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Management Needs and Development of Nursing Administrators in the Long Term Care Industry

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MANAGEMENT NEEDS AND DEVELOPMENT OF NURSING ADMINISTRATORS IN THE LONG TERM CARE INDUSTRY

Myrtle Jean Darnell, R.N., B.S.

An Abstract Presented to the Faculty of the Graduate School of Lindenwood College in Partial Fulfillment of the Requirements for the Degree of Master of Gerontology

1997

ABSTRACT

This thesis will focus on the role of the nursing administrator in long-term care in the past, at present, and the requirements for the future. The major emphasis will be to focus on the educational needs required for the nursing administrators to function effectively in their role as top nursing leader of the facility.

There are many external forces affecting long-term care facilities: early discharges from hospitals result in sicker residents in the nursing home, a case mix prospective payment system is being piloted for rollout to all fifty states, and managed care enrollment is increasing for the Medicare population, just to name a few. The requirements for nursing leaders have changed. In addition to clinical knowledge, they must also become knowledgeable in all aspects of managing an organization. The days of hiring nurses as nursing administrators in long-term care, sometimes just after

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graduating from nursing school or with little or no management education or experience, is no longer acceptable

The number of nursing managers realizing the need for further education in management and returning to school to pursue degrees is increasing. The purpose of this thesis is to explore the educational needs of the NAs and to present managerial information addressing those needs.

MANAGEMENT NEEDS AND DEVELOPMENT OF NURSING ADMINISTRATORS IN THE LONG TERM CARE INDUSTRY

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1997

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Chapter I

INTRODUCTION

The roots of the nursing home industry in the United States date back to a system of public almshouses, county poor farms and private homes for the aged run by fraternal organizations and religious orders. Religious, ethnic, and fraternal homes for the aged were created to ensure the provision of care for the older members of the community. The public facilities existed because of legal statutes. The public almshouses and poor farms did not distinguish between the poor, the elderly, the chronically ill, the insane, or other social outcasts. All were grouped together because of poverty. The almshouses were probably more like the present day shelters for the homeless than a modern nursing facility (Mercer et. al. 17).

Perhaps the first major change to have an impact on institutional service to the elderly was the 1935 passage of the Social Security Act. With social security

income, the elderly had the resources to purchase care and did not have to rely on charitable or government institutions (Eliopoulos 403). In the early versions of the Social Security Act (SSA), there were prohibitions against federal financial participation in the cost of any relief given in any kind of institutional setting. Later this prohibition continued in relation to public facilities because public institutions were considered a state responsibility. The intent of the legislation was to encourage the elderly to live at home or with foster families. However, the actual effect was the displacement of people from public facilities-particularly to boarding homes. As these facilities began to add nurses to their staffs, the name nursing home emerged (Gelfand 223).

A shorter life expectancy, a lack of sophisticated medical technology, and the absence of any major government role in medical care meant that the demands placed on these early homes were different from the demands placed on present-day facilities. The modern-day nursing home, by contrast, is primarily a product of the second half of this

century. Enactment of the Medicaid program 30 years ago spurred the dramatic development of nursing homes in this country and signaled the rise of the for-profit side of the industry. With a ready source of government reimbursement at hand and a growing demand for long-term-care services, for-profit nursing homes came to play a significant role in a field that heretofore had been primarily a not-for- profit endeavor (Goldberg 78).

Public outrage over several tragic nursing home incidents in the early 1970s provoked the Nixon administration to implement standards enforcement. Since 1974, reimbursement for skilled nursing and intermediate care facilities has come under Medicaid and reimbursement for skilled nursing care under Medicare. The highest reimbursement by Medicare and Medicaid is for skilled care. Nursing homes are licensed according to whether they provide skilled nursing care, intermediate care, or some combination of both. To qualify for funding, licensed facilities must follow state and federal regulations that mandate physician services,

nursing services, medical records, rehabilitative services, dietetic services, and quality assurance. The regulations stipulate the number of staff required and their educational standards (Shield 32).

Skilled nursing facilities provide complex medical care, and in some cases total care, for the seriously mentally or physically impaired. Skilled nursing facilities are usually more medically oriented than intermediate care homes and are the appropriate choices when recuperating from surgery or in other situations where round-the-clock medical care is required (Pieper 32).

