

Cambridge University Press

978-0-521-71704-5 - Core Topics in Operating Department Practice: Leadership and Management

Edited by Brian Smith, Paul Rawling, Paul Wicker and Chris Jones

Excerpt

[More information](#)

Managing change in perioperative education

Brian Smith

Key Learning Points

- Explore the key milestones in perioperative education
- Define some of the conflicts and tensions that occurred
- Discuss new ways of teaching and learning in perioperative education

The purpose of this chapter is to highlight the confusion, conflicts and challenges faced by many academic staff and staff involved with perioperative education. To appreciate the changes that have occurred, this chapter will navigate through the key milestones in perioperative education, offering an insight into how they have provided a road map of today's perioperative education.

Operating department assistant training

From 1976 and until the 1990s, education for the operating department assistant and the operating department practitioner (ODP) was available through regional training centres. The City and Guilds of London Institute approved the regional training centres following recommendations made by the Lewin Report (Department of Health 1970). This offered many recruits, who came from diverse backgrounds and who did not always have perioperative experience, an opportunity to enter into perioperative practice.

The course itself comprised of two calendar years where the 'trainee ODA' was exposed to specialities within the theatre suite. Trainees were also invited to visit other departments that had a direct influence on their perioperative work. For some, visiting accident & emergency, sterile services, coronary care and intensive care units expanded their knowledge and understanding of medicine and healthcare.

Managing this programme was not straightforward. Day-to-day coordination of ODA's training and welfare resided with the local assessment coordinator (LAC) or local assessment manager (LAM). The person performing this role was either from a theatre nursing or an ODA background. The two different names – LAC and LAM – resulted in tensions and conflict. That is, the LAMs viewed their role as a managerial one as opposed to being a coordinator of the City and Guilds' programme. The perceived difference between the two names occurred because of different expectations of the role within clinical practice. Anecdotal evidence at the time suggested the LAMs were recruited because of their seniority in the operating theatres and were expected to line manage the trainee too. However, the regional centre guidance for the LAC's role included the perioperative practitioner (not necessarily in a senior position) designing, implementing and evaluating the training programme. The manager in charge of the operating theatres line managed the trainee.

Core Topics in Operating Department Practice: Leadership and Management, ed. Brian Smith, Paul Rawling, Paul Wicker and Chris Jones. Published by Cambridge University Press. © Cambridge University Press 2010.

2 Brian Smith

Although LAC job descriptions were available, the LAM title continued to be used in several hospitals. We can assume the existence of the two titles may have occurred because of personnel seeking to progress their career or as a result of organic change as the programme developed. Nevertheless, the existence of the LAC & LAM titles continued to create tension for the learner and the perioperative staff. There were examples of how the confusing titles did affect the learning experience, either positively and negatively. For example, the LAM often provided an authoritative voice, ensuring the student gained access to placements. However, the LAC offered pastoral support, guidance and direction for the student. As the LAC was not responsible for the day-to-day management of the trainee's behaviour, attitudes and work ethics, the relationship between the trainee and LAC may have been more sympathetic. Often, trainees felt they could approach their LAC with emotional difficulties. Some felt they were unable to approach the LAM and preferred to consult a LAC, who acted independently from any managerial demands. Moreover, the LAM's managerial position may have aggravated the situation. That is, within the nature of management, there is a need for the manager to have some 'control' over staff performance and how it aligns with the service delivery (Tannenbaum 1968: 3). Control within this context is not restrictive or oppression of an individual's autonomy or capabilities, but is one where the trainee ODA is motivated and inspired to learn by performing healthcare activities that are within their scope of practice and which meet the organization's purpose. The LAC role, at the time, did offer stimulus for the trainee to learn new competencies in many areas of anaesthesia, surgery and recovery. Nevertheless, LACs were also faced with trainee ODAs 'failing to progress' or underperforming. The 'control' element would have tried to influence poor performance and undesirable behaviour to encourage progress. The LAM role would have a certain amount of responsibility to manage this, whereas the LAC would have referred the problem to their line manager or the regional centre. Given that the

two titles existed, trainee ODAs often became confused, leaving them to undertake a complex and demanding programme along with trying to make sense of who was supporting them; was it the LAC or the LAM?

