learned. Dingel-Stewart and LaCoste (2004) note that nurses' focus and commitment are on quality care rendered at the bedside, and on interactions with the client. Porter-O'Grady and Malloch conclude that attachment to past rituals and routines is an impediment to nurses' ability to embrace fundamental changes to their practice. Dingel-Stewart and LaCoste (2004) agree that this narrow focus of hospital based care makes nurses paralyzed by the constant change, and causes them to focus on the losses to such an extent that they are unable to move to a broader, more integrative view of healthcare. This resistance to change by nurses is not a new phenomenon. In the 1800's, Florence Nightingale made reference to this same issue:

> No system can endure that does not march. Are we walking to the future or to the past? Are we progressing or are we stereotyping? We remember that we have scarcely crossed the threshold of uncivilized civilization in nursing; there is still so much to do. Don't let us stereotype mediocrity. We are still on the threshold of nursing. Cited in (Ulrich, 1992, p. 11).

In particular, the "mature" worker, with many years of nursing experience, may suffer loss in the change from an "institutional" to a "mobility" model of work. Porter-O'Grady and Malloch (2003) note that in the 20th century, work was exemplified by the relationship between employers and employees, characterized by work within a defined workplace. Younger nurses may enjoy the flexibility of the infrastructure of information and technology, whereas more mature nurses may feel the loss of the brick and mortar workplaces. Experienced nurses sense the loss of allegiance, loyalty, or affiliation to individual workplaces, and hence a loss of control in the context of their work.

Baumann et al. (2001) conducted a study to determine whether nurses who experienced job change perceived their work differently than those who did not undergo job change and whether nurses who experienced different types of job change (new role, new unit, new hospital) varied in their perceptions. A questionnaire was administered to nurses (n = 3408) in two large Ontario teaching hospitals. The findings suggested that nurses who experienced job change were more dissatisfied with their work environments, less confident in their practice, more concerned about impact on patient welfare, and had less organizational commitment than nurses whose jobs were not affected. Despite this experience of job change, the findings of this research confirmed there is still a strong commitment to the nursing profession. Dissatisfaction with the work environment, lack of confidence in their practice, as well as concern for their patients, is important for nursing leaders to acknowledge, and show patience and understanding by listening, supporting, and encouraging nurses during the change process.

Samuel (2001) concurs that while the losses must be acknowledged, the change process must continue. Litch (2005) shares this view, suggesting that respecting the employees' need to mourn the losses that they face helps achieve "buy-in for the change" (p. 21). People want to know they have made a difference. Litch concludes that recognition of past contributions not only brings a sense of closure, but also inspires in people a sense of accomplishment that will carry them into the next phase of the change, which is the adaptation to new rules.

New Rules

The third section of the UDT Model considers new rules. Central to effective leadership during the adaptation to new rules, is accountability, both on the part of the

leader, as well as their expectations of others. Accountability is defined in Webster's (2002) dictionary as "a quality or state of being accountable, liable or responsible, bound to give an explanation" (page 5). This sense of accountability is supported by Higgs and Rowland (2005), who delineate one of the emerging themes related to leadership as making others accountable. Drucker's (1998) definition of management also makes reference to this concept: "It (accountability) is to make people capable of joint performance, to make their strengths effective and their weaknesses irrelevant" (p. 81).

In both industry and health care management literature, there is reference to accountability. Goldsmith (2005) identifies a need for accountability in industry in terms of satisfying external constituencies, performing efficiently in economic and financial terms, being effective, and finally, respecting the human dignity of workers. Drucker (1998) refers to accountability as an individual's performance that is observable by the total organization and not dependent upon the goodwill of one person. Goleman (1998) further emphasizes this point by suggesting that accountable leaders are driven to achieve beyond expectations, "their own and everyone else's" (p. 99). Goldsmith (2005) goes as far as to comment that accountability in industry and healthcare shares many similarities: "To be successful, managers need to develop a positive attitude toward the organization and the job, be joiners and innovators, accept the organizations goals as their own, and invest their spiritual and physical energy in building an organization" (p. 95). This positive attitude promotes accountability which is consistent with new rules.

Specific to healthcare, there are many levels and many areas that will need to become more accountable in the transformation process, including all levels of government, regional senior executives and their programs, hospital administrators, and

front line staff. All will be required to improve the quality of care for clients. This will include reviewing issues related to client safety, quality improvement, fiscal responsibility, waitlist reduction, and accessibility to services. Samuel (2001) identified six elements of accountability. In order to have an accountable system, Samuel notes the need for clear intention, interlocking ownership, effective execution, attack on dysfunctional habits, responsive recovery, and measurable results. Effective execution of the new rules is the process of linking people and processes to achieve high performance, whereas responsive recovery is being prepared to handle inevitable glitches. There is a public expectation that health care investments should consistently lead to high quality results.

These elements of accountability present many leadership challenges. Interlocking ownership involves issues at both the system and individual level. This ownership suggests that the operations and processes should be "transparent" to all concerned. Hibberd and Smith (2006) refer to the need for a strong relationship between those making the decisions and those affected by them, agreed upon responsibility, delegated authority conferred by government to individuals and organizations, answerability for decisions and actions, judgments about performance, and processes for sanctions and correction. Bannerman and Nixdorf (2005) declare that turf wars among health bureaucrats and professionals conspire to maintain the status quo. This desire to resist change also can apply to the nursing profession. According to Newhouse, Dearholt, Poe, Pugh, and White (2005) nurses must operate in an "age of accountability" where quality and cost issues drive the direction of health care.

With the new rules in health care, clients and their significant others also will be called to be accountable. Samuel's (2001) definition of accountability is simple, "counting on one another to keep performance commitments and communication agreements" (p. 6). This accountability will require clients to be active members of the healthcare team in maximizing their physical and emotional health.

Hibberd and Smith (2006) propose that accountability "conjures up processes in which citizens might come to understand where their tax dollars go, why certain policy decisions are made or where they can turn if they are dissatisfied with the care they receive" (p. 332). This hints at an environment in which a healthcare system might take responsibility for improving the health of the population.

However, a leadership role will require convincing the public and professionals themselves, of the need for this personal accountability. Righton (2006) claims that "in theory, Canadians say we need to stay healthy, but they are not ready to hold people accountable" (p. 16). In a 2006 Innovative Research Group survey of 3759 Canadians published in Maclean's magazine, 8 out of 10 respondents declared that those who rely on the public health care system have a responsibility to maintain their own health. This study suggests that, in theory, the public accepts the new rule of accountability. However, a later study revealed ambivalence on the part of Canadians to hold others accountable. Righton (2006) reported that only one third of Canadians believe that smokers should be given lower priority in the public health care system. This ambivalence also is evident in the Maclean's survey where 55% of the Canadian respondents disagreed when asked if priority healthcare should be withheld from those who do not look after themselves. Specific to exercise, only 16% of those surveyed were

supportive of those who exercise receiving preferential treatment, and only 19% felt that overweight people should receive lower priority (Righton, 2006).

The challenge for the health care leaders will be to engage the public to become accountable and participate in a health promoting life style. Hibberd and Smith (2006) refer to this accountability as answering for one's actions and the consequences of those actions. Collaboration between the health care team and the client is described by Kouzes and Posner (2002) as a "Master Skill" that will contribute to a sense of mutual reliance between the client and health care team – the feeling that 'we are all in this together.'

Porter-O'Grady (2000) suggests that information technology has created a new potential that has altered the consumer and provider relationship forever. Everyone now has access to information that is available to anyone else. However, Samuel (2001) views the leadership challenge as leaders being effective at mobilizing others and creating a climate in which people turn challenging opportunities into remarkable successes. Porter-O'Grady (2003) suggests this mobilization requires a true gift in leadership, that includes being able to "walk back to where those they lead are living and translate what they have seen into a language that has force and meaning for those that can hear it" (p. 36).

This expectation for increased public accountability will require a change in culture. Aikman et al. (1998) suggests "this will alter clients' expectations of being taken care of" (p. 29). Healthcare leaders will need to be more flexible and create processes and systems that will encourage all individuals to participate and thrive. Bridges and Mitchell (2000) recommend collaborative assistance that is both problem solving and

developmental. The target is both the situation and the capability of the person, where the leader's fundamental role for the client is that of a coach. Yeboah (2005) refers to this relationship as a "partnership that creates a sense of ownership" (p. 2). These new rules will require healthcare leaders to acuminate their skills of persuasion as they convince staff and consumers to undertake new work (Conger, 1998).

New Work

In order to operationalize the new rules, a new way of working must be established. This will involve change. Within the management of this change will be the need for strong leadership. Facilitating the change will require strategic planning, the formation of a team, and the evolution of an intervention. This intervention must cross the continuum of care.

The new work will require strategic planning. Stern (2005) advises that leaders must be aware of their vision as it defines strategy, which in turn defines the structure. However, Kouzes and Posner (2002) caution that visions are not strategic plans. Strategic planning is not strategic thinking, and can actually limit such thinking. The most successful strategies are visions and not plans. Visions engage team members to help shape the course, thus building enthusiasm. A calculated style, fixed on a destination and how to get there is of no value as it does not infuse the participants with energy. Fisher (2001) supports these concepts by reminding business executives that enterprise is driven by passion, which is spiritual and symbolic. The project management literature acknowledges that the operationalizing of a vision is risky business and can be constrained by three factors, namely time, cost, and quality (Onisk, Hennard, & Koster, 2000). Such constraints will require flexibility on the part of the leader.

The concepts of visioning related to new work described in the business literature are also relevant to health care. Porter O'Grady (2001) defines visioning as "building with the end in mind and breathing life into preferred future" (p. 184). He cautions that vision is not a monologue, but rather a dialogue. Kouzes and Posner (2002) note that leaders believe they can "make a difference by engaging others in shaping the vision" (p. 86).

The composition of the team is critical. Kanter (2000) stresses that key supporters must be identified in the early planning stages and the leader must sell the dream for the program with as much passion and deliberation as an entrepreneur. The ability of team members to work interdependently towards common goals is essential (Kirkman & Rosen, 2000; Scott & Caress, 2005). Gryskiewicz (2005) stresses the importance of diversity within the team and the value of members with a broad range of skills and backgrounds so the information generated by the team will not be uniform. Goleman (1998) notes this diversity will present challenges for the leader as alliances form and clashing agendas are set. He advises that the leader must be able to understand the viewpoints of everyone around the table. Fisher (2001) states that leadership is a collective will, vision, and intent to serve collective objectives. Julia Wood (2004) suggests the leader should focus on group cohesion and identity, which often crystallizes through fantasy themes, which are chains of ideas that spin out in a group and frame how group members think about what they are doing and how they define success. Porter O'Grady (2003) advises that leaders should always be on the lookout for the potential of conflict. He notes that if team members believe they are on the receiving end of unfair or inequitable treatment, they will descend down Maslow's ladder. This means their focus

will be on their own basic physiological needs rather than on creative solutions for the problems under discussion.

Building alliances and validating this involvement of the various team players requires the leader to have an awareness of the team dynamics. Brousseau et al. (2006) examined Korn/Ferry International's database of detailed information on more than 1,200,000 predominantly North American executives to identify the decision making qualities and behaviors associated with executive success. Their research showed that senior managers analyze and act on problems far differently than their junior colleagues to minimize conflict and encourage group cohesion. Seasoned executives recognize there will be two types of people within a group, namely maximizers and satisfiers. The maximizers can not rest until they are certain they have the best approach. This will result in a well informed decision, but it may come at a cost in terms of time and efficiency. Satisfiers are ready to act as soon as they have enough information to satisfy their requirements within the group. There will be both single focused and multi-focused decision makers. The single focused decision makers believe in one course of action, while the multi-focused counterparts generate lists of possible options and may pursue multiple courses of action.

The role of leaders in strategic planning, team building, and the evolution of an intervention includes not only what they do well, but also their style of working with people. This includes the ability to empower action and create short term wins. Porter O'Grady (2000) stresses that the role of the leader is no longer controlling or authoritarian. Bruhn (2004) envisions tradition and bureaucracy as the biggest obstacles to change. Drucker (1998) supports this contention by declaring that leaders of change

believe that members of their organizations are their greatest asset. In spite of the volumes of literature on the importance of the team, Glaser (2005) claims that, at the heart of many leadership programs, is the desire to help leaders move from doing it all themselves, to motivating and engaging others to deliver results.

The literature stresses the role of emotional intelligence in regards to flexibility and accountability in leadership. Goleman (1998) reports that an individual can have the best training in the world, an inclusive analytical mind, and an endless supply of smart ideas, but will not make a great leader without emotional intelligence. Conger (1998) supports this contention by suggesting that credibility grows out of two sources: expertise and relationships. From the relationship perspective, people with high credibility demonstrated that they could be trusted to listen and work in the best interest of others. Bridges and Mitchell (2000) conclude that these attributes result in the most effective kind of leadership where the leader, in a fundamental sense, becomes a coach. Higgs and Rowland (2005) collected qualitative and quantitative data from 40 informants in seven organizations, and concluded that a move from leader-centric, directive behaviors to more facilitating and enabling styles is associated with success.

Goleman (1998) analyzed the capabilities that typified outstanding leaders in 188 businesses. The leaders of companies with high profit margins were interviewed, tested in accordance with the Emotional Competence Framework, and compared to each other. Data analysis revealed that emotional intellect was a driver of outstanding performance, as was 'big picture thinking' and long-term vision. A ratio was calculated of technical skills, I.Q, and emotional intelligence as ingredients of excellent performance. The analysis revealed that emotional intelligence was twice as important as other indicators

for jobs at all levels. It was increasingly important at the highest levels of the company, where differences in technical skills are of negligible importance. In the comparison done between star and average performers in senior leadership, 90% of the difference in profiles was attributed to emotional intelligence, rather than cognitive abilities.

In another study, done in a global food and beverage company McClelland (1996), found that senior managers with a critical mass of emotional intelligence capabilities led divisions that outperformed the yearly earnings in other divisions by 20%. This high performance stresses the need for leaders to be flexible and emotionally responsive to their teams in order to transform the system.

The literature surrounding the change process related to new work, including strategic planning, formation of a team, as well as leadership styles in regards to the new work aligns with the Kotter and Cohen Model of Change. Once a strategy has been planned and a team has been formed, the third essential part of the new work is determining the actual intervention. Leaders must look to the work of others in order to determine appropriate interventions. In the business literature, Drucker (1998) declares that management does not need more information about what is happening inside, but rather what is happening outside and identifies the need for a systematic review of meaningful, actual information. Kanter (2000) advises leaders to tune in to the environment and actively collect information that suggests new approaches. She refers to this as "kaleidoscope thinking" – constructing patterns from the fragments of data available, and then manipulating them to form different patterns. Others e.g., (Litch, 2005; Shelton, 2005) support this concept by acknowledging that the "why" is compelling enough to drive the "how" and will make people more apt to accept these

changes. Gryskiewicz (2005) acknowledges the importance of external information, but contends it must be converted into something meaningful. Garvin and Roberto (2005) support this opinion by suggesting that at the time of delivery to the team, the external information must be presented as a framework through which employees can interpret the information and messages. Kirkman and Rosen (2000) declare that this approach will provide teams with a sense of meaningfulness that will give the team a strong collective commitment to mission, a sense of purpose, and an intrinsic caring about their tasks.

Finally, a central component of planning interventions in healthcare is the consideration of desired outcomes. Havens and Aiken (1999) declare that one of the greatest needs of our time is to capture what works and replicate it when suitable. Keller, Schaffer, Lia-Hoagberg, and Strohschein (2002) refer to a theory of action, which explains the connection between factors contributing to the problem, the program activities, and the health status outcomes expected to result from the activities. Porter-O'Grady (1999) concurs that successful change is always seen in outcomes. Reviewing outcomes is also supported by Wolf (2002) who concludes that a center of excellence is established by clinical outcomes superior to those of other health organizations.

The new work requires accountability on the part of the leader to have a vision, engage staff to share that vision, and create a strong team. There will need to be flexibility within leadership as well as the internal drive to refuse to let up in order to have the new work responsive to the new rules and the ever changing socio political, technical, and economic driving forces.

New Script

With the new rules and the new work will come a new script, or a new way of doing things. This new script is identified in one of the five circles in the Porter-O'Grady and Malloch (2003) UDT Model. The concept of a new script represents the relational and whole systems thinking that is the foundation upon which the UDT Model was created. The various concepts are interdependent and often encroach upon each other. This is particularly evident when differentiating between the new rules and the new script. The new rules identify the need for accountability on the part of politicians, health care administrators, physicians, frontline staff, clients, and their families. The new script focuses on flexibility and the need to be responsive to the driving forces, as well as the evaluation of the new work. Within this flexibility will need to be a high level of accountability. There are several concepts that will be central to the new script. However, the most influential, when developing a program that will transform the system, will be the need for flexibility.

The locus of accountability for clinical quality lies within each profession and the content is defined by their professional organization's mission, vision, and values. The new rule of improving accountability in the Canadian healthcare system has become a matter of key public concern and professional debate and requires flexibility on the part of leaders (Hibberd & Smith, 2006).

Flexibility in planning for the system process requires clearly defined expectations for performance. Keller et al. (2002) argue that effective program planning and evaluation require clearly written, measurable objectives. These objectives provide the basis for accountability and emphasize the need for flexibility in planning as the

factors contributing to the problem, the intervention, and health status outcomes become connected.

This flexibility in organizational development includes accessing and responding to health outcomes. Samuel (2001) claims outcomes are the means to knowing that "the system is doing the right things and that it is doing the right things right, namely providing quality care" (p. 56). He stresses the importance of focusing on desired outcomes rather than process. The focus on process rather than outcomes has resulted in health care activity, but few assessments of the system's performance. Hibberd and Smith (2006) support this allegation by claiming that 30% of medical care is inappropriate. Within healthcare, leaders need to review outcome measures for the clients who receive care, providers of care, and organizations in which care is delivered. Outcome measures for clients should include clinical endpoints, such as mortality and survival, functional status, as well as perceptual outcomes, such as well-being and satisfaction with care.

Nursing outcomes could include job satisfaction and burnout. Organizational outcomes include the broad context of patient care, such as hospital LOS data, hospital acquired infection rates, employee retention, patient satisfaction, and cost per patient day. Madson and Gygi (2005) affirm that outcome measures are essential if leaders are to be accountable, and that effective leadership is all about results. They claim that if leaders do not produce good results for organizations, then their leadership is not effective. Leaders are required to be flexible so as to respond to outcome measures and produce the required results.

The new script requires flexibility in approach in order to be fiscally accountable. Total healthcare spending in Canada reached $130.1 billion in 2004, or $4,077 per person. There was an increase of $30-billion dollars in Canadian health care-related spending between 1993 and 2003. Health care expenditures represent 10% of Gross Domestic Product, which places Canada fourth among G8 countries in the scope of healthcare spending (Kozhaya 2005). Kozhaya claims that the healthcare system has deteriorated despite the injection of billions of extra dollars in government funds. She challenges healthcare leaders to make major changes in improving the efficiency in the provision of healthcare in order to limit costs. This will require leaders to 'act differently' in order to contain expenditures and still provide service.

Dingel-Stewart and LaCoste (2004) identified a knowledge deficit in nurses with regards to healthcare budgets. They observed that staff nurses' foci and commitment is to quality care at the bedside and interaction with the patient. This narrow focus limits their involvement in policy making and health care finance. In a 1989 study, Wieske and Bantz (1992) found that 45% of nurses did not have knowledge of the nursing budget model used by their hospital. Fisher (2001) stresses that professionals need to learn to speak the language of money. The new script will require nurses to be more flexible and connect to the broader perspective of healthcare finance, which includes provision, distribution, consumption, and compensation not only for nursing services, but for all healthcare-related costs.

Drucker (1998) stresses the importance of transparency in the organization. Fisher (2001) highlights the need for flexibility when he refers to transparency between professional disciplines. The boundaries of their roles should be transparent so that they

may function within organizations where walls can be moved like partitions, as needed. Porter-O'Grady (1999) notes that disciplines typically represent specific categories of work and performance and show minimal flexibility. "Doctors do doctoring, nurses do nursing, therapists have their specific functions and so on" (p. 3). Transparency would end sealed off silos between disciplines and would also support the true integration between acute care and community health care sectors.

In the new script, the larger system will be required to be flexible in order to provide client care across the continuum. Working across the continuum will be a different way of functioning in order to achieve seamless care for clients. The complexity of today's healthcare requires numerous caregivers and specialists. Grohar-Murray and DiCroce (2003) suggest that the hospital is no longer dominant in the delivery of healthcare and that the focal point for the new system is primary care. Collaborating with primary care will be the new script and will require flexibility on the part of all parties in the acute care and community sectors to assume joint responsibility for the cost and quality of healthcare. Politicians argue that savings will occur and health will improve if people are cared for in their home. However, Bannerman and Nixdorf (2005) declare "these words are not backed up with budget allocations where money needs to be extracted from the powerful (hospitals, bureaucrats, doctors, unions) and transferred to the weak (home care infrastructures)" (p. 43). Moving towards seamless care delivery will require considerable compromise from both groups.

