

## Healthy Work Environment Best Practice Guidelines

SEPTEMBER 2012

# Managing and Mitigating Conflict in Health-care Teams



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## Contact Information

Registered Nurses' Association of Ontario  
Healthy Work Environments Best Practice Guidelines Project  
158 Pearl Street, Toronto, Ontario M5H 1L3  
Website: [www.rnao.ca/bpg](http://www.rnao.ca/bpg)

# Greetings from Doris Grinspun,

## Chief Executive Officer (CEO) Registered Nurses' Association of Ontario

It is with great pleasure that the Registered Nurses' Association of Ontario (RNAO) releases the *Managing and Mitigating Conflict Guideline in Health-care Teams* Healthy Work Environments Best Practice Guideline. This is one of a series of Best Practice Guidelines (BPG) on Healthy Work Environments (HWE) developed by the nursing community to date. The aim of these guidelines is to provide the best available evidence to support the creation of healthy and thriving work environments. These guidelines, when applied, will serve to support the excellence in service that nurses are committed to delivering in their day-to-day practice. RNAO is delighted to be able to provide this key resource to you.



We offer our endless gratitude to the many individuals and institutions that are making our vision for HWE BPGs a reality: the Government of Ontario for recognizing RNAO's ability to lead the program and providing generous funding; Irmajean Bajnok, Director, RNAO International Affairs and Best Practice Guidelines (IABPG) Centre, for her expertise and leadership in advancing the production of HWE BPGs; all HWE BPG Team Leaders, and for this BPG in particular Joan Almost, Derek Puddester, Angela Wolff and Loretta McCormick for their superb stewardship, commitment and, above all, exquisite expertise. Thank you also to Program Manager Althea Stewart-Pyne who provided leadership to the process and worked intensely to see that this BPG move from concept to reality.

A special thanks to the BPG panel – we respect and value your expertise and volunteer work. To all, we could not have done this without you!

The nursing community, with its commitment to and passion about, excellence in nursing care and healthy work environments, has provided the knowledge and countless hours essential to the creation, evaluation and revision of each guideline. Employers have responded enthusiastically by nominating best practice champions, implementing and evaluating the guidelines, and working toward a culture of evidence-based practice and management decision-making.

Creating healthy work environments is both an individual and collective responsibility. Successful uptake of these guidelines requires a concerted effort by governments, administrators, clinical staff and others, partnering together to create evidence-based practice cultures. We ask that you share this guideline with members of your team. There is much we can learn from one another.

Together, we can ensure that nurses and other Health-care workers contribute to building healthy work environments. This is central to ensuring quality patient care. Let's make Health-care providers and the people they serve the real winners of this important effort!

A handwritten signature in black ink that reads "Doris Grinspun". The signature is written in a cursive style and is underlined with a single horizontal line.

Doris Grinspun, RN, MSN, PhD, LLD(Hon), O.ONT.  
Chief Executive Officer (CEO)  
Registered Nurses Association of Ontario

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# How To Use this Document

This Healthy Work Environments Best Practice Guideline is an evidence-based document that focuses on managing and mitigating conflict<sup>G</sup> in Health-care teams<sup>G</sup>.

The guideline contains much valuable information but is not intended to be read and applied at one time. We recommend that you review and reflect on the document and implement the guidelines as appropriate for your organization at a particular time. The following approach may be helpful.

**1. Study the Healthy Work Environments Organizing Framework:** The *Managing and Mitigating Conflict in Health-care Teams* is built upon a Healthy Work Environments organizing framework that was created to allow users to understand the relationships between and among the key factors. Understanding the framework is critical to using the guideline effectively. We suggest that you spend time reading and reflecting upon the framework as a first step.

**2. Identify an area of focus:** Once you have studied the framework, we suggest that you identify an area of focus for yourself, your situation or your organization. Select an area that you believe needs attention to provide an environment that understands conflict and when intervention may be necessary.

**3. Read the recommendations and the summary of research for your area of focus:** For each major element of the model, a number of evidence-based recommendations are offered. The recommendations are statements of what nurses, Health-care teams, organizations and systems do, or how they behave, in order to provide a supportive work environment for nurses. The literature supporting those recommendations is briefly summarized, and we believe that you will find it helpful to read this summary to understand the rationale for the recommendations.

**4. Focus on the recommendations or desired behaviours that seem most appropriated for you and your current situation:** The recommendations contained in this document are not meant to be applied as rules, but rather as tools to assist individuals, organizations and systems to make decisions that work towards providing a supportive environment for nurses and Health-care teams, recognizing everyone's unique culture, climate and situational challenges. In some cases there is a lot of information to consider. You will want to further explore and identify those behaviours that need to be analyzed and/or strengthened in your situation.

**5. Make a tentative plan:** Having selected a small number of recommendations and behaviours for attention, consider strategies for successful implementation. Make a tentative plan for what you might actually do to begin to address your area of focus. If you need more information, you may wish to refer to some of the references cited, or to look at some of the additional resources identified in Appendix F.

**6. Discuss the plan with others:** Take time to get input into your plan from people who may be affected or whose engagement will be critical to success, and from trusted advisors, who will give you honest and helpful feedback on the appropriateness of your ideas. This is as important a phase for the development of individual practice skills as it is for the development of an organizational conflict management initiative.

**7. Revise your plan and get started:** It is important that you make adjustments as you proceed with implementation of this guideline. The development of a healthy work environment is a journey. **Enjoy the journey!**

## Purpose

This Best Practice Guideline (BPG) focuses on nurses, Health-care teams and processes that foster healthy work environments. The focus for the development of this guideline was managing and mitigating interpersonal conflict among health-care teams with the view that while some conflict is preventable, **healthy conflict can also be beneficial**. For the purpose of this document, conflict is defined as a dynamic process occurring between interdependent individuals and/or groups as they experience negative emotional reactions to perceived disagreements and interference with the attainment of their goals (Barki & Hartwick, 2004).

A healthy work environment for nurses is a practice setting that maximizes the health and well being of nurses, quality patient/client outcomes and organizational performance. Effective nursing teamwork is essential to the work in Health-care organizations.

The following research questions were developed by the panel to assist with the review of the evidence related to managing and mitigating conflict in nursing/Health-care teams:

1. What are the incidences or prevalence of conflict in Health-care teams?
2. How can conflict be prevented, mitigated and managed in Health-care settings?

## Scope

The development of this BPG was based on the best available evidence and where evidence was limited, the best practice recommendations were based on the consensus<sup>G</sup> of expert opinion<sup>G</sup>.

The BPG was developed to assist nurses in all roles and all settings, other health professionals and management teams to enhance positive outcomes for patients/clients, nurses and Health-care teams, and the organization itself.

### This BPG identifies:

- Knowledge, competencies and behaviours for effective conflict management;
- Best practices that effectively recognize, address, mitigate and manage conflict;
- Educational requirements and strategies;
- Policy changes at both the organizational and system levels needed to support and sustain an environment that understands, prevents, mitigates and manages conflict;
- Implementation strategies and tools; and,
- Future research opportunities.

## Guiding Principles and Assumptions

It is the consensus of the Guideline Development Panel that the use of the Conceptual Model of the Antecedents and Consequences of Conflict (Almost, 2006)(Figure 2) guide the development of this BPG and that the following assumptions are critical starting points to promote a move towards managing and mitigating conflict in Health-care teams. The Panel believes the first focus should be understanding what conflict is, and the second focus the use of de-escalation interventions to manage conflict.

### We believe:

- That conflict is inevitable in work settings.
- The perceived and actual differences that may contribute to conflict include, but are not limited to: professional identity; cultural identity; gender; gender identity; nationality; race or ethnic origin; colour; religion; age; sexual orientation; marital status; educational background; disability; work values; goals; and interests.
- Leadership is required across all organizational and Health-care sector levels to create environments that practice management and mitigation of conflict.
- All conflict has a meaning and/or contributing underlying cause.
- Understanding, mitigating and managing conflict may result in positive outcomes such as new ideas and initiatives.
- Where situations of conflict that may have arisen based on discriminatory practices, legal consultation supported by the *Canadian Human Rights Act* should be sought.

*Change the way you think about disagreements  
with others, and how you behave during conflict.  
Be willing to engage directly, constructively, and  
collaboratively with your colleagues  
(Cloke & Goldsmith, 2011)*

# Summary of the Recommendations for Managing and Mitigating Conflict in Health-care Teams

The following recommendations were organized using the key concepts of the Healthy Work Environments Framework and therefore identify:

- Organizational recommendations
- Individual/Team recommendations and
- External/Systems recommendations.

## 1.0 ORGANIZATION RECOMMENDATIONS

**1.1** Organizations identify and take action to prevent/mitigate factors contributing to conflict, for example:

- effects of shift work;
- team composition and size;
- workload and staffing;
- manager span of control<sup>6</sup>;
- level of staff involvement in decision-making and provision of care;
- resource allocation;
- diversity in the workplace; and
- physical space.

**1.2** Organizations support the systems and processes that minimize conflict, promote team functioning, value diversity and enact a culture of inclusiveness. Common attributes that exist between and among Health-care professionals include:

- educational background;
- work values;
- ethnicity and culture;
- age;
- roles and responsibilities;
- power;
- scope of practice; and
- gender.

**1.3** Organizations implement a regular assessment, which may include quality indicators, to identify the types and outcomes (short- and long-term) of conflict among nurses, physicians and other Health-care professionals. Assessment data is used to develop and implement both action and communication plans for the organization.

**1.4** Organizations implement and sustain evidence-based strategies that support/enable leaders to foster self-awareness, possess emotional intelligence<sup>6</sup>, competencies and utilize conflict management principles.

**1.5** Organizations ensure all employees, physicians, and volunteers have the knowledge and competencies related to conflict management by:

- Providing ongoing mandatory skills-based education regarding cooperative or active style of managing and mitigating conflict, clear communication, effective team building through transformational leadership<sup>6</sup> practices, and the promotion of mastery of emotional intelligence<sup>6</sup> skills;
- Ensuring education is accessible to shift workers;
- Supporting changes in staff behaviour by using a comprehensive educational approach for different levels (e.g. individuals, teams, organization) tailored to specific settings and target groups. This includes implementing mechanism for refresher courses and/or regular updates; and
- Being congruent with the competencies frameworks for leaders (e.g LEADS in Caring Environment Framework) and interprofessional practice. (e.g. Canadian Interprofessional Health Collaborative, A National Interprofessional Competency Framework).

**1.6** Organizations provide internal and/or external third party assistance (e.g. spiritual care, ethicists, safe workplace advocate, and professional practice specialists/consultants) to offer productive support, shared decision-making, and/or manage/mitigate conflict.

**1.7** Organizations commit to the sustained use of cooperative or active conflict management styles (e.g. integrating and compromising), clear communication (e.g. crucial/learning conversations) and transformational leadership<sup>6</sup> practices to create healthy work environments<sup>6</sup> by:

- Ensuring all leaders, future and present, acquire leadership competencies in the management of conflict;
- Adopting recruitment processes that assess conflict management capabilities;
- Recognizing individuals, leaders and managers who demonstrate active management styles<sup>6</sup>;
- Implementing a formal mentorship program for managers and point-of-care leaders;
- Meeting the College of Nurses of Ontario's *Nursing Practice Standards* (CNO, 2009) for nurses in an administrator role; and
- Requiring managers to demonstrate accountability for effective conflict management styles, clear communication and transformational leadership<sup>6</sup>.

**1.8** Organizations evaluate the feasibility and effectiveness of the strategies, standards and policies of conflict management.

**1.9** Organizations ensure multi-faceted and comprehensive structures, processes, and supportive policies are in place. Organizations should support those in leadership roles to apply organizational policies and processes that exist to recognize, assess, monitor, manage and mitigate conflict.

**1.10** Organizations value, promote, enable and role model a culture that recognizes, prevents, mitigates and manages conflict, while enhancing the positive outcomes by:

- Developing structures and processes to foster effective intra- and interprofessional collaborative relationships;
- Utilizing a professional practice model that supports practice accountability, autonomy, reflection, self-awareness and decision-authority related to the work environment and patient/client care;
- Promoting professional autonomy and decision-making;
- Implementing and sustaining effective staffing and workload practices;
- Ensuring a climate of appreciation, trust and respect;
- Including resources in orientation sessions; and
- Utilizing a variety of tools such as education, media campaigns and performance review processes.

**1.11** For interprofessional collaborative practice, organizational supports are provided to address conflict in a constructive manner by:

- Valuing the potential positive outcomes of conflict;
- Identifying common situations that are likely to lead to disagreements or conflicts, including role ambiguity, power gradients and differences in approaches to patient/client care goals;
- Establishing a safe environment in which to express diverse opinions and viewpoints regardless of outcome; and
- Establishing consistency and clarity about role expectations among Health-care professionals.

## 2.0 INDIVIDUAL/TEAM RECOMMENDATIONS

**2.1** Nurses and Health-care teams acknowledge that conflict is normal and seek to understand through self-reflective practice how their behaviours, values, beliefs, philosophies and perceptions affect relationships with others, and how the behaviour of others influence conflict by:

- Identifying personal behaviours and/or attitudes that may have contributed to conflict, and strive to alter this behaviour;
- Acknowledging and understanding their personal conflict management style;
- Developing conflict resolution skills by taking advantage of education offered. Where education is not offered, the individual should bring this need to the attention of their manager/director; and
- Understanding the importance of emotional intelligence<sup>6</sup>, lived experiences and their relationship to conflict.

**2.2** Nurses and Health-care teams contribute to a culture that supports the management and mitigation of conflict by:

- Seeking resolutions when necessary through counseling (employee assistance programs), accessing support (occupational health) and education offered in their organizations or settings;
- Acknowledging and discussing the issue at forums such as staff meetings;
- Demonstrating accountability for their actions, and commitment to managing and mitigating conflict;
- Actively and constructively participating in their Health-care team initiatives;
- Being accountable for, and respectful in the manner in which they communicate to patients/clients, families and members of the Health-care team;
- Seeking opportunities and assuming the responsibility for sharing knowledge and best practices in nursing and health care.

**2.3** Nurses, Health-care teams and Health-care professionals:

- Acknowledge that conflict is addressed in different ways, depending on the relationship of the person one is having conflict with;
- Understand how they uniquely contribute to the client's experience of health or illness and the delivery of Health-care services, in addition to facilitating the paramount importance of improving health outcomes, which is guided by the philosophy of patient/client-centered care; and
- Understand and respect the roles, scope of practice and accountability of all members of the Health-care team<sup>6</sup>.

**2.4** Nurses and Health-care teams practice and collaborate with team members in a manner that fosters respect and trust by:

- Ensuring open communication related to the provision of patient/client care and other work related activities;
- Setting clear and objective goals for patient/client care;
- Utilizing processes for conflict resolution and problem-solving;
- Participating in a decision-making process that is open and transparent;

- Being an active, engaged member of the Health-care team<sup>6</sup> while demonstrating respect and professionalism;
- Contributing to a positive team morale;
- Understanding that the work environment is in part constructed by each member of the team; and
- Supporting each individual team member working to their own full scope of practice.

**2.5** Individuals contribute to the development of clear processes, strategies, tools and structures that promote the management and mitigation of conflict with emphasis on:

- Open, honest and transparent communication;
- Constructive and supportive feedback; and
- Clear goals and objectives that foster professionalism, respect and trust.

**2.6** Individual nurses and Health-care teams actively participate in education to achieve a constructive approach to the management and mitigation of conflict.

**2.7** Consult organizational and professional guidelines, policies and procedures related to the management and mitigation of conflict by:

- Seeking support;
- Obtaining information; and
- Providing support to others.

**2.8** Utilize management tools/strategies for management and mitigation of conflict such as the following:

- Listen empathetically and responsively;
- Allow the other person to express their concern;
- Search beneath the surface for hidden meanings;
- Acknowledge if you are at fault and reframe emotions;
- Separate what matters and what gets in the way;
- Learn from difficult behaviours;
- Lead and coach for transformation; and
- Negotiate collaboratively to resolve an issue.

## External/System Recommendations

### 3.0 GOVERNMENT RECOMMENDATIONS:

**3.1** Governments recognize that conflict within Health-care teams<sup>6</sup> is a priority issue.

**3.2** All levels of government promote a healthy workplace environment by:

- Developing policies and legislative frameworks that support the management and mitigation of conflict;
- Developing policies and legislative frameworks that encourage intraprofessional, interprofessional collaboration and teamwork;
- Ensuring sustainable financial resources to effectively prevent, manage and mitigate conflict in all Health-care settings; and
- Establishing accountability requirements, such as through quality improvement plans, accreditation or other accountability agreements that address the management and mitigation of conflict within all Health-care settings.

**3.3** Government agencies, policy and decision-makers strategically align conflict management with other initiatives pertaining to healthy work environments<sup>6</sup>, patient/client<sup>6</sup> safety, interprofessional collaborative practice, and quality patient/client care.

**3.4** Governments commit to establishing and supporting research with appropriate levels of funding, acknowledging the complexity of the type of studies required to examine conflict within Health-care teams.

### 4.0 RESEARCH RECOMMENDATIONS:

**4.1** Researchers partner with governments, professional associations, regulatory bodies, unions, health service organizations and educational institutions to conduct research into conflict within Health-care teams<sup>6</sup>.

**4.2** Interprofessional researchers study the:

- Range of impacts of the different types of conflict in the workplace on individuals, patient/client<sup>6</sup>, organizational and system outcomes, including quality of care, patient safety, recruitment and retention;
- Prevalence and incidence of conflict, including an understanding of the different types of conflict, in workplaces throughout all types of organizational settings and sectors;

- Antecedents<sup>6</sup> and mitigating factors influencing the different types of conflict in the workplace experienced by individuals throughout all types of organizational settings and sectors;
- Existence and effectiveness of current management philosophies and practices to prevent, manage and mitigate conflict in the workplace, including training and education programs;
- Multiple levels where conflict occurs (e.g. individual, team, Health-care system, society) using a wide variety of methods and theoretical tools; and
- Feasibility efficacy and sustainability of programs and interventions developed to prevent, manage or mitigate conflict.

**4.3** Researchers develop, implement, and evaluate a conflict intervention based on the conceptual model shown in Figure 2, page 30.

**4.4** Using effective knowledge translation strategies, researchers report research findings and outcomes back to their partnering government bodies, professional associations, regulatory bodies, unions, Health-care organizations, educational institutions, and the individuals who participated in the research.

## 5.0 Accreditation Recommendations:

**5.1** Accreditation bodies develop and implement evidence-based standards and criteria on the management and mitigation of conflict on Health-care teams as part of their standards and accreditation process.

## 6.0 Education Recommendations:

**6.1** Academic settings value, promote and role model a learning culture which recognizes, prevents, manages and mitigates conflict, while enhancing the positive outcomes of conflict.

**6.2** Education for all Health-care professionals in academic settings include:

- Formal and informal opportunities for discipline specific and interprofessional students to develop and demonstrate the ability to recognize, prevent, manage and mitigate conflict in the workplace;
- Recognition of the different types of conflict and subsequent outcomes on personal health, career, workplace dynamics and learning;
- Appropriate communication strategies for responding to conflict in the workplace from patients/clients, peers, and other Health-care professionals, physicians, supervisors and faculty; and
- Learning related to how and when to use internal and external workplace supports for addressing conflict, and encouragement to seek individual, organizational and systemic solutions.

**6.3** Academic settings partner with Health-care organizations to develop transition-to-practice, mentorship or residency programs for new graduates.

## 7.0 Nursing Professional / Regulatory Recommendations:

**7.1** Professional, regulatory and union bodies for Health-care professionals should:

- Educate all Health-care professionals regarding the management and mitigation of conflict in Health-care teams;
- Develop competency standards for managers and leaders that clearly reference and prioritize conflict management;
- Incorporate conflict management and mitigation in all applicable policies, standards, guidelines and educational resources;
- Minimize role ambiguity by creating standards that clearly define and distinguish roles and responsibilities of various Health-care professionals;
- Collaborate with policy makers to ensure priority and funding is dedicated to conflict research and interventions to support conflict mitigation and management in all Health-care settings;
- Partner with Health-care and academic organizations to evaluate applicable policies, standards, guidelines and educational resources; and
- Advocate for research standards, accreditation, education, policies and resources to address conflict in the workplace.