In the USA there are more nursing home beds than acute care hospital beds. There are between six and seven thousand acute care hospitals with a total of approximately one million beds, and there are over 19,000 nursing homes with over 1.5 million beds. Table 1 outlines selected characteristics of nursing homes in the USA (Ouslander 1001).

Table 1

Selected Characteristics of American Nursing Homes

	Nursing Homes Number	%	Nursing Home Beds %
Total	19,100	100	100
Ownership			
Proprietary	14,300	75	69
Non-profit	3800	20	23
Government	1000	5	8
Affiliation			
Chain	7900	41	49
Independent	10,000	52	42
Government	1000	5	8
Unknown	100	1	1
Certification*			
Not certified	4700	24	11
SNF only	3500	18	19
SNF/ICF	5700	30	45
ICF only	5300	28	25
Bed size			
<50	6300	33	9
50-99	6200	33	27
100-199	5400	28	43
200+	1200	6	20

*Certification by federal and stage government; SNF skilled nursing facility; ICF--intermediate care facility

SOURCE: Textbook of Geriatric Medicine and Gerontology. "The American Nursing Home," by J.R. Ouslander (1002). In Textbook of Geriatric Medicine and Gerontology (1992).

In recent years, the implementation of diagnostic related groups (DRG's) has had a significant impact on nursing homes. Hospitals are reimbursed according to particular formulas that

key to specific diseases. Each disease is worth a certain number of days and a certain amount of reimbursement. One important effect of this policy has been to discharge elderly patients from hospitals earlier than before. As a result, they leave the hospital sicker than they used to and enter the nursing home in worse condition (Shield 33).

Neu, in the article, "Post hospital Care Before and After the Medicare Prospective Payment System" (1988) found Skilled Nursing Facilities (SNFs) Medicare users to be the sickest patients in each DRG category; SNF admission was found to probably substitute for some of the hospital stay (Mezey 7). The nursing home setting, which previously had been regarded as a low status area for nursing, is emerging as a complex, dynamic care site (Eliopoulos 411). Indeed, today's nursing home has the capacity to perform, at much less cost, many procedures once associated only with acute care settings (Goldberg 80).

The demand for nursing facilities to provide more complex services is growing in response to several trends,

including increased age and disability of residents, medical technology, cost containment pressures, and government policies (Wunderlich et al. 59).

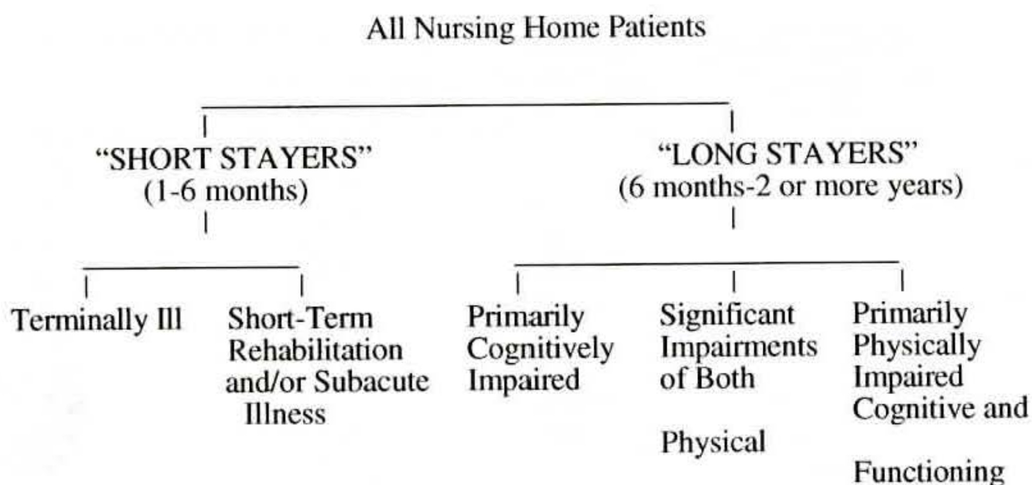
Medical technology, formerly used only in the hospital, is being transferred to nursing facilities. The use of intravenous feedings and medication, ventilators, oxygen, special prosthetic equipment and devices, and other complex technologies has made nursing home care more difficult and challenging. The kinds of services that are increasingly being provided in some nursing facilities are also creating a greater need for skilled nursing care, in particular, greater professional nursing involvement in the direct care of patients and in supervision, more clinical evaluation, and more financial and human resources (Wunderlich et al. 59).