Irrespective of the LAC or LAM dilemma, the regional management of the hospital ODA qualification from the City and Guilds of London Institute involved the regional health authorities. They became responsible for the regional training centre as it was funded from public money collected by the UK Government. The managerial structure of the programme included a local steering group, which was sometimes referred to as the local management committee. The membership of this group included ODAs, nurses, anaesthetists and surgeons, with representatives from hospitals in the area. These senior colleagues were given the responsibility to ensure that the National Health Service Training Authority standards were integrated alongside the course syllabus. Again there was some disjointedness in the names applied to this group; however, the benefit of having a steering group meant that rigorous scrutiny of the programmes ensured that they were fit for purpose and did, in fact, make a difference to the patient and the trainee's experience. Although City and Guilds of London Institute was primarily responsible for quality assurance, the local steering groups also saw their role as quality assurers of the course. Managing quality assurance is something that needs significant thought and does need a dedicated body of experts to question what they implement. This also applies to any perioperative practitioners under their related codes of conduct (Health Professions Council and Nursing and Midwifery Council). Indeed LACs were champions of quality, which was seen in the highly effective training packages that they provided for the trainee ODA. The quality was measured through the high success rate of the programme and the high volume of applicants wishing to train in their hospital. The reputation of good ODA training spread across the country, thus promoting the new profession.

Cambridge University Press

978-0-521-71704-5 - Core Topics in Operating Department Practice: Leadership and Management

Edited by Brian Smith, Paul Rawling, Paul Wicker and Chris Jones

Excerpt

[More information](#)

Given that ODA training was successful, many have asked why there was a need for change. There was some controversy with how the trainee ODA was assessed during the programme. The assessment included a multiple-choice questionnaire examination and two practical assessments: anaesthesia assistance and surgical scrubbing. A report of 'good' trainees passing the practical and failing the examination was seen as unfair. That is, the trainee who excelled in practice and did not cope with examination pressures was seen as disadvantaged because there was too much emphasis on the theoretical element. Furthermore, in 1989, the Department of Health published the Bevan Report, which investigated the utilization and management of operating theatres (NHS Management Executive VFM Unit 1989). Changing UK demographics in health were placing more demands on healthcare, and the study helped to identify where and how healthcare could be improved. Professor P. G. Bevan led the study and later recommended that the nurse education body (English National Board (ENB)) and the National Health Service Training Directorate (NHSTD; formerly the National Health Service Training Authority) should work collaboratively to develop a common training programme for theatre staff. He recognized that there was much commonality in what nursing and ODA staff studied during their education. The report also recommended that 'levels of competence' should be ascertained for each role in the operating department so the boundaries of professional practice, the division of labour, were clear. Sharing knowledge was seen as good practice and it was hoped that this would lead to greater harmony among the professions.

Perioperative nursing programmes

For several years, the ENB offered specialist courses for registered nurses (RN) to develop their knowledge and skills: ENB 176 Operating Department Practice Award, ENB 182 Anaesthetic Nursing and

ENB 183 Anaesthetic and Theatre Award. The ENB qualifications for the operating department became UK recognized. The 'theatre course' was much sought after, with many nurses leaving their home towns to undertake the course. The theatre course focused on skill acquisition and was supported heavily by testing the nurses' understanding through course work. As Brett (1996) has previously explained, these courses migrated into higher education, offering opportunities for the RN to achieve a diploma or degree pathway in theatre nursing. Reshaping of the ENB courses led to topics such as ethics and research skills becoming important in the curriculum. This resulted in a reduction of time previously earmarked for specialities such as anaesthesia. This caused controversy among the nursing staff and concern from the ODA profession. There were claims that the new short courses were inadequate to teach the full range of skills, thus not producing the 'knowledgeable doer'. Disagreement over this issue followed, with conflict growing between the ODA and nursing groups.