# Sources and Types of Evidence for Managing and Mitigating Conflict in Health-Care

## Sources of Evidence

The search for evidence revealed experimental, quasi-experimental, descriptive and qualitative studies.

Sources included:

- A systematic review of the literature on conflict was conducted (see Appendix C)
- Supplemental literature searched by Panel Members

## Types of Evidence

Current practice in creating best practice guidelines involves identifying the strength of the supporting evidence (Moynihan R., 2004) The prevailing systems of grading evidence identify systematic reviews of randomized controlled trials (RCT) as the “gold standard” for evidence with other methods ranked lower (Pearson A., Laschinger, H. and Porritt K., et al. 2004) However, not all questions of interest are amenable to the methods of RCT particularly where the subjects cannot be randomized or the variables of interest are pre-existing or difficult to isolate. This is particularly true of behavioural and organizational research in which controlled studies are difficult to design due to continuously changing organizational structures and processes. Moreover, since health professionals are concerned with more than cause and effect relationships and recognize a wide range of approaches to generate knowledge for practice, we have adapted the traditional levels of evidence used by the Cochrane Collaboration (CCNET, 2006) and the Scottish Intercollegiate Guidelines Network to identify the type of evidence contained in this guideline (SIGN, 2005)

## Types of Evidence System

Type of Evidence	Description of Evidence
A	Evidence obtained from controlled studies, meta-analyses <sup>G</sup>
A1	Systematic Review <sup>G</sup>
B	Evidence obtained from descriptive correlational studies <sup>G</sup>
C	Evidence obtained from qualitative research <sup>G</sup>
D	Evidence obtained from expert opinion <sup>G</sup>
D1	Integrative Reviews <sup>G</sup>
D2	Critical Reviews <sup>G</sup>

## Development Panel Members

### Joan Almost, RN, PHD

Panel Co-Chair  
Assistant Professor  
School of Nursing  
Queen's University  
Kingston, Ontario

### Derek Puddester, MD, MED, FRCPC

Panel Co-Chair  
Associate Professor, Psychiatry/Director,  
Wellness Program Faculty of Medicine,  
University of Ottawa  
Ottawa, Ontario

### David Gladun, RPN

Staff Nurse  
Thunder Bay Regional Health Sciences Centre  
Thunder Bay, Ontario

### Lesley Hailstone, RN

Charge Nurse  
Chateau Gardens Long-Term Care Facility  
Parkhill, Ontario

### Lina Kiskunas

Year Three Nursing Student  
Ryerson University  
Toronto, Ontario

### Maureen Kitson, RN, BA

Director, Client Services, Burlington Branch  
Hamilton Niagara Haldimand Brant CCAC  
Burlington, Ontario

### Loretta G. McCormick, RN(EC), BSCN, MSCN

Health Care Nurse Practitioner  
Cambridge Memorial Hospital, COPD Clinic  
Cambridge, Ontario

### Anne-Marie Malek, RN, BN, MHSA, CHE

President, CEO & CNE  
West Park Healthcare Centre  
Toronto, Ontario

### Maria Pena, RN

Staff RN in Pacemaker Clinic  
Guelph General Hospital  
Guelph, Ontario

### Dawn Ricker, BA

Safe Workplace Advocate  
Hotel-Dieu Grace Hospital  
Windsor, Ontario

### Diane Strachan, RN, BN

Bargaining Unit President, ONA  
London Health Science Centre  
London, Ontario

### Patricia Sutton, RN

Senior Manager Cardia Critical Care  
Sick Kids Hospital  
Toronto, Ontario

### Lorraine Telford, BSCN, MN, CCHN(C)

Manager, Quality Assurance (Acting),  
Toronto Public Health  
Toronto, Ontario

### Angela Wolff, PHD, RN

Director, Clinical Education, Professional Practice  
Fraser Health Authority  
Surrey, British Columbia

### Althea Stewart-Pyne, RN, BN, MHSC

Program Manager  
Registered Nurses' Association of Ontario  
Toronto, Ontario

### Erica D'Souza, BSC, GC, DIPHLTHPROM

Project Coordinator  
Registered Nurses' Association of Ontario  
Toronto, Ontario

### Patti Hogg, BA (HONOURS)

Project Coordinator  
Registered Nurses' Association of Ontario  
Toronto, Ontario

Declarations of interest and confidentiality were made by members of the Guideline Development Panel. Further details are available from the Registered Nurses' Association of Ontario.

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# Stakeholder Acknowledgement

The Registered Nurses' Association of Ontario wishes to acknowledge the following for their contribution in reviewing this nursing best practice guideline and providing valuable feedback:

NAME, CREDENTIALS	TITLE, ORGANIZATION, CITY, PROVINCE
SUSAN ASHTON, RN, BScN, PHN	Principal, Ashton Consulting, Ashton Consulting, Yellowknife, Northwest Territories
SUSAN BAILEY, RN, BA, MHSCN	Best Practice Coordinator, Registered Nurses' Association, Toronto, Ontario
NANCY A. BAUER, HONBA, HONBUSADMIN, RN, ET	RNAO Champion Facilitator, Registered Nurses' Association, Toronto, Ontario
SHAWNA BELCHER, RN, BSCN, CPMHN	Team Leader, Orillia Soldiers Memorial Hospital, Orillia, Ontario
BARBARA BELL, RN, BSCN, MN, CHE	Chief Nurse and Health Professions Officer, West Park Healthcare Centre, Toronto, Ontario
JENNIFER BERGER, RN, BScN, MSC	Clinical Specialist Canadian Institute for Health Information (CIHI), Oakville, Ontario
SUSAN BERNJAK, RN, BA, CACE, GNC(C)	Regional Educator, Winnipeg Regional Health Authority Personal Care, Home Program, Winnipeg, Manitoba
MARGARET BLASTORAH, RN, PHD	Director, Nursing Research, Sunnybrook Health Sciences Centre, Toronto, Ontario
DEBBIE BRUDER, BA, RN, MHS	Clinical Informatics Specialist, Grand River Hospital, Kitchener, Ontario
VANESSA BURKOSKI, RN, BScN, PCNP,	Vice President, Prof. Practice & CNE, LondonMScN, DHA Health Sciences Centre, London, Ontario
CHRISTINE CALDWELL, RN, CPMHN(C)	Coordinator Outpatient Clinic, Mood Disorder Royal Ottawa Mental Health Centre, Ottawa, Ontario
LOUISE CAICCO TETT, RN, BScN, CRS	Occupational Health Consultant, President Health & Safety Professionals Inc. , Sault Ste. Marie, Ontario
FARAH KHAN CHOUDHRY, RN, BScN, MN	Nursing Unit Administrator, Mount Sinai Hospital, Toronto, Ontario
DEBORA COWIE, RPN	Staff Nurse, Ontario Shores Centre for Mental Health Sciences, Whitby, Ontario

<b>MICHELLE DAGLORIA, RN, BScN</b>	Clinical Educator Medicine, Guelph General Hospital, Guelph, Ontario
<b>SYLVIA DAVIDSON, MSC, BSc, DIP GER, OT REG. (ONT.)</b>	Advanced Practice Leader – Geriatrics, Toronto Rehabilitation Institute University Centre, Toronto, Ontario
<b>CHRISTINE D’SOUZA, RN, BScN, MScN STUDENT</b>	Masters Student–University of Toronto, Cardiology & Cardiovascular Surgery, Toronto, Ontario
<b>DEBORAH DUNCAN, RN</b>	Vice President Regional Programs, Waypoint Centre for Mental Health Care, Penetanguishene, Ontario
<b>CHRISTINE DUNN, RN, BScN (HONS), MScN</b>	Education Co-coordinator, St. Joseph’s Health Centre, Toronto, Ontario
<b>MICHELE DURRANT, BSc, MSC</b>	Advanced Nursing Practice Educator, the Hospital for Sick Children, Toronto, Ontario
<b>LAURA FARRELLY, RN, BScN, MED</b>	Chief of Nursing Practice, Hamilton Health Sciences, Juravinski Hospital and Cancer Centre Hamilton, Ontario
<b>ROBIN FERN, RN, MSC</b>	Staff Nurse, St. Michael’s Hospital, Toronto, Ontario
<b>LELA FISHKIN, RN</b>	Supervisor, Regional Nursing Services, Richmond Hill, Ontario
<b>BETTYANN GOERTZ, RN, BScN, CPMHNC</b>	Staff Nurse, London Health Sciences Center, London, Ontario
<b>FRANKLIN F. GOROSPE IV, RN, BScN, MN</b>	Faculty/Staff Nurse, School of Health Sciences – Humber College, Institute of Technology and Advanced Learning & Preoperative Department – Toronto General Hospital (University Health Network) Toronto, Ontario
<b>KATHY-LYNN GREIG, RPN, BScN STUDENT</b>	Staff Nurse, The Scarborough Hospital – Birchmount Campus West Park Healthcare Centre, Toronto, Ontario
<b>WENDY HOLMES, MPH, RN, CCHN(C)</b>	Program Coordinator – Clinical Services, Haldimand Unit, Simcoe, Ontario
<b>SYLVIA A. KOMMUSAAR, RN</b>	Supervisor, Extendicare Van Daele, Sault Ste. Marie, Ontario
<b>ARUNA S. KOUSHIK, MSW</b>	Commissioner, Mediation & Human Rights Services, Windsor Regional Hospital, Windsor, Ontario
<b>RUBY LIBRADO, RN, MScN, CRRN, ACPN,</b>	Advanced Practice Nurse, Veterans Centre Sunnybrook, Center, GNC(c) Health Sciences, Toronto, Ontario
<b>LISA MILLS, RN, BScN</b>	Nursing Consultant, Chartwell Seniors Housing REIT, Mississauga, Ontario
<b>ROLA MOGHABGHAB, NP-ADULT, MN,</b>	Nurse Practitioner, St. Michael’s Hospital, Toronto, GNC(C), GEM Ontario
<b>JAMES MURRAY, RN</b>	Clinical Nurse, ONA Local 100 V.P., London Health Sciences Centre, London, Ontario

LINDA OGILVIE, RN, BSN, MS	Manager, Corporate Health Care, Ministry of Community Safety and Correctional Services, Toronto, Ontario
GLADYS PEACHEY, RN, PHD	Assistant Professor, McMaster University, Hamilton, Ontario
CHRISTINE PICHIE, RN, BScN, PNC(C)	Staff nurse in Special Care Nursery, Peterborough Regional Health Centre, Hastings, Ontario
LEANNE PROVEAU, RN, BScN, MScN(C), CNCC(C)	Clinical Nurse Educator, Critical Care St. Mary's General Hospital, Kitchener, Ontario
SHARON RAMAGNANO, RN, BScN(E), ENC(C), MSN MHA	Advanced Practice Nurse Emergency/Trauma, Sunnybrook Health Sciences Centre, Toronto, Ontario
JUDY SMITH, RN, BScN, MDE, ENC(C)	Geriatric Emergency Management Nurse GEM, York Central Hospital, Richmond Hill, Ontario
ORLA M. SMITH, RN, BScN, MN, PHD(C)	Research Manager, St. Michael's Hospital, Toronto, Ontario
MICHELLE SOBREPENA, RN, BScN, CNCC(C), MScN STUDENT	MScN Student–York University, York Central Hospital Patient Care Coordinator, Intensive Care Unit, Toronto, Ontario
GEMMA SMYTH, BA, LLB, LLM, CMED	Professor and Academic Clinic Director, University of Windsor Faculty of Law, Windsor, Ontario
LILY SPANJEVIC, RN, BScN, MN, GNC(C), CRN(C)	APN Geriatrics–Medicine, Joseph Brant Memorial, Hospital, Burlington, Ontario
SUSANNE SWAYZE, RPN	RPN Staff Nurse, St. Joseph Healthcare Hamilton – Secure, Forensic Unit, Hamilton, Ontario
STANLEY STYLIANOS, BS, BA (HONS.)	Program Manager, Psychiatric Patient Advocate Office, Ministry of Health and Long-Term Care, Toronto, Ontario
BARB TAIT, RN	Shift Manager, Ontario Shores Centre for Mental Health Sciences, Whitby, Ontario
MEREDITH WHITEHEAD, RN, BScN, MScN, ENC(C)	Professional Practice Leader, Nursing York Central Hospital, Richmond Hill, Ontario
JANET WILLIAMS, RN	Staff nurse/Clinical instructor, Quinte Healthcare, Loyalist College, Belleville, Ontario
ROSEMARY WILSON, RN(EC), PHD	Assistant Professor, Queen's University School of Nursing, Kingston, Ontario

# Background to the Healthy Work Environments Best Practice Guidelines Project

In July of 2003 the Registered Nurses' Association of Ontario (RNAO), with funding from the Ontario Ministry of Health and Long-Term Care, (MOHLTC) working in partnership with Health Canada, Office of Nursing Policy, commenced the development of evidence-based best practice guidelines in order to create healthy work environments<sup>G</sup> for nurses<sup>G</sup>. Just as in clinical decision-making, it is important that those focusing on creating healthy work environments<sup>G</sup> make decisions based on the best evidence possible.

The Healthy Work Environments Best Practice Guidelines<sup>G</sup> Project is a response to priority needs identified by the Joint Provincial Nursing Committee (JPNC) and the Canadian Nursing Advisory Committee (CNAC, 2002). The idea of developing and widely distributing a healthy work environment guide was first proposed in *Ensuring the care will be there: Report on nursing recruitment and retention in Ontario* (RNAO, 2000) submitted to MOHLTC in 2000 and approved by JPNC.

Health-care systems are under mounting pressure to control costs and increase productivity while responding to increasing demands from growing and aging populations, advancing technology and more sophisticated consumerism. In Canada, health care reform is currently focused on the primary goals identified in the Federal/Provincial/Territorial First Ministers' Agreement 2000 (CICS, 2000), and the Health Accords of 2003 (Health Canada, 2003) and 2004 (First Ministers, 2004):

- the provision of timely access to health services on the basis of need;
- high quality, effective, patient/client-centered and safe health services; and
- a sustainable and affordable Health-care system.

Nurses are a vital component in achieving these goals. A sufficient supply of nurses is central to sustain affordable access to safe, timely health care. Achievement of healthy work environments<sup>G</sup> for nurses is critical to the safety, recruitment and retention of nurses.

Numerous reports and articles have documented the challenges in recruiting and retaining a healthy nursing workforce (RNAO, 2000; COUPN, 2002; CNA, 2002; Bauman et al., 2001; ACAAT, 2001; Nursing Task Force, 1999). Some have suggested that the basis for the current nursing shortage is the result of unhealthy work environments (Schindul-Rothschild, 1994; Grinspun, 2000; Grinspun, 2002; Dunleavy, Shamian & Thomson, 2003). Strategies that enhance the workplaces of nurses are required to repair the damage left from a decade of relentless restructuring and downsizing.

There is a growing understanding of the relationship between nurses work environments, patient/client<sup>G</sup> outcomes and organizational and system performance (Dugan et al., 1996; Lundstrom et al., 2002; Estabrooks et al., 2005). A number of studies have shown strong links between nurse staffing and adverse patient/client outcomes (Needleman et al., 2002; Person et al., 2004; Blegen & Vaughn, 1998; Sasichay-Akkadechanunt, Scalzi & Jawad, 2003; Tourangeau et al., 2002; Needleman & Buerhaus, 2003; ANA, 2000; Kovner & Gergen, 1998; Sovie & Sawad, 2001; Yang, 2003; Cho et al., 2003). Evidence shows that healthy work environments<sup>G</sup> yield financial benefits to organizations in terms of reductions in absenteeism, lost productivity, organizational Health-care costs (Aldana, 2001) and costs arising from adverse patient/client<sup>G</sup> outcomes (USAHRQ, 2003).

Achievement of healthy work environments<sup>G</sup> for nurses requires *transformational change*, with “interventions that target underlying workplace and organizational factors” (Lowe, 2004). It is with this intention that we have developed these guidelines. We believe that full implementation will make a difference for nurses, their patients/clients and the organizations and communities in which they practice. It is anticipated that a focus on creating healthy work environments<sup>G</sup> will benefit not only nurses but other members of the Health-care team<sup>G</sup>. We also believe that best practice guidelines can be successfully implemented only where there are adequate planning processes, resources, organizational and administrative supports, and appropriate facilitation.

### A healthy work environment is...

...a practice setting that maximizes the health and well-being of nurses, quality patient/client outcomes, and organizational performance and societal outcomes.

### The Project has resulted in nine Healthy Work Environments Best Practice Guidelines

- Collaborative Practice Among Nursing Teams
- Developing and Sustaining Effective Staffing and Workload Practices
- Developing and Sustaining Nursing Leadership
- Embracing Cultural Diversity in Health Care: Developing Cultural Competence
- Professionalism in Nursing
- Workplace Health, Safety and Well-being of the Nurse
- Preventing and Managing Violence against Nurses in the Workplace
- Preventing and Mitigating Nurse Fatigue in Health Care
- Managing and Mitigating Conflict in Health-care Teams

*Conflict can be corrected through listening, informal problem solving, dialogue and collaborative negotiation  
(Cloke & Goldsmith, 2011)*

# Organizing Framework for the Healthy Work Environments Best Practice Guidelines Project

RECOMMENDATIONS

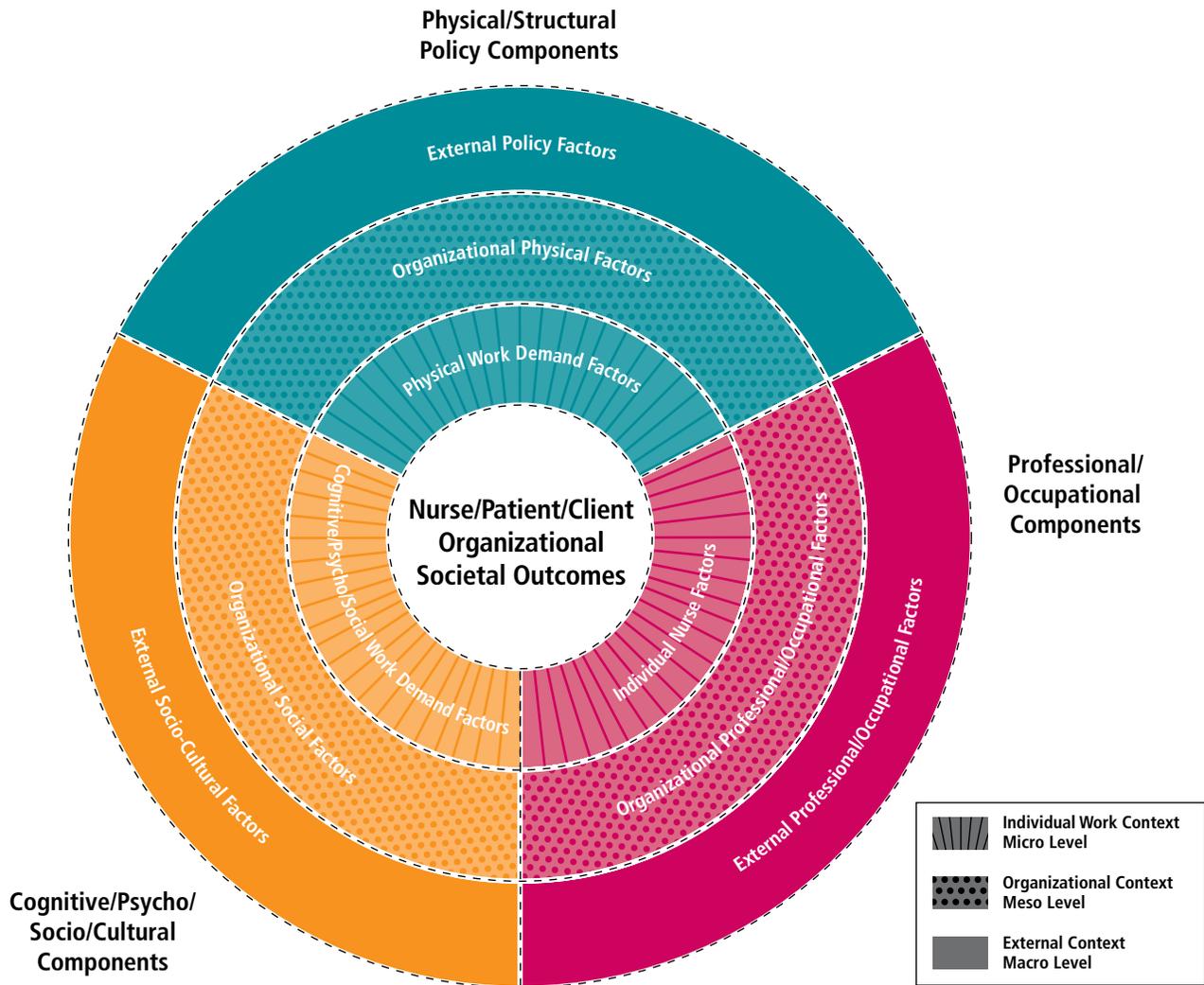


Figure 1. Conceptual Model for Healthy Work Environments for Nurses Components, Factors & Outcomes <sup>1,2,3</sup>

A healthy work environment for nurses is complex and multidimensional, comprised of numerous components and relationships among the components. A comprehensive model is needed to guide the development, implementation and evaluation of a systematic approach to enhancing the work environment of nurses. Healthy work environments for nurses are defined as practice settings that maximize the health and well-being of the nurse, quality patient/client outcomes, organizational performance and societal outcomes.