As described by Doerge (2005), the primary goal of the new work will be to build linkages to coordinate care of clients. These linkages will present many leadership challenges. The health care system is fragmented and has many points of service in

place, including home care, rehabilitation units, and inpatient tertiary care. However, there are limited strategies, as well as aspirations on the part of health care providers to coordinate care and move forward with a disease management / health promotion approach. Bannerman and Nixdorf (2005) reported that during 1991 to 1997, the occupancy rate of acute care beds in Toronto hospitals exceeded 90% and peaked at 96% in 2000. They estimated that 10 to 25% of available funded hospital beds are taken by so called "bed blockers" – people who should be receiving care outside a hospital. Through personal observations, it has been noted that hospital nurses often perceive longer LOS as being better. However, studies in Canada and the US have demonstrated that the number one killer in society, as great as any disease, and far worse than crime or any traffic statistics, is iatrogenic illness, misadventures caused by the healthcare system, in hospitals, clinics, and doctors' offices (Bannerman & Nixdorf, 2005). They reviewed the admission data for a group of Ontario hospitals and found that 2/3 of all patients in acute care hospitals were there for diagnostic purposes, observation, or recovery. They question why this is happening in such expensive beds where individuals are routinely exposed to iatrogenic illness. There is a need to examine hospital admissions critically and display flexibility in approach by developing programs within the community.

Dingel-Stewart and LaCoste (2004) encourage nurses "to become more flexible and see themselves as healthcare engineers rather than technicians" (p. 215) so that self imposed boundaries across the different settings begin to fall. They recommend creating fluid working relationships to prevent the dis-continuum of care of patients falling through the cracks of the current healthcare system. Aikman et al. (1998) stress that it is of paramount importance to organize health services around the needs of the patient.

Villeneuve and MacDonald (2006) suggest that nurses should act as shepherds coordinating care, delivering direct services, and helping to understand options and navigate the healthcare system. Health professionals should not carry out tasks that can be accomplished safely by patients and their families. This could include assisting with meals and personal hygiene. Deegan (1988) supports this approach for the disabled persons who share the same fundamental needs and aspiration of the general public and are not passive recipients of rehabilitation services.

The new script will require flexibility from the healthcare system in order to provide effective, efficient care with predictable outcomes across the continuum. This flexibility will require an emphasis on prevention and health promotion, rather than the current treatment of disease (Maljanian, Effken, & Kaerhle, 2005). Gryskiewicz (2005) cautions healthcare providers that encouraging personal accountability will require listening to clients to identify gaps in the services or products offered. Garvin and Roberts (2005) encourage the use of persuasion in order to engage citizens. This persuasion will include the development of a bold message that will provide compelling reasons to do things differently. They suggest skilled leaders use "frames" to provide context and shape perspectives for new proposals and plans. By framing the issues, leaders help people digest ideas in particular ways. For example, framing will help build confidence in the chronically ill patients, which will enable them to control their symptoms and be health enhancing in and of itself (Marks, Allegrante, & Lorig, 2005).

The new script also requires flexibility from family members or significant others to become partners in care. Considerable flexibility will be required from hospital staff as they work closely with families and their many different styles and expectations.

Durston (2006) describes this relationship between family and client as one of hands-on support "based on compassion, communication and choice that will empower people to heal in a nurturing manner" (p. 105). Porter-O'Grady (2001) reinforces this point by encouraging the involvement of family in delivery of services and in counseling, supporting, and caring for loved ones.

Villeneuve and MacDonald (2006) forecast that healthcare in 2020 will have self-care and patient-led care as the norm. Healthcare professionals will be partners and consultants with clients and families in a "shared care" model of responsibility and accountability for health and illness care. Durston (2006) studied more than 100 organizations in which the family was actively involved in a patient's care and learned that facts were not enough to create behavior change. The shift in behavior and culture needs to help people feel differently, thus appealing to their emotions. The engagement of the public, which includes clients, their families, and the healthcare providers, will be a critical element of the required flexibility in the new script. The Banner Desert Medical Center developed a program where patients were asked to identify a "partner in care." The role of this partner could be as simple as feeding a loved one, to as complex as changing dressings. Their study reported that over a 3 year time frame, from the implementation of this program, the nursing section of the satisfaction survey moved from the 29th percentile to the 52nd percentile (Durston, 2006). The survey results suggest that families want to be accountable in caring for their loved ones and are more satisfied with nursing care when they are encouraged to participate. Thus, in the future, a great deal of flexibility will be required on the part of both the families and the care providers. Certain hospital routines will have to be adhered to in order to ensure safe care for all

patients. However, the hospital staff also will need to be receptive to requests from clients and families in order to create a true partnership.

Plans, such as moving care to the community and partnering with families, will require immense flexibility from leaders, as required by the new script. The rate of change within healthcare is rapid and has been described in terms such as spontaneous, chaotic, constant, turbulence, permanent white water, tumultuous (Gryskiewicz, 2005; Porter-O'Grady, 1999; Skelton-Green, Bruce & Cumming, 1997; Smith & Hibberd, 2006). This constant change or flux presents struggles for the healthcare system.

Change is challenging for all organizations. The business literature identifies an eight point process that successful organizations can use to implement change. By studying more than 100 organizations, Kotter and Cohen (2005) created a model of change framework. In this model, flexibility was of paramount importance. They proposed that facts were not enough to create behavior change. They concluded that shifts in behavior and culture need to help people feel differently, thus appealing to their emotions (Durston, 2006). The Kotter and Cohen Model of Change (Kotter, 2005) framework encourages leaders to get the vision right, create a sense of urgency, build a guiding team, communicate effectively, empower action, create short-term wins, and refuse to let up (Gray, 2004).

Gerstner (2005) believes that current leadership is all about providing an exciting environment. This belief is supported by Stefan (2005) who looks for leaders who can energize the work force and win some commitment to change. Kanter (2000) concurs that the most important things a leader can bring to a changing organization are passion, conviction, and confidence in others. Arnold (1995) views today's leader as someone

who is primed to champion the goals of an organization. Porter-O'Grady (2000) describes the role of encouraging and inspiring others in the way that keeps them committed to the direction and values of the organization.

The ability of leaders to create excitement and energy must be accompanied by a willingness to take risks. Schaffer (1991) acknowledges change can appear risky to leaders and these perceived risks can exert tremendous inhibitions on performance expectations. However, Arnold (1995) is convinced that today's value-driven leaders must be willing to take risks and support positions that may be unpopular with the status quo. Kanter (2000) believes that, in order to follow a vision in a high tech world, organizations need to be more fluid, inclusive, and responsive. Porter-O'Grady (1999) coins this fluidity as being able to read the signposts of change, explain to others what they mean, and engage others in activities that will move the organization in the direction indicated by the signposts. Some leaders want the perfect plan in the hope that naysayers will be comfortable with the plan when it is implemented. Samuel (2001) declares this approach is not consistent with what today's leaders require. Dreher (1997) epitomizes Tao leaders "who have the strength of bamboo – able to bend, blend with circumstances, adjust to change and overcome adversity. They can meet any challenge with courage and compassion" (p. 42). Kouzes and Posner (2002) also support the concept of a shared vision. They advise leaders to live their lives backwards, where a clear vision of the future pulls them forward.

Gelinas (2004) reminds us that healthcare planning is usually a combination of art, science, and common sense, and on that basis, all key stakeholders must be included in the planning process. In this planning, Gelinas cautions that no plan is ever final and

that ongoing calibration and adjustment is simply a way of life in all effective organizations. Scott and Caress (2005) caution leaders that this approach requires continuous flexibility and that it would be counterproductive to pay lip service to the concept of empowerment, while continuing to adopt a top-down approach for decision making.

Kirkman and Rosen (2000) conclude that team members who share a sense of potency believe in themselves. They exhibit a can-do attitude. Bruhn (2004) claims this attitude develops when leaders are flexible enough to assume responsibility for the organization's plan of change and nurture and guide its implementation, but trustingly delegate the details. Kouzes and Posner (2002) support that employee choice builds commitment and extra employee effort. Employees need latitude or necessary leeway to do their work. The need for latitude is supported by a study described in Fortune Magazine (2006), where the productivity of businesses was observed over two decades. Thirteen of the top two-hundred companies outperformed all other companies based on a few key factors. The primary factor for high performance allowed higher spending authority at the divisional level, or in other words, the necessary leeway to do their work.

In the new script, an essential part of emotional intelligence is telling the truth, looking people in the eye, and remaining true to oneself (Arnold, 1995). The painful recognition will be that some staff may not want the organization to succeed. These individuals may establish work agendas that further their own careers, rather than support the organization. Samuel (2001) declares that, if employees are not accountable and this is not addressed by leaders, the "non-performers will thrive, while the rest of us do double work picking up the slack" (p. 5). This lack of accountability on the part of the

individual will impact the culture of the organization where there will be fighting, rebelling against change, and protecting each other at the cost of hurting others.

There is research evidence on the negative impact of retaining poor performers on the culture of an organization. Leadership IQ, a leadership training and research company in Washington, DC, conducted employee surveys with 70,305 employees, managers, and executives from a 116 health care agencies (Leadership IQ News, 2006). According to this study, 87% of employees said that working with a low performer made them want to change jobs. Ninety three percent of employees said that working with a low performer decreased their productivity. Only 14% of senior executives say their company effectively manages low performers and 17% of middle managers felt comfortable improving or removing low performers. The new rules require leaders to address performance issues as part of their commitment to accountability. The new script will then promote the recruitment of individuals who will have different ideas and new ways of doing things. This type of recruitment will require flexibility on the part of leadership.

The final aspect of the new script to be discussed is the role of evaluation. This step is imperative and is part of both the new rules and the new script. It involves both accountability and flexibility. Porter-O'Grady (1999) refers to evaluation as the need to fluidly respond to current demands and changing circumstances, remaining open to messages carried by longer term indicators and acting in accordance to these messages. According to Gardner (1990), "An ever renewing organization is infant-like – curious and open to new experience and change" (as cited in Kouzes & Posner, 2002, p. 28). He

concludes that the only way to conserve an organization is to keep it changing or it will become stagnant and die.

There are many methods of evaluation. Langley, Nolan, Norman, Provost, and Nolan (1996) developed a Model for Improvement (see Figure 3) which is based on a plan-do-study-act framework. This method evaluates a problem and develops a change. The results of this change are then evaluated on a continuing basis and further changes are implemented as necessary. The framework asks three questions: What are we trying to accomplish? How will we know that a change is an improvement? What change can we make that will result in improvement?

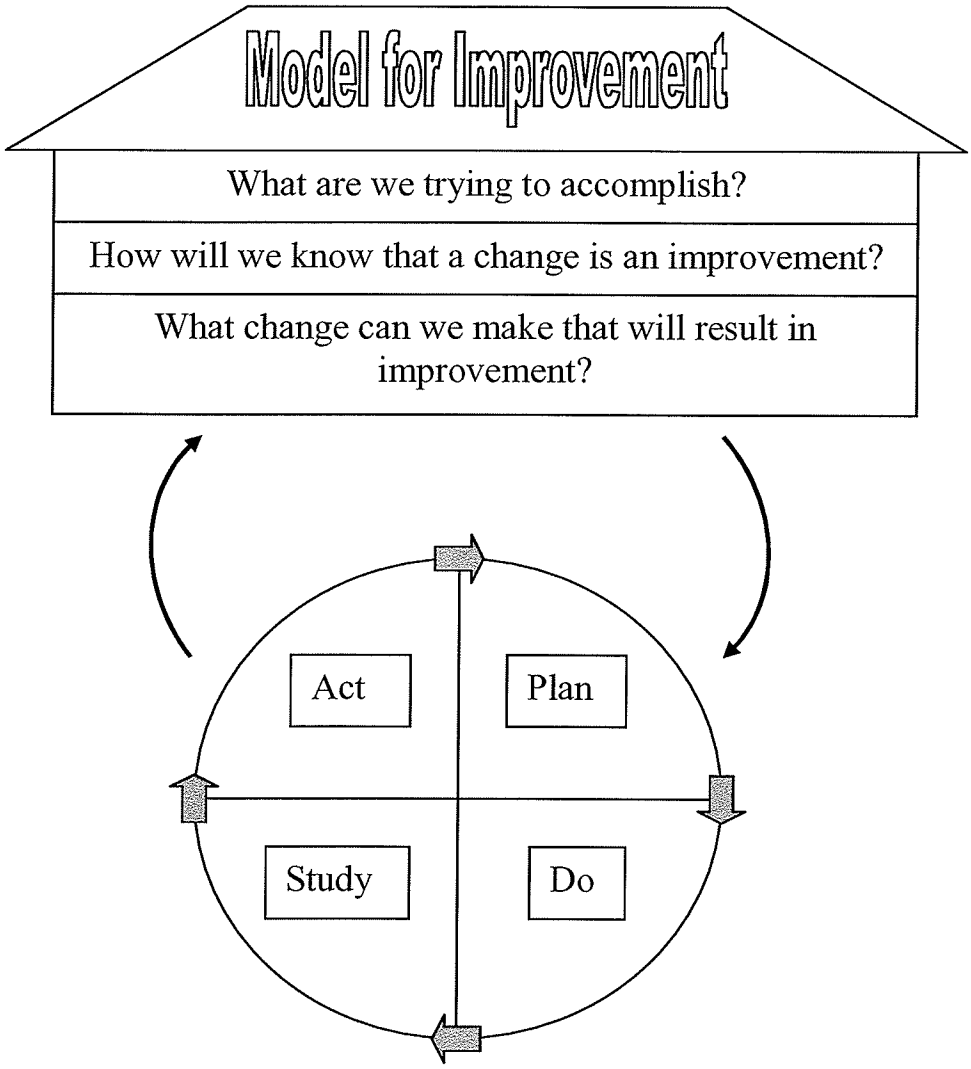


Figure 3. Model for Improvement from the Improvement Guide: A Practical Approach to Enhancing Organizational performance by G. Langley, K. Nolan, C. Norman, L. Provost and T. Nolan, 1996, p. 10.

Similarly Litch (2005) claims the evaluation process is ongoing and the status quo is always changing. Barstad (2002) argues that constant change is conducive to iterative planning processes where "you try, you err, you go back seeking new paths and you evaluate to see if you are getting closer to the desired situation" (p. 1). These steps are illustrated in a loop-like model where one goes backwards in the step-line and then runs through a new cycle (see Figure 4).

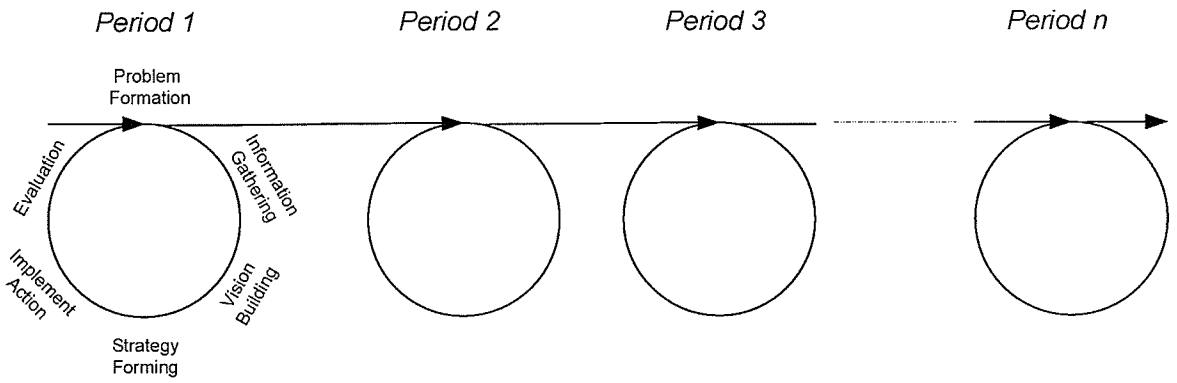


Figure 4. Planning as a Rolling Cycle from Iterative Planning Processes: Supporting and Impeding Factors by J. Barstad, 200, p. 3.

Lindbloom described the "muddling through theory" which looks at continuous adaptation. The principle behind this theory is one of constant evaluation and flexibility. It advises using many small steps in an adaptive and learning process and can be a useful tool where there are long term goals and visions. The need for flexibility and responsiveness to evaluation in an environment of change is enthusiastically described by Porter-O'Grady (1999). "The wonderful thing about the times we are in is that no one is sure of anything. In emerging clinical models of care, everything is in motion and subject to evaluation" (p. 176).

These three models of evaluation are congruent with the UDT Model. They all suggest constant change, support the need for accountability through evaluation, and reinforce the requirement for flexibility in new work through continuous adaptation to evaluation results. This continuous adaptation is part of the new script which again overlaps with chaos in the UDT Model.

Summary

The literature review confirms that change is constant. With change, there is often confusion which is interpreted as chaos. The losses felt during times of change are real and require acknowledgement from leaders. Leadership is essential in order to influence human systems to follow new rules, and do new work, within a new script. This leadership is an intentional process whereby individuals lead others to find different ways to solve new problems and seize emerging opportunities in times of revolutionary change.

The literature review has also validated the UDT Model and its application to the Prehab Program. The driving forces are strong, resulting in chaos and an impetus for change. With change comes loss that must be acknowledged before moving on to the new rules of accountability and the new work of change in order to provide seamless care across the continuum. With this will come a new script of flexibility which in itself will result in further chaos. All of these concepts are readily applied to the program planning associated with the Prehab Program.

Chapter 4: Methodology

The purpose of this clinical practicum was to gain knowledge and insight into the program planning process, from a leadership perspective. To this end, I have immersed myself as a participant observer in the development of the Prehab Program. This methodology section will include a discussion of the practicum design including a description of the participants, meetings, data synthesis, and ethical considerations.

The Practicum Design

The design of this practicum was participant observation. This is a form of field research where the aim is to understand the experiences of people as they actually occur (Polit & Hungler, 1983). This allows the collection of loosely structured observational data about people and their environments with a minimum of structure and interference by the observer. In this practicum, there was a broad plan for types of information gathered, such as gaining and understanding the Prehab planning process. Unstructured observational data was gathered in field settings such as the Health Sciences Centre and River East Access Centre boardrooms.

The observational experience was based on a conceptual foundation chosen for the nursing practicum, namely the UDT Model. The observer participated in the functioning of the Prehab Program Steering Committee, while observing and recording information within the context and structure relevant to the group. The observer initially listened to the group to obtain a broad view of the program, as well as to become acquainted and more comfortable in interacting. Subsequent observations became

enhanced by a modest to active degree of participation. The final phase of the observation experience involved reflection on the total process of what transpired, and how people interacted and contributed to the process. There was no manipulation of variables, and as a result, no cause effect relationships could be identified.

Participants

The participants included eleven interdisciplinary representatives from the Winnipeg Regional Health Authority (WRHA) who were appointed to the Prehab Program Steering Committee by their respective regional program directors. Disciplines represented were medicine, physiotherapy, occupational therapy, nursing, social work, foods and nutrition, psychology, and pharmacy. There were 3 physicians on the committee, with representation from orthopedic surgery, anesthesia, and internal medicine. All other disciplines had one representative. The community and acute care sectors were represented. Meetings were chaired by the WRHA Surgery Program Director.

Procedures

Literature Review

A literature review was conducted to situate the program planning experience and change process within a theoretical perspective. Through this literature review, a theoretical model was identified, which was then used as a framework to describe the planning process and its associated changes and achieve the goal of gaining insight into the program planning process.

Organizational Documents

Various organizational documents such as statements of mission, vision, and values were reviewed. Organizational policies and procedures were examined to obtain information regarding the establishment of a new program. Job descriptions were compared and contractual labor requirements were analyzed. These organizational documents provided foundational information regarding the rationale for the program development, and the management of human resources.

Interviews with Key Stakeholders

There was opportunity to discuss additional insights into the leadership aspects of the program planning process with the key stakeholders prior to and following meetings, as well as via email to enhance my understanding of the program planning process. This also allowed time for further elaboration with the various disciplines on their perspective regarding the group processes. In addition, there were teleconferences and personal interviews with individuals in Ontario and Alberta who have had experience with developing programs for individuals on joint replacement waitlists.

Dorothy Wylie Nursing Leadership Institute

This was a 5 day residency program attended by the Prehab Program Steering Committee Chair and the graduate student in October 2006. It was followed by a 'booster' educational weekend 3 months later. The course addressed four domains of leadership competencies, namely nursing practice, the business of healthcare, leadership practices, and the use of self. The goal of the Institute is to develop effective leadership knowledge, skills, and attitudes, as well as strengthen leadership abilities of already established nurse leaders.

Meetings

The practicum took place within the WRHA. The planning was initiated by the Surgery Program in collaboration with the community program team. The Prehab Program Planning Committee meetings were held every 2 weeks, lasting 2 to 3 hours each, from September 2005 to May 2006. A total of 17 meetings were attended. The location of the meetings alternated between the Health Sciences Center and the River East Access Center.

Recording devices were not used at the meetings. Written notes were taken to record the leadership insights and the group process. Following the meetings, participants were invited to provide clarification or additional insights into the program planning process. These discussions took place in a venue and time that was convenient to the participants, and in consideration of confidentiality.