Approximately five percent of the elderly reside in a nursing home, however, the percentage of elderly residing in nursing homes varies with the age of the patient (2% of those aged 65 to 74, 22% of those older than 85). The average age of nursing home residents is 78 years and women comprise the

overwhelming majority of nursing home residents. It is estimated that 25% to 50% of Americans 65 or older can expect to enter a nursing during their lifetime. The mean length of stay in a nursing is 19 months and fifty percent of patients admitted to a nursing home die there. The annual percentage of nursing home deaths is 21.5%. Nursing home patients as described in Figure 1 are categorized as short stay and long stay residents (Ouslander 1002).

Figure 1

Depiction Of Different Types Of Patients In
American Nursing Homes



SOURCE: Textbook of Geriatric Medicine and Gerontology. "The American Nursing Home," by J.R. Ouslander (1002). In Textbook of Geriatric Medicine and Gerontology (1992).

The nursing home industry, as with virtually every other segment of the health care marketplace, has continued to grow and change over the past year (1994 by HCIA Inc. and Arthur Anderson and Co.).

Table 2.

Nursing Home Expenditures as a percentage of National Health Care Expenditures

	Nursing Home ($ billions)	National Health Care ($ billions)	Nursing Home/ National Health Care
1960	1.0	27.1	3.69%
1970	4.9	74.4	6..59%
1980	20.0	249.1	8.00%
1985	34.1	420.1	8.05%
1986	36.7	454.8	8.07%
1987	39.7	494.1	8.03%
1988	42.8	546.1	8.84%
1989	47.7	604.3	7.89%
1990	53.3	675.0	7.90%
1991	59.8	751.8	7.95%
1992*	67.3	840.4	8.01%
1993**	76.0	942.5	8.06%
1994***	85.5	1,060.5	8.06%

*Preliminary
**Estimated
***Projected

SOURCE: Health Care Investment Analysis (HCIA) and Anderson, The Guide to the Nursing Home Industry (1994)

High-occupancy (90-96%) and bed turnover rates reflect expansion and diversification in the industry brought about by (1) an expanded service base (e.g., special care units, subacute care, hospice, respite care, and rehabilitation services); (2) nursing home participation in managed care networks in the "continuum of care;" and (3) the influence of health care cost

containment and reform. Although alternatives to institutional care are expanding, nursing homes will continue to be a significant part of the health care spectrum (Mitty 693).

By 1994, nearly 90,000 beds were dedicated to special care. Most of these beds have been dedicated to residents with Alzheimer's disease or those needing special rehabilitative services. The most dramatic increase has been in ventilator care beds, which rose from 3,162 in 1993 to 13,291 in 1994. Beds dedicated to special rehabilitative patients increased by 2,000 and beds dedicated to AIDS patients grew by 2,300 between 1993 and 1994 (Wunderlich 65).

Over the past five years, nursing facilities increasingly have sought to use their beds to serve a population requiring subacute or super-skilled care. As a result the length of stay has dropped dramatically. Rapid turnaround has become so important that 24-hour-a-day admissions are now possible in many facilities. The move to subacute care has actually

improved the profit margins of those providers who were successful in attracting the subacute client (Wilson et. al 71).

The National Subacute Care Association (NSCA) has lobbied strongly for a prospective payment system (PPS) for Medicare. Under PPS, subacute care providers would be paid per episode of care, a fixed rate based upon certain criteria such as case mix, patient acuity and other factors. According to Tim Carroll, vice-president of investor relations at Vencor, Inc., a PPS would put skilled nursing facilities on a level playing field with hospitals (Stahl 21).

Although a PPS, if passed by Congress and signed into law, will present good opportunities for subacute care providers, the threat of caps on reimbursement for ancillary services suggests that subacute care providers need to reevaluate whether or not their therapy services should be provided in-house by their own employees rather than by subcontracted therapy providers. In fact, there are several for-profit therapy providers who have either laid off some of their employees in order to cut costs or are now in the market

for sale because of these anticipated reimbursement caps. Subacute care providers may find themselves in a similar position (Stahl 21).

Efforts to integrate the nursing facility with the larger health care system are being explored. In some organizations, relationships are being created with such ancillary services as pharmacy, home health, and laboratory as well as providers of various forms of therapy and of durable medical equipment to tap into supplemental revenue sources and to target potential future residents (Wilson et. al 71).