The Comprehensive Conceptual Model for Healthy Work Environments for Nurses presents the healthy workplace as a product of the interdependence among individual (micro level), organizational (meso level) and external (macro level) system determinants as shown above in the three outer circles. At the core of the circles are the expected beneficiaries of healthy work environments for nurses – Health-care teams, patients, organizations and systems, and society as a whole, including healthier communities<sup>4</sup>. The lines within the model are dotted to indicate the synergistic interactions among all levels and components of the model.

The model suggests that the individual's functioning is mediated and influenced by interactions between the individual and her/his environment. Thus, interventions to promote healthy work environments must be aimed at multiple levels and components of the system. Similarly, interventions must influence not only the factors within the system and the interactions among these factors but also influence the system itself.<sup>5,6</sup>

The assumptions underlying the model are as follows:

- healthy work environments are essential for quality, safe patient/client care;
- the model is applicable to all practice settings and all domains of nursing;
- individual, organizational and external system level factors are the determinants of healthy work environments for nurses;
- factors at all three levels impact the health and well-being of nurses, quality patient/client outcomes, organizational and system performance, and societal outcomes either individually or through synergistic interactions;
- at each level, there are physical/structural policy components, cognitive/psycho/social/cultural components and professional/occupational components; and
- the professional/occupational factors are unique to each profession, while the remaining factors are generic for all professions/occupations.

<sup>1</sup>Adapted from DeJoy, D.M. & Southern, D.J. (1993). An Integrative perspective on work-site health promotion. *Journal of Medicine*, 35(12): December, 1221-1230; modified by Laschinger, MacDonald & Shamian (2001); and further modified by Griffin, El-Jardali, Tucker, Grinspun, Bajnok, & Shamian (2003).

<sup>2</sup>Baumann, A., O'Brien-Pallas, L., Armstrong-Stassen, M., Blythe, J., Bourbonnais, R., Cameron, S., Irvine Doran D., Kerr, M., McGillis Hall, L., Vezina, M., Butt, M., & Ryan, L. (2001, June). *Commitment and care: The benefits of a healthy workplace for nurses, their patients, and the system*. Ottawa, Canada: Canadian Health Services Research Foundation and The Change Foundation.

<sup>3</sup>O'Brien-Pallas, L., & Baumann, A. (1992). Quality of nursing worklife issues: A unifying framework. *Canadian Journal of Nursing Administration*, 5(2): 12-16.

<sup>4</sup>Hancock, T. (2000). The Healthy Communities vs. "Health". *Canadian Health Care Management*, (100)2: 21-23.

<sup>5</sup>Green, L. W., Richard, L. and Potvin, L. (1996). Ecological foundation of health promotion. *American Journal of Health Promotion*, (10)4: March/April, 270-281

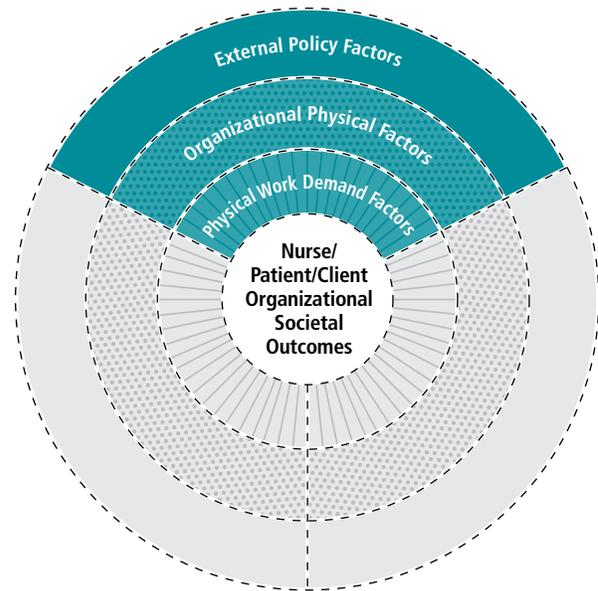
<sup>6</sup>Grinspun, D., (2000). *Taking care of the bottom line: shifting paradigms in hospital management*. In Diana L. Gustafson (ed.), *Care and Consequence: Health Care Reform and Its Impact on Canadian Women*. Halifax, Nova Scotia, Canada. Fernwood Publishing.

<sup>7</sup>Grinspun, D. (2002). The Social Construction of Nursing Caring. Unpublished Doctoral Dissertation Proposal. York University, North York, Ontario.

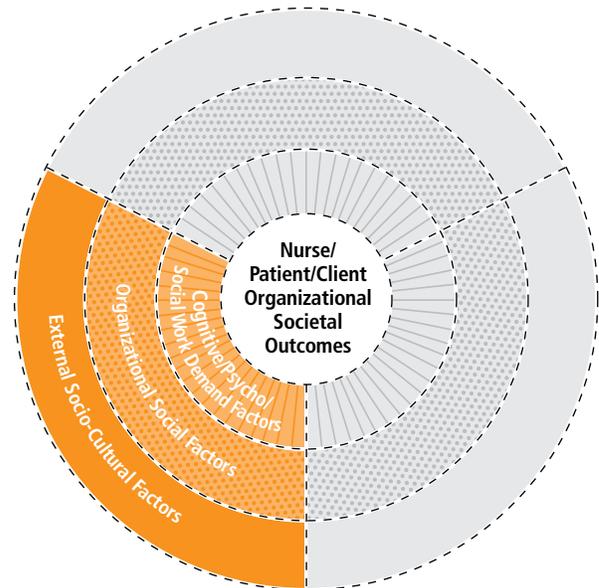
### Physical/Structural Policy Components

- At the individual level, the Physical Work Demand Factors include the requirements of the work which necessitate physical capabilities and effort on the part of the individual. Included among these factors are workload, changing schedules and shifts, heavy lifting, exposure to hazardous and infectious substances, and threats to personal safety.
- At the organizational level, the Organizational Physical Factors include the physical characteristics and the physical environment of the organization and also the organizational structures and processes created to respond to the physical demands of the work. Included among these factors are staffing practices, flexible, and self-scheduling, access to functioning lifting equipment, occupational health and safety polices, and security personnel.
- At the system or external level, the External Policy Factors include health care delivery models; funding; and legislative, trade, economic and political frameworks (e.g. migration policies, health system reform) external to the organization.

### Physical/Structural Policy Components



### Cognitive/Psycho/Socio/Cultural Components



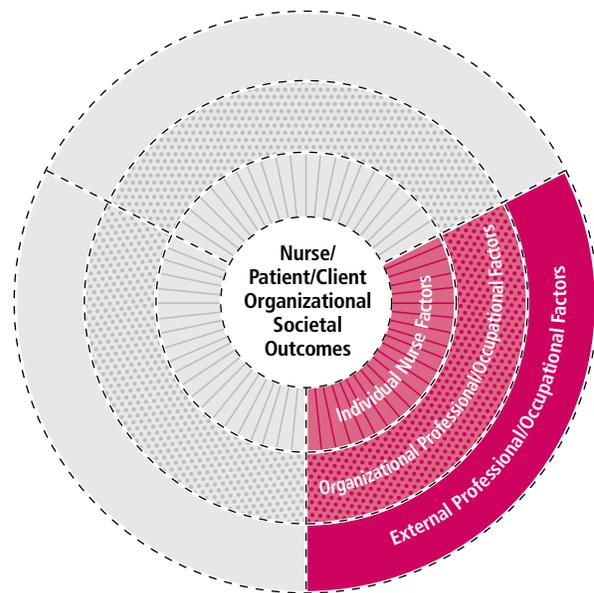
### Cognitive/Psycho/Socio/Cultural Components

- At the individual level, the Cognitive and Psycho-social Work Demand Factors include the requirements of the work which necessitate cognitive, psychological and social capabilities and effort (e.g. clinical knowledge, effective coping skills, communication skills) on the part of the individual.<sup>7</sup> Included among these factors are clinical complexity, job security, team relationships, emotional demands, role clarity, and role strain.
- At the organizational level, the Organizational Social Factors are related to organizational climate, culture, and values. Included among these factors are organizational stability, communication practices and structures, labour/management relations, and a culture of continuous learning and support.
- At the system level, the External Socio-cultural Factors include consumer trends, changing care preferences, changing roles of the family, diversity of the population and providers, and changing demographics – all of which influence how organizations and individuals operate.

## Professional/Occupational Components

- At the individual level, the Individual Nurse Factors include the personal attributes and/or acquired skills and knowledge of the nurse which determine how she/he responds to the physical, cognitive and psycho-social demands of work.<sup>7</sup> Included among these factors are commitment to patient/client care, the organization and the profession; personal values and ethics; reflective practice; resilience, adaptability and self confidence; and family/life balance.
- At the organizational level, the Organizational Professional/Occupational Factors are characteristic of the nature and role of the profession/ occupation. Included among these factors are the scope of practice, level of autonomy and control over practice, and intra-disciplinary relationships.
- At the system or external level, the External Professional/ Occupational Factors include policies and regulations at the provincial/territorial, national and international level which influence health and social policy and role socializations within and across disciplines and domains.

**Professional/Occupational Components**



# Background Context of The Guideline on

## Managing and Mitigating Conflict in Health-care Teams:

Conflict is inevitable in any work environment due to inherent differences in goals, needs, desires, responsibilities, perceptions and ideas. Nursing is about relationships, and the quality of those relationships is vital to everyday interactions and positive outcomes for patient/client care and role satisfaction (Cohen & Bailey, 1997). Interpersonal relationships within the workplace can make the difference between difficult situations and intolerable ones. However, the increasing prevalence and subsequent impact of interpersonal conflict in Health-care settings necessitates the requirement for organizations to have a process to manage conflict that may occur<sup>8</sup>. Interpersonal conflictive interactions among members of the Health-care team create subtle unpleasant experiences that result in negative attitudes and behaviours. In turn, this can create a stressful work environment with negative consequences such as job dissatisfaction, weak organizational commitment, lack of involvement, low morale, poor working relationships, a diminished sense of well-being, emotional exhaustion, a lack of trust and sense of support in the workplace, absenteeism, burnout and turnover (Almost, 2006; Almost et al., 2010; Ayoko, Callan, & Hartel, 2003; Cox, 2001, 2003; De Dreu, C.K.W, van Dierenonck, & Maria, 2004; Hesketh, et al., 2003; Jehn & Bendersky, 2003; McKenna et al., 2003; Rowe & Sherlock, 2005; Warner, 2001; Wolff, 2009). In addition to these negative consequences, persistent interpersonal conflict also results in reduced coordination and collaboration and low efficiency for Health-care teams (De Dreu et al., 1999; Spector & Jex, 1998).

Research indicates that interpersonal conflict within the Health-care system is present globally. In one Canadian study, several Canadian nurses admitted that they reduced their work hours because of conflict with nursing co-workers (Warner, 2001), while nurses in Japan who were also experiencing conflict with other nurses were more likely to leave their current nursing position (Lambert, Lambert & Ito, 2004). Similarly, new nursing graduates in New Zealand experienced high levels of interpersonal conflict during their first year after graduation, resulting in lower self-esteem, increased absenteeism and intent to leave nursing as a consequence (McKenna et al., 2003). Researchers have shown that in the general population and among Health-care providers, the occurrence of burnout, particularly emotional exhaustion, can be attributed to negative collegial interactions and interpersonal conflict (Giebels & Janssen, 2005; Mulki, Jaramillo, & Locander, 2008; Taris, et al., 2005). Therefore, it is important that organizations and individuals address the management of interpersonal conflict through a guided process which includes education and accountability to prevent recrimination and negativity.

### Definition of Interpersonal Conflict:

For the purposes of this guideline, interpersonal conflict is defined as:

“...a dynamic process that occurs between interdependent individuals and/or groups as they experience negative emotional reactions to perceived disagreements and interference with the attainment of their goals.” (Barki & Hartwick, 2004).

In a review of the literature, Barki and Hartwick (2004) examined the numerous conceptualizations and definitions of conflict. Three general themes were identified: disagreement, interference and negative emotion:

- *Disagreement* represents the key cognitive component of interpersonal conflict. When individuals think that a divergence of values, needs, interests, opinions or goals exists, there is disagreement. However, disagreement by itself is not sufficient for conflict to emerge.
- When the behaviours of one individual **interferes with or opposes** another’s attainment of their interests, objectives or goals, conflict is said to exist. Indeed, many researchers believe that the core process of conflict is the behaviour where one or more individual opposes another’s interests or goals (Wall & Callister 1995). While behaviours such as debating, arguing, competing, and backstabbing may be typical of conflict, they do not always imply the existence of conflict.

- Finally, while a number of emotions have been associated with conflict, overwhelmingly it has been **negative emotions** such as fear, jealousy, anger, anxiety and frustration that have been used to characterize interpersonal conflict (Amason, 1996; Barki & Hartwick, 2002; Jehn 1995).

### Types of Interpersonal Conflict

Research illustrates three main types of interpersonal conflict:

- 1. Relationship conflict** exists when there are interpersonal incompatibilities among individuals, including irritation about personal taste, interpersonal style, different personal values, or other non work-related preferences (Jehn & Bendersky, 2003; Jehn, 1995). This type of conflict is usually very counterproductive, taking the focus away from the issues that need to be resolved and replacing it with personal antagonism (Friedman, et al., 2000; Jehn, 1994).
- 2. Task conflict** exists when there are disagreements about the content of tasks being performed, including differences in viewpoints, ideas and opinions (Jehn & Mannix, 2001). Task conflict has the potential to create positive effects on productivity and team performance (Simons & Peterson, 2000). However, task conflict can lead to job dissatisfaction (Baron, 1991), decrease individual's perceptions of teamwork (Kabanoff, 1991; Jehn, 1999), increase anxiety (Jehn, 1999) and increase propensity to leave a job (Jehn, 1995). Research also shows that task conflict usually produces relationship conflict (Jehn, 1995). For example, if individuals harbour particularly strong feelings about a task issue (e.g. the goals of patient care), they may become emotionally invested about an issue.
- 3. Process conflict** focuses on disagreements about how to accomplish a task, which is responsible for a task, or the delegation of duties and resources (Jehn & Benersky, 2003). Thus, disagreements about work can be about how to accomplish or approach a specific task (process) or the content or substance of the task itself (task).

### Descriptions of Other Concepts Related to Interpersonal Conflict:

Nursing literature has established that the social climate in which nurses work includes various forms of conflictive interactions and co-worker mistreatment such as aggression, verbal abuse, violence, bullying, ostracism, incivility, dysfunctional interactions and horizontal violence (Rowe & Sherlock, 2005; Farrell, 2001; Ferris 2008; Agervold, 2007; Quine, 2001; Randle, 2003, Taylor, 2001; Spence-Laschinger, 2009; Leiter, Price & Spence-Laschinger, 2010). These negative behaviours are distinct from interpersonal conflict as described below:

- **Bullying** has been characterized as a constellation of repeated acts by one or more individuals, undertaken with an intention to cause harm and create a hostile work environment (Yamanda, 2000; Einarsen, 1999). It is not a one-off or accidental event, but a form of intentional workplace behaviour that is abusive, often subtle or hidden, and intensely harmful. Bullying is publicly belittling or finding fault with others; it is inherently societal and organizational, in that bullies may be supported by the workplace culture (Twale & DeLuca, 2008). Bullies are overt, direct, active, and visible and engage the target in a social dynamic that gives the target attention from others, even if that attention is negative.
- **Workplace Incivility** is a form of organizational deviance, characterized by behaviours that violate respectful workplace norms. It is not necessarily meant to harm. Uncivil behaviours are characteristically rude and discourteous displaying a lack of regard for others. Examples include insulting comments, insensitive actions, unintentional slights, denigration of a colleague's work, and spreading false rumors (Andersson & Pearson, 1999).
- **Horizontal violence** embodies an understanding of how oppressed groups direct their frustrations and dissatisfactions towards each other as a response to a system that has excluded them from power (Leap, 1997). It most commonly takes the form of psychological harassment, which creates hostility, as opposed to physical aggression. It involves verbal abuse, threats, intimidation, humiliation, excessive criticism, innuendo, exclusion, denial of access to opportunity, disinterest, discouragement and the withholding of information (Farrell, 1997; Thomas & Droppleman, 1997; Quine, 1999). It can result in absenteeism and intentions to leave the nursing profession (McKenna, et al., 2003).

- **Ostracism** refers to the experience of feeling ignored, left out or excluded by coworkers. Examples of ostracism are ignoring individuals, ‘silent treatment’, and not being invited to social events. Ostracism is covert, silent and often invisible. It reflects the absence of behaviour and represents mistreatment that is not verbally communicated; nonetheless, it disengages the target from the social context and takes away all forms of interaction, essentially removing any resemblance of belonging to the social context or connection to others (Ferris et al., 2008).

Although these concepts share the fact that parties are interdependent and have opposing interests, values or beliefs, interpersonal conflict need not involve intent to harm another party and need not cause negative outcomes. Effectively managed, interpersonal conflict can produce positive benefits as there has been a strong emphasis upon constructive aspects of conflict in organizations (De Dreu & Van de Vliert, 1997). Although it is recognized that conflict does have negative outcomes, particularly if based upon personality disagreements (relationship conflict), one of the most important contributions of the interpersonal conflict literature has been to enhance understanding of the conditions under which interpersonal conflict exerts positive outcomes (De Dreu & Van de Vliert, 1997; Jehn, 1995; Jehn & Mannix, 2001).

### Sources of Interpersonal Conflict:

Several studies have found that nurses experience conflict with doctors, nurse colleagues, managers, families and patients/clients (Boychuck-Duchscher & Cowin, 2004; Hillhouse & Adler, 1997; Kushell & Ruh, 1996). However, recent studies have found that nurses identify their managers and nursing colleagues as the most common source of conflict, with nursing colleagues being the most stressful type (Almost et al., 2010; Bishop, 2004; Lawrence & Callan, 2006; Warner, 2001).