Data Synthesis

Observations were made at the meetings and documented. No formal research instruments were used during the observation period. The data gleaned from the aforementioned sources were synthesized within the context of the UDT Model.

Ethical Considerations

Ethical approval was obtained from the Education/Nursing Research Ethics Board (see Appendix B). The purpose of the nursing practicum, as well as the participant observation process was described to potential participants. Informed consent was obtained from all members of the Prehab Program Steering Committee (see Appendix C).

The participants were assured that anonymity and confidentiality would be respected and maintained. All the information provided to the student was kept

confidential. Names did not appear in any reports, publications, or presentations about this practicum. All records that contained identity were treated as confidential in accordance with the Freedom of Information and Protection of Privacy Act. Notes taken during the meetings focused on the leadership insights gleaned from the group process and did not identify specific committee members. The notes were kept in a locked cupboard in the student's office and then destroyed following the oral defense for the Masters of Nursing degree.

There were no known risks to participating in the observational experience. No compensation was provided. All participants were invited to review the scholarly paper prior to the oral defense for the Masters of Nursing degree. The review provided an opportunity to address any concerns related to the observations being reported. A brief summary of the project was available to the participants upon written or verbal request to the student.

Summary

The opportunity to observe the development of the Prehab Program from infancy to fruition provided an exemplary learning experience. A variety of leadership techniques were employed and insight was gained as to their effectiveness. This learning experience was also guided by the literature and further strengthened by attendance at the Dorothy Wylie Nursing Leadership Institute where there was exposure to other leaders, as well as different theoretical perspectives.

Chapter 5 – Findings

The findings of the participant observer experience are integrated throughout this chapter. The leadership insights gained during the clinical practicum experience, which focused on the planning process of the Prehab Program will be highlighted, summarized, and discussed. Porter-O'Grady's (2003) Universal Dynamics of Transformation (UDT) Model is utilized to organize the results.

Dorothy Wylie Nursing Leadership Institute

The knowledge gained at the Institute enriched the participant observer practicum experience. Insights were gained into the business of health care and included an understanding of the political influence upon the system, as well as organizational behavior, and resource management. Leadership competencies provided information into many aspects of change, such as challenging the process, inspiring a shared vision, and enabling others to act. The role of leaders and their use of self were examined in regards to successful change management. Other considerations such as scope of practice, standards, and professionalism within the practice setting were beneficial in the planning of a new program. All aspects of this learning experience were relevant to the planning of the Prehab Program and the application of the UDT Model.

Application of The UDT Model

The UDT Model was very applicable to the program planning process and heightened an awareness of the many concepts that must be considered and their

influence on all aspects of the program development. Consequently, this model will provide guidance to all aspects of the implementation process of the Prehab Program.

Driving Forces

The UDT Model classifies external driving forces as contributors to the chaos within a system. The three driving forces for change, identified in the model, namely sociopolitical, economic, and technical were very evident in the Prehab Program planning.

Sociopolitical drivers. There was considerable political pressure, both federally and provincially, to respond to the lengthy waitlist for hip and knee replacement surgery. Reducing the waitlist is one of the stated top five priorities for the recently elected Federal Conservative Government. Benchmarks for acceptable wait times are being established and the expectation is that leaders within the healthcare system will ensure these timelines are met. The politicians are hearing from their constituents that the health care system needs to be more responsive. The public voice is particularly powerful in Manitoba, where the NDP Government is in the third year of a four year term. Myrna Driedger, Tory Health Critic, contends "The government's slogan 'better care sooner' has become a joke" (Skerritt & Rabson, 2006). In Manitoba, many individuals remain on the waitlist. On April 1, 2006, there were 2618 people on the waitlist for joint replacement surgery. Some of these individuals were waiting for more than one joint to be replaced. This resulted in a waitlist for 2835 joint replacements (Macdonald, 2006; see Figure 5).

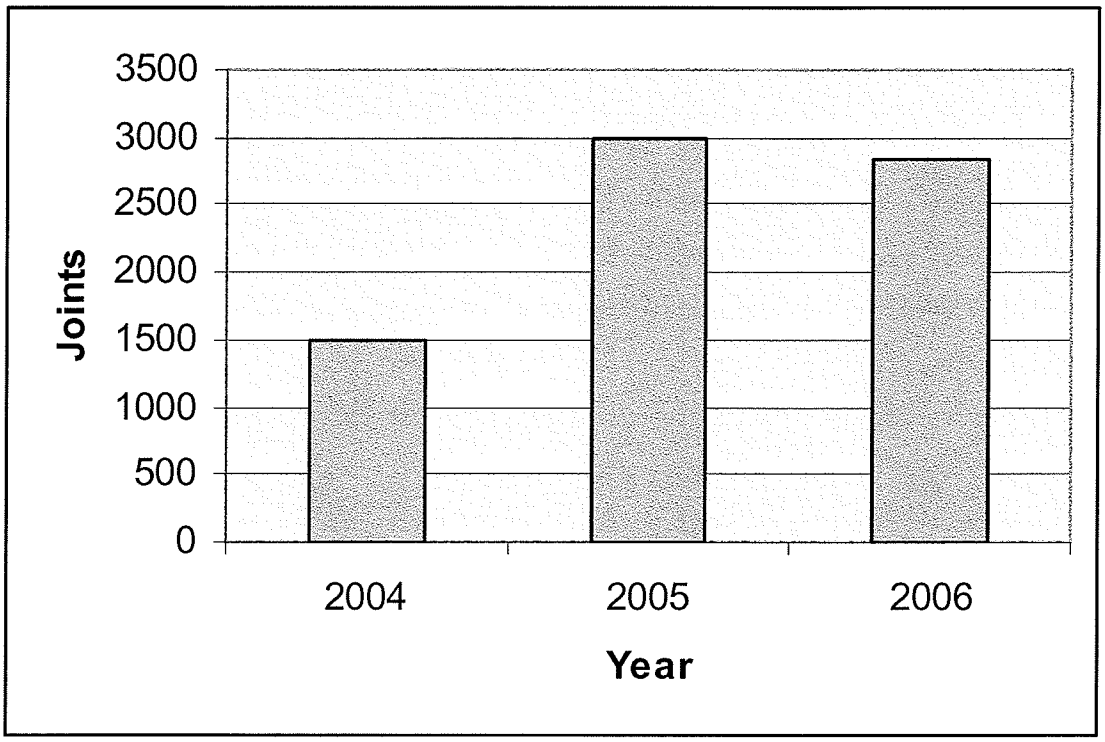


Figure 5. Number of Joints on Manitoba Waitlist Registry. In 2004 reporting waitlist numbers were not compulsory and only 80% of surgeons reported. From Manitoba Waitlist Registry, L. Macdonald, Nov.2006, Winnipeg Regional Health Authority.

The power of this partisan voice was apparent in the development of the Prehab Program. Several months into the planning, there was political unrest regarding the length of time some individuals had been waiting for joint replacement surgery (See Figure 6).

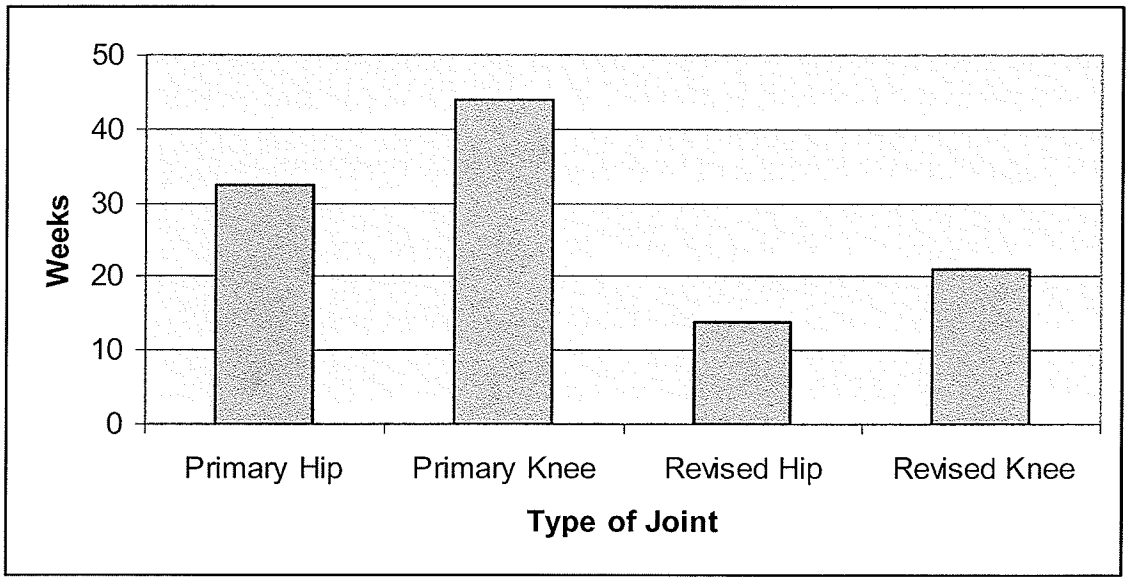


Figure 6. Average Wait Time for Completed Hip and Knee Replacement Surgeries 2006. From Canadian Joint Registry Report, T. Sawchuk, Nov.2006, Winnipeg Regional Health Authority

The lengthy waitlist resulted in a ministerial directive that there would be no summer slowdowns in the hospital operating rooms and those patients on the 'tail of the waitlist' – having waited 42 or more weeks, would be fast tracked through the system. Responding to this directive required flexibility on the part of leadership. The vision of the Prehab Program to maximize physical and emotional functioning of patients pre-operatively, to optimize outcomes, was not going to be offered to the long waiters. The leadership was then required to briefly shift their focus to identifying those on the 'tail of the waitlist', contacting the individuals and arranging for surgical dates. This was done in tandem with the continued planning for optimization of the other individuals on the waitlist. Attempting to fast track those on the tail of the waitlist revealed several issues. Some clients no longer wanted surgery, others did not want to be hospitalized and

recuperate during the summer, and a few had actually died. These unanticipated political directives, as well as the autonomy of the public in deciding about the timing of their health care, contributed to the chaos within the system.

Economical drivers. Coupled with these sociopolitical forces are the economic driving forces. The current cost of health care in Manitoba is $3,284 per capita, the second highest spending in Canada, next to Alberta (Skerritt & Rabson, 2006). The Province of Manitoba spends $3.6 billion on health care annually (Skerritt & Rabson, 2006). Those patients in chronic pain awaiting joint replacement surgery require additional medical care, which escalates the health care costs. There is also the issue of reduced productivity while waiting for surgery. As stated previously, 80% of working age patients referred to the University of Manitoba Joint Replacement Group (UMJRG) for hip replacement surgery are still in the workforce and nearly 25% of these patients report being off work secondary to their hip condition (Bohm, 2006). Thus, waiting time results in increased cost to the system and decreased contribution to society by the patient. However decreasing the waitlist at a more rapid rate also adds costs to the system with an average joint replacement costing $5,500. This contributes to the chaos within the system. If the decision is to rapidly reduce the waitlist, there will need to be an influx of funds to cover implant costs, as well as hospitalization. This will include salary for additional staff, as summer is generally a time for reduced elective surgical activity, resulting in cost savings to the system. These additional funds will come from the one existing Manitoba Health budget and will have an impact on funds available to other programs, including transfers to the community programs to help increase their capacity.

The Prehab Program recognized that clients can become more debilitated as they wait for surgery, which results in extensive post-operative rehabilitation and longer hospital stays. This in itself is an economic driver for changing the system. There is also concern that many individuals are presenting for surgery in poor physical shape, carrying extra weight, and smoking which increases the risk of complications and extends the rehabilitation phase. With the Prehab Program, there is the possibility that clients will maximize their health to such an extent that they may choose to delay surgery, could potentially not require it, or become fit and ready so that outcomes will be improved. Improved outcomes include a shorter length of stay, which will positively impact the provincial economy. Patients will be able to return to the work force sooner and some of the drain currently placed on the system by lengthy hospitalizations will be alleviated.

Attached to a longer LOS is a per diem funding allocated for staffing and other operational needs. There is also the risk of iatrogenic infections which results in additional costs to the system, patients, and their families (Bannerman & Nixdorf, 2005). The LOS issues contribute to the waitlist as they impede the throughput of patients. If patients remain in hospital beds longer, fewer surgeries will be slated and referrals to the waitlist will continue to multiply.

Technical drivers. The technical drivers were influential in the development of the Prehab Program. Clients are accessing the internet for information regarding waitlists in other provinces, in private clinics, and for individual surgeons. Politicians are being bombarded with questions about two-tiered medicine, as well as requests for referrals to surgeons in the United States, who have shorter waits. Clients are researching types of implants and some are then approaching their surgeons with requests for a specific type

of implant that is reported as being more durable, and often more expensive. Clients are informed and asking sophisticated questions about the benefits of ceramic implants compared to the metal on metal implants. They are also asking about outcomes and the longevity of various procedures. Some individuals are prepared to extend their waiting time in order to remain on the list of a specific surgeon. Many are aware that revision rates are high (see Figure 7) and choose to remain with the surgeons that have documented better outcomes. Thus, the informed public has high expectations, which contribute to the chaos when a system that is accustomed to deciding the time and type of surgery is now required to become accountable to the public and flexible in meeting their needs.

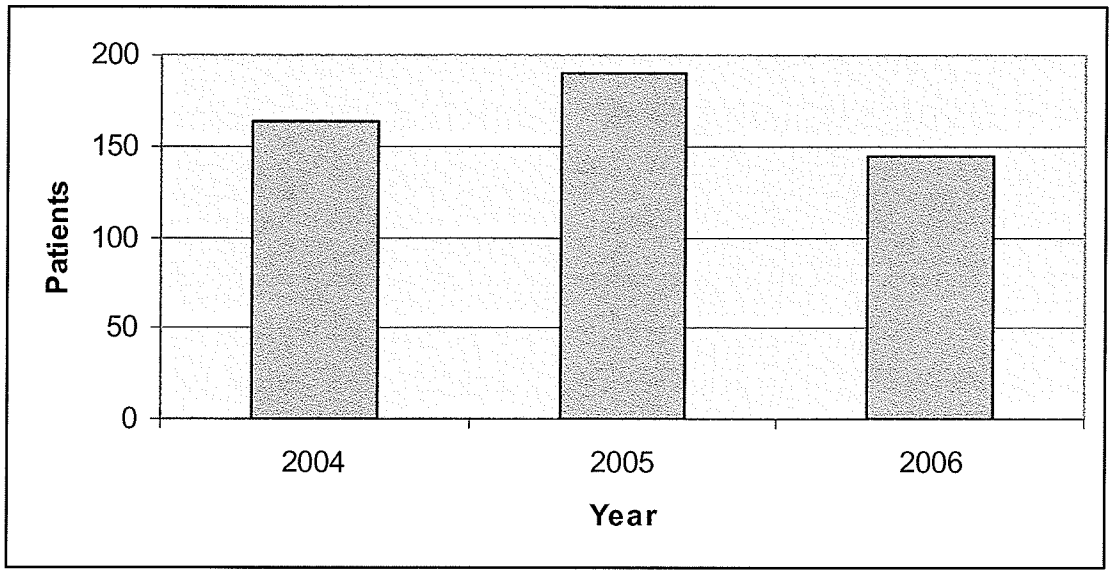


Figure 7. Number of Patients that had Revisions. From Manitoba Waitlist Registry, L. Macdonald, Nov.2006, Winnipeg Regional Health Authority

Expert surgeons are being pressured by Manitoba Health and the healthcare system to perform additional surgery. This leads to new initiatives, such as 'double days' in the operating room, where one arthroplasty surgeon works with two surgical teams,

going between two adjoining theatres for the critical part of each surgery. In so doing, the surgeon is able to perform seven joint replacements, rather than the usual three in one day. This too contributes to the chaos, as recovery room space becomes congested, and available in-patient beds are limited. Thus, sociopolitical unrest, economic limitations, and technical advances are all active contributors to the chaos within the healthcare system, and driving forces for the need to transform the current system.

Chaos

As identified in the UDT Model, the three driving forces are inducing chaos within the system and accentuating the need for its transformation. The chaos emanates from lack of trust by the general public in regards to the healthcare system. Clients are experiencing long waits for surgery, but can also identify duplication of services across the system, lack of trust between the community and acute care sector, and poor coordination in discharge planning. They are identifying repeated communication break-downs between care providers in regards to individual treatment plans. This was exemplified in the operationalization of the Prehab Program where clients received forms from the surgeon's office, the Prehab Program, and the hospital pre-admission clinic. Clients asked poignant questions of healthcare providers such as, "Don't you talk to each other?" There were occasions when patients had an appointment with the Prehab Program scheduled after their slated surgical date. Patients identified the system as being in a state of chaos.

Simultaneously, healthcare providers are describing clients as more demanding in terms of timeliness and quality of services requested. In informal discussions with members of the Prehab Program Steering Committee, it was learned that some clients

choose not to have surgery during the summer months when there is an operating room and a surgeon available. Likewise, they may be insistent that home care provide services post-operatively and be reticent to engage family in their care. The inability of the system to meet these demands is perceived by some as loss.

Leaders were conscious of the driving forces and open to acknowledging the chaos of the current system. The Program Director made a conscious decision not to be defensive when criticism arose regarding the lengthy waitlists, and more specifically, current OR slating practices, frequent surgical cancellations, lengthy hospital stays, and communication breakdowns, but rather encouraged the Prehab Program Steering Committee to provide solutions and new ideas about how care could be improved. When ideas, such as increased teaching in the community prior to surgery were suggested, the leader quickly focused on this suggestion. Enthusiastically acknowledging a suggestion by a member of the group helped engage the team and encouraged others to contribute to the brainstorming sessions. If members started with a litany of why the suggestions would not work, the leader would bring focus back to the suggestion and elicit ideas regarding the feasibility of this suggestion and other new approaches. Leadership quickly realized that negativity rapidly depleted the energy of the brainstorming sessions. However, in limiting the discussion regarding why suggestions were not ideal, the leader needed to maintain a degree of sensitivity to what may be perceived as loss to both staff and clients, as the system was being transformed to new ways of doing things. This acknowledgement of the past and its contributions was an essential part of the management of the Prehab Program planning process.

Loss

There is loss associated with the adaptation to a new and transformed system. The new system requires consumers and those working in health care to become more accountable. At present, the health care consumer expects to present for surgery, be "cared for," and discharged home when recovery is complete. There will be losses associated with the new accountability, when individuals are required to take more responsibility for their own health and the chances of a better outcome from surgery. The premise of the Prehab Program is that improving their fitness, losing weight, and stopping smoking prior to surgery will optimize their surgical outcomes. The average BMI of patients presenting for hip and knee replacement surgery in Manitoba in 2005 was 30.2 (Sawchuk, 2006). Health Canada refers to a BMI score of 25 to 29.9 as overweight and 30+ as obese. For some clients, the expectation for weight reduction, smoking cessation, and improved fitness may lead to further delays in their surgery.

After surgery, families now are expected to assume more responsibility for the care of their loved ones. Support will need to be provided at home in the early post-operative period. Families may be asked to help with the application and removal of thromboembolytic deterrent stockings (TEDS), or with the subcutaneous injection of Fragmin to prevent deep vein thrombosis. They will be required to pick their family members up at a specific time, regardless of their personal and/or employment responsibilities.

Health care providers also experience loss in this transition. For example, based on observations and discussions with nursing staff, nurses are still reluctant to mobilize patients on the operative day as, in the past, they have gained satisfaction in positioning

patients comfortably and maximizing their pain control. This was deemed synonymous with being a 'good nurse.' Hospital staff also feel ambivalent about discharging patients so quickly prior to maximizing their function. They mourn the time to develop relationships and fear negative outcomes for their patients.

Leaders anticipated questions from staff such as "why are we pushing patients through so fast?" These concerns were frequently heard on the acute surgical ward. There appeared to be a disconnect in hospital staffs' understanding of prolonged LOS and its association to people waiting, in pain, for their surgery. Therefore, as a leadership strategy in this regard, an education day was planned for nursing staff. Hospital staff were appalled to hear patients describe the constant pain they had experienced and the inactivity they had endured while waiting to be admitted to hospital for joint replacement surgery. Pain had prevented them from sleeping and they claimed that their lives were essentially put on hold. Clients reinforced the wonder of a new joint and their renewed mobility after two long years of waiting. This education day acknowledged staff and their past contributions, provided information, and created a new energy for change. A member of the Prehab Planning Steering Committee commented that the lunch and nutritional breaks provided to the attendees had been described by one of her staff as "making us feel important and a part of the new and exciting initiative."

Surgeons are expressing a loss of control as surgery is booked according to waitlist dates, rather than surgeon's case preferences. The ability of surgeons to advocate for their patients on the basis of social factors, for example, a single parent off work due to joint pain, is compromised. Concern for the stamina of the individual surgeons is blurred in this process. Some prefer to alternate between the slating of a hip and a knee

replacement due to the physical demands of performing the surgery. However, this is discouraged if there are more patients awaiting knee replacement surgery than hip replacement surgery. Others like to perform emergency cases during peak times and leave the electives cases until later in the day. These emergencies usually involve the repair of fractured hips and can safely wait several hours. However, these individuals are often frail and elderly, and therefore, some surgeons prefer to do the operation during regular hours when more support staff is available. Concern was expressed that standardized booking does not provide this flexibility, and that control over their individual practices has been lost. In order to give credibility to these changes, with the intent to influence the behavior of other physicians, leaders engaged forward-thinking surgeons who were respected by their medical colleagues, to participate in the planning of the new initiative.