Another major impact on nursing homes is the Nursing Home Reform law, Title C, Social Security Act, P.L. 100-203, popularly known as OBRA 1987. This law requires each state to assure quality services from Medicare- and Medicaid-certified facilities. Each facility is to care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident (Holder 693).

The federal regulations defined explicit expectations for the care of institutionalized frail individuals with multiple functional, medical, psychological, and social problems. These requirements cover both the quality of life and the quality of care. Quality of care issues are concerned with the appropriate and timely identification, prevention, and management of medical conditions that may profoundly affect an individual and thus the quality of life (Levenson 69).

Although federal regulations define expectations for quality care, only minimal standards for staffing are mandated. Central to the staffing of any long term care facility is nursing which represents about 60% of the total employee complement. Three distinct groups of people provide the care delivered by the nursing department: registered nurses, licensed practical (or vocational) nurses, and aides (Goldsmith 14).

Three staffing issues for nursing facilities are notable: turnover and retention rates for nurse aides; adequacy of

staffing levels, particularly in light of increasing patient acuity; and reimbursement levels (Wunderlich 263).

Turnover among nursing staff presents a major management problem in nursing homes, with turnover rates usually ranging from 45 to 75%, with some reaching 500%. Turnover rates and turnover rates by position are demonstrated in Figures 2 and 3.

Figure 2

Turnover Rates in Nursing Homes

Study	Stryker[7]	Brennan & Moos[8]	Kasteler[9]	Pecarchik & Nelson[10]
Nursing homes	88% Before 64% After interventions	46%	96%	40%
Comparison facilities		26% Veterans LTC		
Number of facilities	19	117	83	83
Geographic location	Minnesota	Nationwide	Utah	Pennsylvania

SOURCE: Jiska Cohen-Mansfield "Turnover Among Nursing Homes" (28.5:59)

Figure 3

Turnover Rates By Position-Nursing Homes

Study	Caudill & Patrick[2]	Indiana LTC Nursing[48]	Wagnild[49]	American Journal of Nurses[6]	Halbur[44]	George[50]	Bergman et al.[51]
Nurses' aides	93%	69%	143%	37%	68%	65%	37%
RNs	45%	45%		19%	36%	55%	21%
LPNs		45%		19%	51%	61%	37%
Number of facilities	26		11		122	15	12
Geographic location	Western state	Indiana	Texas	National	North Carolina	North Carolina	Israel

SOURCE: Jiska Cohen-Mansfield "Turnover Among Nursing Homes" (28.5:59)

The Director of Nursing or Nurse Administrator is responsible and accountable for all the patient care activities of the facility. As the nursing home industry has expanded, the role of the nursing administrator has become extremely complex. The nursing director must wear many hats and the quality of the clinical services is significantly determined by how successfully these various job responsibilities are achieved (Eliopoulos 404).

The various roles of the nursing director are:

- Leader (by virtue of title): Leadership effectiveness is influenced by how well she(he) manages and utilizes all sources of power.
- Analyzer: Needs to be sensitive to all sources of information and their significance.
- Planner: Develops a realistic plan based on the previous year's evaluation of assessed needs and desired outcomes. The plan should include staffing levels, schedules, supply needs, staff development, employee motivators, evaluations, and new programs.
- Educator: Ensures mandatory-in-service programs are presented, that staff is well oriented, and that staff's skills are maintained and upgraded. Uses opportunities to educate staff personally, both formally and informally.
- Resource Gatekeeper: Carefully plans and monitors human and material resources, as cost containment is vital to the survival of any health care facility.

- Personnel Manager: Assures and maintains the appropriate quality and quantity of nursing staff. Provides regular feedback to employees regarding their performance, accompanied by corrective action plans when necessary.
- Communicator: Communicates organizational goals, administrative mandates, practice changes, consumer response, quality of services and needs. Keeps the professional and lay communities abreast of new programs, improvements and changes.
- Advocate: Must advocate practices that support highest possible quality of patient care and the advancement of the specialty of long term nursing. Must also advocate for themselves through negotiating salaries reflective of their level of responsibility and assuring their continued professional growth.
- Opportunist: Must learn to capitalize on opportunities to benefit their facilities and themselves.
- Other roles: Consultant, Negotiator, Motivator, Change Agent, and Spokesman (Eliopoulos 405-413).

Traditionally, nurses promoted to management positions were excellent clinical nurses having leadership potential and few skills or training in business disciplines. They received most of their indoctrination to specific management theories and skills as a result of on-the-job training (Strassen v).