In several studies such as Almost et al. (2010), Bishop (2004) and Warner (2001), the manager’s role has been identified as a key contributor to the level of interpersonal conflict. The impact of the manager’s leadership style including her/his ability to act as a mentor, diffuser of conflict, her/his level of respect for nurses, and supportive attributes have illustrated a profound impact on nurses’ experience of conflict and their quality of work life (Bishop, 2004). In addition, some studies identified the impact of the role of individuals’ cultural or ethnic background, their response to conflict situations and resolution styles (Kim-Jo, Benet-Martinez, & Ozer 2010; Al-Hamdan, 2009).

### Prevalence of Interpersonal Conflict

Approximately one in seven employed Canadians report that poor interpersonal relations in their workplace are a source of stress or excess worry. Similarly conflict among Health-care teams has been identified as a significant issue within health settings. Studies have shown that the frequency of conflict with nursing coworkers is on the rise (Hesketh et al., 2003; Warner, 2001) with a significant impact on the quality of the work environment for nurses (CNAC, 2002; Baumann, et al., 2001). The nursing literature has established that the social climate in which nurses work is fraught with poor nurse–nurse interpersonal relationships, which include various forms of conflictive interactions (Almost, 2006; McKenna et al., 2003; Quine, 2001; Sa & Fleming, 2008; Stevens, 2002; Yildirim & Yildirim, 2007). In 2005, among Canadian registered nurses almost one half (46%) reported low coworker support (Shields & Wilkins, 2006). Individuals between the ages of 45 and 54 years were found to be slightly more likely to report low coworker support (48%), but on the whole, the differences across age groups were small (younger than 35 years = 44% and 55 years or older = 39%). In this large, national survey, coworker support was determined by assessing nurses’ exposure to conflict and the helpfulness of others at work. Both female and male nurses were found to be exposed to hostility or conflict within their workgroup (44% and 50%, respectively). Moreover, 47% did not feel supported by their coworkers.

Other researchers have identified similar patterns confirming the presence of conflictive interactions among nurses. Rowe and Sherlock (2005) reported that nurses identified their staff nurse colleagues as the most common source of verbal aggression. A small percentage (13%) reported that a verbally abusive experience contributed to a practice error; in one of six of these cases, the experience remained unresolved. The most common long-term consequences of verbally abusive experiences with other nurses were poor working relationships with the aggressor, job dissatisfaction, a diminished sense

of well-being, and a lack of trust and sense of support in the workplace (Rowe & Sherlock, 2005). In a different study, McKenna et al. (2003) found that nurses in their first year of practice frequently experienced covert interpersonal conflict, feeling undervalued by other nurses, experiencing a lack of supervision, and being distressed by the conflict occurring among others. Those under the age of 30 years were more likely to experience interpersonal conflict, particularly being undervalued and verbally humiliated. Consequences of the conflict experienced by new graduates were absenteeism (14%) and intentions to leave the profession (34%).

### Conceptual Model of the Antecedents and Consequences of Conflict

The *Conceptual Model of the Antecedents and Consequences of Conflict* (Almost, 2006) organizes and guides the discussion of the recommendations. It provides a thorough understanding of the sources and outcomes of conflict and could enable preventive action. The model includes the following:

- Conflict antecedents (including individual characteristics, interpersonal factors and organizational factors);
- Perceived conflict;
- Conflict management style; and
- Conflict consequences (including the effects of conflict on individuals, interpersonal relationships, and the organization).

### Antecedents of Conflict

A review of the scholarly literature found that nursing research has focused mainly on the management of conflict with only a few studies examining the causes, elements and effects of conflict (Almost, 2006; Almost et al., 2010; Bishop, 2004; Cox, 2001; Rolleman, 2001; Warner, 2001; Wolff, 2009).

In addition to the antecedents identified in the Conceptual Model (Figure 2), important antecedents of interpersonal conflict include:

- Lack of communication or understanding of another's perspectives (Sexton et al, 2006).
- Unconstructive personal factors such as lack of collaboration and the four components of emotional intelligence: self-awareness, self-management, social awareness, and relationship management (Morrison, 2008).
- Role of practice environment which neglects leadership, communication, support system and collaborative decision-making (Sui, Spence-Lashinger, & Finnegan, 2008).
- Organizational culture which involves diminished flexibility, authoritarian leadership, rigid policies and procedures and lack of employee engagement (Hendel, Fish, & Galon, 2005).
- Perceived differences in nurses work values Wolffe (2009) found that nurses who perceived themselves to be different from their colleagues in terms of their work values were more likely to experience interpersonal conflict which, in turn, resulted in job stress or burnout (Wolff, 2009).

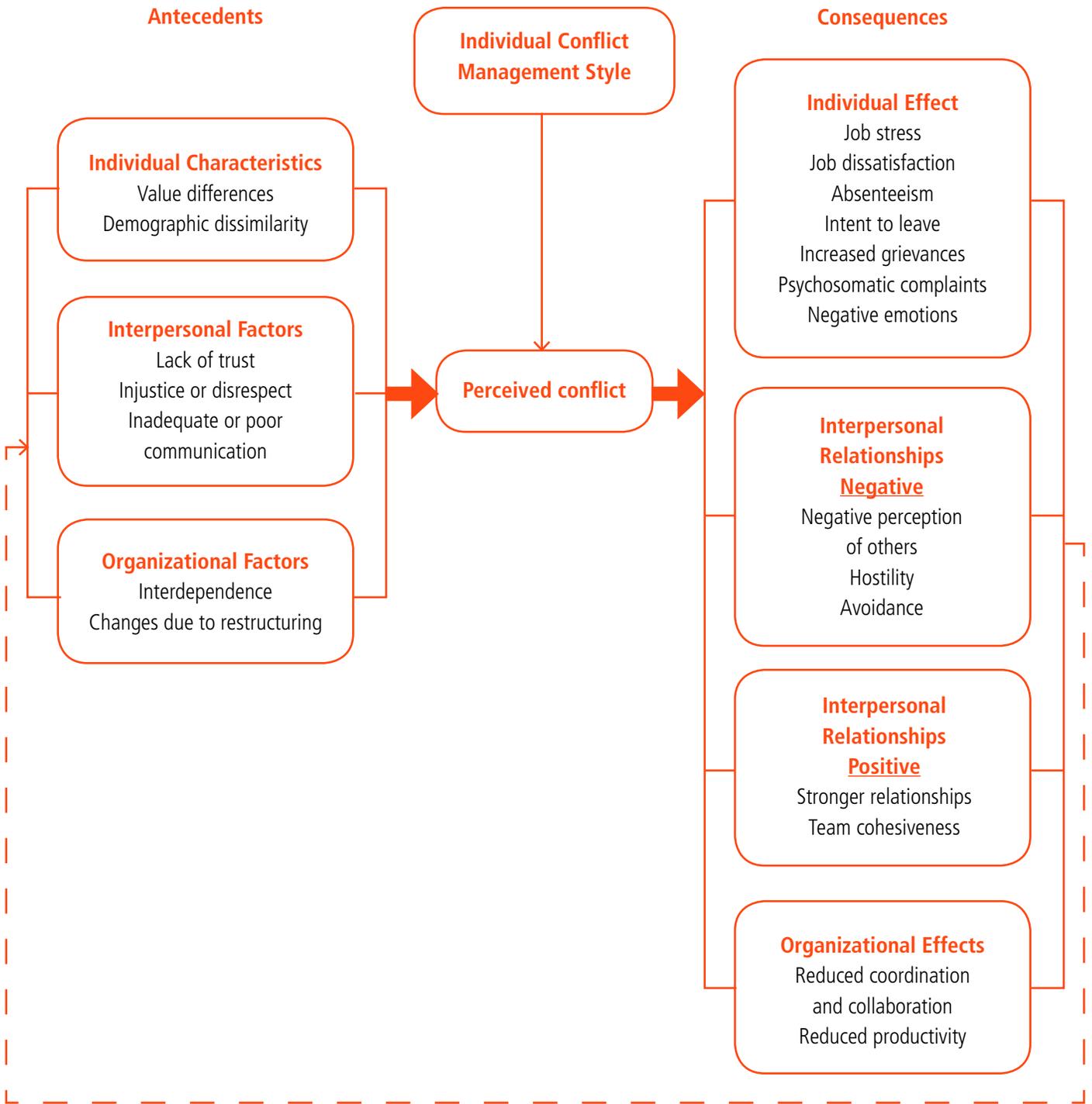


Figure 2: The Conceptual Model of the Antecedents and Consequences of Conflict (Almost, 2006, page 446)

## Outcomes of Interpersonal Conflict

Unaddressed interpersonal conflict can interfere with the personal well-being of the individual; result in negative co-worker relationships; undermine safe patient care/outcomes; and be disruptive to the organization. Perceived disagreements and interference about different desires/goals/approaches often results in negative emotions such as fear, anxiety, frustration, and jealousy. As an outcome of interpersonal conflict, individuals experience negative emotions such as feeling angered, betrayed, frustrated and dismayed by workplace relationships that are abusive and not supportive (Bishop, 2004).

When examining the different types of conflict, research has shown that relationship and task conflict have different consequences or outcomes. The existence of relationship conflict produces negative emotional reactions in individuals such as anxiety, fear, mistrust or resentment (Jehn, 1995). High relationship conflict also means that individuals suffer frustration, tension and fear of being rejected by other team members (Murnighan & Conlon, 1991). At the same time, high relationship conflict appears to cause dysfunction in team work, diminish commitment to team decisions, decrease organizational commitment (Jehn, Northcraft, & Neale, 1999), raise communication problems within team members (Baron, 1991), job dissatisfaction (Jehn, 1995; Jehn, Chadwick, & Thatcher, 1997), and increase stress levels (Friedman et al., 2000).

In contrast, findings concerning task conflict are not as conclusive. Task conflict has been associated with several beneficial effects such as improving the quality of ideas and innovation (Amason, 1996; West & Anderson, 1996), increasing constructive debate (Jehn et al., 1999), facilitating a more effective use of resources, and leading to better service provision (Tjosvold, Dann, & Wong, 1992). However, other studies have shown that task conflict may also have harmful effects by decreasing individuals' perceptions of teamwork and job satisfaction (Jehn et al., 1997), increasing anxiety (Jehn et al., 1997), burnout (Wolff, 2009) and greater intentions to leave (Jehn, 1995).

Although high levels of intense and prolonged conflict hurt individual and team performance, moderate levels of task-related conflict can be beneficial by mitigating biased and defective group decision-making (Brodbeck et al., 2002). These positive consequences of conflict tend to come about especially when relationship conflict is absent (De Dreu & Weingart, 2003a; Simons & Peterson, 2000), and when members engage in problem-solving dialogue and thus debate in an open-minded way about their opposing views, beliefs and opinions (De Dreu & Weingart, 2003; Tjosvold, 1998). Some studies show that on certain occasions, conflict may increase creativity and job quality in a group (Amason, 1996), and improve organizational effectiveness and development (Eisenhart & Schoonhoven, 1990).

## Implications for Best Practice Guidelines on Interpersonal Conflict

This best practice guideline on interpersonal conflict will be beneficial for interprofessional team members, nursing and non-nursing administrators, at the organizational and system level; policy makers and governments; educational institutions, professional organizations, employers, labour groups; and federal, provincial and territorial standard-setting bodies. The Managing and Mitigating Conflict in Health-care Teams guideline offers the best evidence to support recommendations on understanding the etiology and source of managing and mitigating, and provide meaningful solutions at various levels of practice. This approach may include an attitudinal shift on how nurses can positively use conflict situations in their practice.

Further, the Panel determined that this BPG will help assess, recognize, define, intervene, mitigate, manage and evaluate conflict in Health-care teams. This guideline provides nurses and decision-makers with tools and resources to educate team members, to identify ways to positively influence the culture within the Health-care team in order to mitigate conflict, and assist nurses and leaders to positively manage conflict and enhance the quality of care. Several strategies to address conflict among nurses are discussed such as providing education to individual practitioners and creating a work culture that recognizes the impact of unresolved conflict on team functioning and nurses overall health and well-being.

# Managing and Mitigating Conflict in Health-care Teams: Recommendations and Discussion of the Evidence

## 1.0 Organization Recommendations

The following recommendations are organized using the Healthy Work Environments framework, and reflect the physical/structural, cognitive, psychological, social, cultural, professional and occupational components of managing and mitigating conflict in the workplace that must be addressed at the external/system level to ensure best practice. External systems factors identified in the various components include:

### Physical/Structural components:

- Physical characteristics and environment of the organization (e.g. sleep rooms for all staff);
- Organizational structures and processes created to respond to the physical demands of work (e.g. decision-making process regarding overtime and scheduling);
- Leadership support;
- Staffing practices; and
- Occupational health and safety policies.

### Cognitive/Psychological/Social/Cultural components:

- Organizational climate, culture and values;
- Cultural norms, especially those that foster support, trust, respect and safety;
- Communication practices;
- Labour /management relations; and
- Culture of continuous learning and support.

### Professional/Occupational components:

- Characteristics of the nature and role of nursing within the organization, including organizational policies that influence scope of practice, level of autonomy and control over practice; and
- Nurse intra- and interprofessional relationships within the organization.

### 1.0 ORGANIZATIONAL RECOMMENDATIONS

- 1.1 Organizations identify and take action to prevent/mitigate factors contributing to conflict, for example:
- effects of shift work;
  - team composition and size;
  - workload and staffing;
  - manager span of control<sup>6</sup>;
  - level of staff involvement in decision-making and provision of care;
  - resource allocation;
  - diversity in the workplace; and
  - physical space.

	<p>1.2 Organizations support the systems and processes that minimize conflict, promote team functioning, value diversity and enact a culture of inclusiveness. Common attributes that exist between and among Health-care professionals include:</p> <ul style="list-style-type: none"> <li>• educational background;</li> <li>• work values;</li> <li>• ethnicity and culture;</li> <li>• age;</li> <li>• roles and responsibilities;</li> <li>• power;</li> <li>• scope of practice; and</li> <li>• gender.</li> </ul>
	<p>1.3 Organizations implement a regular assessment, which may include quality indicators, to identify the types and outcomes (short-term and long-term) of conflict among nurses, physicians and other Health-care professionals. Assessment data is used to develop and implement both action and communication plans for the organization.</p>
	<p>1.4 Organizations implement and sustain evidence-based strategies that support/enable leaders to foster self-awareness, possess emotional intelligence<sup>6</sup>, competencies and utilize conflict management principles.</p>
	<p>1.5 Organizations ensure all employees, physicians, and volunteers have the knowledge and competencies related to conflict management by:</p> <ul style="list-style-type: none"> <li>• Providing ongoing mandatory skills-based education regarding cooperative or active style of managing and mitigating conflict, clear communication, effective team building through transformational leadership<sup>6</sup> practices, and the promotion of mastery of emotional intelligence<sup>6</sup> skills;</li> <li>• Ensuring education is accessible to shift workers;</li> <li>• Supporting changes in staff behaviour by using a comprehensive educational approach for different levels (e.g., individuals, teams, organization) tailored to specific settings and target groups. This includes implementing mechanism for refresher courses and/or regular updates; and</li> <li>• Being congruent with the competencies frameworks for leaders (e.g. LEADS in Caring Environment Framework) and interprofessional practice (e.g. Canadian Interprofessional Health Collaborative, A National Interprofessional Competency Framework).</li> </ul>
	<p>1.6 Organizations provide internal and/or external third party assistance (e.g. spiritual care, ethicists, safe workplace advocate, and professional practice specialists/consultants) to offer productive support, shared decision-making, and/or manage/mitigate conflict.</p>

	<p>1.7 Organizations commit to the sustained use of cooperative or active conflict management styles (e.g., integrating and compromising), clear communication (e.g., crucial/learning conversations) and transformational leadership<sup>6</sup> practices to create healthy work environments<sup>6</sup> by:</p> <ul style="list-style-type: none"> <li>• Ensuring all leaders, future and present, acquire leadership competencies in the management of conflict;</li> <li>• Adopting recruitment processes that assess conflict management capabilities;</li> <li>• Recognizing individuals, leaders and managers who demonstrate active management styles<sup>6</sup>;</li> <li>• Implementing a formal mentorship program for managers and point-of-care leaders;</li> <li>• Meeting the College of Nurses of Ontario <i>Nursing Practice Standards</i> (2009) for nurses in an administrator role; and</li> <li>• Requiring managers to demonstrate accountability for effective conflict management styles, clear communication and transformational leadership<sup>6</sup>.</li> </ul>
	<p>1.8 Organizations evaluate the feasibility and effectiveness of the strategies, standards and policies of conflict management.</p>
	<p>1.9 Organizations ensure multi-faceted and comprehensive structures, processes, and supportive policies (e.g. Universal Code of Conduct and Respect in the Workplace) are in place. Organizations should support those in leadership roles to apply organizational policies and processes that exist to recognize, assess, monitor, manage and mitigate conflict.</p>
	<p>1.10 Organizations value, promote, enable and role model a culture that recognizes, prevents, mitigates and manages conflict, while enhancing the positive outcomes by:</p> <ul style="list-style-type: none"> <li>• Developing structures and processes to foster effective intra- and interprofessional collaborative relationships;</li> <li>• Utilizing a professional practice model that supports practice accountability, autonomy, reflection, self-awareness and decision-authority related to the work environment and patient/client care;</li> <li>• Promoting professional autonomy and decision-making;</li> <li>• Implementing and sustaining effective staffing and workload practices;</li> <li>• Ensuring a climate of appreciation, trust and respect;</li> <li>• Including resources in orientation sessions; and</li> <li>• Utilizing a variety of tools such as education, media campaigns and performance review processes.</li> </ul>
	<p>1.11 For interprofessional collaborative practice, organizational supports are provided to address conflict in a constructive manner by:</p> <ul style="list-style-type: none"> <li>• Valuing the potential positive outcomes of conflict;</li> <li>• Identifying common situations that are likely to lead to disagreements or conflicts, including role ambiguity, power gradients and differences in approaches to patient/client care goals;</li> <li>• Establishing a safe environment in which to express diverse opinions and viewpoints regardless of outcome; and</li> <li>• Establishing consistency and clarity about role expectations among Health-care professionals.</li> </ul>

## Discussion of Evidence

There is A1, B, C, and D type of evidence to support these recommendations.

Organizations have a significant influence and responsibility for the management of conflict experienced by employees. Organizations must gain understanding of the various precursors to conflict, and the importance of physical and structural components of an employment work environment towards the conflict. The following paragraphs explain these in detail.

### Precursors to Conflict and Organization

Organizational and leadership awareness of precursors to conflict is paramount in all Health-care settings. Organizations must understand the effects of staffing, shift work and scheduling practices such as length of shift hours, overtime, changes to shifts and the ability to backfill absences can increase stress and tension amongst staff, thereby contributing to interpersonal conflict. Moreover, employers should also understand the impact of working conditions such as time constraint, limited access to information and poor communication structures (De Raeve et al., 2008; Dewitty et al., 2009; Gerardi, 2004; Roy, 2010). Team size and composition, as well as regular contact between managers and team members are important organizational factors to establish team identity and interprofessional collaboration (Baxter & Brumfitt, 2008). Other work-related risk factors include: higher psychological job demands; higher levels of role ambiguity; the presence of physical demands; higher musculoskeletal demands; a poorer physical work environment; and higher levels of job insecurity – all of which predict the onset of both conflict among coworkers and supervisors (De Raeve et al., 2008). The nature of nurses and Health-care teams' work as patient/client advocates also predisposes them to conflictual situations (Arford, 2005). Moreover, conflict around goals of care and roles among team members may result in task and process conflict, thereby affecting the quality of interprofessional practice and team interactions (Meth et al., 2009). Establishing a common goal to focus on the patient/client is one way to minimize conflict (Powell-Kennedy & Lyndon, 2008). Finally, organizational mandates or competition fuelled by unfair resource allocation across departments and scarcity of resources may also cause interpersonal conflict (Kresselet al., 2002; Tengilimoglu & Kisa, 2005). Managers need to be supported to use best practice guidelines to build and manage staffing proactively and reduce this stressor (Registered Nurses' Association of Ontario [RNAO], 2007).