Conflict is unavoidable in any organization where multiprofessional groups operate, as one group will have a different paradigm to another. While conflict itself cannot be avoided, any adverse effects that might occur can be managed, and as a result, this was a time of great activity in theatre management, and debate in the perioperative literature. Many theatre managers tried to clarify the objectives of the service. Educators involved in both programmes delivered conference presentations and journal articles, or found other ways to clarify the misunderstandings. With any organizational conflict, Mullins (1999) tells us that there are several strategies that can be used. One key strategy that can work for the operating department is to develop interpersonal and group process skills. This approach encourages everyone to communicate their viewpoint and become involved in developing constructive solutions to the conflict. This approach may work if the issue is restricted to organizational levels. Given that the conflict between the ODA and nurse was national and in many organizations, then an independent body needed to intervene.

Introduction of the operating department practitioner role

The Bevan Report (NHS Management Executive VFM Unit 1989) was timely in identifying the issues among the groups working in the operating department, giving hope that the changes would be worthwhile for all.

The Bevan Report was a catalyst for the new generation of theatre worker, the ODP. The ODP role was not intended to replace the traditional roles of the nurse and ODA. Instead, the ODP was envisaged to have the appropriate skills and knowledge to move between different theatre situations and perform alongside colleagues in anaesthesia, recovery and surgery.

At the time this role was developed, tension grew between many nursing and ODA staff. It was common knowledge that a divide existed between the two groups, with most of the ODA staff remaining in the specialist area of anaesthesia. Assisting the surgeon became the home place for RNs, with few moving into the anaesthetic field. At times, this division caused disputes and unsatisfactory working conditions for both groups, resulting in 'bad feelings'. Some managers adopted an autocratic style of managing, providing limited opportunity for staff consultation and resulting in the issue intensifying. While it is recognized that the different management styles of autocratic, democratic, consultative and laissez-faire are commonly covered in education and training sessions, the adoption of any one style is at the discretion of the user. An autocratic style of theatre management is not something that is necessarily taught or advocated during training sessions but it may develop as an automatic response to the 'flight, fright and fight' pressure that managers face. This is discussed further in Ch. 8.

Introducing the ODP role further exacerbated the divisions and tensions between the ODA and the nurse. Many ODAs and nurses were unsure of which group the ODP belonged to and, therefore, engaged in further arguments of who should manage the ODP. Underlying this was a feeling that

the ODP would take jobs from nurses wishing to enter theatres following their basic training. The ODAs were concerned that the ODP would be a cheap replacement for them, even though ODAs had always been trained in anaesthesia, surgery and patient care. Both groups had their concerns and entered a battle for control for ODP alliances. Belbin's (1993) discussion about teams at work shows that there are different types of individual within teams, which can also be inherent within groups. In this situation, where the new member, the ODP, does not yet belong within either group or team, there will be courtship towards the individual to become a member of one of the other groups. This occurs unless a new group forms with sufficient membership to maintain its existence.

Introducing national vocational training

As the new role was introduced, the Department of Health also recommended that a vocational training package should be made available for operating department staff. This was part of a wider remit to offer vocational qualifications across the UK for equipping the workforce with correct skills and knowledge. A new governing organization was formed, the National Council for Vocational Qualifications (NCVQ), to approve these new qualifications.

For the operating department, the NCVQ drew on the expertise of the Care Sector Consortium (now referred to as Skills for Health) to write the occupational standards. Experts from the consortium produced the new standards, which later influenced the City and Guilds of London Institute and other providers offering the 'National Vocation Qualification (NVQ) in Health Care: Operating Department Practice Level 3' award. This award was intended to supersede the City and Guilds of London Institute 752 award for the ODA and the ENB certificate for 'theatre practice'. This caused disruption between the two professions, as some believed the vocational programme would devalue their hard-earned

qualification. Media coverage and the comparison by both professions of the new qualification to other NVQ awards, such as hairdressing, were perceived as insulting to their professions. Some predicted that future employment of theatre staff would only be for those with the Operating Department Practice Level 3 NVQ Award. Despite several attempts to clarify and lessen the anxiety of perioperative staff, they remained unconvinced and disheartened with the future of perioperative practice. Disharmony between the managers and the staff caused local and perhaps a national trend of ODAs and nurses seeking other employment. For many, joining an agency was much more attractive as they were not governed by any one manager and the salary was more lucrative.