Nurse administrators (NAs) must have the managerial knowledge and skills to handle the complex care of patients in long-term care facilities today. The majority of NAs in long term care have either a diploma or associate degree. These types of nursing programs prepare the nurse for bedside care of patients, but not for the managerial knowledge and skills required to meet the demands of the job (Vaughan-Wrobel 33).

The changing focus of services and the increasingly complex nature of the care provided in nursing facilities create new demands for skill, judgment, supervision , and the management of nursing services. Most directors of nursing (DON) in nursing facilities are not academically prepared for their positions. Furthermore, turnover among DONs is high, their salaries are low in comparison with hospitals, and they

have limited opportunities for advancement. None of these factors is conducive to strong leadership; however, in view of the number of employees, budgets, and complexity of care in nursing facilities today, strong leadership from DONs is required if high quality, cost-effective care is to be provided. The Institute of Medicine (IOM) committee concludes that nursing facilities should place greater weight on educational preparation when employing new DONs (Wunderlich 14-15).

This thesis will focus on the management education needs of nurse administrators (Directors of Nursing) in the rapidly changing environment of long-term care facilities. The purpose of the thesis is to investigate management philosophies that will assist in management development of Gerontology nursing leaders practicing in the long-term care arena.

Chapter II

LITERATURE REVIEW

A Recent report on director of nursing (DON) education indicated an increasing trend for DONs to seek additional education. However as early as 1981 a study reported by Lodge found that 63% of DONs in long-term care perceived the need for education in management, leadership, human resources, and organizational skills. Alford in the article "Turnover Rate Slows With Creative Training Program" described the need for basic management skills for DONs. Also in 1989 Riskin and Zenas reported a survey of DONs in which 51% described the self-perception of a weak educational background in management (Luggen 50).

Furthermore, A recent report on DON education indicated an increasing trend for DONs to seek additional education (NADONA survey 94). The nurses in the survey were asked to rate the content of the nursing program from zero (0-content not very important) to five (5-content very important). Table 3 illustrates the mean rating score for each area.

Table 3

Present Content In Nursing Administration Programs As Ranked By Long Term Care Nurses

Budgeting and Finance	4.44	Legislative and Health Policy Issues	3.95
Practicum Experiences	4.44	Health Care Economics	3.78
Human Resource Management	4.29	Nursing Care Models	3.72
Organizational Theory	4.02	Nursing Theory	3.72
Strategic Management	3.99	Research in Nursing Administration	2.88

SOURCE: Ann Luggen "Education Needs of the Director of Nursing Administration in Long Term Care: Survey Report (5.2: 77).

During the 1988-1989 academic year, Riskin and Zennas (49-50, 53) conducted two surveys of nursing administrators (NAs) in long-term care facilities and found a need for greater management education. Fifty-one percent of the respondents in the 1988 survey indicated they had "weak" educational

training in management. In the second survey, the NAs were asked to identify content areas for a management program. Content perceived as important by the majority of the respondents included the following:

1. Communicating with superiors and subordinates.
2. Motivating and retraining staff.
3. Dealing with difficult people and managing conflict.
4. Dealing with legal and ethical issues surrounding long-term care.
5. Conducting performance evaluations and disciplining staff.
6. Projecting a professional image.
7. Understanding leadership style and management theory (Vaughan-Wrobel 33).

Of the current NAs, 71% believed they had the necessary management skills to be successful in their position. This response is different from the chief executive officers (CEOs) who believed that only 49% of the NAs had the necessary skills. Even though the NAs thought they had the necessary

management skills, 94% indicated they would participate in a guided self-learning management education program. The NAs and CEOs rated the contents for the education program:

Table 4.

Chief Executive Officer (CEO) And Nurse Administration (NA) Responses To Content Areas For A Management Education Program For NAs In Long-Term Care Facilities

Content area	Yes (%)	No (%)
Nurse as Manager		
CEO	109 (91%)	11 (9%)
NA	152 (86%)	25 (!4%)
Human Relation Skills		
CEO	112 (93%)	8 (7%)
NA	162 (92%)	15 (8%)
Staffing and Scheduling		
CEO	103 (86%)	17 (14%)
NA	146 (82%)	31 (18%)

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Table 4 (Cont'd)

Content area	Yes (%)	No (%)
Budgeting		
CEO	68 (%&%)	52 (43%)
NA	91 (51%)	86 (49%)
Monitoring Facility		
CEO	107 (89%)	13 (11%)
NA	159 (90%)	18 (10%)
Regulations and Standards		
CEO	93 (78%)	27 (22%)
NA	148 (84%)	29 (16%)
Legal Considerations		
CEO	93 (78%)	27 (22%)
NA	148 (84%)	29 (16%)
Unions		
CEO	25 (21%)	95 (79%)
NA	36 (20%)	141 (80%)

Total number of CEOs responses: 120; Total number of NAs responses: 177

Source: Beth Vaughan-Wrobel "Needs of Nurse Administrators in Long Term Care" (19.3:36).