### Differences among Health-care Providers and Organization's Responsibility

Another component of organizational awareness understands how the perceived difference among Health-care providers is a precursor to interpersonal conflict (Wolff et al., 2010). Specifically, diversity in age, educational attainment, and ethnicity/race and work values may be some of the most important attributes that influence nurses and health-care teams' attitude and behaviour. As well, an association exists between perceived diversity in work values and interpersonal conflict. Nurses and Health-care teams who perceived they were different from their coworkers with respect to their work values identified greater amounts of relationship and task conflict with their coworkers; however, perceived differences in educational attainment was not related to conflict (Wolff, 2009). Educational differences among the hospital staff can be a barrier of good communication and information flow between groups (Dreachslin, Hunt & Sprainer 1999; Tengilimoglu & Kisa, 2005). Nurse Managers play an important role in shaping the work environment to create a climate of support for, and acceptance of, diversity. Leaders need to be adept at managing employees' perceptions of differences that exist among team members and facilitating nurses and Health-care teams openness to differences associated with, for example, age, educational attainment and work values. In addition to establishing conditions that embrace diversity, managers require important skills to mitigate and manage interpersonal conflict resulting from employee differences (Wolff, 2009). In addition, organizations should support systems and processes that promote team functioning and reduce conflict resulting from differences/dissimilarity between and among Health-care professional such as educational background, ethnicity and culture, age, roles and responsibilities, power, scope of practice, and other stereotypes.

### Physical and Structural Components of Work Environment Impact on Conflict

Physical and structural components of the work environment may lead to interpersonal conflict and have influence on conflict management/mitigation. Physical and structural components include not only the structures and processes created to respond to the physical demands of the work but also the style of leadership support that is in place, the staffing and scheduling processes, competition for resources between work units and communication structures and their effectiveness (Dewitty et al., 2009, Gerardi 2004; Roy, 2010; Kramer et al., 2007; Maxfield et al., 2005). Working in non-conducive spaces leads indirectly to conflict (by reducing team effectiveness and productivity. The physical space that nurses and Health-care teams work within should support interaction and communication between team members.

### Employee Support and Decision-Making

Conflict can effect patient/client outcomes and contribute to a negative culture (Gerardi, 2004). Support from the employees' supervisor is integral to the management of interpersonal conflict among and between nurses and other Health-care providers (Kramer et al., 2007). Managers that are engaged and demonstrate supportive leadership, act as role models and have clear expectations can also be effective at preventing, mitigating and managing conflictual situations (Barrett et al., 2009). The span of control of managers/leaders will affect communication effectiveness and frequency and their ability to manage and mitigate conflict (Ontario Hospital Association [OHA], 2011).

Examining span of control, implementing a plan regarding span, and providing skill development of nurse managers will be of benefit to managers in learning active styles of conflict management (DeChurch & Marks, 2001; OHA, 2011). The onset of interpersonal conflict among coworkers and supervisors can be minimized by higher levels of co-worker and supervisor social support, more autonomy concerning the terms of employment, good overall job satisfaction, monetary gratification and esteem rewards. Higher levels of decision latitude and more career opportunities are significant in minimizing the onset of supervisor conflict (De Raeve et al., 2008).

Support from nursing leaders is essential (Bishop, 2004). Managers need to have insight into their own behaviours and to be supportive to practice reflective clinical supervision of nursing staff. This contributes to heightened self-management and self-improvement, thereby increasing skill in role modeling behaviours that result in trust and optimism within their respective organization (Davies, 1995 and Wong et al. 1995 as cited by Horton-Deutsch & Sherwood, 2008; Barrett et al., 2009). "The wise and effective leader develops a high level of intuitive and process skills in facilitating the work and interaction of others to anticipate the normally embedded elements of conflict, the potential for the exposition of that conflict, and the early management of the conflict process as part of the ordinary and usual function of good leadership" (Porter-O'Grady, 2004). Reflection is a foundation for the development of emotionally and intellectually competent leaders (Horton-Deutsch & Sherwood, 2008). If leaders undertake a conflict self-awareness inventory and are reflective of their own behaviour, they can then develop a professional development plan in order to address conflict in an effective manner, and develop and maintain respectful professional relationships. (Almost et al., 2010; Porter-O'Grady, 2004). Managers assist in conflict management by role modeling, active listening, and being available for dialogue and reframing situations (Almost et al., 2010).

Organizational leaders, managers, nurses and Health-care teams need a common understanding of what constitutes conflict and the sources of conflict in the work environment. Conflict occurs at many levels within an organization, among and between many Health-care providers and can be about many things. Awareness about what constitutes interpersonal conflict and other forms of co-worker mistreatment, the causes of co-worker interpersonal conflict and the factors that escalate interpersonal conflict to harassment, bullying and violence is essential for organizations and all their employees (Almost, 2006; Desivilya & Yagil, 2005; Giebels & Janssen, 2005; Dewitty et al., 2009). Situations that predict organizational aggression include interpersonal conflict, situational constraints such as scheduling and training, and job dissatisfaction (Herschcovis et al., 2007).

Trust in peers, respect for others, interdependence among team members and identification with the team minimizes conflict (Almost, 2006; Han & Harms, 2008). Moreover, job stress resulting from interpersonal conflict and interactional justice<sup>G</sup> (e.g. how managers treat others and show concern), is associated with a decrease in organizational respect (Spence-Laschinger, 2004).

Organizations need to develop, implement and evaluate organizational ethical decision-making frameworks and conflict resolution guidelines that support managers/leaders' skill and ability to impact positively on conflict (Meth et al., 2009).

### **Education and Organizational Conflict Management Style**

Effective conflict resolution training/education should assist employees with being better equipped to handle work demands (Haraway & Haraway, 2005) and increase employee's awareness of their conflict management styles (Zwiebel et al., 2008). It should incorporate reflective practice, self-awareness for emotional intelligence, self-improvement (Horton-Deutsch & Sherwood, 2008), and promote communication skills to facilitate shared decision-making regarding legal and ethical issues (Meth et al., 2009).

Positive emotions towards co-workers (e.g. collegiality) influences individuals' style of conflict management used (Desivilya & Yagil, 2005) as does one's leadership style. The evidence supports the use of an integrating style of conflict management (Tabak & Koprak, 2007; Friedman et al., 2000) and active styles of conflict management (DeChurch & Marks, 2001). Individuals who use an active style openly discuss differences of opinion, voice their concerns, and exchange information to solve problems together (DeChurch & Marks, 2001). A positive relationship exists between collaborative conflict management styles and emotional intelligence (Morrison, 2008; 2005) as well as positive emotions (Desivilya & Yagil, 2005). Diminished interpersonal conflict is also associated with greater collaboration (Meyer, 2004). Conversely, an accommodating or competing conflict style is associated with lower emotional intelligence competencies (Morrison, 2008; 2005). In contrast, individuals who use dominating and avoiding styles of conflict management are more likely to experience higher levels of task conflict and subsequently, higher levels of stress (Friedman et al., 2000).

Transformational leadership affects an individual's style of dealing with conflict (Hendel et al., 2005). The conflict management style used by leaders/managers influences the relationship between task and relationship conflict on group outcomes such as job performance and overall job satisfaction. In other words, managers that use a more active style of conflict management to address interpersonal conflict will result in productive outcomes which indirectly influence patient/client care (DeChurch & Marks, 2001). Linkages also exist between managers using a more abusive style of handling conflict and employees' absenteeism, accidents and overtime (Meyer, 2004). In addition, high amounts of interpersonal conflict in the workplace results in a shift towards an autocratic or authoritarian leadership style (Almost, 2006). Organizational commitment to provide leadership support is necessary to enact effective conflict management styles (Bishop, 2004).

The relationship between intractable interpersonal conflict and the amount of stress experienced by an individual or negative emotional well-being (e.g. psychological disengagement, withdrawal, presenteeism) is minimized by third party assistance (e.g. expert mediators or external consultants) (Giebels & Janssen, 2005; Meth et al., 2009). Third party assistance can reduce the negative stressful long-term effects (e.g. burnout) of conflict situations (Giebels et al., 2004). In other words, third party assistance provides a buffering effect to mitigate the ongoing effects of interpersonal conflict. Third party assistance assists with conflict management by providing active listening, being helpful, providing validation, empathic attunement and their reputation for expertise (Kressel et al., 2002).

### **Organizational Culture**

Organizations need to make a commitment to conflict resolution by building a culture that is not conflict adverse (Porter-O'Grady, 2004). Organizational structures that create collaborative incentives, reduce power imbalances, and conditions for joint success can prevent or reduce conflict (Almost, 2006). The very nature of interdisciplinary teams with multiple professionals, each having their own set of values, practice beliefs and focus of care, can lead to tension (Harmer, 2006). When there is conflict in teams there is reduced coordination and collaboration between people or teams (Almost, 2006). Perceptions of injustice or disrespect are seen as a cause of conflict (Almost, 2006). This perception can affect interprofessional relationships specifically with delegation of authority creating a power imbalance (Bishop, 2004; Nelson et al, 2008). Nurses and physicians perceptions differ in terms of collaboration (Chadwick, 2010). Nurses can become reluctant to share expertise and opinions regarding patient/client care because of a perceived power differential (Nelson, King & Brodine, 2008). This may result in less the optimal patient/client care when the nurse does not provide her/his contribution to the formulation of the patient/client plan of care.

Health-care organizations may consider creating a culture of safety, one in which every member of the Health-care team feels safe in voicing opinions and concerns regarding a patient's/client's plan of care, and the fear commonly associated in disagreeing with those in positions of authority is eliminated (Porto & Lauve, 2006). Organization may achieve this by creating a universal code of conduct that is specific and provides guidance to all employees, including leaders, physicians, patients/clients, families, guests and so forth. Specifics should be provided about clear description of behaviours that are unacceptable and any policies, procedures or regulations to serve as grounds for dismissal or termination for violators. The code should be developed and modified as needed by an interdisciplinary committee. To enact the universal code of conduct and embed it within the organizational culture, a planned implementation should be executed for all groups guided by the code. A compliance monitoring system must be implemented to ensure sustainability and culture change (Porto & Lauve, 2006).

Mitigating and managing conflict is an important component of a healthy work environment (Eman et al., 2005) Communication gaps related to perceived conflict exist and are responsible for errors and reduced patient/client safety, dissatisfaction, reduced commitment and turnover (Maxfield, et al., 2005). At the same time, work environment climates/organizational cultures are shaped by individuals' style of preventing, mitigating and managing conflict and the amount of conflict produced (Friedman et al., 2000).

Organizational cultures and work environments which have been identified as “good”, “positive” or effective in reduced negativity are less likely to experience conflict and more likely to have effective conflict management styles that display the following (OHA, 2011; Sui et al., 2008):

- Cohesive workgroups/teams – Leaders with clear sense of direction, a vision for the future and who are accessible to employees, are more likely to create cohesiveness among employees by fostering camaraderie, trust between the manager and staff, and boosting morale.
- Appreciation, integrity and respect – The organization fosters a positive attitude, supports a culture of respect, celebrates successes and where mistakes are seen as opportunities to learn. The workplace is morally safe, ethically sound and there is sufficient time for continuing education/professional development. People are appreciated.
- Culture of teamwork–People work as a team and work is fairly distributed. There is effective, ongoing communication in the team while using collaborative and/or active conflict management styles (e.g. integrating and compromising)
- Work-life balance – There is recognition that employees have personal commitments outside of work and employees who leave on time or do not take extra shifts are not made to feel guilty.
- Attune to Professional Practice – Organizations supportive of nurses' professional practice foster cooperative work contexts.

Some conversations are especially difficult yet essential for Health-care providers to master – employee satisfaction and commitment, quality of care improve with mastery of these conversations (Maxfield et al., 2005)

## 2.0 Individual/Team Recommendations

The following recommendations are organized using the Healthy Work Environments framework and reflect physical/structural, cognitive, psychological, social, cultural and professional and occupational components of managing and mitigating conflict in the workplace that must be addressed at the individual level to ensure best practice. The individual factors that are identified in the various components include:

### Physical/Structural components

- Work demands;
- Work design;
- Work characteristics; and
- Workforce composition.

### The Cognitive/Psychological/Social/Cultural components

- Cognitive, psychological and social capabilities, and effort;
- Cultural competency;
- Gender;
- Working relationships – communication patterns, decision-making, conflict resolution and member mentoring;
- Role clarity;
- Role strain;
- Emotional demands;
- Job security;
- Clinical complexity; and
- Clinical knowledge, coping skills communication skills.

### Professional/Occupational components

- Experience, skills and knowledge;
- Personal attributes;
- Communication skills; and
- Motivational factors.

## 2.0 INDIVIDUAL/TEAM RECOMMENDATIONS

- 2.1 Nurses and Health-care teams acknowledge that conflict is normal and seek to understand through self-reflective practice how their behaviours, values, beliefs, philosophies and perceptions affect relationships with others, and how the behaviour of others influence conflict by:
- Identifying personal behaviours and/or attitudes that may have contributed to conflict, and strive to alter this behaviour;
  - Acknowledging and understanding their personal conflict management style;
  - Developing conflict resolution skills by taking advantage of education offered. Where education is not offered, the individual should bring this need to the attention of their manager/director; and
  - Understanding the importance of emotional intelligence<sup>9</sup>, lived experiences and their relationship to conflict.

	<p>2.2 Nurses and Health-care teams contribute to a culture that supports the management and mitigation of conflict by:</p> <ul style="list-style-type: none"> <li>• Seeking resolutions when necessary through counseling (employee assistance programs), accessing support (occupational health) and education offered in their organizations or settings;</li> <li>• Utilizing problem-solving techniques</li> <li>• Acknowledging and discussing the issue at forums such as staff meetings;</li> <li>• Demonstrating accountability for their actions, and commitment to managing and mitigating conflict;</li> <li>• Actively and constructively participating in their Health-care team initiatives;</li> <li>• Being accountable for, and respectful in the manner in which they communicate to patients/clients, families and members of the Health-care team;</li> <li>• Seeking opportunities and assuming the responsibility for sharing knowledge and best practices in nursing and health care.</li> </ul>
	<p>2.3 Nurses, Health-care teams and Health-care professionals:</p> <ul style="list-style-type: none"> <li>• Acknowledge that conflict is addressed in different ways, depending on the relationship of the person one is having conflict with;</li> <li>• Understand how they uniquely contribute to the client’s experience of health or illness and the delivery of Health-care services, in addition to facilitating the paramount importance of improving health outcomes, which is guided by the philosophy of patient/client-centered care; and</li> <li>• Understand and respect the roles, scope of practice and accountability of all members of the Health-care team<sup>6</sup>.</li> </ul>
	<p>2.4 Nurses and Health-care teams practice and collaborate with team members in a manner that fosters respect and trust by:</p> <ul style="list-style-type: none"> <li>• Ensuring open communication related to the provision of patient/client care and other work related activities;</li> <li>• Setting clear and objective goals for patient/client care;</li> <li>• Utilizing processes for conflict resolution and problem-solving;</li> <li>• Participating in a decision-making process that is open and transparent;</li> <li>• Being an active, engaged member of the Health-care team<sup>6</sup> while demonstrating respect and professionalism;</li> <li>• Contributing to a positive team morale;</li> <li>• Understanding that the work environment is in part constructed by each member of the team; and</li> <li>• Supporting each individual team member working to their own full scope of practice.</li> </ul>
	<p>2.5 Individuals contribute to the development of clear processes, strategies, tools and structures that promote the management and mitigation of conflict with emphasis on:</p> <ul style="list-style-type: none"> <li>• Open, honest and transparent communication;</li> <li>• Constructive and supportive feedback; and</li> <li>• Clear goals and objectives that foster professionalism, respect and trust.</li> </ul>
	<p>2.6 Individual nurses and Health-care teams actively participate in education to achieve a constructive approach to the management and mitigation of conflict.</p>

	<p>2.7 Consult organizational and professional guidelines, policies and procedures related to the management and mitigation of conflict by:</p> <ul style="list-style-type: none"> <li>• Seeking support;</li> <li>• Obtaining information; and</li> <li>• Providing support to others.</li> </ul>
	<p>2.8 Utilize management tools/strategies for management and mitigation of conflict such as the following:</p> <ul style="list-style-type: none"> <li>• Listen empathetically and responsively;</li> <li>• Allow the other person to express their concern;</li> <li>• Search beneath the surface for hidden meanings;</li> <li>• Acknowledge if you are at fault and reframe emotions;</li> <li>• Separate what matters and what gets in the way;</li> <li>• Learn from difficult behaviours;</li> <li>• Lead and coach for transformation; and</li> <li>• Negotiate collaboratively to resolve an issue.</li> </ul>

**Discussion of Evidence**

There is A1, B, C and D type of evidence to support these recommendations.

**Self-awareness and Emotional Intelligence**

At the individual level, self-reflection provides nurses and Health-care professionals with an opportunity to review aspects of their care and determine what worked and what could have been done differently (CNO, 2009). Individuals participating in a process of purposeful reflection can gain a deeper understanding of the issues and develop judgment and skill (Cirocco, 2007). Nurses and Health-care teams that are aware of their individual contribution to the structure of the Health-care team through the process of reflection may have an enlightened awareness which can facilitate the management and mitigation of conflict (Morrison, 2008). In turn, effective conflict management can be facilitated by increased emotional intelligence.

Emotional intelligence is defined as, “the ability to deal effectively with others and have a positive control over emotions” and includes “an array of abilities a person possesses in order to read the emotions of others and to act accordingly” (Morrison, 2008, p. 976). Acting according to the situation while maintaining control over emotions requires the ability to perceive process and manage emotional information. As well, increased emotional intelligence helps us to integrate and understand information (Morrison, 2008). Ultimately, mastering the skills of self-awareness, social awareness, self-management and relationship management can strengthen a person’s ability to perceive process and manage conflict (Morrison, 2008). Research has shown a positive relationship between collaboration and emotional intelligence (Morrison, 2008).

Horton-Duesch & Horton (2003) discuss the process of increasing awareness of persons and their role in the construction of conflict as ‘mindfulness’ (p. 192). The authors describe ‘mindfulness’ as a “process of looking back and forth, between themselves and another person until eventually they were able to see and approach the situation differently.” (p. 192). This process can begin as self-awareness and builds as individuals become aware of their strengths and limitations.

**Work Environments**

While Friedman et al. (2000) argues that, “An individual’s work environment is (at least partly) of his or her making” (p. 49), work environments are also constructed by each employee and their individual interactions with others. Work

environments that generate conflict through disrespect can decrease morale of team members and cause dissatisfaction within the team. Conflict within teams can be generated through personal attacks on any one of the members or interpersonal disagreements, and can decrease the amount of collective effort that is put into completing group tasks. Nurses that feel valued and respected by all members on the team are more able to engage in conflict management strategies (Siu et al., 2008). In addition, nurses who work in a professional practice environment that consists of professional autonomy, strong leadership and collaboration are more confident in themselves and more likely to problem solve collaboratively, respectfully and with open communication.

Nurses as part of their self-reflection are aware and recognize that personal disposition can affect the process of conflict resolution and can be integral to the creation of work environments that foster respect, collaboration and unity (Siu et al., 2008). Work environments are constructed by each individuals' contribution and behaviours; therefore, each individual group member is, "significantly shaped by the behaviours that their personal styles generate in others" (Friedman et al., 2000, p. 49). Appreciation that conflict exists in many situations and can be resolved or managed is paramount to the development of effective strategies for negotiation of increased levels of conflict (Xiao et al., 2007). Creating a culture that supports effective conflict resolution requires skills of negotiation and the development of coping processes to support collaboration, fairness and justice (Xiao et al., 2007).