As the number of ODAs and nurses leaving to join an agency grew, the perioperative service faced several challenges. Day-to-day management of operating lists required the team leader (or person in charge) to pay closer attention to skill mix, the resources available (staff and equipment) and to any disruption in work flow. That is, if a delay occurred when transferring a patient from the ward to the operating theatre, the time and reason was noted and later reported in a departmental meeting. Audits too were conducted to identify time wasted because of delays, staff sickness, lack of equipment and other reasons. Managing this change required a new set of skills by the team leader, and some undertook an academic course of study. The importance of leadership and management were mentioned in the *NHS Plan* (Department of Health 2000), which advocated that leadership and managerial skills were something that all grades of staff should acquire. Furthermore, increased authority to make appropriate decisions within their job role empowered the manager to improve working conditions, job satisfaction and patient care.

Most higher education institutions offer generic and discipline-specific leadership and management courses. Perioperative staff have inherently chosen the health-related leadership programmes. Those attending these programmes were exposed

to many theoretical models of leadership and management. Problem-based learning, with examples of good and bad leadership, aided the learner in appreciating how to manage the complexities of running an operating list.

For the LAC or other educators involved in the new ODP training, the differentials that emerged during recruitment of the 'trainee ODP' caused confusion. The NVQ concept of training was that it was open to all students irrespective of sex, sexual orientation, race, religion or creed, and that the training should not be bound by time. The belief that the trainee does not 'fail' but simply does 'not achieve' the skill, knowledge or attitude required of the function encourages individuals to continue to try to succeed. This was not adhered to as most employers restricted the timescale by using training contracts. The employer would require successful candidates to agree and sign a two-year training contract. If the individual had not completed the course after the two-year period, he or she could be considered for an extension. Some individuals were unsuccessful in obtaining an extension and did not complete their Operating Department Practice Award. Naturally, when this occurred for the unfortunate few, the LAC would have been involved either in the decision making or after the event with pastoral support. The decision not to continue with a trainee ODP would have been taken through a thorough process, looking at achievements, retention of knowledge, general demeanour and suitability for perioperative practice. The LAC would have provided information and given their account of the individual's abilities. Following this decision, the LAC would have provided emotional support for those who perceive they had 'failed'. In this situation, the LAC would have used counselling skills, such as active listening and paraphrasing to assist the individual to make sense of the outcome. Not all LACs had undertaken learning about counselling skills and, therefore, relied on their own thoughts on how to offer emotional support. This is a particular area where access to further education for staff in this role could have strengthened the quality of support provided.

Cambridge University Press

978-0-521-71704-5 - Core Topics in Operating Department Practice: Leadership and Management

Edited by Brian Smith, Paul Rawling, Paul Wicker and Chris Jones

Excerpt

[More information](#)

Likewise, the work-based trainers and assessors may have felt that they had failed in their duties in helping the trainee to gather enough evidence proving their competence. Anecdotal evidence at the time from work-based assessor meetings indicate how involved the work-based assessor became with the trainee's progress. If a fail occurred, many reflected on their activities and wondered how they could have improved the opportunities for the trainee. Although there were elements of reflection in their practice, the reflective cycle of Gibbs, Kolb, Driscoll and others were not necessarily in use. This came much later as the ODP award progressed into higher education.

In any award, be it NVQ or higher education, there are internal and external quality assurances that ensure that the learner's achievements have met national standards. Within the NVQ structure, the guardians of these were the internal and external verifiers. Rigorous scrutiny of the trainee's work took place and it was then 'signed off' by the external verifier. This report triggered the final process within the City and Guilds London Institute by awarding the certificate of achievement. This is similar to what takes place today in universities.

Moving into higher education

During the 1990s, the ODP programme took a leap of faith into higher education as the polytechnics were being reshaped and becoming universities. From the mid 1990s, universities offering the ODP NVQ Level 3 Award also offered a Certificate of Higher Education in the ODP programme. The dual award gave the recently renamed student ODP (formerly trainee ODP) recognition of the detailed knowledge and practice the ODP was expected to attain. Likewise, the change of status from trainee to student was a mark of acceptance that their studies were not just vocational but also academic.

The dual award ran for almost five years until a campaign led by the Association of Operating Department Practice came to fruition in 2001,

where the new ODP award was the Diploma of Higher Education in Operating Department Practice. This award, and accepting ODPs as a profession by the Health Professions Council in 2004, meant that their new award would face further scrutiny.