The DON's job is not getting any easier due to the fact that their role has more responsibility and accountability than ever before. Many of the outside influences that they were

insulated from a few years ago are impacting even the quietest, most rural nursing facility. This myriad of influences include: the downsizing of professional personnel in acute care hospitals, the evolving seamless continuum of care, Medicare and Medicaid managed care, the ever-increasing governmental regulatory system, new quality improvement programs, minimal staffing requirements, the continuing plague of turnover, and the increasing acuity of nursing home residents (Luggen 50).

If DONs had managerial knowledge and skills they could participate more fully in decisions, i.e., conflict management, time management, quality assurance, and standards and regulations, thus providing more job satisfaction and a decrease in turnover rate (Vaughan-Wrobel, et al. 33).

The Geriatric Education for Nurses in Long Term Project (GENLTCP) was a three-year, multi-function continuing education project that was funded by the Division of Nursing, United States Public Health Service, and implemented by the Midwest alliance in Nursing (MAIN). The purpose was to

improve care of chronically ill elders in thirteen Midwestern states by increasing management knowledge and skills of directors of nursing and inservice teachers in long term care agencies (Gillies et al. 33).

Findings of this study suggest that: 1) diploma prepared nurses can upgrade management knowledge and skills through extended continuing education (CE) programs, and 2) task satisfaction of diploma nurse managers is enhanced through continuing education. It is possible that the improved performance and increased satisfaction of CE enhanced managers will lead to decreased recruitment and orientation costs (39).

Anne Hegland discussed the reasons why directors of nursing need to increase management knowledge:

> Continuing education in management is very important for Directors of Nursing (DONs) due to the fact that DONs management styles and practices are impeding the quality of their care delivery systems, while holding back other managers from developing their roles within the organization. The problem stems from outdated structures of long term care management and a failure to educate nurse managers in management and leadership principles. (53)

Education programs must incorporate the new concepts of management in this country. The new management principles focus on the customer, how to build on quality and do things right the first time rather than setting up programs that check on the checkers to see if a medication was passed right (54).

The current candidate In the field of managing quality variously terms the basic concepts as Total Quality Management (TQM) or Continuous Quality Improvement (CQI). Introducing TQM or CQI activities is primarily a matter of gradual but systematic changes which focus on results not activities. To accomplish TQM or CQI's basic goal, a healthcare institution should measure performance according to results-driven programs which focus on measurable, short-term improvement goals rather than according to activity centered programs which, often implemented on too large a scale, delay achievement and bring too little reward in proportion to the efforts invested in them. Figure 4 outlines Deming's Total Quality Management Principles.

Figure 4

Total Quality Management Principles

1. Create constancy of purpose for improvement of product and service. (This refers to the organization's mission and future).
2. Adopt the new philosophy. (Continuously strive for improvement rather than setting thresholds of performance as in quality assurance).
3. Cease dependence on inspection to achieve quality. (Replace inspection by improvement processes).
4. End the practice of awarding business on price alone. (Consider long-term cost and appropriateness of products).
5. Constantly improve every process for planning, production and service. (Empower workers by inviting them to contribute to the improvement process).
6. Institute training and retraining on the job. (Employees must be encouraged not driven).

7. Assure qualified leadership for quality improvement. (Qualified managers improve systems, which in turn improves employees performance).
8. Drive out fear. (Encourage employees to make suggestions because they are the only ones "in the trenches").
9. Break down barriers between staff. (Help employees understand the needs of other departments).
10. Eliminate slogans, exhortations and targets for the work force. (Let employees know what is being done by management to make it easier for them to so their jobs).
11. Eliminate numerical quotas both for the work force and for management. (Quality first: quantity will follow).
12. Remove barriers to pride of workmanship. (Promote the philosophy of employees working together rather than focusing on individual performance).
13. Institute a vigorous program of education and self improvement for everyone. (Encourage employees' personal development even in areas not related to their jobs).