According to Saulo & Wagener (2000) managing and mitigating conflict is a skill that can be learned – learners that are actively engaged in the process and motivated to be involved benefit from specific conflict management programs.

### **Teamwork and Conflict**

Conflict can arise from situations of increased complexity of patient/client care, workload issues and time constraints (Brown et al., 2011). The effects of conflict can be seen in poor work relationships and delayed patient/client care (EHCCO, 2010; Siu et al., 2008). Conversely, appropriately managed conflict can result in positive behaviours and positive clinical patient/client outcomes and satisfaction, and can sometimes be dependent on the ability of an individual team member's awareness of their contribution to a particular situation. Groups that encourage conflict resolution have a higher level of group satisfaction, and conflict is manageable when groups work cohesively towards a collective goal (DeChurch & Marks, 2001; Cox, 2003). In addition, groups that share similar values are congruent in their ability to communicate and increase the ability of the group to work effectively (Bryan-Sexton et al., 2006; Jehn, Chadwick & Thatcher, 1997).

Teamwork is a product of collaboration which includes a process of interactions and relationships between health professionals working in a team environment (CHSRF, 2006a). The key to the reduction of conflict is the development of team structures that foster collaborative relationships (Almost et al. 2010). Nurses and Health-care teams need to be aware that working together in a team-focused manner is the foundation for structuring positive outcomes. Managing fluctuating patient-care needs, positively acknowledging the contribution of each member of the team is fundamental to the delivery of excellent health care for each patient/client or family member. Each member of the team must have a clear understanding of their role and the role of others, and work collaboratively and respectfully with client-care as the primary focus. The process of decision-making and accountability becomes especially important with complex clients.

Fundamental to the performance of a team is awareness that the perception or interpretation of actions is conditional on trust (Almost et al., 2010). "If colleagues trust each other, they are more likely to accept disagreement at face value and less likely to misinterpret behaviours." (Almost et al., 2010, p. 448). Further to this, the perception of disrespect can also manifest itself into conflict. Displays of disrespect can be perceived by nurses and Health-care teams as communication that minimizes invalidates or ignores nursing concerns (Almost et al., 2010).

### Understanding Conflict and Developing Strategies

As inevitable as conflict is in the working environment, it is the responsibility of each nurse to increase their own awareness of the destructive capacity of conflict by actively participating in strategies to manage and mitigate conflict. Understanding what constitutes conflict and the related consequences is instrumental to developing strategies to manage and mitigate conflict (Almost et al., 2010). Each nurse can participate in conflict resolution training that includes communication skills to learn how to express feelings appropriately, anger control and strategies to de-escalate situations. Engaging nurses and Health-care teams to participate in the development of an organizational structure to manage conflict can empower nurses and Health-care teams to identify, report and respond appropriately to situations of conflict by increasing their understanding and confidence level (Deans, 2004).

Managing conflict requires specific training that promotes a team approach to resolution (Deans, 2004; Meyer, 2004). Escalating conflict increases frustration related to unmet needs and poor job performance resulting in delayed nursing responsibility and ultimately delayed nursing care. Therefore, the goal of engagement of nurses and Health-care teams in the development of strategies to manage and mitigate conflict would be increased quality of work life and, subsequently, improved nursing care.

Policy development and professional guidelines provide information related to the identification of various types of conflict, assessment and opportunities for management and resolution of conflict that is impacting group dynamics and individuals. Policies that outline unacceptable behaviours such as threats, discrimination, violence, aggressive behaviour, yelling and swearing support the development of a positive work environment (Meyer, 2004).

As well, participating in implementing evidence that decreases stress provides fundamental structure and support for the development of a healthy work environment. Participating in a professional practice environment by promoting co-operative work conditions provides the foundation for effective identification, assessment and management of conflict within the Health-care team. Although there are multiple benefits to addressing conflict, the primary benefit would be improved patient/client safety (EHCCO, 2010).

### *Qualities of Good Working Relationships*

- *Balancing reason and emotion*
- *Understanding other's needs and interests*
- *Fostering good communication*
- *Being reliable*
- *Using persuasion rather than coercion*
- *Mutual acceptance*

*(Fisher, R., & Brown, S., 1998)*

## External/System Recommendations

The following recommendations reflect physical/structural, cognitive, psychological, social, cultural, professional and occupational components of managing and mitigating conflict in the workplace that must be addressed at the external/system level to ensure best practice. The external systems factors contained in the recommendations include:

### Physical/Structural components:

- Health-care delivery models;
- Funding; and
- Legislation/Policy.

### Cognitive/Psychological/Social/Cultural components:

- Consumer expectations;
- Changing roles of family; and
- Diversity of population and Health-care providers.

### Professional/Occupational components:

- Policies and regulations at the provincial/territorial, national and international levels that influence how organizations and individuals behave with respect to managing and mitigating conflict in the workplace; and
- Competencies and standards of practice that influence the behaviour/culture of team members.

3.0 EXTERNAL/SYSTEM RECOMMENDATIONS	
	3.0 Government Recommendations:
	3.1 Governments recognize that conflict within Health-care teams <sup>6</sup> is a priority issue
	3.2 All levels of government promote a healthy workplace environment by: <ul style="list-style-type: none"> <li>• Developing policies and legislative frameworks that support the management and mitigation of conflict;</li> <li>• Developing policies and legislative frameworks that encourage intraprofessional, interprofessional collaboration and teamwork;</li> <li>• Ensuring sustainable financial resources to effectively prevent, manage and mitigate conflict in all Health-care settings; and</li> <li>• Establishing accountability requirements, such as through quality improvement plans, accreditation or other accountability agreements that address the management and mitigation of conflict within all Health-care settings.</li> </ul>
	3.3 Government agencies, policy and decision-makers should strategically align conflict management with other initiatives pertaining to healthy work environments <sup>6</sup> , patient/client <sup>6</sup> safety, interprofessional collaborative practice, and quality patient/client care.
	3.4 Governments commit to establishing and supporting research with appropriate levels of funding, acknowledging the complexity of the type of studies required to examine conflict within Health-care teams.

## Discussion of Evidence

There is C, D and D1 type of evidence to support these recommendations.

At the system level, legislative and regulatory reforms need to keep pace with changes and trends in the practice environment. Policy makers must enable organizational level autonomy to promote the systemization of collaborative practices. In Sweden, for example, the *Swedish Work Environment Act* requires that the employer take actions necessary to secure a safe and healthy work environment, including physical, social, psychological, organizational and technical factors, and that the employer and employees should collaborate to achieve a satisfactory work environment. It is mandatory for the employer to manage the work environment in a systematic manner (AFS, 2001).

Similarly, in the European Union, the *Luxembourg Declaration on Workplace Health Promotion* sets as a goal “improving the work organization and the working environment; promoting active participation and encouraging personal development” (Menckel, 1999). The desired results are improved quality of work life and better economic performance.

This autonomy could be in the form of resource allocations, decentralization of services or human resource management, among others. Simultaneously, at the system level, best practices should be disseminated nationally and tied to accountability requirements (CHSRF, 2006a).

A Health-care system that supports effective teamwork can improve the quality of patient/client care, enhance patient/client safety, and reduce workload issues that cause burnout among Health-care professionals (CHSRF, 2006a). Successful team interventions are often embedded in initiatives aimed at improving the quality of care through better co-ordination of Health-care services and the effective utilization of health resources. While some government policies support the development of collaborative and interprofessional models, these alone are not sufficient to transform the system. Effective teamwork can only be achieved when all levels of the Health-care system work together.

Policy and system barriers currently hampering the transformation to team-based healthcare must be addressed if effective teamwork is to become a reality. These barriers include inconsistent government policies and approaches; limited health human resource planning; limited research funding; regulatory/legislative frameworks that create silos; and models of funding and remuneration that discourage collaboration (CHSRF, 2006a).

The impact of these barriers is aggravated by a shortage of Health-care providers and an absence of ongoing, adequate funding to support collaborative activities. There is a critical need for decision-makers to act as “leaders” in breaking down these barriers and developing the infrastructure required to support teamwork at the practice, organizational and system levels. Conflict competency should be integrated into every job throughout the system to provide the depth and breadth of capacity in the Health-care system (CHSRF, 2006a).

Leaders and governing bodies should strategically align conflict management programs with patient/client safety efforts, human resource strategies and, in particular, retention programs (Mayer, 2008; Hetzler & Record, 2008; Marshall & Robson, 2005). However, many government initiatives, documents and policy reports do not explicitly refer to the importance of managing and mitigating conflict in Health-care settings. All sectors, including the professional regulatory bodies, education institutions, accreditation organizations, patients/clients, and providers themselves must examine current practices and embark on new initiatives that will reduce conflict, improve collaboration and ultimately, improve the health of the Canadian population (CHSRF, 2006).

Evidence that is readily accessible and can be directly translated into practice presents an important challenge (Glasgow et al., 2004). To be meaningful, research studies examining conflict within Health-care teams must take into account all elements of the practice environment at the individual, unit, organizational and system level. In addition, interventions studied in single studies under specific conditions may not be seen by end users as having applicability across settings (Daly, Douglas & Kelley, 2005). Thus replication of studies across populations and settings has been suggested (Glasgow et al., 2004). The best way to achieve this is through sequential studies that build on, and expand upon, results of prior studies.

4.0 Research Recommendations	
	<p>4.1 Researchers partner with governments, professional associations, regulatory bodies, unions, health service organizations and educational institutions to conduct research into conflict within Health-care teams<sup>6</sup>.</p>
	<p>4.2 Interprofessional researchers study the:</p> <ul style="list-style-type: none"> <li>• Range of impacts of the different types of conflict in the workplace on individuals, patient/client<sup>6</sup>, organizational and system outcomes, including quality of care, patient safety, recruitment and retention;</li> <li>• Prevalence and incidence of conflict, including an understanding of the different types of conflict, in workplaces throughout all types of organizational settings and sectors;</li> <li>• Antecedents<sup>6</sup> and mitigating factors influencing the different types of conflict in the workplace experienced by all individuals throughout all types of organizational settings and sectors;</li> <li>• Existence and effectiveness of current management philosophies and practices to prevent, manage and mitigate conflict in the workplace, including training and education programs;</li> <li>• Multiple levels where conflict occurs (e.g. individual, team, Health-care system, society) using a wide variety of methods and theoretical tools; and</li> <li>• Feasibility, efficacy and sustainability of programs and interventions developed to prevent, manage or mitigate conflict.</li> </ul>
	<p>4.3 Researchers develop, implement, and evaluate a conflict intervention based on the conceptual model shown in Figure 2, page 30.</p>
	<p>4.4 Using effective knowledge translation strategies, researchers report research findings and outcomes back to their partnering government bodies, professional associations, regulatory bodies, unions, Health-care organizations, educational institutions, and the individuals who participated in the research.</p>

### Discussion of Evidence

There is A1, B and C type of evidence to support these recommendations.

In several studies, nurses working in acute care settings have indicated that conflict is occurring more frequently in their current work environment than in the past (Hesketh et al., 2003; Rolleman, 2001; Warner, 2001). Nurses have often reported conflict with doctors, nurse colleagues, managers, families and patients/clients (Boychuck-Duchscher & Cowin, 2004; Hillhouse & Adler, 1997; Kushell & Ruh, 1996). However, recent studies have found that nurses identify their managers and nursing colleagues as the most common source of conflict, and that conflict with nursing colleagues is also the most stressful type (Almost et al., 2010; Bishop, 2004; Lawrence & Callan, 2006; Warner, 2001). In a CHSRF report (2006b) examining the major issues affecting nurse human resources in Canada, poor relations with colleagues was identified as one of the many challenges faced by nursing today.

However, a review of the nursing research literature identified a noticeable gap related to causes and impacts of conflict. Nursing research has focused mainly on the management of conflict with very few studies examining causes, elements and effects of conflict (Almost, 2006). In addition, in the majority of nursing research, the term ‘conflict’ is often not defined

or is poorly defined ranging from gossiping to physical violence and the majority of studies examining conflict do not use theoretical frameworks to guide the research. In order to develop strategies that will reduce conflict, research is needed to define more thoroughly the concept of conflict in nursing work environments, and develop a more in-depth understanding of the causes and impact of conflict on nurses. A thorough understanding of the sources of conflict would enable a shift from conflict management to conflict prevention (Almost, 2006). In addition, longitudinal studies would provide for better characterization of the relationship amongst causes and effects (Cox, 2001). Additionally, the large majority of research that has been conducted has taken place in acute care settings. It is timely to study the nature, prevalence and incidence of conflict in the workplace occurring across the whole spectrum of nursing workplaces. Nurses work in a wide variety of settings, ranging from institutional to independent environments. To further understand the scope and impact of conflict in the workplace, research that takes the organizational and situational context into account is needed (Montoro-Rodriguez & Small, 2006; Wall & Callister, 1995).

Interprofessional researchers must partner with governments, educational and Health-care professional organizations, and health service organizations to design research that will increase the understanding of the impact of the different types of conflict in the workplace on Health-care professionals. From an organizational perspective, impacts of interest are those that affect coordination and collaboration among team members, recruitment and retention, increased grievances, team efficiency, patient/client safety, and clinical outcomes (De Dreu, Harinck, & Van Vianen 1999; Institute of Medicine, 2004; Pearson et al., 2006; Spector & Jex, 1998). From the perspective of individuals, there is a wide range of consequences such as job stress, job dissatisfaction, absenteeism, distrust and lower commitment (Almost, et al., 2010; Cox, 2003; Hoel & Cooper 2001; McKenna et al., 2003; Warner, 2001), all of which can result in long-term consequences such as intent to leave, burnout and psychosomatic complaints (Danna & Griffin, 1999; Lambert et al., 2004; McKenna et al., 2003). From the perspective of the Health-care team, impacts of interest include handover communication, group cohesion, interpersonal relationships (Pearson et al., 2006; Tjosvold, 1997; Wall & Callister, 1995).

Conflict in the workplace is not a new phenomenon and a wide variety of workplace-based approaches to address conflict have been developed over time. The existing literature provides solutions that can be implemented to improve conflict processes and outcomes, however interventions are needed to determine the feasibility and efficacy of most programs developed to address conflict (Brinkert, 2010). It is not currently clear to what extent management practices may facilitate or hamper addressing conflict in the workplace or whether these practices encourage or aggravate patterns of conflict. Nurse managers can play an important role by partnering with researchers when applying new and existing interventions (Brinkert, 2010). It is important to evaluate these educational prevention and intervention programs, as well as related policies to determine their efficacy.

*The Conceptual Model of the Antecedents and Consequences of Conflict* (Almost, 2006) discussed on page 30 provides a thorough understanding of the sources and outcomes of conflict and could enable preventive action. Interprofessional researchers should design, implement and evaluate a conflict intervention based on the elements identified in this model.

## 5.0 Accreditation Recommendations

- 5.1 Accreditation bodies develop and implement evidence-based standards and criteria on the management and mitigation of conflict on Health-care teams as part of their standards and accreditation process.

### Discussion of Evidence

There is B, C and D type of evidence to support this recommendation.

Accreditation bodies, such as Accreditation Canada (previously The Canadian Council on Health Services Accreditation (CCHSA), Canadian Association of the Schools of Nursing (CASN), Commission on Accreditation of Rehabilitation Facilities (CARF) and Ontario Council on Community Health Accreditation (OCCHA), must be diligent in assessing the health of the workplace environment and be committed to improving the quality of work life for nurses and other Health-care professionals.

Addressing conflict associated with unprofessional conduct and abuse of power across all professions is an essential component of efforts designed to improve patient/client safety. The impact of the work environment on patient/client care was underscored in a recent study which indicated that one quarter of team members identified that patient/client treatment was complicated by team conflict (Ostermann et al., 2010). In the United States, the Joint Commission for the Accreditation of Health Care Organizations released a sentinel event alert citing evidence of the correlation between disruptive behaviours and the incidence of medical errors and preventable adverse events, patient/client satisfaction, costs of care and retention of qualified personnel (The Joint Commission, 2008). The alert indicates that there is a history of tolerance and indifference to such behaviours and that failure to address these behaviours at both the individual and system levels contributes to unsafe care. Recognizing the impact of the healthcare culture on patient/client safety, the Joint Commission published updated leadership standards effective in January 2009 for organizations seeking accreditation (Schuyve, 2009). These include two new standards that encompass expectations regarding management of disruptive behaviour that impacts the safety and quality of patient/client care, and a mandate for implementation of conflict management processes for addressing conflict between leadership groups, including physician leaders. The elements of performance issued as a part of the standards require that those individuals implementing these processes be skilled in conflict management. In addition, there is an existing standard mandating processes be implemented for managing and mitigating conflict between individuals. The physical, social and psychological aspects of the workplace must be reviewed during the accreditation process if a truly healthy work environment is to be achieved (The Joint Commission, 2008). Each of the new standards recommend the need for expanding conflict competency among health professionals for quality patient/client care. These standards have led early adopters to integrate conflict training into continuing education and orientation programs, and many health professionals are prioritizing conflict skills as a desired professional development topic (Emerging HealthCare Communities [EHCCO], 2010).

The concept of quality of work life is central to the Accreditation Canada Qmentum program (Accreditation Canada, 2010). Work life is one of the quality dimensions of Qmentum with content throughout the core standards, Required Organizational Practices (ROPs), and the Work life Pulse Tool. In 2010, Accreditation Canada introduced new criteria to address workplace violence including education and training on preventing and reporting incidents. In addition, a new Required Organizational Practice (ROP) on preventing workplace violence came into effect in January 2010. The Work life Pulse Tool helps organizations identify strengths and opportunities for improvement in their work environments, plan appropriate interventions to improve the quality of work life, and develop a clearer understanding of how quality of work life influences the capacity of an organization to meet its strategic goals. Work environment is evaluated on a number of aspects including satisfac-

tion with communication, supervision, learning, involvement in decision-making, safety, and work life balance (Accreditation Canada, 2010). However, these standards do not explicitly address the importance of managing and mitigating conflict in the workplace.

In contrast to the Accreditation Canada Qmentum program, a review of the 2009 Ontario Council on Community Health Accreditation principles and standards (OCCHA, 2009) as well as the Canadian Association of Schools of Nursing [CASN] Accreditation Program (CASN, 2009) and Commission on Accreditation of Rehabilitation Facilities (CARF) illustrated that a similar assessment of quality of the work life or work environment is not completed for either accreditation program. In fact, many policy efforts do not explicitly refer to the importance of managing and mitigating conflict in the workplace.

6.0 Education Recommendations	
6.1	Academic settings value, promote and role model a learning culture which recognizes, prevents, manages and mitigates conflict, while enhancing the positive outcomes of conflict.
6.2	Education for all Health-care professionals in academic settings include: <ul style="list-style-type: none"> <li>• Formal and informal opportunities for discipline specific and interprofessional students to develop and demonstrate the ability to recognize, prevent, manage and mitigate conflict in the workplace;</li> <li>• Recognition of the different types of conflict and subsequent outcomes on personal health, career, workplace dynamics and learning;</li> <li>• Appropriate communication strategies for responding to conflict in the workplace from patients/clients, peers, and other Healthcare professionals, physicians, supervisors and faculty; and</li> <li>• Learning related to how, and when to use, internal and external workplace supports for addressing conflict, and encouragement to seek individual, organizational and systemic solutions.</li> </ul>
6.3	Academic settings partner with Health-care organizations to develop transition-to-practice, mentorship or residency programs for new graduates.

RECOMMENDATIONS

**Discussion of Evidence**

There is B, C and D type of evidence to support this recommendation.

There are a number of initiatives that are being undertaken to help individuals mitigate and manage conflict in their workplace.