Community healthcare workers also are ambivalent. Some are experiencing loss as their past supportive role within the community is becoming altered by the increased acuity in their clients and the urgency to provide resources in an expedited fashion. Others are challenged by the changes. However, members of the Prehab Program Steering Committee who represented the community were anxious about the needed transfer of financial resources from the acute care setting to the community, and skeptical that this will transpire. If adequate budget transfers do not occur, work loads will become excessive for the existing home care providers and they will experience loss as they are unable to meet their standard of care.

Leaders in the community worked with leaders in the acute care sector to review the evidence for current practices. This occurred in regards to the use of TEDS stockings.

The literature was reviewed and an evidence based decision was made that the removal of TED stockings once daily rather than the past regimen of twice daily, was adequate. This change in practice lessened the need for home care services to assist clients in the application of stockings, which in turn reduced hospital hold days. Collaborative efforts such as this assisted with workload demands both in hospital and in the community.

Shortening length of stay, promoting recovery in the home and standardized booking of slates can be perceived as loss by the individuals affected. Comments such as, "it's not like the good old days" or "remember when we used to" are frequently heard. During the Prehab Program planning the leader acknowledged these losses. Such acknowledgement would be referred to as 'encouraging the heart,' where the leader recognized past contributions in order to keep hope and determination alive. The group could then refocus on the vision of improved outcomes for clients following hip and knee replacement surgery. Attention was directed at individuals waiting in relentless pain, and how valuable each staff member's contribution was in shortening the waitlist. The focus on the client helped respond to the healthcare providers' personal need 'to care.' This need was reframed by the leader from a shorter LOS to shorter time on the waitlist. Such reframing was an effective leadership strategy in engaging staff on a quest for increased system efficiency, which began the transformation from loss to the new rules.

New Rules

The new rules require leaders to become accountable, but also remain cognizant of these losses. In the Prehab Program, the goal of the leader is for the staff to work as a cohesive team between hospital and community, with the patient and family being the central focus of this team.

Leaders recognized the importance of accountability within the context of the new rules. Expectations from Manitoba Health were discussed regularly in order to promote improved working relationships across the continuum of care. Meetings were arranged between managers within the community and hospital based managers to discuss the new rules. These meetings created an opportunity to share concerns, as well as solutions for common client related issues. They also established a shared understanding of the need for improved communication so both sectors would be consistent in their teaching with clients and families. In discussion with community representatives on the Prehab Program Steering Committee, the impression was that these meetings helped close the gap between community and acute care through networking and the development of collegial relationships.

The new rules will require accountability from both the client and the care providers. For example, prior to surgery, the client will need to recognize the need to maximize physical fitness within the limits of joint disease, lose weight, stop smoking, and prepare for the post-operative phase in the home. The preparation may include the purchasing of TEDS stockings, practicing their application, arranging for installation of grab bars in the shower, availability of raised toilet seats, and booking a ride home at the designated discharge time.

All care providers need to be accountable to bigger system issues, such as waitlist reduction. Patients will need to be provided with information prior to hospital admission, and have timely consults to community resources, such as home care and the home intravenous therapy program. Care providers will need to critically examine hospital LOS so that discharges are timely. They will also need to build strong relationships with

rural hospitals so that patients can be repatriated to their community if an extended hospital stay is required. This will facilitate the slating of the required volume of surgery to reduce the waitlist. In order to implement these new rules, the leaders will need to maintain focus on the goal of waitlist reduction, to overcome the resistance from both staff and customers to this new approach. Leaders will need to repeatedly remind themselves and the staff about the individuals waiting in pain in the community, and the need to keep reducing the arthroplasty waitlist.

Leaders also need to be accountable for cost containment. From a systems perspective, this included timeliness of the implementation of the Prehab Program. At regular meetings with the Deputy Minister of Health, the Chair was required to present an update on the progress of the Prehab Program Steering Committee. This required communicating a sense of urgency to the committee because money had already been forwarded by the Government to the Prehab Program with an expectation that it would be immediately operationalized for the constituents.

This cost containment also includes analyzing process flow and information sharing between community and hospital, and back to community to prevent duplication in function. For example, it will not be cost effective to have the Prehab Program and the pre-admission clinic performing similar roles, such as listing current medications, recording past medical history, and repeating baseline blood work. Leaders also will need to monitor the accessibility to the Prehab Program to ensure that another wait time has not been created.

The leader displayed accountability in the adaptation of continuous care between community and hospital through their own actions. Prehab Program Steering Committee

meetings alternated between hospital and community. Refreshments were served, which created a welcoming environment. The program was planned jointly with the acute care sector managing the budget and the community providing space for the clinic operations. It is this level of accountability regarding service, patient flow, and budgetary constraint that will sustain the new work.

New work

In the UDT model, there is overlapping of the circles representing the various concepts of the model. The overlapping is especially relevant with the new rules and the new work. The new rules overlap with the new work. In this practicum, the new work was the Prehab Program working with community and acute care. The new work is influenced by the new rule of accountability and the new script demanding flexibility. This work entails an interdisciplinary team that has developed an intervention to assist individuals awaiting joint replacement surgery to maximize physical and emotional functioning prior to surgery. The background work, the establishment of the committee, the intervention, as well as the need for evaluation were discussed.

Background work

Leaders realized there needed to be a congruent approach to clients on the waitlist. Based on discussions with the Prehab Program Steering Committee members, there was recognition that strictly increasing the volume of surgical procedures was not the answer. They had a vision. A team was created after extensive background work had been completed by the WRHA Surgery Program Director, Administrative Director, and Medical Director. A proposal had been written, submitted to Manitoba Health and funding had been approved for the creation of a Prehab Program for individuals awaiting

hip and knee replacement surgery. Stakeholders were identified at the time of the government submission. A grid was constructed to identify the various levels of stakeholders and their degree of influence.

Establishing the Committee

The Prehab Program Steering Committee was created upon the written confirmation of funding from Manitoba Health. The team was composed of the various disciplines that would be instrumental in developing and managing the program. The directors of the relevant WRHA programs were invited to sit on the steering committee. The disciplines represented were physiotherapy, occupational therapy, foods and nutrition, nursing, social work, psychology, community health, anesthesia, internal medicine, and orthopedic surgery. Steering committee meetings were chaired by the WRHA Surgery Program Director.

At the initial meetings, the goals, values, and vision for the program were outlined (see Appendix D). Based on subsequent discussions with committee members, this vision created a sense of enthusiasm within the team, as well as a common goal. The individuals who submitted the proposal to government had the high level vision for the program and at this point were engaging the team to help shape the course.

Leaders were aware that many initiatives fail because of ineffective or insufficient communication. At the third meeting, a communication plan was established. This plan listed a variety of stakeholders, ranging from the Minister of Health to the graduate student attending the Prehab Program as a participant observer. The relevant message for each stakeholder was determined, as well as the communication medium to be used and the appropriate timing. For example, the Minister of Health message would center

around the benefit the program would have for patients on the waitlist, the medium of communication would be briefing notes, and the timing ongoing. The university student message would concentrate on research opportunities; the medium would be engagement in program development and outcome evaluation with periodic updates.

The next step was determining program planning milestones and target dates. The leader was also aware of creating short term wins. The starting point was defining the patient population to be served. In discussion with the chair of the Prehab Program Steering Committee, she was aware of the diversity within the team and viewed this as an asset to the team program planning. Some members were cognizant of the acute care aspect of joint replacement surgery, while others had expertise in mobilizing community resources. For example, the psychologist on the committee had experience with non-pharmacological pain management, while the pharmacist was well versed in the use of anti-inflammatory medications and analgesics. In order to orientate all members to the type of patients who were undergoing joint replacement, the nursing representative was asked to prepare three case presentations typifying the patient population. The cases presented varied in age, mobility, extent of co-morbidities, and other health risk factors. The discussion of these cases stressed the importance of the different skills and backgrounds of the members of the team. The discussion contributed to the cohesion of the team and created a fantasy theme as described by Wood (2004). Many ideas came from the group as to how they could contribute to managing these patients and maximizing their surgical outcomes. This strategy created alliances within the team.

Defining the Intervention.

The next phase involved defining the intervention. This was assigned to all representatives on the Prehab Program Steering Committee. In so doing, the leader enabled others to act. Each discipline was requested to review the literature specific to their area of expertise. Collaboration was fostered through making each discipline feel capable. The leader recognized that mutual respect is what sustains extraordinary efforts, such as bringing the Prehab Program to fruition. The scientific evidence was reviewed and used as a framework in determining the interventions to be employed in the Prehab Program. The vision of the Prehab Program is that participation in a new life of exercise, weight management, smoking cessation, and group support will become part of the optimization period prior to surgery, and will result in better outcomes. Outcome measures were reviewed in regards to the five components of the program, namely exercise, weight reduction, pain management, education, and emotional support. The relationship between pre-operative and post-operative health status for clients awaiting hip and knee joint replacement surgery was examined. The following is a summary of the evidence related to the intervention.

In regards to exercise, Jones et al. (2000) found that patients who walked independently rather than using a walker and those who were able to walk longer distances before surgery were more likely to have better function post-operatively. Gilbey et al. (2003) demonstrated that customized pre-operative exercise programs are well tolerated by patients with end stage hip arthritis and are effective in improving early post operative recovery. Gilbey et al. (2003) concluded that an eight week exercise program improved strength, reduced stiffness, and improved quality of life for patients

with hip disease. Ettinger et al. (1997) reported modest improvements in measures of disability, physical performance, and pain from participating in either aerobic or resistance exercise. Minor, Hewett, Webel, Anderson, and Kay (1989) studied an exercise program of aerobic walking and aerobic aquatics and discovered significant improvements in aerobic capacity, fifty foot walking time, depression, anxiety, and physical activity. Similarly, a randomized trial by Hall, Skevington, Maddison, and Chapman (1996) concluded that hydrotherapy significantly improved joint tenderness and knee range of movement.

The research literature also supports the implementation of weight management strategies for clients awaiting lower extremity joint replacement surgery. The number of overweight Canadians has increased four fold over the past twenty years (Kuyumcu, 2006). Excess body weight increases the risk of death from many causes. Weight gain is associated with reduced self esteem and obesity is associated with a higher rate of disability (Dickey & Bray, 1998). Obesity has been documented in multiple studies to be more common among knee replacement clients. The Framingham study found there was double the incidence of obesity in the knee replacement group, with it being greater in females than males (Felson, Anderson, Naimark, & Meenan, 1988). Karlson et al.'s (2003) research showed a two fold increased risk of hip arthritis in women with a BMI greater than 35. Individuals who had an increased BMI at the age of 18, had a 5 fold increased risk of developing hip arthritis. The Canadian Joint Registry data from 2003-2004 shows that individuals with a BMI over 25 have a 1.5% increased chance of requiring joint replacement surgery and those with a BMI greater than 30 increase their chances to three times compared to individuals of normal body weight (Hedden, 2006).

Spector, Hart, and Doyle (1994) found increased risk of disease progression and opposite side involvement in women with a high BMI. They observed that 47% of women with high BMI developed osteoarthritis in the other knee within two years, compared with 10% in the lowest BMI group.

The benefits of weight reduction prior to joint replacement surgery are well defined. However, the effect of obesity on the outcome of knee replacement surgery is unclear. Studies have shown that a greater body mass index is associated with worse physical function, but it was not a predictor of pain or the need of a subsequent revision on the operative joint (Hawker et al., 1998). Moran, Walmsley, Gray, and Brenkel (2005) studied the post-operative complication rate of eight hundred obese patients following hip arthroplasty and found no correlation between the BMI and the development of complications. They supported the need for pre-operative weight loss, but found no justification for withholding hip arthroplasty surgery on the grounds of BMI.

Research based evidence exists to address the three remaining components of the Prehab Program, namely pain management, education, and emotional support. In a multicentre study across Australia, the UK, and the US, Lingard, Katz, Wright, and Sledge (2004) reported that pre-operative pain and functions were the strongest predictors of pain at one and two years following surgery. Nilsdotter, Petersson, Roos, and Lohmander (2003) reported that older patients and those with worse pain pre-operatively had significantly greater odds of poorer function 3.6 years post-operatively. Other pre-operative variables associated with poorer pain outcomes were the presence of depression

and anxiety (Brander et al., 2003), less social support (Fitzgerald et al., 2004), and less education (Fortin et al., 2002).

The importance of patient education is stressed by many authors. Callaghan, Rosenberg, Rubash, Simonian, and Wickiewicz (2003) refer to education as "the cornerstone of treatment of osteoarthritis," while Scuderi and Tria (2002) envision it as a time "to orchestrate post-operative planning." Klippel, Crofford, Stone, and Weyand (2001) define patient education as "planned organized learning experiences designed to facilitate voluntary adaptation of behaviors or beliefs conducive to health" (p. 273). This voluntary adaptation is key to the Prehab Program and relates to issues of motivation and adherence.

Other researchers (Johansson et al., 2002; McGregor et al., 2004; Sjoling et al., 2003) contend that information influences the experiences of pain after surgery. Education results in less pre-operative anxiety and fear, which decreases post-operative pain. Depression and anxiety have been found to be more prevalent in chronic pain syndromes, such as arthritis. Maher, Salmond, and Pelino (2002) claims depression may be as high as 50% in the arthritic population. A vicious circle is established in that pain causes stress and depression. Several researchers, (Kiecolt-Glaser et al., 1998; Magni et al., 1994; Pollock, 1986), have provided substantive evidence that depressed patients experience increased pain. They also observed that individuals who are more anxious are also likely to experience greater post-surgical pain.

The Prehab Program could be viewed as a form of social support for clients during the wait time for knee and hip replacement surgery. Bradley et al. (1987) conducted a randomized clinical trial that concluded a psychological treatment

intervention with a social support program reduced patients' pain behavior and trait anxiety. This effect was maintained for six months post treatment.

This review of the research literature, coupled with the shared experience from the Hamilton Health Sciences Center and the Alberta Bone and Joint Institute, established a framework upon which to define the interventions. There were several meetings ascribed to discussions on the intervention. The leader encouraged all members to participate and promoted discussion regarding concerns raised, as well as suggested changes. For example, issues such as admission criteria for the program, as well as means of determining high risk patients for exercise and associated patient safety concerns were discussed. Questions regarding the reality of achieving weight loss with limited mobility were debated. Other members of the Prehab Program Steering Committee queried whether non-pharmacological means of pain management were maximized prior to moving to pharmacological methods.

Ongoing program planning.

Meetings were held to discuss additional aspects of the planning, such as hours of operation, client assessment, intake screening, and appropriate intake questionnaires. Issues such as staffing, budget, contractual issues, office space, and the ordering of equipment appeared on the agendas for discussion and decision-making. These meetings provided many opportunities for learning about leadership. The insights encompassed topics ranging from preparation, stages of development of the team, and the various roles played by participants.

Each meeting had a well prepared agenda with diverse issues to be discussed. The agenda served as a blueprint for success, as it enabled the leader to provide structure

for participants to follow. The timing of the meetings was at the end of the afternoon, and a light lunch was served. The objective in the timing was based mainly on business, efficiency of time, and availability of participants.

The four stages of group development, as described by Blair (2003), namely forming, storming, norming, and performing, were visible in the Prehab Program Steering Committee. Initially everyone was excited to be part of the planning. Their behavior was polite, and opinions were guarded. The group then advanced to the storming stage, when it became time to establish intake criteria, develop a patient questionnaire, and explicate the roles for each discipline. Disciplines defended their own turf, personalities clashed, and the ability to reach consensus became challenging. The leader managed this phase by listening to each discipline, allowing time for discussion, and interjecting humor when appropriate. This could be referred to as effective 'use of self,' a social awareness of the individuals in the group coupled with a keen understanding of relationship management. On one occasion, the leader stopped the team to partake in refreshments. This allowed a "cooling off" period, and then the team was able to resume discussions. The leader always focused on a holistic view of the client, and not the fractionated stands of the various disciplines. After four or five meetings, the norming stage evolved, where the team was able to agree on a patient-focused questionnaire, as well as a need for blending of the various professional roles within the Prehab Program. The final stage is referred to as performing, during which job descriptions were created, postings arranged, roles defined, and space and equipment allocated. At this point, there was an increased level of comfort with free and frank exchange of ideas, and a high degree of support by the group for collaborative decision making.

The intervention was defined, the clinic pathway drafted, staff hired, and entry criteria for clients determined. The new work was ready to begin. With the new work came several additional challenges which necessitated further meetings. This included the definition of the roles to be played by the various disciplines. All Prehab staff came from a hierarchal system and found it difficult not to have an assigned leader. After several meetings, it was apparent there were only two full time staff, namely the nurse and the clerk. The nurse soon assumed the role of informal leader. There was some reluctance in assuming this role until permission had been granted by the program director. The granting of permission was a form of hierarchal support.

The need for evaluation was identified by the leader, but the sense of urgency to start the program required flexibility in the planning process and the methods of evaluation were to be determined once the Prehab Program was initiated. The key leadership role in this new work was having a vision, as well as, creating enthusiasm within the team to carry out the work instrumental to this vision. In discussion with committee members the effective use of self by the Chair was instrumental in the planning of the program. This included high personal integrity, as well as an awareness of group relationships, recognition of individual contributions, and celebration of accomplishments, all of which were bolstered by appropriately used humour.

New Script

With the new work came a new script for future work. This script has one prominent feature, namely flexibility. Again the overlapping of the concepts within the model is noted. The flexibility determined the work, which was grounded on the rule of accountability. As described in the model, this new script also overlaps with chaos. With

flexibility comes change which continues to be chaotic, although, in a different way. This process of transformation was exemplified in the planning and implementation of the Prehab Program.

The initial Prehab Program plan was that all clients awaiting joint replacement surgery would be assessed and prescribed specific and individualized means of optimizing their health. The Prehab Program Steering Committee soon realized that this was not necessary, as many patients were fit and ready for surgery. It would also be an unmanageable and unrealistic expectation, given the current staffing, and consequently, could create a new bottleneck. Arriving at this revelation required flexibility in planning. A different approach was taken where all intake questionnaires were reviewed. A weighting of questions was assigned, and based on these scores, clients were classified into three categories: A) fit and ready for surgery, B) requires optimization at Prehab, and C) delayed by choice (see Appendix E). In this process, 480 questionnaires were reviewed.

Questionnaires were mailed to all the clients on the waitlist. The Prehab Program staff classified the patients into categories A, B or C (see Figure 8). The clients in category B were assessed by the Prehab Program staff in their clinic and surgery dates were determined, based on the individual's health status. This in itself required flexibility, both on the part of the staff and the client. The questionnaires were not always returned promptly, requiring the adjustment of work days to make follow up phone calls and flexibility with appointment booking. As well, the optimization period varied in length. The booking of surgery dates also was variable, based on operating

room, surgeon, and anesthesia availability. These bookings can also be altered by emergency procedures that vary in number and severity, on a daily basis.

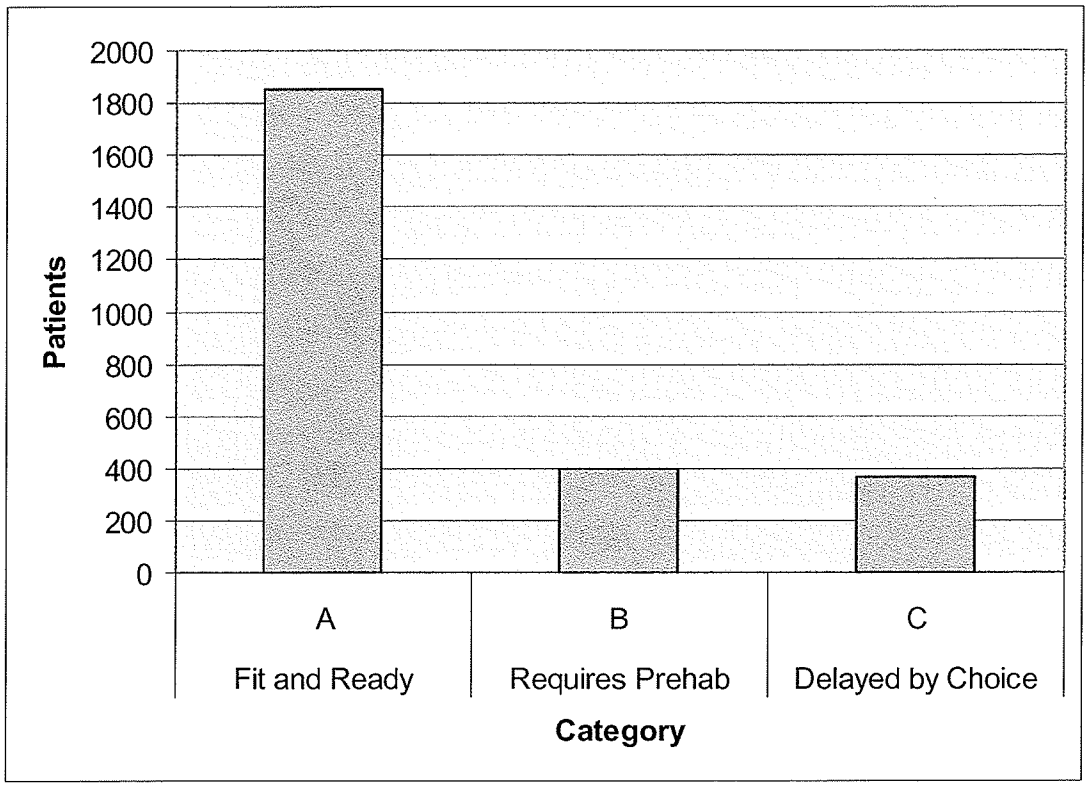


Figure 8. Classification of Waitlist Patients. From Manitoba Waitlist Registry, L. Macdonald, Nov.2006. Winnipeg Regional Health Authority

Planning seamless care between community and acute care requires significant flexibility. At the Prehab Clinic, those classified as 'unfit' are counseled to participate in a fitness program designed especially for individuals with advanced joint disease. There are also expectations regarding weight management and smoking cessation. Some clients are more motivated than others, requiring flexibility in approach by the Prehab Program

staff. The team also is accountable for educating individuals regarding pain management, as well as the perioperative process.