Today, universities offer ODPs access to higher education awards, such as diplomas, first degrees and masters. As the ODP award became set within higher education, many universities managed applications themselves. However, as the Department of Health increased the funding made available to universities, there was a rise in numbers of student ODPs. The larger cohorts required new systems and processes to keep up with demand. This meant organization change in how applications were processed. The application process for the Pre-registration Diploma in Operating Department Practice is similar to the nursing pre-registration programme administered by the central body, the Universities and Colleges Admissions Service (UCAS). Their service provides students with information to make the correct informed choice about their health career. Moving ODP applications to this service removed any subjective elements to the recruitment process that may have existed previously.

Recruitment of qualified ODP and nurses to post-registration courses (i.e. the degree and master programmes in perioperative practice) is managed internally by the university. This is often devolved to faculty or college level, where the numbers of students are often much lower.

Previously, the central team for ODP training carried out administrative duties and teaching, the change in application process has meant that the teaching staff is free to enrich the student learning experience. This change may be straightforward but changes in an organization's systems or process evoke different responses within and from individuals.

Changes in any system should be initiated by first considering what you wish to change and why. In the example above, the desire to change the application process to UCAS was primarily to show

parity between professional groups: the nurses and ODPs. A second reason included the rise in student ODP numbers and the demand this would have placed on teaching staff time.

When viewing the advantages of change, we must consider who it will affect and how they might react to it. Any change should ideally have a 'win-win' situation, where all affected by the change will benefit.

Mode neutral approaches to operating department practitioner education

Further changes are afoot as many universities continue to break new ground into learning, teaching and e-learning research. Given that the National Health Service (NHS) has a strong e-learning strategy and values the flexibility of developing staff without removing them from the clinical setting, universities continue to explore and invest into blended and online learning.

Orthodox classroom teaching often involves an academic providing a linear and didactic approach to transferring knowledge to the student (ODPs and nurses). This style of teaching and learning is referred to as instructivism. Absorbing the ideas or directives from those delivering the session has been through repetition either in clinical skills laboratories or within the clinical setting. It can be argued that in healthcare it is necessary to appreciate what is best practice in order to lessen the risk of a patient being harmed. Indeed, this is paramount to the learner's practice; however, the internalization of the repeated events does not necessarily show deep levels of cognition. It has been claimed that the student merely memorizes sequences or responses to the situation in instructivist learning cultures. They may respond to a question or clinical situation; however, most recall the detail without making sense of what they have learnt.

The alternative, which is gaining popularity, is constructivist learning and teaching. Instead of students being passive recipients, they are expected to actively construct their knowledge and ideas from

interaction with others and drawing on resources. Inherent within this style of facilitating learning, there are elements where the student can reflect and deconstruct their understanding of a particular matter. This can occur in any 'learning space', such as the classroom, online or in the clinical setting. The key difference here is how the academic and clinical staff act as a resource rather than a source of knowledge. Increasingly within the digital society there is a harnessing of collective intelligence, where one learns from another, and this offers greater opportunity for deeper learning to take place. The work of Smith, who incidentally is a perioperative practitioner, has stimulated a new wave in learning and teaching not only for perioperative staff but also for other disciplines through publishing principles of teaching and learning known as 'mode neutral pedagogy' (Smith *et al.* 2008).

Mode neutral was first hypothesized in 2006, where the creator tested the theory with post-registration students; theatre nurses and ODPs studying anaesthesia and/or recovery. The teaching and learning experience in mode neutral is designed to embrace each learner's characteristics, as described by Landsberger (2004:8): 'learners increasingly will be from different backgrounds. They will desire and require flexibility in the ways that they study, the resources they use, the sorts of activities that they do and the ways in which they interact and communicate.'

Therefore, 'Mode Neutral is a method that allows students to progress across modes of delivery at any point throughout their study when their preferences, requirements, personal and professional commitments demand, without compromising their learning experience' (Smith *et al.* 2008).

One research study found that there was greater connection within the clinical setting using this method, suggesting that the much-acclaimed theory-to-practice gap in nursing (Landers 2000) was, in fact, closing (Smith & Rawling 2008:191). Similarly, Smith & Rawling (2008) reported how a mixed group of learners, ODPs and nurses, interacting online or in the classroom, were breaking down barriers and working collaboratively.