14. Put everyone to work on the transformation. (All employees should be trained so they can be involved in the transformation process) (Lopresti and Whetstone 35).

Since staff employees are the core group who will become the major problem solvers, their continuing education is essential to the TQM/CQI process. The whole staff should receive at least two weeks training per year in this process. This is essential to keep employees involved and informed of refinement to the process and to maintain interest (Lopresti and Whetstone 36).

The evidence that CQI will help improve performance on health care comes mostly from other industries since its application is so new to the health care industry (Flood et al. 331). To maintain and improve quality of care, the manager must:

1. Develop a participative, team-oriented organizational culture that encourages input from professionals and other workers from all levels of the organization.

2. Establish high standards that appeal to professional standards. Link professional values and goals to those of the organization.
3. Develop information systems that provide relevant, timely, and accurate data for purposes of taking corrective action and reaching ever-higher standards. Use statistical thinking and tools to identify desired performance levels, measure current performance, interpret it and take action when necessary.
4. Look for opportunities to improve quality by detecting and preventing potential problems in the process. Focus on the most important processes to improve.
5. Design work to make the best of professionals' experience and expertise.
6. Develop reward systems that reinforce participation and high performance. Do not blame the individual for defects in the process.

7. Develop organizational structures that promote communication, coordination, and conflict management (Flood et al. 342).

Richard McElhaney states that conflict management is rated as of equal or slightly higher importance that planning, communication, motivation, and decision making.

> Identifying the causes of conflict and the effective measures to negotiate successful solutions encourages win-win situations. Six areas that cause conflict within nursing are defiant behavior, stress, space, physician authority, beliefs, values and goals. Stressors include too little responsibility, lack of participation in decision making, lack of managerial support, increasing standards of performance, and coping with rapid technological change. (49)

To resolve conflict, look forward rather than backwards. Several common approaches to handle conflict include avoiding, accommodating, collaborating, and competing. Avoiding is simply not addressing the conflict-a lose-lose situation. This approach is appropriate to use when the other party is more powerful; one has no chance of obtaining his/her goals; the cost of assessing the conflict is higher than the

benefit of resolution; or the issue is not important. It is best to temporarily avoid the issue to gain composure or to gather information. Avoiding the problem does not resolve the issue; it only prolongs the inevitable confrontation (49)

Accommodating to meet the goals of the other party is more appropriate when the issue is more important to someone else or when the person is wrong. This lose-win situation prompts harmony and gains credits that can be used at a later date (49).

Collaborating promotes effective problem solving because both parties try to find mutual agreeable solutions. In this win-win situation, problems are identified, alternatives are addressed and agreeable solutions are reached (49).

Competition is power-driven. The person may be aggressive, uncompromising and may pursue his/her own goals at the expense of another. Although this approach is a win-lose situation, it is appropriate when a quick or unpopular decision has to be made (49).

Compromising combines assertiveness and cooperation. This lose-lose situation is effective when expedient answers are needed and both parties are of equal power. Conflict management should broaden the understanding about problems, increase alternative solutions and achieve a workable consensus and a genuine commitment to decision making. A common form of conflict resolution is positioning bargaining, a form of give and take, in which proposals are made, then negotiated. In this form of negotiation, win-lose or lose-win situations often result (50).

In addition to quality issues, effective management has to be a top priority for the top nursing manager of an institution. According to research done by the Research Management Research Group in Portland, Maine, six behaviors or management practices distinguish effective from less effective managers and are important at all management levels. These six behaviors hold true across industries, the private and public sectors, organization size, and type of work

performed. The research, conducted with 5,300 managers, identified the following characteristics of effective managers:

- Communication. Highly effective managers are clear in defining their expectations for employees.
- Management Focus. Highly effective managers are comfortable in the management role; they gain job satisfaction from performing as a manager. They are comfortable dealing with issues of power and conflict and are at ease in assuming managerial accountability.
- Production. Highly effective managers are not only clear about what they expect, they also tend to expect high levels of performance.
- People. Highly effective managers balance their strong concern for production and performance with empathy and authentic concern for employee growth and development.
- Control. Highly effective managers have systems in place that allow them to periodically and consistently review and monitor employee performance. This process takes into consideration previously established expectations and

objectives and is done to assist rather than police employees in their efforts to attain good job performance.