The Prehab team was proactive, by establishing an open relationship with the pre-admission clinic (PAC) within the hospital setting. Establishing an open relationship required developing trust so that information gathering was shared between the community and acute care and duplication was avoided. The PAC staff needed to be reassured that their role was still valuable and that the Prehab Program's goal was to optimize the health of individuals prior to presenting at the PAC clinic. The acute care sector will need to be accountable for reviewing current processes and identifying means of communicating and planning discharges with community teams, prior to the client's admission to hospital. Trust will be a big issue with the Prehab Program, as leaders strive to create seamless care for individuals across the continuum of care. The temptation within the acute care setting will be to repeat all tests and education. Leaders will need to bridge this gap and promote trust between community and hospital through regular meetings and relationship building. Arranging an afternoon's observation experience for the PAC staff at the Prehab Program assisted in their understanding of the program. It also was the beginning of promoting trust between the two groups by establishing a relationship.

The new script requires flexibility. This was clearly illustrated in the planning of the Prehab Program. The initial mandate was to establish a program for individuals who have been waiting an extended period of time for surgery. During this time, many have become increasingly immobile and have exhibited a decline in physical function. Several months into the planning, the directive was received from Manitoba Health, that all

individuals who had waited an extended period of time must be fast-tracked through surgery over the upcoming summer. In discussion with the Chair of the Committee, it was determined that there was internal conflict regarding this imposed change, but also a recognition that political direction must be followed. The ability of the leader to deal with this internal conflict and to "read the signposts of change," namely waitlist reduction, enabled her to engage the team to adapt to the change and continue planning the Prehab Program.

The overlapping of the five concepts in the UDT model was exemplified in the development of the patient questionnaire. The questionnaire development was part of the new work, but required application of the new script. It required considerable flexibility and was an example of the storming phase of group development (Blair, 2003). Initially each discipline wanted a section in the questionnaire. At this time, there was considerable forming, storming, norming, and finally, performing of the group. The leader allowed this to happen and was supportive of the creation of eleven different versions of the questionnaire. This included several variations on the wording of questions, their clustering, as well as the weighting of the relevance of questions in regards to the Prehab Program admission process. The final product was a cohesive questionnaire that provided information for all disciplines in a form that flowed in a patient-friendly manner. Initially, this questionnaire was to be completed manually, but following considerable discussion and flexibility, proceeded to an automated telephone response system. This too involved considerable storming regarding the practicality of an automated telephone response system for elderly clients. The leader was able to convince the group by suggesting a trial focus group, and then proceeded based on those results.

The focus group, although small, (i.e. 6 individuals) helped identify the strengths and gaps of this method of information gathering. Changes were made based upon this feedback. This telephone mechanized system is being trialed, and has the capability of providing a summary response sheet that is used in the Prehab Program and will also be available in the hospital setting.

Flexibility also was required when the Prehab Program was initiated and labor relations issues prevented job sharing since the community and acute care sectors have different unions. Both unions strive to keep 100% of their jobs; transferring care from hospital to the home often becomes a union negotiation focused on the job, not the client. Job descriptions were re-written so as to be acceptable to both unions and then were advertised accordingly. This was accomplished because the leaders had an understanding of the business of health care, which included contract interpretation and the ability to negotiate with union leadership.

Flexibility also requires a responsive approach to evaluation. In the Prehab Program, there was discussion regarding admission criteria, as well as "stopping rules." The stopping rules were specific reasons that would delay surgery until the individual had successfully completed conditioning through the Prehab Program. The need for program evaluation was identified. Discussions occurred with the WRHA Research and Applied Learning Department regarding appropriate timing for the evaluation, as well as salient factors to be studied. Areas to be evaluated included outcome measures for the interventions, hospital LOS, and duplication of service. There was awareness that simply moving patients from one list to another, i.e. surgery waitlist to Prehab Program waitlist, in itself, was not an acceptable option and would not ease client concerns. The flexibility

and associated accountability requirements for the new script demand that the leaders acknowledge that any decision that does not have a positive result in patient care and health is a poor one, and must be re-worked. Thus, leaders must maintain an ongoing sight of their vision for the program.

Summary

The planning of the Prehab Program was rich with learning opportunities about leadership. All five phases in the transformation required a leader who was able to motivate others to share that vision. As a participant observer, it was obvious that there was a wealth of knowledge and skills required by the leader in order to be successful with this motivation. The leader needed to understand and respond to the business aspect of leadership, which included the driving forces, namely political and environmental, consumer/community responsiveness, and economic in the form of resource management. Through observation, there was learning about accountability in regards to the professional standards issues and an awareness of scope of practice, quality practice settings, and contractual guidelines.

Leadership competencies such as modeling the way, inspiring a shared vision, challenging the process, enabling others to act, and encouraging the heart were observed many times at each meeting, and were pivotal in the transformation of care for clients awaiting hip and knee replacement surgery. The leader demonstrated these qualities in the managing of chaos, supporting staff and clients through the losses, as well as adapting to the new rules, new work, and new script. In order to utilize these competencies, the leader was required to be highly proficient with the use of self. Observation of this level

of leadership provided tremendous insight that will be readily applied to challenging transitions in the future.

Chapter 6 – Discussion

This final chapter provides the reader with a brief synthesis of the clinical practicum project. The findings presented in the previous chapter were based on the observations related to leadership associated with the development of a new program. The following discussion and recommendations for future program development are based on these findings, relevant to the evidence from the literature and the five concepts described in Porter-O'Grady's Model of Transformation (2003). In addition, the applicability of the framework and limitations of the process will be discussed.

The model and the research literature suggest that transformation is initiated or triggered by chaos, which results from the sociopolitical, technical and economic driving forces. This is consistent with observations in the evolution of the Prehab Program. The public currently is frustrated with the long waits for joint replacement surgery. This unrest results in more political pressure for change so as to meet the demands of the constituents both in regards to access to health care and also fiscal accountability. The public aspires for optimal healthcare, but also expects the best infrastructure and educational systems. These sociopolitical and economical driving forces create chaos. The public is informed about health care and are requesting, and expecting timely care, as well as the latest in surgical techniques and types of implant. These driving forces were magnified in the development of the Prehab Program by the fact that the current provincial government is in the third year of a four-year term. The politicians must be responsive to the electorate and support creative plans, such as the Prehab Program to

tailor some of the chaos associated with the current lengthy waits for hip and knee replacement surgery. The leader was aware of these driving forces, and in personal communication, stressed the impact of political pressure and how essential it was for the health care system to be responsive to the current chaos. In so doing, there was recognition that, as displayed in the UDT Model, this transformation is circular. Driving forces cause chaos, but transition and change, also result in a different chaos. This is consistent with the literature in that in a time of constant change and evolution, there is a combination of randomness and order, or in other words chaos.

Chaos

Generally, the powerful influence of the three driving forces, namely sociopolitical, economic and technical, in the creation of our current state of chaos, requires considerable tenacity on the part of leaders. The need for tenacity was supported by Romanow (2002) when he stated that "providing leadership against a backdrop of turbulent times is never easy" (p. 5). This tenacity was observed in the Prehab Program planning. The leader was persistent in meeting deadlines and regularly reminded the committee members of the fiscal constraints. At times when the committee became mired in small details they would be reminded of the number of weeks until the Prehab Program would start seeing patients. These observations were consistent with the literature as the focus was on the vision and a sense of urgency was being created.

The political agenda is closely associated with the economy, both local and global, and dictates abrupt changes to which leadership must respond. Specific to this practicum experience, this occurred as a result of the lengthy waitlist, which included younger individuals who were unable to work. Political forces advised that many extra

surgical slates must be created to perform arthroplasty surgery over the summer of 2006. This coincided with the Prehab Program planning. It was observed that the leadership response to the chaos included marketing the sudden changes to the team. There was considerable unrest at the Prehab Program Steering Committee table regarding the required change in approach. It meant that long waiters would not have the opportunity to optimize their health, but rather would be fast tracked through surgery. The literature suggests that leaders may identify conflict within themselves at the time of such a change, but must remain focused on the goal and the new approach. In discussion with the Chair of the Committee, it was determined that there was internal conflict regarding this imposed change, but also a recognition that political direction must be followed. This need for focus is supported by Gryskiewicz (2005) who stresses the need for leaders to understand the forces impacting the organization, decide which ones to bring in and gauge reactions to them so that the working environment may be kept positive.

In the Prehab Program initiative, the leader allowed several meetings to discuss the change in direction, consistently identifying positives associated with this change, but also listening to concerns expressed by the team. This is consistent with the literature. There is a need to acknowledge the three aspects of Kurt Lewins theory, that is unfreeze, move and refreeze (Dannemiller & Jacobs, 1992; Marrow, 1969). The ability of the leader to maintain focus on the goal, namely improved health outcomes for the client, and to reframe the process, facilitated moving the team forward.

Consistent with the UDT model, technical forces contributed to the chaotic state. The general public has high expectations of the healthcare system, in terms of service as well as outcomes. Many people, both consumers and healthcare providers, conduct

research via the internet and expect the best. The leader needed to balance all these expectations within the confines of the budget and the political force. As the words of Bannerman and Nixdorf (2005) illustrate, this included listening to many critical comments.

> "Hospitals budget on the basis of an annual lump sum, and from then on view the patient as someone who is using up the hospital's money. They don't really know what any procedure costs. There is too much bureaucracy and too much overhead that has nothing to do with patient care" (p. 123).

Similar criticism occurred with the Prehab Program, but the leader remained focused on the vision. The goals were stated, and the evidence supporting the intervention reviewed.

Loss

The leader acknowledged and allowed exploration of the losses, but was not thwarted by them. This approach was supported in the literature by Samuel (2001) who supports acknowledging the loss, but insists the change process must continue. In this project there were losses associated with work routine, changes in infrastructure, and the blending of professional boundaries.

A shortened length of hospital stay will alter work for both the hospital and community staff. The change in work will have implications for those responsible for curriculum development in the nursing faculties. As the role of the bedside nurse is changed, leaders need to constantly educate and remind hospital staff that there are risks associated with hospital care, and there is a pressing need to change our practice. Leaders can reinforce this need for change by referring to data such as that prepared by CIHI that

shows 23,750 deaths occur each year in Canadian acute care hospitals due to error, clearly preventable mistakes, most often due to surgery, drug reactions and infection. The literature would refer to the presentation of this data as the leader tuning into the environment and actively collecting information. In so doing, staff could be engaged in LOS discussions. Monthly bed utilization meetings were organized by the leader. Each week, the individual managers reviewed the patients who had been on their nursing units for greater than 30 days. This review was shared with the interdisciplinary ward staff and the entire team was engaged in active discharge planning.

The second loss is associated with infrastructure. Nurses generally start their career within a hospital where there is a hierarchy with whom they can consult. According to the literature, leaders need to identify role models and mentors for staff working independently in the community. The need for mentors became apparent in the Prehab Program where young staff committed to doing a good job experienced stress as a result of the lack of infrastructure and uncertainty about the associated work processes. Initially, the leader provided the support with weekly meetings. She soon learned she could not do it all by herself, or as the literature describes "dependant upon the goodwill of one person" (Drucker, 1998, p. 156). The staff continued to flounder until the waitlist coordinator was relocated to the Prehab Clinic. The availability of an individual with more experience, who was readily available to assist with problem solving, helped this team to develop quickly. This strategy is supported by the literature. Glaser (2005) stresses the importance of leaders moving from doing it all themselves, to motivating others to deliver results. Bridges and Mitchell (2000) identified this approach of selecting a coach as effective leadership. The strategic selection of this individual is also

consistent with Conger's (1998) contention that credibility in regards to expertise, as well as relationships and a keen ability to listen and work in the best interest of the clients is the ideal.

The third loss can be associated with the blending of professional roles. The creation of an intake questionnaire for the Prehab Program, as well as the writing of a patient education booklet, illuminated how complicated the blending of professional roles can be. Initially, each discipline was insistent that a section be allocated to the requirements of their profession. This is consistent with Goleman's (1998) reference to the leadership challenges that diversity presents, as alliances form and clashing agendas are set. Considerable tact was required on the part of the leader, acknowledging professional expertise, and focusing on the client and the common goal. The literature supports this need for transparency between disciplines. Time was allowed for trust and respect to build within the team. Small modifications were made to the document, feedback requested, and eventually a patient focused questionnaire and education booklet were effectively created by the cohesive interdisciplinary team. The leader was aware of the existing silos between professionals and acknowledged the areas of expertise to facilitate a blending of roles and to create a cohesive, client focused team. Similarly, Kirkman and Rosen (2000) and Scott and Caress (2005) support nurturing the ability of team members to work interdependently toward a common goal. Wood (2004) stresses the importance of group cohesion; Fisher (2001) envisions leadership as a collective will, vision, and intent to serve collectively. This leadership approach of fostering collaboration and enabling others to act helped build a spirited team that could accept the challenge of developing a Prehab Program.

New Rules

The UDT Model identifies the need for leaders to adapt to new rules in order to transition to the new work and the new script. At this point, the whole systems thinking attached to this model becomes visible. The framework is about wholes, not parts. The script (i.e. flexibility) defines the context for the work, which in turn characterizes the rules, (i.e. accountability). In the past, there was linear thinking, and leaders created a step by step plan, with specific time lines developed with clearly defined rules.

At the first meeting, the need for accountability was highlighted by the leader. This accountability was specific to timelines for the operationalization of the program, as well as the need to remain fiscally accountable. The team was frequently reminded that the process must move forward quickly and that bi-weekly reports were expected by the Minister of Health. In personal communication with the Chair, it was learned that there was risk that the funding could be allocated to another program if the planning did not proceed rapidly and remain within budget. This need for accountability in regards to time and finances is supported by the literature. Samuel (2001) advises that the change process must continue and leaders cannot wait for 'buy in.' Stressing the need to be accountable regarding budget and timelines is also recommended by Gryskiewicz (2005). The decision by the Chair to not share the risk publicly of losing funding to another program would be deemed by Garvin and Roberto (2005) as framing external information in such a way that it presented a positive framework through which the team could work.

In this project, the student had anticipated a precise project plan. However, the new rules insist that participants become "owners in the journey," rather than participate passively as subordinates or employees. This was visible in the new rules attached to the

Prehab Program planning process. There was not a hierarchy, rather the leader played a coordinator role and promoted relationships, based on contributions, roles, and action. This approach is repeatedly supported in the literature. For example, Goleman (1998) refers to the emotional intelligence of the leader, while Fisher (2001) advocates for relational leadership. Managers and workers perform as partners rather than follow an authoritarian model of command. The desired outcomes were clear, but the process was open for debate. At times, the lack of process was anxiety producing for the team, as their vision may not have been as clear as the leader's in regards to the planned outcomes. However, these rules do allow leaders latitude to "push the walls" of acceptability, routine, and behaviours that no longer work.

This is an exciting time for leaders. According to Conger (1998) this should be perceived as an opportunity to establish credibility through expertise and relationships. The new rules allow leaders to become creative in finding new solutions to old problems. Everything is in motion, in striving to reach a new vision. There were twists and turns along the journey, but the new rules required the leader to focus on the desired outcome. Creative ideas, such as shared patient records between community and acute care, as well as job sharing in the community and hospital, comply with the rules of being accountable and contributed to the vision of seamless care across the continuum. This leads to a new way of doing work.

New Work

In this practicum, the new work involved the community and acute care sector working together to improve delivery of care for patients awaiting joint replacement surgery. This evolved into the intervention, which was the development of the Prehab

Program. This was, and will continue to involve change and its many aspects, such as visioning, engaging, and team building. Such an approach is strongly supported by the literature where there is an emphasis on vision, rather than linear plans. Successful leaders view people as their greatest asset and believe together they can achieve extraordinary things. In the Prehab Program planning, there was comradery created by the leader as all accomplishments, even small ones, were publicly acknowledged.

The insights gained regarding leadership through observing the actual development of the Prehab Program were abundant. The need for attention to the business of health care was apparent. The budget determined the staffing model, the equipment purchased, as well as the need to effectively and efficiently treat adequate numbers of patients. At times, frustration was experienced as the team enthusiastically created new ideas which required additional resources. The leader encouraged these suggestions and listened to them, but was always mindful of fiscal limitations. Newhouse et al. (2005) describes this leadership strategy as operating in an age of accountability, where quality and cost issues drive the direction of healthcare.

The interdependencies within the larger health care system, as described by Porter O'Grady (2002), were apparent. The healthcare administrators recognized that responding to the waitlist required more rapid throughput for patients post-operatively. In order to do more surgery within the current system, the length of stay in hospital needs to be shorter. The surgeons may have additional operating time, but if beds are not available, they can not proceed with surgery. This bed availability is also dependent upon community resources. Patients who need additional home care support can not be discharged unless resources are in place. This interdependency can have a domino affect.

If home care resources are not available, the hospital beds will not be vacated, the recovery room will become overloaded, the operating room will be put on hold, surgery will be cancelled, and the waitlist will remain lengthy. This requires a leadership focus on the efficiency within the larger system. Leaders in both community and hospital identified concerns and presented them to the WRHA Senior Management and Manitoba Health for further resolution. The WRHA Senior Management is responsible for all health care issues within the region, both in the community and acute care sectors. They are able to resolve issues across the continuum of care by adjusting planning and removing barriers between the community and the hospital. In order to be able to do so, the senior executive recognizes the need to be attentive to the concerns of the program directors in the field as they are closer to the day to day activities. This responsiveness by the WRHA senior executive would be described by Brousseau et al. (2006) as flexible and integrative leadership. They are flexible in planning and can integrate between hospital and community. Brousseau found this to be a trait of successful senior managers. They recognize the need to listen to directors so that decisions can be made quickly that will impact the broader system and change the course of activity.

Health care providers are primed to close the gap between community and acute care, and to plan efficient care across the continuum. Discharge planning is to start prior to the client's admission to hospital. The surgery itself is getting much more efficient. At Concordia Hospital, the "OR double day" concept has been introduced where a surgeon works with two teams and a clinical assistant. One team prepares the patient; the surgeon inserts the implant and moves to the next theatre where a second patient has been prepared. This maximizes the surgeon's time and permits the booking of more patients.

Patients are recovering more quickly. Different types of analgesia are prescribed resulting in less nausea and vomiting. Intra-articular joint injections during surgery result in less post operative pain and earlier mobilization. These interdependencies can cause chaos if the supports are not adequate within the community. The program directors for surgery and community health were aware of this risk, and related their concerns to the Minister of Health. This situation reinforces the overlapping of the concepts in the UDT Model. New work can respond to chaos, but it also creates a different type of chaos. Fisher (2001) advises leaders to be passionate about their vision and Stern (2005) reminds them to keep focused on it.

Constant chaos highlights the need for the new work to transform the approach currently in place for the care of individuals requiring lower extremity joint replacement surgery. Individuals need to follow the new rules and be accountable for maximizing their personal health, while the new work will ensure that care is provided in a seamless fashion across the continuum. The acute care sector must be amenable to working collaboratively with the community and families must assume an active role in the care of their loved ones. The leaders who led these discussions between community and hospital displayed emotional intelligence as they carefully listened to both sides, but also provided examples of the disconnects in care for the clients being served. This approach is strongly supported by Goleman (1998) that a great leader must have emotional intelligence and Keller (2002) who stresses the importance of explaining the connection between factors contributing to the problem and associated outcomes.