The findings of Smith and colleagues have brought insight into how perioperative education can be reconceptualized to offer *freedom to explore and learn* without causing any risk to the patient. Although mode neutral pedagogy is not fully discussed here, in short the key principles are:

1. Encouraging the learner to own and control how they learn
2. Modes of learning are more prevalent than modes of delivery
3. Harnessing collective intelligence enriches personal learning
4. A flexible single learning space encourages a single community of practice.

Given that this new pedagogy differs from traditional methods of delivering perioperative education, some challenges may be faced by students, staff and the organizations.

A student of perioperative practice with a previous educational experience involving conditioning to be recipients of information may find that internal adjustments have to be made to the new experience. As one of the mode neutral principles suggests, the student (learner) will own and control their learning: that is, they will have autonomy to seek out information rather than wait to be given it. By shifting the 'Locus of Control' (Rotter 1996), they can learn in multiple ways outwith the classroom environment. That is, the use of their own digital technology (mobile phone, MP3 players, computers) and that made available by the universities will encourage continual learning at times convenient to the student.

Similarly, academic and perioperative staff using digital forms or conventional forms of teaching will have to reconcile to the fact that they are no longer the 'controllers' of knowledge information. Instead, they act as one of many sources of specialist knowledge that the student can draw on. Mode neutral style of teaching will also place demands on staff to create closer alignment of theory with practice. This involves fostering effective conditions within the learning space (physical and virtual) for the student to become involved in communication for learning.

Within the clinical setting, the change that would be necessary to promote an effective learning experience is to gain access to the 'academic' curriculum. That is, academics, clinical and mentoring staff should have an identical view to the perioperative student. Mode neutral offers this view by presenting the curriculum through a single learning space; a virtual learning environment or other social and content management systems. Campus sessions can be recorded and archived within the space, offering an opportunity for learning to be extended beyond the traditional classroom session. For the perioperative staff supporting the learner, this means that they can assist with integrating the student's knowledge into clinical practice by using the virtual learning environment as a teaching resource. Discussions in the clinical setting may also occur from the online activities, leading into a sense of shared learning among the operating team, including medical colleagues.

For this new approach in perioperative education to continue successfully, perioperative practitioners will need to develop closer affinities with the universities and this will provide encouragement and direction for becoming effective mentors. That is, such staff will be able to see how their contribution has a significant part to play in deepening the knowledge, skills and attitudes of the student in perioperative practice.

Furthermore, the university embracing mode neutral to enrich the student experience will provide the appropriate resources (human and digital) so that students can exercise their learning wherever and whenever they want. This will place demand on the academic rigour for supporting and encouraging student progression.

Conclusions

Perioperative education has faced and conquered many challenges since the late 1970s. The continuous reshaping of health education has brought many benefits to the student, the provider and the health service; however this does not mean that the current programmes (pre- and post-registration) are

Cambridge University Press

978-0-521-71704-5 - Core Topics in Operating Department Practice: Leadership and Management

Edited by Brian Smith, Paul Rawling, Paul Wicker and Chris Jones

Excerpt

[More information](#)

without any flaws. The health demographics in the UK population do change and this creates challenges not only for the health service but also for providers of health education. As the health service continues to find new ways of working to meet new demands, researchers in higher education methods investigate the impact of such education within healthcare. Their search to discover new ways of teaching and learning, as well as subject-specific links between poor and good health, provide timely education. This means that they can provide education that enriches the learner's experience but they also realize that there will never be a 'perfect' programme because of the continual changes in health matters. Moreover, they realize that providing a flexible experience that stimulates the practitioner to embrace their learning and to use that knowledge as a scaffold will lead these practitioners to become 'fit for purpose'.

This chapter has considered key milestones in the timeline of perioperative education that have caused confusion, conflict and challenges requiring management. Those who have dealt with these milestones during the ODA and ENB training have provided a legacy for future generations of perioperative staff in clinical, academic or researcher roles to draw upon when searching for new ways of aligning theory with practice and of enriching the perioperative student experience. For some, accepting change can cause internal conflict; however, reconciling and embracing the change may offer a more collaborative and personally satisfying experience. Ultimately, it will show that perioperative practitioners who continue to adopt an evidence-based approach to their practice will offer their patients a high quality of care.

