

Appendix D: Examples of Conflict Management

Case Scenario: The Ripple Effects of Conflict

Background: a charge nurse brought forward a complaint regarding a relationship with Nurse X. The charge nurse reported that over a period of six months, since her appointment to the unit, tension continued to escalate between the two and at the time of the complaint the charge nurse indicated that she felt as though she were working in an unhealthy, hostile environment.

The charge nurse could not identify when the conflict began but did recognize that an on-going deterioration of the relationship had resulted and that a series of small events contributed to the problems. The individuals were no longer speaking directly to each other unless absolutely necessary. The other staff members noticed that communication was significantly impacted and even information regarding patient care was shared with limitations.

The charge nurse reported that the two individuals had very different work styles and approaches to patient care. She reported feeling that Nurse X was a strong personality that others avoided for fear of disapproval or reprisals. She felt as though she were excluded from the group of seasoned employees because she was new to the unit, essentially an outsider. She felt that a power imbalance existed and that the Nurse X held a great deal of influence over others, regardless of the fact that she was in a leadership position. Additionally, the charge nurse believed that the respondent did not complete her work and this perception contributed to the conflict.

Addressing the Conflict

The charge nurse indicated that she had finally come forward after significant contemplation and a final incident that could be perceived to be rather insignificant but was yet another example of what she believed was a long series of behavioural and code of conduct infractions.

When advised of the complaint, Nurse X indicated that the allegations of bad behaviour were unfounded and, that in fact, she was the recipient of bullying behaviour.

Nurse X agreed that there was an ongoing relationship issue and was preparing to forward documentation that would support her allegations of harassment and bullying. She maintained that the charge nurse was known to be difficult and abrasive and that co-workers were fearful of her abusive verbal and non-verbal communication style and her position of leadership. Nurse X disclosed that the charge nurse, in her position of leadership, had the authority to initiate policy changes that impacted breaks and schedules. She stated that others did not come forward for fear of retaliation.

Nurse X also reported that the two had very different work styles, and communication abilities. Nurse X felt the charge nurse was rude, overly directive and abrupt with patients.

Impact of the Conflict

Both parties began to accumulate significant sick time and attributed the absenteeism, at least in part, to work-related stress. Unfortunately, members of the unit knew about the difficulties and began openly discussing the peers involved. A number of staff members had chosen a “side” to support and further relationship damage was the result. Unit division was an identified problem. Leadership met in an effort to create a plan to mitigate damage and put an end to the gossip. Close monitoring of any discussion regarding the relationship problems was required and occurred.

Mitigation of Conflict

Mediation was attempted without sustainable success. One of the participants reported that she was raised in a culture whereby direct discussion of conflict issues was avoided, and therefore she found the process difficult to participate in.

An investigation was conducted by an external third party. The investigator explored competing bullying/harassment allegations. The investigator concluded that allegations of bullying were unfounded. The investigator identified the problem as one in which neither party took reasonable responsibility in an effort to resolve differences.

Management of Conflict

Ultimately the parties agreed to work with individual coaches that would empower them to find a way to effectively communicate their perceptions of the conflict, as well as to propose solutions for resolution. During this process a work accommodation occurred and the parties were not required to have any contact.

The staff was asked by their administrators to collaborate, discuss and identify issues that negatively impacted the unit.

The group identified several issues that contributed to problems:

- Generational issues and differences in perceptions of work practices;
- Gossip;
- A perceived administrative failure to act on reported problems and, as a result, a lack of faith in the timely resolution to sensitive conflict related issues;
- Communication deficiencies between staff;
- Infrequent or incomplete communication between staff and leadership;
- Deficient conflict resolution skills in individuals; and
- Lack of knowledge regarding formal processes to address Code of Conduct and other policy breaches.

The group agreed to work together on an ongoing basis to discuss potential initiatives and identify educational sessions that would help address the identified areas or concern. The hospital recognized this initiative to be of priority importance and agreed to compensate the individuals for their time.

Education sessions regarding communication, conflict, workplace violence, harassment and bullying were scheduled and occurred at various times to allow individuals to attend in small groups and at their convenience. Internal individuals, removed from the unit, facilitated the education sessions.

The group began initiatives designed to identify staff members contributing to a positive team environment. Those members were nominated and recognized for their efforts. These members received unit recognition based on nomination.

Ultimately, positive behaviours began to receive more attention than the negative. Peer monitoring and recognition resulted significantly increased healthy interactions.

The above scenario and setting has been adapted from an actual situation of conflict and is being used with permission of the participants

Case Scenario: United We Stand, Divided We Fall

Background

A small unit in a hospital was staffed with two professional disciplines totalling approximately 14 people. This staff on this unit had strong personal friendships with each other and often gathered socially outside of work. The hospital implemented an initiative designed to improve work flow and functioning which changed the standard duties of the two professional disciplines. In fact, one group took over an integral role that replaced the need for the other group. Consequently, the second group lost the opportunity to acquire overtime, at the same level as they had in the past. Within a span of three or four months, a number of individual concerns related to inappropriate behaviours and conflict were brought forward.

The supervisor of the group had been very involved in an initiative that took her away from the unit for significant periods of time. The staff reported to be unclear about the roles and responsibilities of the interim leaders, and to whom they should report complaints.