The leader engaged the team with this strategy. The program was developed based on a vision and also background work by the leaders and the committee. This

helped create alliances among the committee members. This program, with five described facets, namely exercise, weight reduction, pain management, education and social support, was a planned change for patients on the waitlist for hip and knee joint replacement surgery. This was an effective leadership strategy as the review of the research literature encouraged participation by the various committee members. Lutjens and Tiffany (1994) says planned change provides a way to induce structural innovations designed to meet situational demands. The Prehab Program is an innovative approach to transferring care from the acute care sector to the community in order to optimize the physical functioning of clients at a time of increased demand for hip and knee replacement surgery. This is supported by Grohar-Murray and DiCroce (2003) who envision primary care as the focal point of healthcare delivery, rather than the hospital. The leader was able to refer to the literature regarding the need to relocate care to the community, and relate it to the Prehab Program as a progressive initiative, which then created enthusiasm within the team.

The new work is multifocal, multidisciplinary, and complex, over a continuum of care where the characteristics and services that were offered were so fragmented that the existing infrastructure did not work. This required leaders to promote the emergence from the current hospital based model into one that is community based. This will demand a different set of clinical relationships. For example, the standard practice for individuals needing joint replacement surgery has been to see their family doctor, await an appointment with an orthopedic surgeon, await an OR date, and await an appointment in the pre-anesthesia clinic. At each of these junctures, the individuals are asked for a history of their present illness. The individual meets with the pre-admission nurse,

occupational therapist, and physiotherapist who again ask for the history, and on the day of surgery, the admitting nurse does likewise. Leaders needed to listen to clients and respond to their disillusionment with the system. After being asked by seven professionals for the same information, there is little wonder the public had lost trust and were able to identify why participants in healthcare delivery are so busy. This is consistent with Bruhn's (2004) description of tradition and bureaucracy being the biggest obstacle for change. With a resolve to move beyond this tradition, the leader recognized the need to build trusting relationships. Meetings were held with the Prehab and the PAC staff. Issues such as too much documentation and the lack of a concise summary sheet of the clients' care were raised by the PAC staff. Likewise, the Prehab staff expressed frustration regarding the amount of preparatory work that was being done to optimize patient outcomes, but was not being utilized by the PAC staff. Through listening to concerns from both areas, identifying frustrations, the leader was able to create alliances with the two teams. These relationships are beginning to develop, but still have considerable room for growth. The leader continues to promote these relationships through listening, making changes to the wording in the questionnaires and altering medication templates. The literature would describe this as creating small win-win situations and not letting up (Kotter, 2005).

Another example of changing tradition and building alliances between community and hospital is the current referral program for home intravenous therapy. The leaders created a communication plan. In so doing, they were able to mobilize their staff to improve client care. The community I.V. program allocates thirteen spaces to joint replacement patients. Weekly, via email, the I.V. program informs the hospital how

many spaces are filled. On the same day, the hospital sends the names of patients who may require home I.V. therapy in the upcoming week. With communication such as this between hospital and community, services can be put into place and patients discharged more quickly to their home environments.

This vision of seamless care requires leaders to be both creative and persuasive. The current way of caring for patients is based on many years of experience. The admission process, documentation, and discharge plan are part of the hospital foundation. As recommended by Kanter (2000), this included actively looking at new approaches being used at other centers, as well as the research reported in the literature. Hamilton Health Sciences Centre was contacted regarding the work they are initiating and ideas were shared. Two representatives from the Alberta Bone and Joint Institute were invited to Winnipeg to share their experience. Information from both centres was incorporated into the Winnipeg Prehab Program plan. Kanter refers to this as 'kaleidoscope thinking,' where fragments of available data were manipulated into forming a new plan.

The leader was a visionary, as Prehab Program Committee members were prevailed upon to work with direct caregivers to refocus their efforts in both the community and hospital, based on what a person needs in the context of a shorter hospital stay. This is consistent with the literature, as discussion regarding the vision created enthusiasm within the team and a common point from which to start the work. It was a strategy for engaging the team. Health care providers will be required to remove the dependency relationship for care. Hence, leaders need to work with the practitioners to identify the skills that can be transferred to the client and others in a way that allows them

to survive and heal in an environment where health care professionals are not the key players.

This required specific leadership skills and the "use of self" (Kouzes & Posner, 2002). This was also a part of the learning in the observation of the Prehab Program planning. The leader engaged all members of the team. Meetings were held at the end of the day and a snack was provided. Frank (1989) supports the timing of the meetings as a strategic move on the part of the Chair. He suggests that meetings at the end of the day tend to be more focused, and food contributes to the establishment of relationship among the team.

Blair (2003) suggests that when people work in groups, there are two issues involved, namely the task and the process or mechanisms by which the group acts as a unit. This was evident in the Prehab Program Steering Committee. The leader promoted the formation of fantasy themes in the Prehab Program Steering Committee meetings, where the focus was frequently moved to thinking of a short waitlist with healthy clients arriving for elective surgery. The group developed a spirit of cooperation, and was able to coordinate commonly understood procedures. There was considerable laughter at these meetings, which was encouraged by the leader and her personal use of humour. This style of leadership is supported by Bruce and Cumming (1997), who attest humor can achieve equality among a group because people who share laughter are on common ground. In this practicum, the leader's ability to support equality and commonality within the team put them in a good position to support change and to carry on the work associated with the new script.

As learned at the Dorothy Wylie Nursing Leadership Institute (DWNL), there are four dimensions of effective leadership (see Appendix F). Firstly, the business of leadership involves an understanding of the driving forces, namely political and environmental knowledge, consumer/community responsiveness and resource management. There is also the professional standards issue including: scope of practice and quality practice settings, which are all part of the new rules and accountability. The two final dimensions stressed at the DWNL Institute were the competencies of leadership and the use of self. The use of self was effectively used by the Chair of the Committee. Her personal integrity was recognized and her emotional intelligence was highly developed. She was proficient at remaining optimistic, generous with sharing the credit for completed assignments, and able to interject humour in such a way that it enlisted participation.

New Script

The new script defines the context for the new work. It provides the needed direction. The major theme within the new script is flexibility. As described earlier, within this theme, there are the four principles, namely, partnership/team, equity, accountability, and ownership. These are the cornerstones of the unfolding structure of health care and were very applicable to the planning of the Prehab Program. The partnership/team is expansive with the new script. It extends to and includes the clients and families, as well as the various health care disciplines in the different sectors of the system. This will present many ongoing leadership challenges in order to dissolve the silos between professions, adopt clients and families as partners in care, and eradicate the walls between hospital and community.

The organizational responsibility for flexibility is exemplified in the waitlist guiding principles developed by the Winnipeg Regional Health Authority (WRHA, 2006). There is recognition of the WRHA's responsibility for a patient centered approach that includes personal dignity, concern, and respect, as well as timely access to care. The guiding principles acknowledge the stressful disruption that waitlists and canceling procedures impose on clients. The expectation to fulfill these guidelines is clear, but not prescriptive, thus allowing for flexibility in the planning process. A commitment has been made at all levels, and in every hospital / facility to improve the quality of care by finding ways to better manage waitlists and reduce wait times through improved processes and innovations.

The equity will include accessibility issues for all people, rural and urban and all socio-economic levels. Currently, the Prehab Program is only being offered in Winnipeg, at one community site. Other modalities of service will need to be part of the new script, such as telehealth, and distance education.

The accountability and ownership principles will apply to fiscal responsibility, transparency, and also to the maintenance of one's own health. Leaders are committed to improving the system, but may not personally role model exemplary health habits. This will be included in the accountability and ownership part of the new script.

All these principles require flexibility on the part of leaders. The work is what unfolds as a result of living with the new script. This was demonstrated in the Prehab Program planning. The addition of seventeen arthroplasty slates over the summer in the midst of the Prehab Program planning, required flexibility. Two months after the official opening of the program, discussions started regarding the benefits of a Pre-Prehab

Program where individuals would start conditioning as soon as they developed joint disease and prior to the need for a surgical consultation. A concept such as this requires leaders to think creatively and acknowledge, as Grohar-Murray and DiCroce (2003) suggest, that the hospital is no longer dominant in the delivery of care. Doerge (2005) contends that the primary goal of health care will be to build linkages to coordinate care.

Nursing leaders need to work with their profession to participate in the excitement of this new script. They need to encourage creative thinking about how the health care system can become more responsive to the needs of the general public. This includes pursuing what can be done to move away from the illness treatment model to a health promotion model. Health care is in a state of constant change and filled with opportunities for nursing leaders who are flexible and prepared to move with the changing times. Without embracing the new approach to health care, Porter O'Grady believes the profession will "become subordinate, lose steam and be placed on a questionable agenda in terms of their ability to be sustained in an age where the whole process is changing" (p 202).

Program evaluation also will require flexibility on the part of leaders. As the WRHA Research and Applied Learning team commence their formal evaluation of the Prehab Program, there will be recommended changes. The Prehab Program Steering Committee has discussed this and eagerly await their recommendations. A criticism of the planning could be that evaluation was not started at the time the intervention was initiated. However, as the UDT Model suggests, the planning occurred at a time of rapid change and shifting foundations. After considerable discussion, the Prehab Program Steering Committee concluded that the program needed to be operational for a few

months before it could be properly evaluated. However, there was consensus that timely program evaluation was essential. Samuel (2001) stresses the importance of this focus on outcomes rather than process, while Gardner (1990) describes making changes based on evaluation as what keeps an organization 'ever renewing.'

Summary

In the transformation of a system, chaos is ever present. It triggers the change, but also exists as the new way of doing things is implemented. Change is constant and it is only with leaders who have a vision and are able to excite others about this vision, that new work will be accomplished. Successful leaders have highly developed emotional intelligence and recognize that people are their greatest asset. The days of authoritarian leadership with highly developed linear plans are over. Leaders need a vision, must demonstrate accountability, and through relational leadership, be able to move with the changing times. Program evaluation will be an essential part of the new script, as well as a willingness by leaders to respond to the recommendations in order to improve outcomes for the population being served. Flexibility in leadership is the way of the future in health care.

Application of the UDT Model

The UDT Model is well suited for the planning process of a new program within healthcare and would be a model of choice for future work. The relational and whole systems thinking is applicable to the current complex and chaotic health care environment. The reference to linkages and intersections reminds leaders of interdependencies that exist within the system. This model was relevant to the establishment of the Prehab Program, which provides care across the continuum. The

emphasis on being a learning organization, where outcome rather than process is valued, is very applicable in the current rapidly changing environment.

In a telephone interview with Dr. Porter O'Grady, (personal communication, May 10, 2006) it was learned that the UDT model was developed from his personal observations made in the thirty six years he has been involved in health care. His roles in a variety of health care settings have ranged from staff nurse to senior executive. Although the model was not evidence based, it was influenced by work done by Kouzes and Posner (2002). The leadership concepts identified are the result of extensive research with their Leadership Practices Inventory tool. This is a well validated instrument that has been used internationally to determine characteristics of management and leadership roles, and hence provides credibility to the model in regards to leadership.

The UDT model has had thousands of applications within health care. Dr Porter O'Grady was unaware if it has been used in the actual planning of a specific program. However, he did confirm the use of the UDT Model as a framework for larger system change. This project has determined that it is also applicable to program planning within health care and would be recommended for future projects.

Limitations of the Practicum

Although numerous insights were gleaned from observing the development of the Prehab Program, there were several limitations from a learning perspective. The most obvious related to the methodology used for the practicum. It was qualitative research which evolved over a nine month period. Specific data were not collected; rather observations were made, and then described. The analysis of these observations could have been subjected to researcher bias. The collection of data specific to a defined area

of the planning would have provided concrete evidence related to the program planning process. Other limitations were related to the type of research available, lack of exposure to consumers, and time constraints in regards to participating in the program evaluation.

The business literature is replete with lived experiences in leadership, change management, and organizational change; the healthcare literature does cite some research in this area. However, the research is generally non-experimental in design and is frequently used to support the construction of a picture of events, as they naturally occurred. Several survey studies collected detailed descriptions of existing phenomena and then used the data to justify and assess current conditions and practices or to develop more intelligent plans for improving them. Surveys support the collection of considerable data, but these data often tend to be relatively superficial. The lack of attention to sampling techniques, questionnaire construction, interviewing, and data analysis may limit the reliability and validity of the studies. Non-experimental research designs, such as surveys and case studies do not enable the investigator to establish cause-effect relationships between the variables (LoBiondo-Wood & Haber, 1990). However, there were surveys in the literature that implied a cause-effect relationship existed between a leadership style and the profitability of a firm (McClelland, 1996). In this practicum project, the lack of evidence based information on leadership made it difficult to differentiate between concrete leadership strategies and the leader's personal style. Hence, much of the insight gleaned was not based on research evidence.

The absence of leadership research in the nursing literature is not surprising. At the May 2006 Canadian Nurses Association annual meeting, Michael Villeneuve, the past CNA president, reported that nursing is "data rich and information poor" as results have

not been synthesized and moved from idea to action. This lack of information made the project more experiential than evidence based.

A second limitation in this practicum was the lack of exposure to consumers. Interviewing consumers and listening to their interpretation of this health care initiative would have provided insight in regards to the planning of future projects. There would have been value in participating in focus groups regarding wait times, responsiveness of the current system, as well as hearing specific recommendations for improvement in healthcare delivery from individuals actually requiring hip or knee joint replacement surgery. The only involvement of consumers was in regards to the intake questionnaire, where 6 individuals randomly selected from the waitlist were asked to participate in a focus group regarding their ability to complete the questionnaire on the telephone response system rather than the traditional mailed form. This focus group was a cost effective way to explore the patients' perspective on the new modality of obtaining patient information. It would have been beneficial to observe leader's responses to the consumers as they provided input in regards to program content, time of appointments or continuity of information flow from the Prehab Program in the community to the surgical procedure in the acute care hospital.

This lack of consumer input was also a weakness of the Prehab Program development process. The current strategy for client input is the complaints process. However, it is generally recognized that only a minority of negative patient experiences are identified through the complaint process and that these reported experiences may not be representative of the whole (Bowen, 2006). To date, patients and their families are an untapped resource for improving the care of individuals awaiting joint replacement

surgery. These individuals are intensely committed to quality and safety and could provide the twenty-four hour, cross discipline / cross program perspective that is otherwise often hidden from providers in a complex system. They are the only ones who truly know how things work for the patient. Patient involvement needs to be part of the new script. Caution must be taken to prevent "token" client input to legitimize decisions already taken. There must be recognition by leaders that genuine client participation signifies a shift in power, and a different stance between providers and clients (Bowen, 2006). Accountability is increased with both the client and the care provider. Thus, this practicum experience would have been enriched by the opportunity to listen to the recommendations of consumers and then to observe how the leaders responded to their suggestions and incorporated them into the planning.

The third limitation was the lack of involvement in the evaluation of the Prehab Program. The need to evaluate the Prehab Program services and method of care was clearly outlined by the steering committee. However, this was just being initiated as the practicum ended and so it was not possible to participate in this process. There was clear recognition that a new program was being developed, which presented an opportune time for baseline data collection. A pilot project was in the planning phase. However, the chaos of the healthcare system, combined with the powerful sociopolitical driving forces required that the program commence promptly. Evaluative research has been planned in order to document the value of the program and will be starting shortly. Healthcare consumers and Manitoba Health require documentation of the effectiveness of the Prehab Program. They want to know if and how well the goals are being fulfilled, as well as the reasons for specific successes and failures. These findings will then help direct and even

redefine some of the objectives of the program. It would have been a valuable learning experience to have participated in this evaluation and observed the leadership role in responding to the results.

Summary

The insights gained into leadership during this practicum were abundant. It was characterized by experiential learning which provided an opportunity to link theory and practice. Through this learning, many successful leadership practices, including an ability to engage other individuals to effect change, were observed.

Implications for Nursing

Learning was enhanced by the participant observer experience in the planning of the Prehab Program. Numerous implications for nursing were gleaned from this experience. The following discussion will focus on nursing leadership, but will also include implications for nursing education, practice, and research.

Leadership

The UDT Model is a framework that has relevant application for future program planning since it draws attention to the impact of driving forces on the transformation of a system with the emphasis on outcomes rather than process. The current system can be paralyzed by process and this model promotes movement/ progress. The leadership implications are also apparent within the context of education, practice, and research.

Education

There are education needs regarding leadership and administration. Many nurse leaders have been recruited to administrative positions as a result of being expert clinical nurses. Their administrative abilities have been learned "on the job." Exposure to more

theory and research prior to assuming leadership roles would improve performance, as well as minimize the frustrations aligned with administration. As learned at the Dorothy Wylie Nursing Leadership Institute, the business of healthcare is an essential part of nursing leadership. This was noticeable in the planning of the Prehab Program. However, the availability of business courses is sparse. Nurse leaders need to know how to develop and interpret large budgets, develop policies, understand staffing models, create rotations, and have knowledge of labor relations. They need to understand organizational behaviour, as well as the organization of the healthcare system regionally, provincially, nationally, and internationally. An understanding of government funding is also essential when developing programs.

It is imperative that healthcare authorities work with university faculties to respond to these organizational learning needs, which includes the micro to the macro system. The current focus on hospital based routines will need to be replaced with mobility based approaches. There will need to be an emphasis on health promotion, rather than illness prevention. Leaders in education will need to create excitement within their students to become involved in changing the system from caring for the sick to encouraging health. Within hospital and community settings frontline nurses displaying leadership ability, including clinical managers, need to be encouraged to attend leadership programs such as the programs offered locally by the WRHA, or more specifically the Dorothy Wylie Nursing Leadership Institute. This exposure creates an interest in broadening one's understanding of political and health environment agendas, as well as practice guidelines and competency issues.

Courses could also be offered at the graduate level in partnership with the faculty of business or community health sciences. According to Porter O'Grady (2001), if nursing leaders do not have a broader understanding of the business of health care, they will "become subordinate" (p. 184). Healthcare will be managed by business graduates who clearly understand the finance and labor relationship issues, but do not have expertise in the health needs of clients.

Through observation of this Prehab Program planning, the dearth of knowledge of the political environment was apparent. Nurses in administration need to learn more about the political process. They need to learn to write government proposals, briefing notes and press releases. This again could be accomplished at the graduate level with exposure to courses in health policy.

Exposure to models of change, such as the UDT model, could enhance the development of effective leadership skills. An awareness of the power of external driving forces could be created, as well as the need for leaders to be accountable and flexible. The importance of relational leadership based on outcomes rather than process needs to be reinforced by the educational system.

Practice

Clinically, nursing leaders need to commit to seamless care for clients across the continuum, which is community to hospital and back to community. Caring for clients in the community and then in the hospital is expensive, both in the terms of efficiency, as well as in the quality of care for clients. There is duplication of work, breakdowns in communication, and care is fragmented. Leadership needs to envision seamless care and empower staff to think creatively and become engaged in new approaches to healthcare

that will be based on improved measurable outcomes. Regional nursing leadership meetings, where broader client related issues can be discussed, need to continue. Program directors need to collaborate and facilitate projects between community and hospital staff so as to construct a greater appreciation of each other's role and subsequently a blending of responsibilities.

Leaders in all domains of practice need to remember that people are their greatest asset. Learning to engage individuals in a vision will help modify attitudes and behaviours in order to advance nursing practice.

Research

This practicum highlighted the dearth of nursing research in the area of leadership. There is a need for further research in regards to the qualities of effective leaders. The correlation between advanced education and effective leadership could be measured with the use of tools such as the leadership profiles inventory. Effective coaching skills could be described, as well as preferred conflict management techniques.

Generally, nursing leaders require further education in regards to the research process, including identifying clinical issues, developing research protocols, conducting research trials, and interpreting results. Many nursing leadership functions are based on tradition and not research based. Nurses need to focus more on outcomes, than process in order to move the profession forward. The outcomes need to be measurable. This includes developing and communicating performance indicators in keeping with organizational direction. It could include patient safety and client satisfaction.

Specific to the Prehab Program, nurses need to look at LOS, as well as other outcomes, to determine if it has been impacted by the optimization of client's health prior

to their surgery. They need to research clinical issues such as TED stockings and determine if they are being used effectively. Compliance with medications, pain management, and improvement following preoperative education are other areas of study. Questions such as whether optimization prior to surgery is sustained post-operatively needs to be determined.

There are other areas of research required in nursing administration, such as human resource management. This could include looking at indicators such as sick time, or even process mapping. Nurses in leadership roles need to promote research within their areas of responsibility, as well as their professional organizations. They will then be able to confidently participate in re-engineering processes based on solid research data.

This nursing practicum has provided many implications for the profession. There is excitement for the nursing profession as leaders promote and support change within the education system, practice environment, and research domain.

Summary

This opportunity to observe and participate in the development of a new program was insightful. It created many learning opportunities as well as an awareness of many personal learning needs. The literature was enlightening and established support for many of the leadership strategies observed throughout the practicum.

The UDT Model was conducive to identifying the many aspects of transforming a system and provided structure for the learning experience. It provided a basis for viewing the ever changing landscape through emphasis on movement, interdependency, complexity, and non-linear thinking.

The limitations of the learning experience have been identified as well as many implications for nursing in regards to leadership, education, practice, and research. Many observations during the practicum were strongly supported by the literature.

The important role of leadership within change was clearly displayed. The striking observation was the need for leaders to recognize that the individuals working with them are their greatest asset. It is through rapport and mobilization of these individuals that goals are achieved.

Conclusion

Three goals related to health care administration were identified for this practicum.