**Integration of Conflict and Communication Training**

One of these initiatives is the integration of conflict and communication training into early academic preparation as a means of building capacity in the next generation of health professionals. These early programs are an important first step in expanding conflict competency among health professionals (EHCCO, 2010). Undergraduate and graduate nursing education programs need to be attuned to the prevalence and reproductive nature of conflict in the workplace in all settings. Courses and core competencies on the elimination, management and resolution of conflict should be integrated into all nursing curricula, starting in the first year (International Council of Nurses [ICN], 2006). The content should include effective conflict resolution, interpersonal communication, self-awareness (Almost et al., 2010), working in diverse workgroups (Wolff et al., 2010), developing and enhancing emotional intelligence competencies (Morrison, 2008), diagnosing the type of conflicts that emerge while learning how to manage each type (DeDreu, Carsten & Weingart, 2003), intricacies of workplace relationships, organizational complexity where nurses work and how this complexity impedes conflict management (Gerardi, 2004).

### Orientation and Extended Support

Another strategy is providing orientation and extended support to new graduates when they progress through their undergraduate program and as they complete their first year of practice (Almost, 2006). All entry-level nurses should possess relational knowledge and skill in therapeutic communication, leadership, negotiation and basic conflict resolution strategies in which situations of conflict with colleagues are transformed into healthier interpersonal interactions (College and Association of Registered Nurses of Alberta [CARNA], 2006). Students who learn to manage conflict more effectively are better able to recognize it earlier and deal with it more confidently. In a study with senior nursing students, Spickerman and Brown (1991) found that students primarily used compromise and avoidance as their main conflict management styles. Following a variety of teaching/learning strategies on the topic, the students' predominant styles changed to compromise and collaboration. In a study with Turkish nursing students, Seren and Ustun (2008) found that the conflict resolution skills (empathy, listening skills, requirement-based approach, social adaptation and anger management) of nursing students enrolled in a problem-based learning (PBL) program were significantly higher than those enrolled in a conventional curriculum. These findings support the need for nurse educators to focus on the development of personal insight, communication skills, self-awareness and conflict resolution which are key features of a PBL curriculum.

### Transition Programs, Including Mentorship/Preceptorship

McKenna et al. (2003) suggested that transition programs (residency programs, internship and extern programs, mentorship/preceptorship) be developed for new graduates, with the development of preceptors and mentors who are sensitive to new graduate issues and can teach strategies to identify the potential for conflict and interventions related to prevention. In the report *The Future of Nursing: Leading Change, Advancing Health* (IOM, 2010), the committee recommended that actions be taken to support nurses' completion of transition-to-practice nurse programs after they have completed a pre-licensure or advanced degree program, or when they are transitioning into new clinical practice areas. Nurse residency programs, recommended by the Joint Commission in 2002, can provide newly graduated nurses with the opportunity to develop skills in such important areas as organizing work, establishing priorities, and communicating with physicians and other professionals, patients/clients, and families. In addition, transition-to-practice residency programs can help develop leadership and technical skills in order to provide quality care. Programs also include collaboration and conflict management (Keller, Meekins, & Summers, 2006; Rosenfeld et al., 2004). Residency programs have been shown to help reduce turnover rates for new graduate nurses, reduce costs, increase stability in staffing levels, and help first-year nurses develop critical competencies in clinical decision-making and autonomy in providing patient/client care.

### Interprofessional Education

When professionals engage in a process of learning together, positive stereotypes and relations are more likely to be fostered, which in turn may enhance the promotion of collaborative practices (Xyrichis & Lowton, 2008). Interprofessional education/interaction is an important factor in preventing the creation of barriers that may impact negatively on professional collaboration and teamwork (Barker, Bosco & Oandasan, 2005). Joint classroom and clinical training opportunities allows students to exchange different theoretical perspectives, address historical stereotypes, and develop communication and leadership skills that are critical to highly functioning teams in the clinical setting (Spear & Schmidhofer, 2005).

An important benefit from the standpoint of university administrators is the potential for sharing resources, including expert faculty, space and physical equipment. For example, sharing a single simulation center provides the various professional programs with opportunities for realistic interprofessional learning. Working together on patient/client scenarios and real-life case studies can improve teamwork and promote better understanding between professions. Ultimately it is the responsibility of educators in the various disciplines to create a learning environment in which students, educators, and patients/clients may teach and learn from one another. Other strategies include a single orientation day for the health professions that introduces the philosophy of interprofessional education, joint faculty appointments, shared courses across schools that includes the completion of assignments by interdisciplinary teams, and interdisciplinary student-managed clinics, educated in an interdisciplinary model, individuals entering the workforce will do so with the mindset that

collaboration among all Health-care practitioners is how patient/client care should be approached. The mindful inclusion of interprofessional educational experiences potentially will lead to more effective communication across disciplines and ultimately patient/client care that is safe, cost-effective and of high quality (IOM, 2010).

## 7.0 Nursing Professional/Regulatory Recommendations

- 7.1 Professional, regulatory and union bodies for Health-care professionals should:
- Educate all Health-care professionals regarding the management and mitigation of conflict in Health-care teams;
  - Develop competency standards for managers and leaders that clearly reference and prioritize conflict management;
  - Incorporate conflict management and mitigation in all applicable policies, standards, guidelines and educational resources;
  - Minimize role ambiguity by creating standards that clearly define and distinguish roles and responsibilities of various Health-care professionals;
  - Collaborate with policy makers to ensure priority and funding is dedicated to conflict research and interventions to support conflict mitigation and management in all Health-care settings;
  - Partner with Health-care and academic organizations to evaluate applicable policies, standards, guidelines, and educational resources; and
  - Advocate for research standards, accreditation, education, policies and resources to address conflict in the workplace.

### Discussion of Evidence

There is B, C and D type of evidence to support this recommendation.

Conflict has been shown to be positively associated with emotional exhaustion, absenteeism and turnover intentions (Giebel & Janssen, 2005), as well as job stress, job dissatisfaction, distrust and lower commitment (Almost et al., 2010; Cox, 2003; Hoel & Cooper, 2001; Kivimaki et al., 2000; McKenna et al., 2003; Warner, 2001). Professional, regulatory and union bodies should provide members with information regarding the human and financial costs related to unmanaged and unresolved conflict, as well as education to assist in managing and mitigating conflict.

It is critical that nurse leaders are well prepared to assume roles as managers in any Health-care setting. National nursing associations should support educational institutions to introduce formal training for managers with regard to conflict (ICN, 2010). Educational preparation will vary according to the roles and career paths of nurse managers. Nursing leadership includes coaching and mentoring others, and creating the environment for ongoing development and quality care. Strong nursing leaders support staff in their practice by addressing both professional and clinical issues, promoting job satisfaction and improving the quality of care for health consumers (ICN, 2010). ICN outlines their role in promoting sound education for management and leadership. Professional, regulatory and union bodies can assist by identifying relevant opportunities and promoting these to their members.

The ongoing need for continuous development of professional competencies in conflict engagement should be reinforced by accrediting bodies and professional associations as an essential component of effective leadership and professional clinical practice (Schyve, 2009). All Health-care professional, clinical and non-clinical, should be required to possess competencies in communication, collaboration, negotiation, conflict engagement and conflict resolution. These competencies should be clearly stated in all applicable policies, standards, guidelines and codes of ethics (Greiner & Knebel, 2004; Health Care Leadership Alliance [HLA], 2005; National Centre for Healthcare Leadership, 2004). The American Nurses Association (ANA) *Code of Ethics* (2001) states the professional nurse must treat colleagues with respect, and maintain a commitment to resolving conflicts with colleagues. It is the ethical duty of each professional nurse to resolve workplace conflicts. The ANA *Code of Ethics* (2001) also notes that it is the responsibility of both individual staff nurses and nursing management to facilitate an environment

of respect. The Canadian Nurses' Association (CNA) Code of Ethics (2008) notes that nurses treat each other, colleagues, students and other Health-care workers in a respectful manner, recognizing the power differentials among those in formal leadership positions, staff and students. They work with others to resolve differences in a constructive way (Code D10). The document refers to respect with no direct reference to conflict.

The existing legislative and regulatory frameworks in Canada are inconsistent in the way they define scope of practice among the health professions (CHSRF, 2006a). In addition to legislative and regulatory factors, professional scopes of practice have evolved over time (Canadian Institute for Health Information [CIHI], 2004); CIHI, 2003). Barriers that prevent practitioners from functioning to their full scope of practice mean that health human resources are not being fully utilized (Lahey & Currie, 2005). To remove these barriers, individual and team competencies and the skill sets that health professionals require to work effectively as a team must be considered. Professional, regulatory and union bodies need to change their prevailing mindset about how Health-care professionals can work together, given the entrenched attitudes about scopes of practice and the resistance to change (CHSRF, 2006a). A collaborative relationship between all Health-care providers is necessary for the provision of high quality care. This kind of relationship is built on a mutual understanding and respect for each other's roles and responsibilities. Because of the overlap in competencies among different professions, it is important that effort be put into role clarification and the same information be disseminated in a clear and easily accessible manner to all Health-care providers.

Minimizing confusion about responsibilities or duplication of roles will alleviate the potential for tension as Health-care professionals may sometimes feel displaced or resentful that others are taking their roles (Kennedy & Lyndon, 2008; CARNA, 2009). Professional, regulatory and union bodies need to address "turf" issues and adopt common goals, break down traditional hierarchical power structures and educate individuals about how each team member will contribute to quality care (Silen-Lipponen, Turunen, & Tossavainen, 2002; Deber & Baumann, 2005). Expectations of collaboration and conflict engagement vary across the professions and there are differing definitions of these terms as various professional groups use them (Stockwell et al., 2005; ANA, 2001; Mitchell et al., 2006). Nurses and other Health-care professionals, including physicians, have both similar and different conflict management skills and attitudes; creating commonality in understanding may promote better professional and personal outcomes (Chatwick, 2010). It is helpful for individuals to recognize the differences in approaches to conflict resolution. Recognition of these differences can promote understanding and collaboration.

# Evaluation and Monitoring of Guideline

Organizations implementing the recommendations in the Healthy Work Environments *Managing and Mitigating Conflict in Health-care Teams* Best Practice Guideline are encouraged to consider how the implementation and its impact will be monitored and evaluated. The following table, based on the *Conceptual Model for Healthy Work Environments* illustrates some examples of indicators for monitoring and evaluation. Many of these indicators can be measured through use of one or more of the measures of concepts related to the *Healthy Work Environments* model.

## Evaluation and Monitoring of Guideline

Level of Indicator	Structure	Process	Outcome	Measurement
<b>Objective</b>	To evaluate the organizational supports that promote management and mitigation of conflict	To evaluate conflict management processes	To evaluate the impact of implementation of the Guideline recommendations at all levels	To measure monitor indicators of structures processes and outcomes
<b>Organization/ Unit</b>	<p>Specific plans within the organization to implement Managing and Mitigating Conflict in Health-care Teams guidelines</p> <p>Structures consistent with recommendations related to organizational supports are evident in the organization such as :</p> <ul style="list-style-type: none"> <li>• Code of conduct / Respect in the workplace</li> <li>• Client-centered care</li> <li>• Safety practices</li> <li>• Effective staffing and workload practices</li> <li>• Access to educational opportunities related to managing and mitigating conflict in Health-care teams</li> </ul>	<p>Communication mechanism established and used through:</p> <ul style="list-style-type: none"> <li>• Newsletter</li> <li>• Open forum</li> <li>• Access to e-mail</li> <li>• Team meetings</li> <li>• Interdisciplinary patient/client care rounds</li> <li>• Systems of monitoring for effective results</li> <li>• Workload measurement tool in place and used appropriately to plan staffing</li> </ul> <p>Continuing education promoted through support and flexible staffing for all levels of the organization.</p> <p>Respectful working relationships are promoted through human resource development processes.</p>	<p>Organizational Outcomes such as</p> <ul style="list-style-type: none"> <li>• Turnover rates</li> <li>• Sick time and long-term disability</li> <li>• Retention</li> </ul>	<ul style="list-style-type: none"> <li>• Exit interviews and retirement interviews</li> <li>• Human resources statistics baseline and trends over time related to nursing staff mix, number of staff turnover, sick time/ long-term disability, retention of nursing staff in all roles</li> <li>• Safety Audits</li> <li>• Safety Attitudes Questionnaire (Bryan-Sexton et al., 2006)</li> <li>• Number of incidents reported related to conflict and disrespect in the workplace, code of conduct</li> <li>• Turnover Intention scale (subscale of the Michigan Workload measurement tool audits)</li> </ul>

Level of Indicator	Structure	Process	Outcome	Measurement
	<ul style="list-style-type: none"> <li>• Role descriptions include expectations of individual accountability in conflict resolution and management</li> <li>• Role descriptions include expectations of individual accountability in conflict resolution and management</li> <li>• Collaborative inter-professional mandatory skills-based education regarding cooperative or active management styles, clear communication, and effective team building through transformational leadership practices</li> <li>• Partnership with educational institutions to provide formal interdisciplinary collaborative education</li> </ul> <p>Policies that support the management and mitigation of conflict.</p> <p>An evaluation plan for ongoing assessment about the type and amount of contributing factors to conflict in the workplace, and the effectiveness of conflict resolution guidelines and strategies.</p>			<ul style="list-style-type: none"> <li>• Practice environment of Nursing Work Index (Lake, 2002)</li> <li>• Organization Assessment Questionnaire (Cammann et al., 1983)</li> <li>• Leader self-awareness inventory (Porter-O’Grady, 2004).</li> <li>• Funds for continuing education in relation to managing and mitigating conflict in Health-care teams.</li> <li>• Audit reports of code of conduct/respect in the workplace evaluations violations</li> <li>• Safety audits</li> <li>• Thomas Killman Conflict Mode Instrument (Barrett et al., 2009)</li> <li>• Organizational conflict inventory (Desivilya &amp; Yagil, 2005; Tabak &amp; Koprak, 2007)</li> <li>• Conflict Management scale (Austin, Gregory &amp; Martin, 2009)</li> <li>• Performance appraisal</li> <li>• Include demonstration of conflict competency</li> <li>• Collaborative Practice Scale (Nelson, King &amp; Brodine, 2008)</li> </ul>

Level of Indicator	Structure	Process	Outcome	Measurement
	<p>Collaborative interprofessional mandatory skills-based education regarding cooperative or active management styles, clear communication, and effective team building through transformational leadership practices</p> <ul style="list-style-type: none"> <li>Partnership with educational institutions to provide formal interdisciplinary collaborative education</li> </ul> <p>Policies that support the management and mitigation of conflict.</p> <p>An evaluation plan for ongoing assessment about the type and amount of contributing factors to conflict in the workplace, and the effectiveness of conflict resolution guidelines and strategies.</p>			

RECOMMENDATIONS

Level of Indicator	Structure	Process	Outcome	Measurement
<b>Nurse Leader</b>	<p>Ensure that an environmental scan is completed that will assess the knowledge of conflict within the unit/organization</p> <p>Support for nurses and health professionals through scheduling to allow attendance to in services</p> <p>Demonstrate appropriate conflict management and crucial conversational skills</p>	<p>Hold focus groups and surveys to assess current state of conflict, understanding and incidents</p> <p>Regular tracking of conflict incidents should be included in quality reports Include healthy work environment on agenda for staff meetings</p> <p>Ensuring nurses and other professionals within the team are scheduled appropriately</p> <p>Nurses in leadership roles demonstrate understanding of leadership competencies</p>	<p>Outcomes such as full staff participation in survey</p> <p>Staff satisfaction</p> <p>Rate of absenteeism is monitored related to disclosed conflict</p> <p>Number of grievances related to conflict is included in quality reports</p> <p>Unit/organizational commitment</p>	<p>Nurse Organizational Climate Description Questionnaire (Duxbury et al. 1982)</p> <p>Where Do You Stand? Assessment: A Self-Assessment for Measuring Your Crucial Conversational Skills</p>
<b>Nurse/Team</b>	<p>Demonstrate personal contributions that may cause conflict</p> <p>Demonstrate an understanding of how communication can prevent or instigate conflict</p>	<p>Attend educational sessions on conflict and participate in education provided</p> <p>Incorporate knowledge gained on conflict and self-monitor communication style</p>	<p>Number of staff that participate in educational sessions</p> <p>Feedback from educational sessions</p>	Quality indicators
<b>Patient /Client</b>	<p>Quality improvement programs are implemented</p>	<p>There is a clear understanding and demonstration of staff as to how conflict may impact the safety of the patient</p>	<p>Documentation by patient/client of nursing team</p>	<p>Patient satisfaction scores (e.g. PICKER)</p>
<b>Financial</b>	<p>Ensuring sustainable financial resources to effectively prevent, manage and mitigate conflict</p>		<p>Recruitment and retention cost savings</p> <p>Sick time cost savings</p> <p>Overtime cost saving</p>	

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# Process for Reviewing and Updating Guideline

The Registered Nurses' Association of Ontario proposes to update this best practice guideline as follows:

1. Each nursing best practice guideline will be reviewed by a team of specialists (Review Team) in the topic area, and will be completed every five years following the last set of revisions.
2. During the period between development and revision, RNAO program staff will regularly monitor for new systematic reviews, randomized controlled trials and other relevant literature in the field.
3. Based on the results of the monitor, program staff may recommend an earlier revision plan. Appropriate consultation with a team of members composed of original panel members and other specialists in the field will help inform the decision to review and revise the guideline earlier than the five-year milestone.
4. Three months prior to the five-year review milestone, the program staff will commence the planning of the review process by:
  - a) Inviting specialists in the field to participate in the Review Team. The Review Team will be comprised of members from the original panel as well as other recommended specialists.
  - b) Compiling feedback received, questions encountered during the dissemination phase, as well as other comments and experiences of implementation site representatives regarding their experiences.
  - c) Compiling new guidelines in the field, systematic reviews, meta-analysis papers, technical reviews, randomized controlled trial research and other relevant literature.
  - d) Developing a detailed work plan with target dates and deliverables.
5. The revised guideline will undergo dissemination based on established structures and processes.

*There is no single tried-and-true response to conflict that will work for everyone, always and everywhere. There are no simple step-by-step methods. All you can do is find your own way by moving into your conflicts, seeing what works and what does not and being courageous enough to alter your approach as you go. (Cloke & Goldsmith, 2011)*

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# Appendix A: Glossary of Terms

**Active Management Styles:** Extent to which there is discussion or confrontation resulting in a responsive and direct form of conflict management. Individuals who use an *active* style openly discuss differences of opinion, voice their concerns, exchange information to solve problems together; however they may also dominate the conflict episode by firmly pursuing their own sides of disagreements (Van de Vliert & Euwema, 1994).

**Antecedents:** Events or situations that are generally found to precede an instance of conflict (Rodgers, 1989).

**Conflict:** A phenomenon occurring between interdependent parties as they experience negative emotional reactions to perceived disagreements and interference with the attainment of their goals (Barki & Hartwick, 2001)

**Consensus:** A collective arrived at by a group of individuals working together under conditions that permit open and supportive communication, such that everyone in the group believes he or she had a fair chance to influence the decision and can support it to others.

**Critical Review:** A scholarly article based on a review of the literature on a particular issue or topic, which also includes the author's considered arguments and judgments about it.

**Emotional Intelligence:** The ability to perceive accurately, appraise and express emotion; the ability to access and/or generate feelings when they facilitate thought; the ability to understand emotion and emotional growth (Mayer & Salovey, 1997) and is thought to contribute to workplace success (Emmerling & Goleman, 2003).

**Expert opinion:** The opinion of a group of experts based on knowledge and experience, and arrived at through consensus.

**Health-care Team:** In healthcare, the most common types of teams are care delivery teams and management teams, which are the focus of this BPG. These teams can be subdivided according to:

- patient population (such as geriatric teams);
- disease type (such as stroke teams); or
- care delivery settings (such as primary care, hospital and long-term care). (CHSRF, 2006)

**Healthy Work Environments:** A healthy work environment for nurses is a practice setting that maximizes the health and well-being of nurses, quality patient/client outcomes and organizational performance.

**Healthy Work Environment Best Practice Guidelines:** Systematically developed statements based on best available evidence to assist in making decisions about appropriate structures and processes to achieve a healthy work environment (Field& Lohr,1990).