Impact of the Conflict

It became obvious that the conflict was not restricted to individual relationships and had spread unit-wide. Several individuals were no longer speaking to each other, the groups would no longer sit in the lunchroom together, and many reported daily stress and anxiety directly related to negative behaviours.

Addressing the conflict

Senior Leadership, Management and Human Resources met over a period of time in an effort to create an inclusive and agreed-upon action plan.

Management met with the groups separately in an effort to hear perceptions of the problem. Antecedents to the conflict were identified and documented. Staff were then met with individually and asked to share their perceptions of the nature of the conflict. Individuals were assured that their observations would remain confidential.

Mitigating and Managing the Conflict

As a result of the information shared, numerous practical recommendations were created for the individuals and management. These recommendations were brought back to Management for input discussion and dissemination to the staff. Many of the recommendations were designed to bring staff together through various collaborative initiatives and create opportunities for dialogue or to clarify roles.

Examples of these recommendations are found below.

1. What am I responsible for?
 - My own behaviour and, in a respectful manner, holding my colleagues accountable for their own behaviour.
 - Active participation in mandatory education regarding reflective communication, asking questions and conflict resolution.
 - Seeking out a peer mentor who will offer feedback and support when issues related to conflict present themselves.
 - Participating and providing feedback.

2. What is unit Management and Leadership responsible for?
 - Creating a common unit-wide mission statement and goals with equal input from all.
 - Defining individual roles and responsibilities, including management and physician leadership.
 - Reviewing and revising, if necessary, duty task lists.
 - Developing, issuing and compiling tools designed to monitor the success of the memorandum of understanding (MOU) and the move forward plan. (e.g. regular staff surveys, focus groups, and peer and team member evaluations).
 - Conducting routine performance appraisals and ensuring that appropriate supporting resources are in place to improve performance where needed.
 - Prioritizing accountability and timely follow-up when unacceptable behaviours are identified.
 - Posting agreed upon inappropriate AND appropriate behaviours.

3. How will the unit be managed?

- A unit organizational chart will be created.
- The group will be provided with information that clearly establishes how and to whom complaints should be created and forwarded.
- Daily ‘huddles’ will occur to build common understanding of the “daily events” as it relates to patient procedures, staff availability, supply management, bed availability, scheduling, information sharing and quality indicator reporting.
- Monthly staff meetings, with agendas, will include all interdisciplinary staff of the team.
- Opportunities for group collaboration and problem-solving will be encouraged with input from any member wishing to contribute to the agenda of meetings.
- Clear plans for information dissemination will occur whenever change occurs.
- Individuals responsible for the information sharing will be identified.
- Clearly defined mechanisms will be put in place to deal with clinical issues and/or conflicting clinical perspectives.

Additionally, a working group was formed with peer-nominated staff and physician participation. The purpose of the working group was to come to agreement about specific behaviours that would be discouraged within the group and other behaviours that would be encouraged. After much discussion, the group came to agreement. This process gave staff the opportunity to consider and express what was important to them and the staff they represented. It allowed people to dialogue about, and consider their perception of an “ideal, aspired-to workplace”.

The peer group then presented the information to the larger group for feedback and staff was asked to sign a document as a demonstration of their commitment to the cultural improvement initiative.

This document became a Memorandum of Understanding. All staff of the unit was accountable for behaviours. By creating the document, staff knew precisely what was expected within their unit, as well as those behaviours unacceptable amongst group staff.

Examples

Exemplary and Encouraged Behaviours

- Accepting one’s fair share of the workload
- Working collaboratively, despite feelings of dislike
- Adhering to departmental policies and procedures including, but not limited to, calling in sick, requests for time off, call in, overtime and following task lists
- Fostering communication that demonstrates politeness, genuine listening and responsive reactions so that staff feel safe voicing opinions or concerns
- Acknowledging a misunderstanding and apologizing where necessary
- Fairness to anyone in an interaction, taking into account all circumstances and explaining the position taken and the reasons for the decision-making
- Willingness to participate in creative problem-solving without fear of criticism articulating a defensive position
- Demonstrating compassion and empathy while engaging in appropriate social interaction
- Never be a silent witness; speak up when a co-worker is gossiping, criticizing or talking badly about a peer.
- Hold yourself accountable and seek out feedback from peers regarding your own performance and behaviour

Unacceptable and Discouraged Behaviours

- Behaviours that have the effect of suppressing input by other staff of the Health-care team and team collaboration
- Undermining of performance, reputation and professionalism of others by deliberately withholding necessary information or engaging in passive non-cooperation
- Non-verbal conduct such as condescending eye rolling or staring into space when communication is being attempted with a colleague patient or family member
- Reluctance, impatience or rudeness when required to answer a question or phone call
- Contemptuous disrespectful or defiant language or deportment that results in isolation of individuals or damaged relationships
- Arriving to work late, or leaving the unit early without the appropriate supervisor/director's permission or other applicable authorization
- Discussion of interdepartmental issues with colleagues and other Health-care providers that has the effect of contributing to a negative perception of the unit
- The use of profane language or unprofessional discussions in the presence of team staff, patients and families

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