1. To describe the evolution (or development) of the Prehab Program in terms of a change/leadership model.
2. To review the existing evidence regarding the role of leaders in guiding change.
3. To observe the leadership techniques used in the development of the Prehab Program and determine how they did or did not concur within the model and/or the existing evidence.

The UDT Model provided an appropriate framework for this practicum project, which focused on leadership insights in the evolution of the Prehab Program. It guided the observational experience of the practicum by highlighting the driving forces of the transformation. All three forces, sociopolitical, economic and technical, were influential in the Prehab Program planning. Through the acknowledgement of the chaos in the system, this model promotes relational and whole-systems thinking. It encourages leaders to find balance in the change process by acknowledging loss while progressing to the new rules, new work and new script.

The existing literature on leadership and guiding change is abundant. Much of this material is based on experience and is thought provoking. The lack of evidence based literature is concerning, but reinforces the fact that leadership is a combination of art and science. Many of the attributes of successful leaders are difficult to measure.

The observational experience was insightful. There were opportunities to learn about leadership techniques that responded to the business of healthcare, as well as the need for emotional intelligence. Leaders described their vision for the Prehab Program in

such a way that it had meaning for the Prehab Program Steering Committee, resulting in their commitment to create a program of high standard. The aspect of continued learning, and remaining fluid and adaptable to changing times, was exciting. The planning based on outcomes, rather than process, was particularly appealing.

Further research is required to provide evidence related to effective leadership qualities. Educational opportunities for nurse administrators on the business of healthcare need to be promoted. This participant observation experience in the planning of the Prehab Program was valuable in that it provided considerable insight into leadership, as well as areas for further personal and professional growth.

References

Agnes, M. (2002). Webster's New World Dictionary and Thesaurus (2nd ed.). Cleveland, Ohio: New World Dictionaries.

Aikman, P., Andress, I., Goodfellow, C., LaBelle, N., & Porter-O'Grady, T. (1998). System integration: A necessity. *Journal of Nursing Administration, 28*(2), 28-34.

Arnett, G., & Hadorn, D. (2003). Developing priority criteria for hip and knee replacement: Results from the western Canada waiting list project. *Canadian Journal of Surgery, 46*(4), 291-296.

Arnold, W. (1995). Lessons of value-driven leadership. *Healthcare Executive, 10*(4), 12-15.

Ashton, M. (2005). Paradigm shift from illness to wellness: The nurse as the wellness coach [Electronic Article]. *Nursing Spectrum.* Retrieved January 22, 2006, from http://nsweb.nursingspectrum.com/cfforms/guestlecture/paradigm.cfm: Google

Bannerman, G., & Nixdorf, D. (2005). *Squandering billions - Healthcare in Canada.* Surrey, B.C: Hancock House Publisher.

Barstad, J. (April 2002). *Iterative planning processes; Supporting and impeding factors.* Paper presented at the COST Action E19 meeting in Savonlinna, Finland.

Baumann, A., Giovannetti, P., O'Brien-Pallas, L., Mallette, C., Deber, R., Blythe, J., et al. (2001). Healthcare restructuring: The impact of job change. *Canadian Journal of Nursing Leadership, 14*(1), 14-20.

Blair, G.M. (2003) Groups that work (On-line serial) Available http://www.sce.ed.ac.uk/~gerard/management/art.html (Aug 25, 2006)

Bohm, E. (May 10, 2006). *Waiting time reduction initiatives for hip and knee replacement surgery.* Paper presented at the meeting of "Joint" Endeavor Winnipeg.

Bohm, E. (November 25, 2004). *Hip and knee replacement surgery waitlist working group report.* Paper presented at the meeting of Joint Replacement Group, Winnipeg, Manitoba.

Bowen, S. (May 2006). *Learning from patient experiences: Strategies for obtaining patient input.* WRHA Concept Paper.

Bozić, K., Saleh, K., Rosenberg, A., & Rubash, K. (2004). Economic evaluation in total hip arthroplasty - analysis and review of the literature. *Journal of Arthroplasty, 19*(2), 180-189.

Bradley, L., Young, L., Anderson, K., Turner, R., Agudelo, C., McDaniel, L., et al. (1987). Effects of psychological therapy on pain behavior of rheumatoid arthritis patients. *Arthritis and Rheumatism, 30*(10), 1105-1114.

Brander, V., Stulberg, S., Adams, A., Harden, R., Bruehl, S., & Stanos, S. (2003). Predicting total knee replacement pain: A prospective observational study. *Clinical Orthopedic Related Research, 416*, 27-36.

Bridges, W., & Mitchell, S. (Spring 2000). Leading transition: A new model for change. *Leader to Leader, 16*, 30-36.

British Columbia Orthopaedic Association. (2004). Orthopaedic and Arthritis Care: The problem [Brochure]. Vancouver, British Columbia: Arthritis Society.

Brousseau, K. R., Driver, M. J., Hourihan, G., & Larsson, R. (February 2006). The seasoned executive's decision - making style. *Harvard Business Review. 84*(2), 110-121.

Bruhn, J. (April June 2004). Leaders who create change and those who manage it - how leaders limit success. *The Health Care Manager, 23*(2), 132-140.

Bryant, M. (Sept 9, 2004). *Waiting lists: The symptom of a universal health care system?* Paper presented at the Conference on Healthcare, University of Western Ontario.

Callaghan, J., Rosenberg, A., Rubash, H., Simonian, P., & Wickiewicz, T. (2003). *The Adult Knee* (Vol. 1). Philadelphia: Lippincott, Williams & Wilkins.

Canada Health Act Annual Report (1985 C-6, p. 1-13). (June 2001).

Chatman, J., & Cha, S. (2003). Leading by leveraging culture. *California Management Review, 45*(1), 20-34.

Clancy, T. (2004). Navigating in a complex nursing world. *Journal of Nursing Administration, 34*(6), 274-282.

Conger, J. (May / June 1998). The necessary art of persuasion. *Harvard Business Review, 76(3),* 84-95.

Connors, R., Smith, T., & Hickman, C. (1994). *The Oz principle: Getting results through individual and organizational accountability.* Englewood Cliffs, NJ: Prentice Hall.

Crowe, J., & Henderson, L. (2003). Pre-arthroplasty rehabilitation is effective in reducing hospital stay. *Canadian Journal of Occupational Therapy, 70*(2), 88-96.

Dannemiller, K., & Jacobs, R. (1992). Changing the way organizations change: A revolution of common sense. *The Journal of Applied Behavioural Science, 28*(4), 480-498.

Deegan, P. (April 1988). Recovery: The lived experience of rehabilitation. *Psychological Rehabilitation Journal, 11*(4).

Dickey, R. A., & Bray, G. (September October 1998). Obesity Statement. *Endocrine Practice, 4*(5), 297.

Dingel-Stewart, S., & LaCoste, J. (2004). Light at the end of the tunnel: A Vision for an empowered nursing profession across the continuum of care. *Nursing Administration Quarterly, 28*(3), 212-216.

Doerge, J. (2005). Creating an outcomes framework. *Outcomes Management of Nursing Practice, 4*(1), 1-10.

Dreher, D. (1997). *The Tao of Personal Leadership.* New York: Collins.

Drucker, P. (1998). Management's new paradigms. *Forbes, 162*(7), 152-170.

Durston, P. (2006). Partners in caring. A partnership for healing. *Nursing Administration Quarterly, 30*(2), 105-111.

Ettinger, W., Burns, R., Messier, S., Applegate, W., Rejeski, W., Morgan, T., et al. (1997). A randomized trial comparing aerobic exercise and resistance exercise with a health education program in older adults with knee osteoarthritis. *JAMA, 277*(1), 25-31.

Felson, D., Anderson, J., Naimark, A., & Meenan, R. (1988). Obesity and knee arthritis: Framingham study. *Annals of Internal Medicine, 109*(1), 18-24.

Field, L. (Spring 2005). *The TVC Talk Team.* [Brochure]. Florida.

Fisher, J. (Summer 2001). Obstacles - and overcoming them - to leadership among professional workers. *Journal of Organizational Excellence, Summer 2001, 20*(3), 27-34.

Fitzgerald, J., Orav, E., Lee, T., Marcantonio, E., Poss, R., & Goldman, L. (2004). Patient quality of life during the twelve months following joint replacement surgery. *Arthritis Rheumatology, 51*(1), 100-109.

Fortin, P., Penrod, J., Clarke, A., St.Pierre, Y., Joseph, L., & Belisle, P. (2002). Timing of total joint replacement affects clinical outcomes among patients with osteoarthritis of the hip or knee. *Arthritis Rheumatology, 46*(12), 3327-3330.

Frank, M. (1989). *How to run a successful meeting in half the time.* New York: Simon and Schuster.

Gardner, J. W. (1990). *On Leadership.* New York: The Free Press.

Garvin, D., & Roberto, M. (2005). Change through persuasion. *Harvard Business Review,* 104-113.

Gelinas, M. (May / June 2004). Strategic planning: Five common problems with the implementation phase. *The Journal of Oncology Management,* 14-19.

Gerstner, L. (2005). Lou Gerstner on change. *Leadership Excellence, 22*(6), 18.

Gilbey, H., Ackland, T., Wang, A., Morton, A., Trouchet, T., & Tapper, J. (2003). Exercise improves early functional recovery after total hip arthroplasty. *Clinical Orthopaedics and Related Research, 408*, 193-200.

Glaser, J. (2005). Making changes. *Leadership Excellence, 22*(9), 7-8.

Glouberman, S. (2005). A new perspective on health policy for social democrats. In. Retrieved January 22, 2006, from http://www.healthandeverything.org/pub/advice_to_social_democrats: Google

Goldsmith, S. (2005). *Principles of health care management - compliance, consumerism and accountability in the 21st century.* Massachusetts: Jones and Bartlett Publishers.

Goleman, D. (1998). What makes a leader? *Harvard Business Review, 76*(6), 93-102.

Gray, J. (2004). Ch-ch-ch-changes. *Canadian Business Magazine, 77*(14/15), 93-95.

Grohar-Murray, M., & DiCroce, H. (2003). *Leadership and management in nursing* (3rd ed.). New Jersey: Pearson Education Incorporated.

Gryskiewicz, S. (2005). Leading renewal: The value of positive turbulence. *Leadership and Action, 25*(1), 8-12.

Hall, J., Skevington, S., Maddison, P., & Chapman, K. (1996). A randomized and controlled trial of hydrotherapy in rheumatoid arthritis. *Arthritis Care and Research, 9*(3), 206-215.

Harris, F. (2004). Waitlists: Standards and solution. *Canadian Health Care Manager, 11*(6), 39-46.

Hauser, D. (1980). Comparison of different models for organizational analysis. In E. Lawler, D. Nadler & C. Cammann (Eds.), *Organizational Assessment: Perspectives on the measurement of organizational behavior and the quality of worklife* (p. 132-161). New York: John Wiley and Sons.

Havens, D., & Aiken, L. (1999). Shaping systems to promote desired outcomes: The magnet hospital. *Journal of Nursing Administration, 29*(2), 14-20.

Hawker, G., Wright, J., Coyte, P., Paul, J., Dittus, R., & Croxford, R. (1998). Health related quality of life after knee replacement. *Journal of Bone and Joint Surgery, 80*(2), 163-173.

Hedden, D. (May 31, 2006). *Causes and prevention of joint disease.* Paper presented at the meeting of The "Joint" Endeavour, Winnipeg.

Hibberd, J., & Smith, D. (2006). *Nursing leadership and management in Canada* (3rd ed.). Toronto: Elsevier Mosby.

Higgs, M., & Rowland, D. (2005). All changes great and small: Exploring approaches to change and its leadership. *Journal of Change Management, 5*(2), 121-151.

Hill, K. (2003). Development of leadership competencies as a team. *JONA, 33*(12), 637-642.

Holtzman, J., Saleh, K., & Kane, R. (2002). Effect of baseline functional status and pain on outcomes of total hip arthroplasty. *Journal of Bone and Joint Surgery, 84*, 1942-1948.

Horak, B.J., (1997). *Strategic planning in healthcare – Building a quality-based plan step by step.* New York: Quality Resources

Hough, D., Crosat, S., & Nye, P. (1991). Client education for total hip replacement. *Nursing Management, 22*, 801-809.

Humber, J., & Almeder, R. (2003). *Care of the aged.* New Jersey: Humana Press.

Iglehart, J. (2000). Revisiting the Canadian health care system. *Health Policy Report, 342*(26), 2007-2012.

Johansson, K., Hupli, M., & Salantera, S. (2002). Patients learning needs after arthroplasty. *Journal of Clinical Nursing, 11*, 634-639.

Jones, C., Voaklander, D., Johnston, D., & Suarez-Almazor, M. (2000). Health related quality of life outcomes after total hip and knee arthroplasties in a community-based population. *Journal of Rheumatology, 27*(7), 1745-1752.

Jooste, K. (2003). Essential managerial attributes of the nowadays nursing service manager in the South African context. *Curationis, 26*(2), 19-29.

Kanter, R. (2000). The enduring skills of change leaders. *Ivey Business Journal, May/June, 64*(5), 31-36.

Karlson, E., Mandl, L., Aweh, G., Sangha, O., Liang, M., & Grodstein, F. (2003). Total hip replacement due to osteoarthritis: The importance of age, obesity and other modifiable risk factors. *American Journal of Medicine, 114*(2), 158-159.

Keller, L., Schaffer, M., Lia-Hoagberg, B., & Strohschein, S. (2002). Assessment, program planning and evaluation in population based health practice. *Journal of Public Health Management, 8*(5), 30-43.

Kiecolt-Glaser, J., Page, G., Marucha, P., MacCallum, R., & Glaser, R. (1998). Psychological influences on surgical recovery. *American Psychologist, 53*(11), 1209-1218.

Kirkman, B., & Rosen, B. (Winter 2000). Powering up teams. *Organizational Dynamics,* 48-66.

Klippel, J., Crofford, L., Stone, J., & Weyand, C. (2001). *Primer on the rheumatic diseases* (12th ed.). Georgia: The Arthritis Foundation.

Kotter, J. (2005). Leading change. *Leadership excellence, 22*(11), 5.

Kouzes, J., & Posner, B. (2002). *The leadership challenge* (3rd ed.). San Francisco: Jossey-Vass.

Kozhaya, N. (2005). Healthcare financing: Squandering billions is not the answer. *Canadian Healthcare Manager, 12*(1), 31-33.

Kuhl, S., Schnelle, T., & Tillman, F. (2005). Lateral leadership: An organizational approach to change. *Journal of Change Management, 5*(2), 177-189.

Kuyumcu, N. (2006). Perfect timing - Alberta joint replacement project reduces wait times. *Canadian Healthcare Manager, 13*(2), 21-23.

Kuyumcu, N. (2006). Vital signs. *Canadian Healthcare Manager, 38*(6), 46.

Langley, G., Nolan, K., Norman, C., Provost, L., & Nolan, T. (July 1996) [ISBN 0-7879-0257]. *The improvement guide: A practical approach to enhancing organizational performance.* Jossey-Bass.

Laupacis, A., Bourne, R., Rorabec, C., Feeny, D., Wong, C., & Tugwell, P. (1993). The effect of elective total hip replacement on health-related quality of life. *Journal of Bone and Joint Surgery, 75*(11), 1619-1626.

LeTourneau, B. (2005). The five stages of physician reaction to change. *Journal of Health Care Management, 50*(1), 5-7.

Lichtenstein, B. (2000). Self-organized transitions: A patter amid the chaos of transformative change. *The Academy of Management Executive, 14*(4), 128-141.

Lingard, E., Katz, J., Wright, E., & Sledge, C. (2004). Predicting the outcome of total knee arthroplasty. *Journal of Bone and Joint Surgery, 86*(10), 2179-2186.

Litch, B. (2005). Facing change in an organization: How to chart your way through the chaos. *Health Care Executive, 20*(5), 21-24.

LoBiondo-Wood, G., & Haber, J. (1990). *Nursing research - Methods, critical appraisal and utilization* (2nd ed.). St.Louis, Missouri: The C.V. Mosby Company.

Lutjens, L., & Tiffany, C. (1994). Evaluating planned change theories. *Nursing Management, 25*(3), 54-57.

Macdonald, L. (November 2006). [Manitoba Waitlist Registry, Winnipeg Regional Health Authority]. Unpublished raw data.

MacStravic, S., & Montrose, G. (1998). *Managing health care demand.* Maryland: Aspen Publication

Madson, S., & Gygi, J. (2005). A conversation with John M. Zenger: Leadership & change setting. *Organizationl Development Journal, 23*(3), 89-98.

Magni, G., Moreschi, C., Rigatti-Luchini, S., & Merskey, H. (1994). Prospective study on the relationship between depressive symptoms and chronic musculoskeletal pain. *Pain, 56*, 289-297.

Maher, A., Salmond, S., & Pelino, T. (2002). *Orthopedic nursing.* Philadelphia: W.B. Saunders Company.

Mahon, J., Bourne, R., Roraback, C., Feeny, D., Stitt, L., & Webster-Bogaert, S. (2002). Health related quality of life and mobility of patients awaiting

elective total-hip arthroplasty: A prospective study. *Canadian Medical Association Journal, 167*(10), 1115-1121.

Maljanian, R., Effken, J., & Kaerhle, P. (2005). Design and implementation of an outcomes management model. *Outcome Management of Nursing Practice, 4*(1), 1-11.

Manitoba Council on Aging. (2004). *The Manitoba Council on aging act introduced.* [Data File]. Winnipeg, Manitoba: News Media Services.

Marks, R., Allegrante, J., & Lorig, K. (2005). A review and synthesis of research evidence for self-efficacy - Enhancing interventions for reducing chronic disability: Implications for health education practice (part 1). *Health Promotion Practice, 6*(1), 37-43.

Marrow, A. (1969). The practical theorist: the life and work of Kurt Lewin. New York: Basic Books.

Mazankowski, D. (December 2001). A framework for reform. *Report of the Premier's advisory council on health.* Edmonton: Alberta Science and Research Authority.

McGregor, A., Rylands, H., Owen, A., Dore, C., & Hughes, S. (2004). Does pre-operative hip rehabilitation advice improve recovery and patient satisfaction? *Journal of Arthroplasty, 19*(4), 464-468.

Minor, M., Hewett, J., Webel, R., Anderson, S., & Kay, D. (1989). Efficacy of physical conditioning exercise in patients with rheumatoid arthritis and osteoarthritis. *Arthritis and Rheumatism, 32*(11), 1396-1405.

Moran, M., Walmsley, P., Gray, A., & Brenkel, I. (2005). Does body mass index affect the early outcome of primary total hip arthroplasty? *The Journal of Arthroplasty, 20*(7), 866-869.

Necheff, J. (January 27, 2006). Alberta alters health rules. *Winnipeg Free Press.*

Newhouse, R., Dearholt, S., Poe, S., Pugh, L., & White, K. (2005). Evidence-based practice - A practical approach to implementation. *Journal of Nursing Administration, 35*(1), 35-40.

Nilsdotter, A., Petersson, I., Roos, E., & Lohmander, L. (2003). Predictors of patient relevant outcome after total hip replacement for osteoarthritis: A prospective study. *Annals of rheumatoid diseases, 62*(10), 923-930.

Noseworthy, T. W., Sanmartin, C., Bohm, E., Conner-Spady, B., DeCoster, C., Dunbar, M., et al. (October 14, 2005). *Toward Canadian benchmarks for Canadian health services wait times - Evidence, application and research priorities* (FRN#/NRF:76440, p. 1-56).

Onisk, M., Hennard, J., & Koster, C. (2000). *Project management fundamentals.* Rochester, New York: Element K. Press LLC.

Ostendorf, M., Buskens, E., VanStel, H., Schrigvers, A., Marting, L., Dhert, W., et al. (2004). Waiting for total hip arthroplasty. *Journal of Arthroplasty, 19*(3), 302-309.

Polit, D., & Hungler, B. (1983). *Nursing research: Principles and methods* (2nd ed.). Toronto: J.B. Lippincott Company.

Pollock, S. (1986). Human response to chronic illness: Physiologic and psycho-social adaptation. *Nursing Research, 35*(2), 90-95.

Porter O'Grady, T. (2001). Profound change - 21st century nursing. *Nursing Outlook, 49*(4), 182-186.

Porter O'Grady, T. (2000). Different landscape. *Hospitals and Health Networks, 74*(5), 10.

Porter-O'Grady, T. (1999). Quantum leadership: New roles for a new age. *Journal of Nursing Administration, 29*(10), 1-10.

Porter-O'Grady, T., & Malloch, K. (2003). *Quantum leadership - A textbook of new leadership.* Sudbury, Massachusetts: Jones and Bartlett Publisher.

Rabson, M. (August 29, 2005). Lineups reaching alarming lengths. *Winnipeg Free Press,* p. A3.

Righton, B. (May 8, 2006). The latest health tip - save medicare by looking after no. 1. *Maclean's Magazine,* 16.

Romanow, R. (November 2002). Building on values. (p. 5). Ottawa, Ontario: National Library of Canada.