REFERENCES

- Belbin, M. (1993). *Team Roles at Work*. Oxford: Butterworth/Heinemann.
- Brett, M. (1996). Educating theatre nurses: a framework for the future. *Nursing Standard*, **11**, 50–51.
- Department of Health (1970). *Organisation and Staffing of Operating Departments [Lewin Report]*. London: The Stationery Office.
- Department of Health (2000). *The NHS Plan: A Plan for Investment, a Plan for Reform*. London: The Stationery Office; http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_4002960 (accessed 10 October 2008).
- Landers, M.G. (2000). The theory–practice gap in nursing: the role of the nurse teacher. *Journal of Advanced Nursing*, **32**, 1550–1557.
- Landsberger, J. (2004). E-learning by design: an interview with Dr Betty Collis. *TechTrends*, **48**, 7–12.
- Mullins, L. (1999). *Management and Organisational Behaviour*, 5th edn. Edinburgh: Pearson Education.
- NHS Management Executive VFM Unit (1989). *Staffing and Utilisation of Operating Theatres: A Study Conducted Under the Guidance of a Steering Group [Bevan Report]*. Leeds: NHS Management Executive VFM Unit.
- Rotter, J. (1966). Generalized expectancies for internal versus external control of reinforcements. *Psychological Monographs*, **80**, 609.
- Smith, B. & Rawling, P. (2008). Anaesthetic assistant competencies: our experience. *Journal of Perioperative Practice*, **18**, 190–192.
- Smith, B., Reed, P. & Jones, C. (2008). Mode neutral pedagogy. *European Journal of Open and Distance Learning (EURODL)*; http://www.eurodl.org/materials/contrib/2008/Smith_Reed_Jones.htm (accessed 10 October 2008).
- Tannenbaum, A.S. (1968). *Control in Organizations*. New York: McGraw-Hill.

2

The role of the operating department manager within the context of the organization

Paul Wicker

Key Learning Points

- Explore the role of the manager
- Define the roles and functions of management
- Discuss organizational structure and function.

The purpose of this chapter is to introduce some of the concepts associated with management in the context of the operating department, the hospital and the health service. Management is management, wherever it is carried out. But operating department management is special because of the context of patient care, the management needs of diverse groups of staff and the challenging environment, distinctive by its high technology, fast pace and constantly changing requirements. This chapter introduces some of these challenges for the operating department manager by looking at the context in which managers work, what managers do and why they do it.

What comes to mind when thinking about management? Some of the key concepts are shown in Table 2.1.

According to Koontz & Weihrich (1990), management is the process of designing and maintaining an environment in which individuals work together in groups efficiently to accomplish their goals or aims. These principles apply at all levels of hierarchy in an organization. The role of the manager is, therefore, concerned with increasing productivity, effectiveness and efficiency. It is the art, or science, of 'getting things done'. In the operating

department, this can be identified as ensuring the maximum numbers of patients are treated safely and quickly and that the best treatment is delivered in the best way, with the least cost. To do this, the manager has to coordinate and integrate the department's activities through planning, organizing, directing and controlling resources to achieve patient expectations and to accomplish their specific departmental goals and objectives (Sullivan & Decker 1988).

Aside from these functions, Mintzberg (1973) suggests that managers also have to perform several roles. For example, in the course of a day, a manager might have to be a figurehead (such as inspiring the team to do a better job), a leader (guiding the team through a difficult situation) or a liaison (acting as a link between surgeons, anaesthetists, practitioners and ward staff). At the same time, the manager will also have to manage the flow of information within the organization, for example receiving information (about an operating list), disseminating information (about a patient's procedure) or acting as a spokesperson (at a meeting). And of course the manager has to be a decision maker, adopting the role of entrepreneur (e.g. identifying opportunities, encouraging and initiating change), allocating resources (rostering staff) and negotiating (discounts on purchases of equipment). Add to this the never ending task of dealing with the sometimes conflicting needs of other managers, patients, surgeons, anaesthetists, operating