**Integrative Reviews:** The integrative process includes the following components: (1) problem formulation; (2) data collection or literature search; (3) evaluation of data; (4) data analysis; and (5) interpretation and presentation of results. Retrieved August 2, 2006, from [http://www.findarticles.com/p/articles/mi\\_ga4117/is\\_200503/ai\\_n13476203](http://www.findarticles.com/p/articles/mi_ga4117/is_200503/ai_n13476203).

**Interactional Justice:** Interactional justice means that people who are affected by decisions are treated with respect and dignity which should work to prevent resentment and conflict (Schermerhorn, 2010).

**Meta-analyses:** The use of statistical methods to summarize the results of several independent studies, thereby providing more precise estimates of the effects of an intervention or phenomena of health care than those derived from individual studies (Clarke& Oxen, 1999).

**Nurses:** Refers to Registered Nurses, Licensed Practical Nurses (referred to as Registered Practical Nurses, in Ontario), Registered Psychiatric Nurses, and Nurses in advanced practice roles such as Nurse Practitioners and Clinical Nurse Specialists.

**Organizational Recommendations:** Statements regarding the conditions required for a practice setting that enables the successful implementation of a best practice guideline. The conditions for success are largely the responsibility of the organization.

**Patient/Client:** Recipient(s) of nursing services. This includes individuals, (family member, guardian, substitute caregiver) families, groups, populations or entire communities. In education, the client may be a student; in administration, the client may be staff; and in research, the client is a study participant (CNO, 2002; Registered Nurses Association of Nova Scotia, 2003).

**Practice Recommendations:** Statements of best practice directed toward the practice of Health-care professionals that are ideally evidence-based.

**Qualitative Research:** A method of data collection and analysis that is non-quantitative. Qualitative research uses a number of methodologies to obtain observational data, including interviewing participants in order to understand their perspectives, world view or experiences.

**Span of Control:** Number of persons who report directly to a single manager, supervisor, or leader and relates to the number of people not the number of full-time equivalent positions (Tourangeau et al., 2003)

**System Recommendations:** Statements of conditions required to enable the successful implementation of a best practice guideline throughout the Health-care system. The conditions for success are associated with policy development at a broader research, government and system level.

**Systematic Review:** Application of a rigorous scientific approach to the preparation of a review article (National Health and Medical Research Council, 1998), systematic reviews establish where the effects of healthcare are consistent, where research results may be applied across various populations and Health-care settings, and where differences in treatment and effects may vary significantly. The use of explicit, systematic methods in reviews limits bias (systematic errors) and reduces chance effects, thus providing more reliable results upon which to draw conclusion and make decisions (Clarke& Oxen, 1999).

**Transformational Leadership:** A leadership approach in which individuals and their leaders engage in an exchange process that broadens and motivates both parties to achieve greater levels of where the leader takes a visionary position and inspires people to follow. Retrieved from October 6, 2005 from: [http://changingminds.org/disciplines/leadership/styles/transformational\\_leadership.htm](http://changingminds.org/disciplines/leadership/styles/transformational_leadership.htm)

## Appendix B: Guideline Development Process

The Registered Nurses' Association of Ontario (RNAO), with funding from the Ministry of Health and Long-Term Care and in partnership with Health Canada, has embarked on a multi-year project of healthy work environments<sup>G</sup> best practice guidelines<sup>G</sup> development, evaluation and dissemination that will result in guidelines developed by expert panels. This guideline was developed by an expert panel convened by the RNAO, conducting its work independent of any bias or influence from funding agencies.

In May 2010, RNAO convened a panel of nurses with expertise in practice, research, policy, education and administration representing a wide of range of nursing specialties, roles and practice settings.

The Panel undertook the following steps in developing the best practice guideline (BPG), *Managing and Mitigating Conflict in Health-care Teams*:

- The scope of the guideline was identified and defined through a process of discussion and consensus in a Scope and Purpose statement;
- Determination of Inclusion/Exclusion parameters: Based on the Purpose and Scope of the guideline;
- Development of research questions by the Panel;
- Search terms relevant to managing and mitigating conflict in healthcare in all roles were sent to the University Health Network Health Search to conduct a broad review of the literature by the librarian;
- An internet search of published guidelines related to nurse conflict was completed and yielded no results;
- The resulting citations and abstracts from the database were sent to the Program Manager at RNAO for review; it was determined that applicable literature was being collected and the librarian continued to search various databases;
- The list of included citations and abstracts was sent to the research assistant (RA) (electronically) to review; the RA reviewed the list and determined which articles should be pulled and printed for data extraction process;
- All included articles were reviewed to determine the quality of each article/study using appropriate assessment tools;
- A detailed summary was developed by the research assistant and submitted to the Panel;
- The Panel was divided into sub groups based on the organizing framework for developing a Healthy Work Environment: a) External level b) Organizational level and c) Individual level;
- The Panel reviewed the report;
- The sub groups organized the concepts and content of the guideline using the Healthy Work Environment framework;
- Supplemental literature was sourced by the panel;
- Through a process of discussion and consensus, preliminary recommendations were developed based on the evidence in the literature;
- Drafts of the BPG were reviewed and reviewed by the expert panel;
- The draft of the BPG was sent out for stakeholder review;
- The sub groups reviewed and discussed all stakeholder feedback;
- Recommendations and evidence were finalized; and
- The expert panel reviewed and approved the final document.

# Appendix C: Process for Systematic Review of the Literature

Two research assistants screened and analyzed the data and reached consensus on grading criteria for each article. A total of 5016 articles (including grey literature) were analyzed for this review process. The literature analyzed for this review stems primarily from the United States, Australia, China, Japan, Turkey and several European countries.

Both researchers screened the titles and abstracts of the potentially relevant studies as identified by the search strategy. Those articles that met the inclusion criteria were then analyzed and reviewed.

Two independent reviewers assessed the methodological quality of all the articles and reached consensus on the overall score, these findings were then compiled into one document for ease of review.

Data extraction was completed by each independent reviewer. Final extraction tables were then examined the data for accuracy by one reviewer. Data were extracted with regard to citation, study design, sample, intervention, measures, outcomes and limitations. Consensus on inclusion of data was confirmed between the two reviewers via frequent discussions of literature reviewed and sharing amongst the research assistants of data collected.

**1. A broad review of the literature using keywords associated with the definition of conflict was entered into:**

Databases

- Medline
- CINHAL
- Proquest
- Psych Info

**Definition of Conflict:** Conflict is defined as a phenomenon occurring between interdependent parties as they experience negative emotional reactions to perceived disagreements and interference with the attainment of their goals (Barki & Hartwick, 2001).

**2. The inclusion/exclusion criteria were:**

Include	Exclude
Peer reviewed	No editorials, commentaries, narratives
English abstracts as minimum (any language)	
5-10 years	
All methodologies if peer reviewed	
Adults older than 18 years	

### 3. Search terms identified included:

- arbitrating
- arbitration
- attitude(s) of health personnel
- boundaries
- cohesion (group team)
- collaboration
- collegiality
- conflict
- conflict and burden
- conflict and competition
- conflict management
- conflict management style
- conflict resolution
- contention
- cooperative behaviour
- cross disciplinary
- disagreement
- discord
- disruptive
- dissent and disputes
- diversity differences or dissimilarity
- employer-employee relations
- encounter
- health care team
- health professional health (taking care of oneself)
- healthcare team
- horizontal/lateral violence
- hostile (hostility)
- Incivility/bullying/ostracism
- inter-agency relations
- inter-disciplinary
- inter-institutional relations
- inter-occupational relations
- inter-organisational relations
- inter-organizational relations
- inter-professional
- inter-professional Relations
- inter-sector relations
- interdepartmental relations
- interdisciplinary
- interdisciplinary communication
- interdisciplinary health team
- interpersonal relations
- interprofessional
- mediating
- mediation
- medical care team
- medical etiquette
- medical staff
- multi-disciplinary
- multi-professional
- multidisciplinary
- multiprofessional
- negative/positive relationships
- negotiating
- negotiation
- negotiation(s)
- nursing staff
- opposition
- organizational behaviour(s)
- organizational culture (unit)
- patient care team
- personnel management
- physician-nurse relations
- power
- resiliency
- resolution
- respect
- self concept(s)
- self efficacy
- self esteem(s)
- self perception(s)
- sense of belonging
- staff
- staff attitude(s)
- strife
- team(s)
- teamwork/high functioning teams
- toxicity
- transdisciplinary
- trust
- workload and conflict
- workplace conflict

4. The review considered nurses in all domains (clinical practice, administration, education and research) and all sectors. The search strategy sought to find published and unpublished studies and papers limited to the English language. An initial limited search of CINAHL and MEDLINE was undertaken followed by an analysis of the text words contained in the title and abstract and of the index terms used to describe the article. A second-stage search using all identified keywords and index terms was then undertaken using the search terms listed above.

5. Studies identified during the database search were assessed for relevance to the review based on the information in the title and abstract. All papers that appeared to meet the inclusion criteria were retrieved and again assessed for relevance to the review objective.

6. Identified studies that met inclusion criteria were grouped into type of study (e.g. qualitative, quantitative, non-research), then into common themes such as experimental, descriptive, etc.).

7. Papers were assessed by two independent reviewers for methodological quality prior to inclusion in the review using an appropriate critical appraisal instrument. Non-research papers were included if they discussed the strategies to manage conflict.

Disagreements between the reviewers were resolved through discussion and, if necessary, with the involvement of a third reviewer.

#### Results of Review

A total of 96 papers, quantitative, experimental, qualitative and textual in nature, were included in the review. The majority of papers were methodologically moderate and therefore results are equivocal with weaker evidence to determine causation. There is a paucity of Canadian literature on the subject of conflict. This review serves as an excellent foundation in the search for best evidence related to the management and mitigation of conflict.

# 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

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

# Appendix E: Resources for Promoting Respect

## Ideas for Responding to Disrespectful Behaviour

### Using Standard Cues

Agree on a code word to use when (a) you are offended by something that is said, and (b) when you fear that you have offended someone. For instance, you might agree that anyone who feels offended or disrespected will simply say “**Ouch!**” to the offender. This is a cue for the offender to ask how the comment was interpreted, apologize if necessary and reach an agreement about how to avoid offending that person in the future. And when you slip and say something potentially offensive, you can say “**Oops!**” and retract or reframe your statement.

*Example: A 50-something manager is inclined to use pop culture references from her younger days (“He was a real Archie Bunker”) and then say to the 20-something budget analyst, “Oh, I’m sorry – you’re too young to understand the reference.” This was really offensive to the young employee, and by saying, “Ouch!” the next time it happened, the manager realized they needed to talk and then determined not to do that again.*

### De-Escalation

When a co-worker is becoming agitated, loud or hostile:

- Assume a calm, firm stance – stand or sit tall, shoulders back, hands quiet, and give the person your full attention.
- Speak in a clear voice but calmly and at normal volume.
- Acknowledge feelings and paraphrase what the person is saying: “I can see that you are very upset about what just happened.”
- Do not interrupt or try to problem-solve until the person has calmed down. Just listen and reflect what you hear them saying. “It sounds like you expect the budget cuts to cause downsizing in your department.”
- Take care not to sound patronizing or sarcastic. The person should feel that you are genuinely listening to her/his perception of the situation.
- Once they are calmer, ask what they want to have happen and how they might go about seeking a solution.

## Conflict Resolution Tools

### Basic Mediation Paradigm

When two people are in conflict about an issue, it is usually because they are seeing the same situation in totally different ways:

Perceptions + Experiences + Priorities = Point of View #1

Perceptions + Experiences + Priorities = Point of View #2

### Cooling-Off Method

When emotions are so charged that people aren’t willing to sit down together, try this:

1. Ask Person #1 to write a letter telling their story as completely as they can.
2. Deliver the letter to Person #2.
3. Ask Person #2 to respond in writing with their side of the story.
4. Deliver this response to Person #1.

Bring them together in private to discuss what each wants and what might satisfy their needs or resolve the problem.

### Informal Version

“Let’s try something. How about if we agree that each of you gives the other person a chance to explain, uninterrupted, what you think is going on here. Then we’ll try to agree on what the main areas of difference are and talk about those one at a time.”

Not only does conflict resolution (another name for Alternative Dispute Resolution) result in better solutions, it leaves both people feeling that they are respected and behaved respectfully. They have learned the wisdom of really listening to other people before making assumptions about them. It is likely that each honestly believes that their point of view is “correct” and the other person is “wrong.” The simple conflict resolution process has been widely used, from elementary school playgrounds to divorce mediation sessions, to help people in conflict listen to each other and work toward a resolution. A supervisor or even a co-worker can serve as the third party or mediator:

- Sit down with them together, in privacy.
- Lay out the ground rules: no interrupting, no name-calling.
- Let them decide who talks first.
- Person #1 tells their story until they are satisfied that the Person #2 understands it. The third-party may ask questions to clarify the story.
- When they are finished, the third-party summarize what they heard, without judgment.
- Then Person #2 tells their story, while #1 listens. Again, the third-party summarizes what they heard.
- Then look for common ground. The third-party asks each person what they want –often they just want an apology, an acknowledgement, or some type of compromise.

The third-party helps the two people make an agreement, within the bounds of what is allowed in the workplace.

*Example: An off-site supervisor feels left out of key decisions because his service chief calls informal meetings on site and forgets to ask for his input or tell him what has transpired. The supervisor feels that the off-site person is “nosy” or just seeking attention. Once they sat down with a third person (a staff psychologist), the supervisor understood that his boss had a spontaneous operating style and was not intentionally ignoring him. And the boss learned that the off-site person had substantive ideas to offer. They agreed on a weekly call time when all supervisors would talk together about issues affecting them all.*

*Used with permission from U.S. Veteran’s Health Administration. National Center for Organization Development. Cincinnati, OH. [www.va.gov/ncod](http://www.va.gov/ncod)*

### Promoting **RESPECT** in the Workplace

**R**ecognize the inherent worth of all with whom you work.

**E**liminate derogatory words and phrases from your vocabulary.

**S**peak with people – not at them – or about them.

**P**ractice empathy. Walk awhile in others’ shoes.

**E**arn the respect of colleagues and co-workers through your behaviours.

**C**onsider your impact on others before speaking and acting.

**T**reat everyone with dignity and courtesy.

Used with permission from Start Right, Stay Right. [Walkthetalk.com](http://Walkthetalk.com)

# Appendix F: Additional Resources

## References & Tools:

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# Managing and Mitigating Conflict in Health-care Teams Tips

## 1. How to become self-aware during conflict:

- Listen, ask questions, make a commitment to resolving the conflict
- Pay attention to the way you are when you are in conflict
- Choose to listen and learn – both to your own internal voice and to the voice of your colleague
- Alter the way you act, by exploring options, separating problems from people, exploring the reasons for your own resistance
- Decide to be a leader in your own conflicts

(Cloke & Goldsmith, 2011)

## 2. Five responses to conflict

- **Avoidance:** withdraw from the situation; maintain neutrality; goal is to delay
- **Accommodation:** satisfy others' needs and concerns over your own; maintain harmony; goal is to yield
- **Aggression/Domination/Competing:** Being assertive and pursuing your own concerns; win/lose power struggle; goal is to win
- **Compromise:** minimally acceptable to all; relationships undamaged; goal is find middle ground
- **Collaboration:** expand range of possible options; achieve win/win outcomes; goal is to find a win/win solution

(Thomas, K. W., 1992)

## 3. Some steps to help resolve conflict in the workplace:

- *Identify the issue(s).* What is the real problem? Is your perception of the problem different than the other person? Communication is key.
- *Look internally.* Consider your role in the conflict.
- *Handle conflict sooner rather than later.* Resolve a conflict when it starts.
- *Invite the other person to talk about the situation.* Best in an undisturbed location with time to address the issue. Don't interrupt. Let the other person talk.
- *Ask nicely.* If somebody has done something that upset you, simply ask them why. "Say, I was wondering why you did 'X' yesterday" or "I've noticed that you often do 'Y'. Why is that?" are good examples. "Why do you always have to 'Z'!" is less constructive.
- *Observe.* Describe the situation as objectively as possible. What is actually happening? What is the other person doing and, not least, what are you doing? You can say, "I've noticed that you're always criticizing me at our meetings" because that's a verifiable fact. You can't say "I've noticed that you've stopped respecting my ideas" because that assumes something.
- *Brainstorm for possible solutions.* It's essential to set a goal so both parties know the outcome they're aiming for. Ask for specific actions that can be implemented right away.
- *Apologize.* Apologize for your part in the conflict. You're not accepting the entire blame, you're taking responsibility for your contribution to the situation.<sup>7</sup>
- *Appreciate.* Praise the other person in the conflict. This can be difficult as few people find it easy to praise and appreciate a person they disagree strongly with, but it's a great way to move forward. (Cloke & Goldsmith, 2011)

4. Some steps to help leadership/managers resolve conflict in the workplace:

- Encourage open communication in the organization. Make sure everyone’s voice is heard.
- Encourage an acceptance of different working styles and perspectives. Encourage diversity. Set a good example.
- Be aware of brewing conflict. Are cliques being formed? Have you witnessed arguing or tempers flaring? Nip the problem in the bud.
- Empower employees. Make them aware of policies regarding the handling of disputes, and uphold that policy.

(Cloke & Goldsmith, 2011)

5. Consider a conflict you have recently experienced and ask yourself the following questions, first for yourself then for the other person in the conflict:

- *Issues.* What issues appear on the surface? Or beneath the surface that are not being discussed?
- *Personalities.* Are personality differences contributing to misunderstandings and tension? If so, what are they and how are they operating?
- *Emotions.* What emotions are contributing to your reactions? What is their contribution? Do you think you are communicating your emotions responsibly or suppressing them?
- *Interests, needs, desires.* Have you proposed a solution to the conflict? What deep concerns are driving the conflict? What are your interests, needs, and desires, and why are they important?
- *Self-perceptions and self-esteem.* How do you feel about yourself and your behaviors as you continue the conflict? What do you identify as your strengths and weaknesses?
- *Hidden expectations.* What are your primary expectations and those of your opponent? Have you clearly communicated your expectations? What would happen if you did? How might you let go of false expectations?
- *Unresolved issues from the past.* Does this conflict remind of you of anything you’re your past? Any unresolved or unfinished issues? What would it take for you to let them go?

(Cloke & Goldsmith, 2011)

6. What questions should you ask?

- “Can you tell me more about what bothers you about what I did?”
- “How did you feel when I did that?”
- “Would you like to know how that made me feel?”
- “Why is that a problem for you?”
- “What did you mean when you said \_\_\_\_\_?”
- “What would you suggest I do to contribute to the resolution?”
- “Can you think of any solutions that might be acceptable for both of us?”
- “What would it take for you to let go of this conflict and feel we have resolved the issue?”
- “Would you care to hear how I would like for you to communicate with me?”

(Cloke & Goldsmith, 2011)

7. Barriers to conflict resolution

- Time constraints
- Poor communication
- Unclear roles
- Diversity
- Power imbalances
- Emotionally charged situations
- Fatigue
- Stress
- Avoidance

8. Most conflict arises from simple misunderstandings, poor choices of language, ineffective conflict management styles, unclear roles and responsibilities, miscommunication, and poor leadership. By listening to others, learning to problem solve, talking and exploring options, most conflict can easily be corrected (Cloke & Goldsmith, 2011).

9. It is important to change the way we think about our disagreements, and, ultimately, how we behave in their presence. Making this conscious choice is our responsibility, and a demonstration of our willingness to engage directly, constructively, and collaboratively with our colleagues (Cloke & Goldsmith, 2011).

10. There is no step-by-step method to conflict that will work for everyone, everywhere and in every situation. The goal is find your own way by moving into your conflicts, seeing what works, what needs to be done differently and being courageous enough to learn and alter your approach as you go (Cloke & Goldsmith, 2011).





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# Managing and Mitigating Conflict in Health-care Teams

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