Sale, T. (May 3, 2006). Length of stay [Letter]. *Minister of Health Legislative Building.*

Sammut-Bonnice, R., & Wensley, R. (2002). Darwinism, probability and complexity: Market-based organizational transformation and change explained through the theories of evolution. *International Journal of Management Reviews, 4*(3), 291-315.

Samuel, M. (2001). *The accountability revolution* (2nd ed.). Arizona: Facts on Demand Press.

Sawchuk, T. (November 2006). *Canadian Joint Registry Report.* Winnipeg Regional Health Authority.

Schaffer, R. H. (1991). Demand better results and get them. *Harvard Business Review, 69*(2), 142-149.

Scott, L., & Caress, A. (2005). Shared governance and shared leadership: Meeting the challenges of implementation. *Journal of Nursing Management, 13*, 4-12.

Scuderi, G., & Tria, A. (2002). *Surgical techniques in total knee arthroplasty.* New York: Springer Publishing.

Sepehri, A., & Chernomas, R. (2005). Is the Canadian health-care system fiscally sustainable? *International Journal of Health Sciences, 34*(2), 229-243.

Shelton, K. (2005). Transformative leadership. Why be responsible? *Leadership Excellence, 22*(9), 8.

Shortell, S.M., & Kaluzny, A.D. (2006) *Health care management – Organization designs and behaviour* (5th ed). New York: Thomson Delmar Learning

Sjoling, M., Nordahl, G., Olofsson, N., & Asplung, K. (2003). The impact of pre-operative information on anxiety state, post-operative pain and satisfaction with pain management. *Patient education and counselling, 51*, 169-176.

Skerritt, J., & Rabson, M. (November 5, 2006). How long should it take to get help? *Winnipeg Free Press,* p. A8.

Spector, T., Hart, D., & Doyle, D. (1994). Incidence and progression of osteoarthritis in women with unilateral knee disease in the general population: The effect of obesity. *Annals of Rheumatoid Diseases, 53*, 565-568.

Stacey, R. (1996). Management and the science of complexity: If organizational life is non-linear, can business strategies prevail? *Research and Technology Management, 39*(3), 2-5.

Stern, S. (February 2005). Forever changing. *Management Today,* 40-43.

Storch, J. (2005). Country profile: Canada's health-care system. *Nursing Ethics, 12*(4).

Tan, J., Wen, H., & Awad, N. (2005). Health care and service delivery systems as complex adaptive systems. *Communications of the ACM, 48*(5), 36-44.

Ulrich, B. (1992). *Leadership and management according to Florence Nightingale.* Norwalk, Connecticut: Appleton & Lange.

Veluswamy, R. (2004). Balancing Yin and Yang: Correlating quality of care and length of stay. *American College of Physician Executive.*

Viens, C., Lavoie-Tremblay, M., Leclerc, M., & Brabant, L. H. (2005). New approaches of organizing care and work: Giving way to participation, mobilization and innovation. *Health Care Management, 24*(2), 150-158.

Villeneuve, M. (April 21, 2006). *Eastern Nursing Research Society 18th Annual Meeting.*

Villeneuve, M., & MacDonald, J. (2006). Canadian Nurse. *Toward 2020. Visions for nursing, 102*(5), 22-23.

Walker, J., & Helewa, A. (2004). *Physical rehabilitation and arthritis.* St. Louis: Saunders Elsevier Incorporated.

Wente, M. (Saturday January 7, 2006). Hip replacement surgery. *The Globe and Mail,* p. F1.

West, L. (December 16, 2004). Waitlist like house arrest to patient: Orthopaedic surgery need puts woman's life on hold. *Winnipeg Free Press,* p. A15.

West, L. (February 7, 2005). System flaws hurt people, society. *Winnipeg Free Press,* A11.

Wheatley, M. (1999). Leadership and the new science (2nd ed.). San Francisco: Berrett-Koehler Publishers.

Wieske, A., & Bantz, D. (1992). Economic awareness of registered nurses employed in hospitals. *Nursing Economics, 10*(6), 406-412.

Wilson, K., & Rosenberg, M. (2004). Accessibility and the Canadian health-care system: Squaring perceptions and realities. *Health Policy, 67*, 137-148.

Winnipeg Regional Health Authority. (2006). Waitlist guiding principles.

Winslow, W. (2004). Creating quality practice environments: Not easy, but essential. *Healthcare Management Forum, 17*(4), 28-33.

Wolf, E. (2002). Employing practices used by centers of excellence. *Healthcare Executive, 17*(1), 20-23.

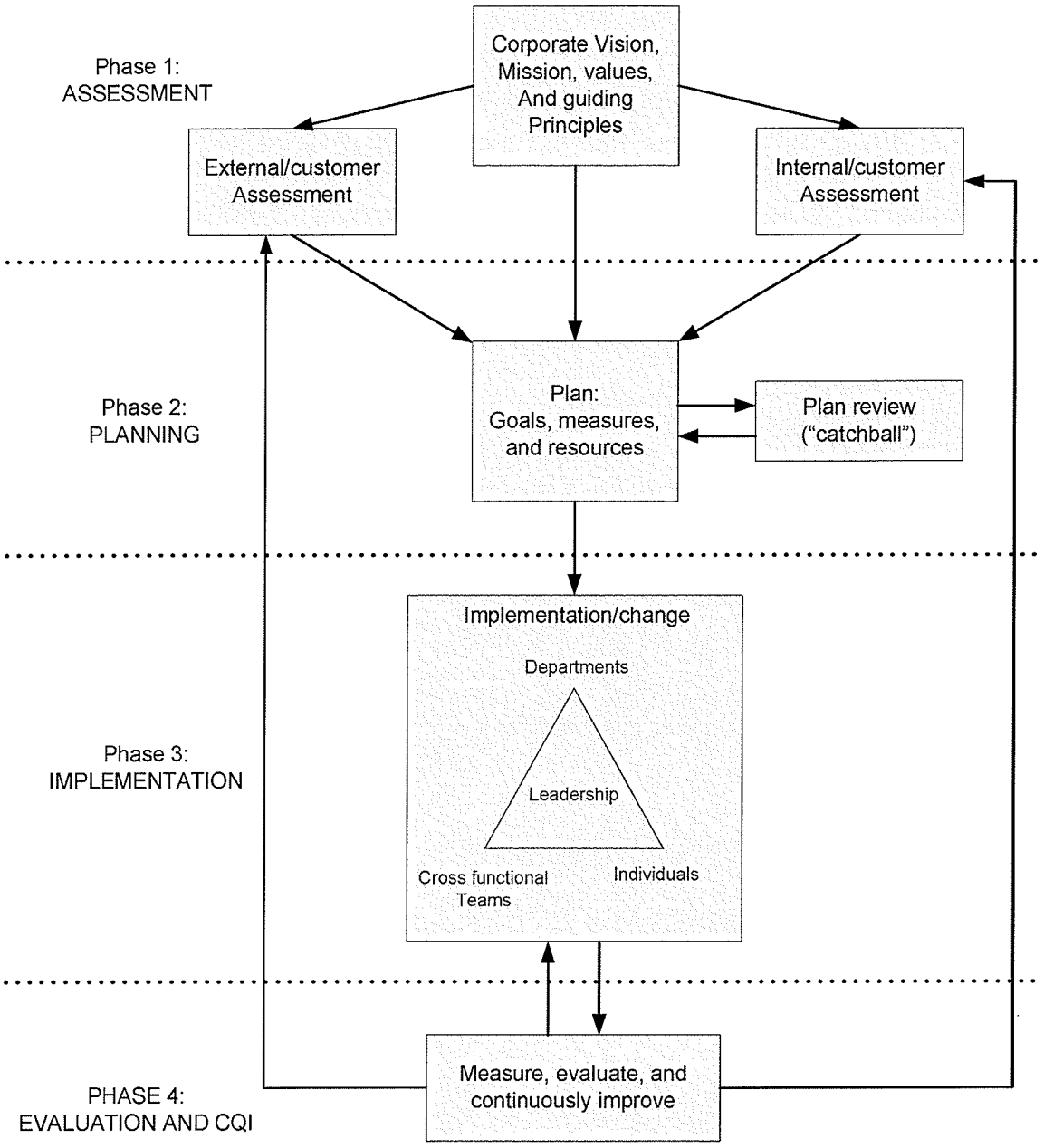
Wren, J., & Dulewicz, V. (2005). Leader competencies, activities and successful change in the Royal Air Force. *Journal of Change Management, 5*(3), 295-309.

Yates, J. (2001). Wait watcher: Cut and thrust. *The Health Services Journal, 111*(5775), 23.

Yeboah, D. (2005). A Framework for place based health planning. *Australian Health Review, 29*(1), 30-37.

Appendix A

Model for Quality-Based Strategic Planning



Appendix B

APPROVAL CERTIFICATE

12 October 2006

TO: **Ann Reichert**
Principal Investigator

FROM: **Stan Straw, Chair**
Education/Nursing Research Ethics Board (ENREB)

Re: **Protocol #E2006:076**
"Prehabilitation Program: Leadership Insights into the Planning Process"

Please be advised that your above-referenced protocol has received human ethics approval by the **Education/Nursing Research Ethics Board**, which is organized and operates according to the Tri-Council Policy Statement. This approval is valid for one year only.

Any significant changes of the protocol and/or informed consent form should be reported to the Human Ethics Secretariat in advance of implementation of such changes.

Please note:

- if you have funds pending human ethics approval, the auditor requires that you submit a copy of this Approval Certificate to Kathryn Bartmanovich, Research Grants & Contract Services (fax 261-0325), including the Sponsor name, before your account can be opened.

- if you have received multi-year funding for this research, responsibility lies with you to apply for and obtain Renewal Approval at the expiry of the initial one-year approval; otherwise the account will be locked.

Appendix C

Concordia HOSPITAL

1095 Concordia Avenue
Winnipeg, Manitoba R2K 3S8
Telephone: 661-7159

Practicum Project Title: Prehabilitation Program:

Leadership Insights into the Planning Process

Practicum Student: Ann R. Reichert, RN, BN

Advisor: Dr. Jo-Ann Sawatzky, RN, PhD, Faculty of Nursing

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the practicum project is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

I. **Purpose of Practicum:** To gain knowledge and insight into the leadership perspective of program planning by being a participant observer at Prehabilitation (Prehab) planning steering committee meetings. This will fulfill requirements of the practicum in completion of a Masters of Nursing degree.

II. **Procedures:** Prehab planning meetings will be attended bi-weekly. The focus of the observations will include attention to the broad sociopolitical and economic driving forces behind the Prehab initiative, as well as the formation of the team, team interactions, and the steps required to bring the program to fruition. Recording devices will not be used; written notes will be taken during the meetings to record the leadership insights and the group process. The subjects will include the interdisciplinary representatives from the Winnipeg Regional Health Authority who are participating on the committee. Following the meetings, subjects may be asked for clarification or additional insights into the program planning process. These discussions will take place via a venue and time that is convenient to the subject, and in consideration of confidentiality. Committee members may refrain from partial or complete participation, without prejudice or consequences.

III. **Risk & Benefits:** There is no known risk to participating in this project. While there may not be any direct benefit to your participation in this project, it is hoped that this project will provide insight into the program planning process, which may benefit others in the future.

IV. **Degree of Confidentiality/Anonymity:** All the information you provide to the researcher will be kept confidential. Your name will not appear in any reports about this study or in any future publications or presentations. Despite efforts to keep your personal information confidential, absolute confidentiality cannot be guaranteed. Your personal information may be disclosed if required by law. All records that contain your identity will be treated as confidential in accordance with the Freedom of Information and Protection of Privacy Act. Notes taken during the meetings will focus on the leadership insights gleaned from the group process and will not identify specific committee members. The notes will be kept in a locked cupboard in the researcher's office and then destroyed following the oral defense for the Masters of Nursing degree. All observations and information related to the identity of the subjects will be reported in such a way that individual subjects cannot be identified.

V. **Feedback to Subjects**: All subjects will be invited to review the scholarly paper prior to the oral defense for the Masters of Nursing degree; this will also provide an opportunity to address any concerns related to the observations being reported. A brief summary of the project will be available to you at your written or verbal request to the researcher.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. If you choose to participate, you are still free to withdraw from the study at any time, and /or refrain from answering any questions you prefer not to answer, without prejudice or consequence. If you have concerns regarding the inclusion of any or all parts of a meeting(s) process, please inform the researcher, and this information will be excluded. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation. Please forward any questions or concerns to:

Practicum Student: Ann Reichert
and/or
Advisor: Dr. Jo-Ann Sawatzky, (204)474-6684

This practicum project has been approved by the Education and Nursing Research Ethics Board. If you have any concerns or complaints about this project you may contact any of the above-named persons or the Human Ethics Secretariat at 474-7122, or e-mail

margaret_bowman@umanitoba.ca. A copy of this consent form has been given to you to keep for your records and reference.

Participant's Signature Date

Practicum Student and/or Delegate's Signature Date

Appendix D

Program Overview

Title

WRHA Surgery Prehabilitation Program

Description

The purpose of this program is to develop, implement and evaluate a comprehensive prehab program utilizing a multidisciplinary assessments, and medical intervention and for people awaiting elective hip and knee replacement surgery with an expectation of improving waiting times.

Goals

1. To work with individuals requiring hip and knee replacement surgery to improve surgical outcomes, their health and well-being.
2. To validate effectiveness of the interventions of the program.
3. To establish a partnership between the community and acute care sector to enhance care across the continuum for those patients requiring lower extremity joint replacement.
4. To decrease the number of patients on the waitlist and reduce the length of stay.

Values

We value:

- Innovation
- Involvement
- Learning
- Team Work
- Customer Focus

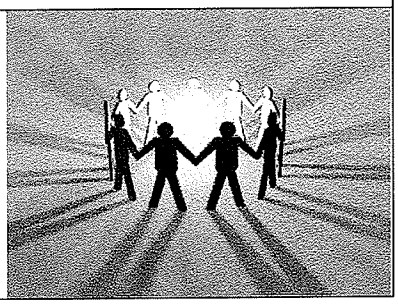
Vision

A Team approach to improving wait times, maximizing physical and emotional functioning of patients requiring hip and knee joint replacement surgery, optimizing outcomes within available resources.

Metaphor

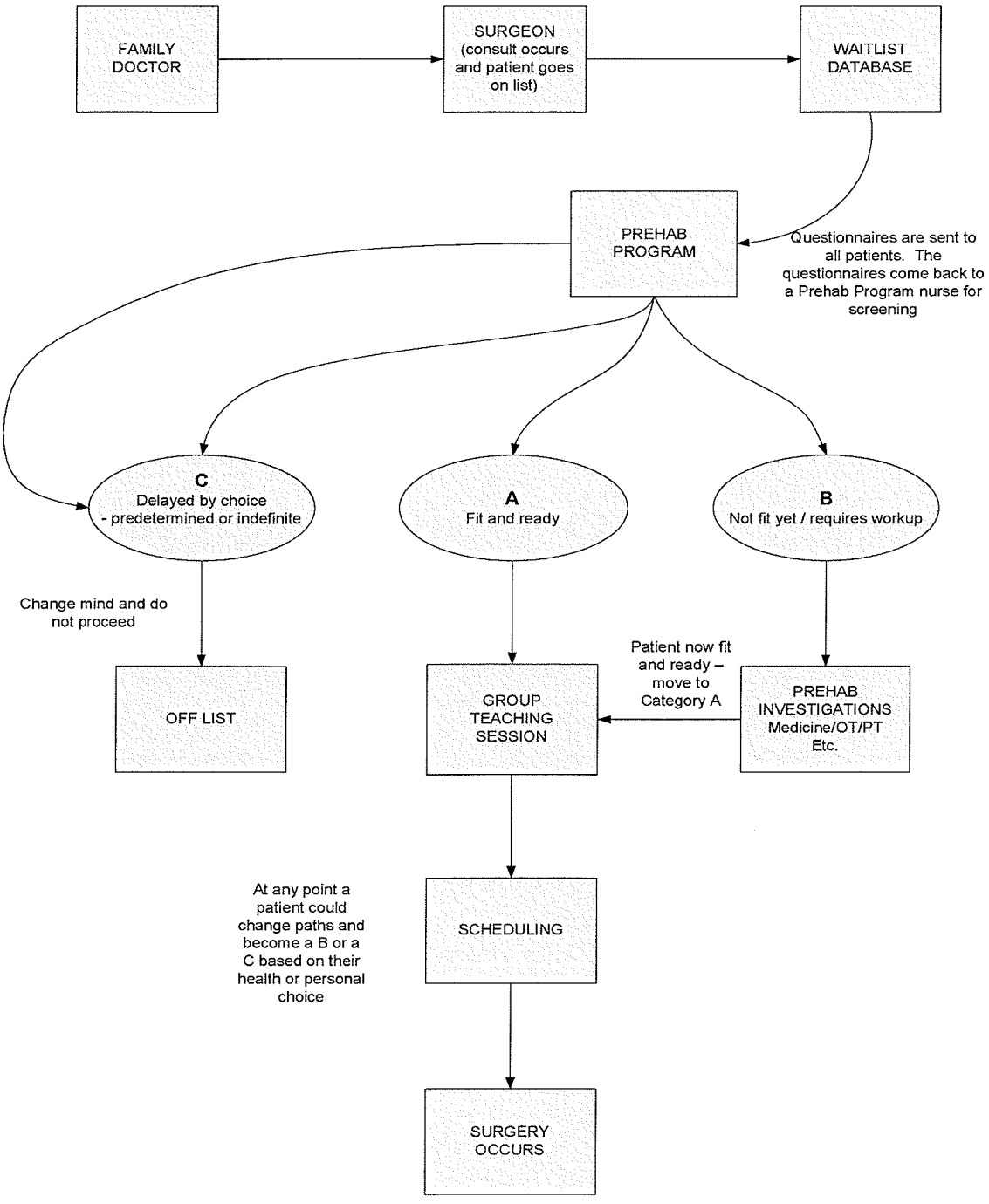
A "Joint" Endeavour

- Community Worker
- Patient
- Hospital Worker

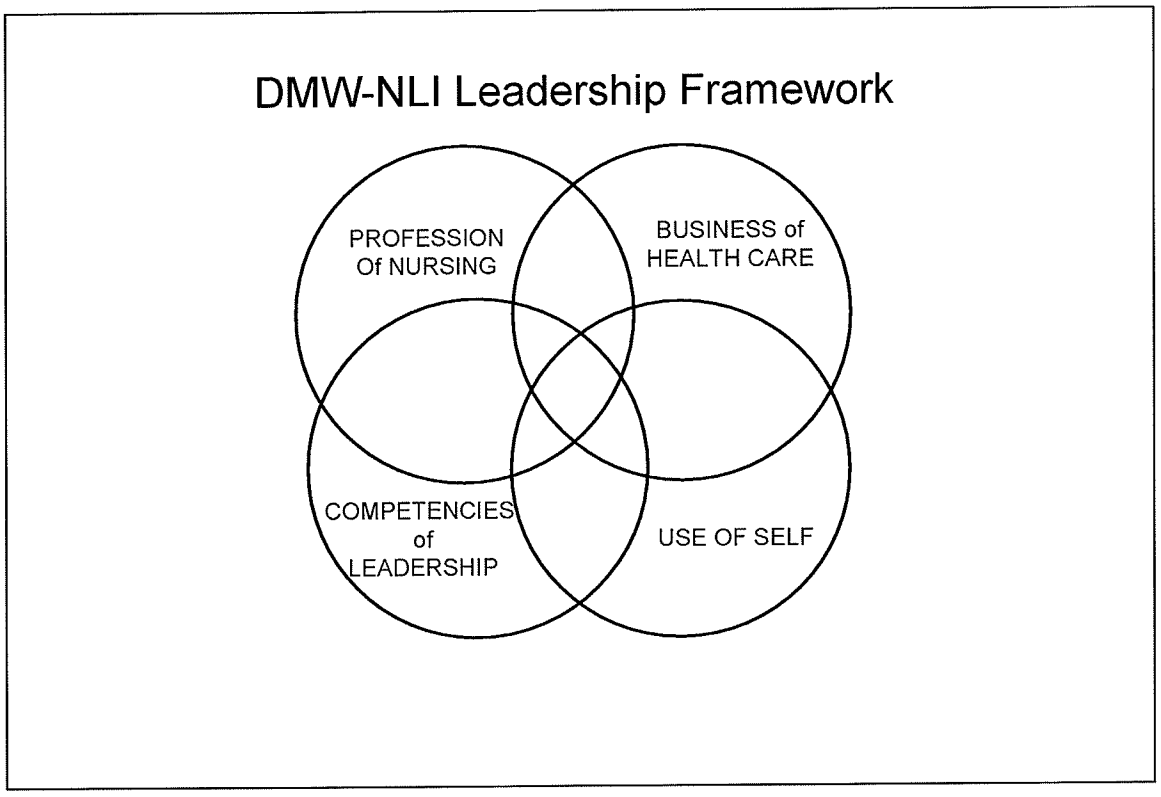


Appendix E

Prehab Program Pathway



Appendix F


DMW-NLI Leadership Framework
PROFESSION Of NURSING
BUSINESS of HEALTH CARE
COMPETENCIES of LEADERSHIP
USE OF SELF