- Feedback. Highly effective managers provide regular, ongoing, and spontaneous feedback concerning the positive and negative aspects of employee performance. Again, feedback is based upon previously articulated expectations (Jamieson et al. 160-161).

The DON will need to have a management development plan. The most effective development plan, whether it is implemented individually or in a group setting, begins with an assessment that gives a clear view of their current behaviors. Assessment can be achieved through feedback, analysis of incidents, or use of diagnostic assessment tools (162).

According to Likert's theory, the highest producing managers operate within a participative system. In this system, there is a high degree of group loyalty with favorable attitudes and trust among peers, subordinates, and superiors. There are four characteristics of management styles as demonstrated in the following table.

Table 5

Characteristics Of Management Styles

System 1 (Exploitive/ Authoritative)	Superiors show little confidence in subordinates. Superiors ignore subordinates' ideas. Communication flows downward, is inaccurate and leaves subordinates feeling suspicious. Goals and decision making are accomplished by top management with resulting orders issued downward. Fears, threats, punishment and occasional rewards are the motivating forces.
System 2 (Benevolent/ Authoritative)	Superiors are condescending to subordinates. Communication is limited, censored and filtered downward. Upward communication may exist in the form of a suggestion system, but employees are intimidated to share ideas. Goals and decision making are made by top and middle management while subordinates are occasionally consulted for input or problem solving. Orders are issued downward. Rewards and some actual or potential punishments are the motivating forces.
System 3 (Consultative)	Superiors have substantial confidence in subordinates. Subordinates' ideas are sought and freedom to discuss work with the superior is felt. Goal-setting responsibility is felt by a substantial proportion of personnel. Employees generally behave in ways to achieve organizational goals. Communication flows down and up but information is limited and viewed with caution. Rewards, occasional punishment and some involvement are motivating forces.
System 4 Participative)	Superiors have complete confidence in subordinates. Subordinates' ideas are always sought and freedom to discuss jobs with superiors is felt. Goals are set at all levels. Communication is abundant and flows down, up and sideways. Information is accurate and received with an open mind. Economic rewards based on a compensated system that is developed through participation is the motivating force.

SOURCE: Rita Moss et al. "Staff Nurse Job Satisfaction and Management Style" (28.1:32)

Before deciding how to lead a certain group, managers will also want to consider a number of forces affecting their subordinates' behavior. They will want to remember that each employee, like themselves, is influenced by many personality variables. In addition, each subordinate has a set of expectations about how the boss should act in relation to him or her (the phrase "expected behavior" is one we hear more and more often these days at discussions of leadership and teaching). The better managers understand these factors, the more accurately they can determine what kind of behavior on their part will enable subordinates to act more effectively (Tannenbaum et al. 25).

Generally speaking, managers can permit subordinates greater freedom if the following essential conditions exist:

- If the subordinates have relatively high needs for independence. (As we all know, people differ greatly in the amount of direction that they desire).

- If the subordinates have a readiness to assume responsibility for decision making. (Some see additional responsibility as a tribute to their ability; others see it as "passing the buck").
- If they have a relatively high tolerance for ambiguity. (Some employees prefer to have clear-cut directives given to them; others prefer a wider area of freedom).
- If they are interested in the problem and feel that it is important.
- If they understand and identify with the goals of the organization.
- If they have the necessary knowledge and experience to deal with the problem.
- If the have learned to expect to share in decision making. (Persons who have come to expect strong leadership and are then suddenly confronted with the request to share more fully in decision making are often upset by this new experience. On the other hand, persons who have enjoyed a

considerable amount of freedom resent bosses who begin to make all the decisions themselves). (Tannenbaum et al. 29).

Tannenbaum states that the long range objectives managers should seek to obtain are:

1. To raise the level of employee motivation.
2. To increase the readiness of subordinates to accept change.
3. To improve the quality of all managerial decisions.
4. To develop teamwork and morale.
5. To further the individual development of employees. (29).

In the context of a modern management philosophy, authoritarian managers are an endangered species-or certainly should be. Iron-fisted managers in most organizations are a liability and simply cannot expect maximum performance and loyalty from their employees; they are a costly management relic which most organizations can no longer afford. But the "rule-by-fear" management concept is an addiction difficult to deny and still exists in many businesses today (Smith 3).

The real premium need in American business is for enlightened management which inspires, stimulates and

rewards employee initiative and creativity, the wellsprings of industrial progress. Employees who are treated with respect, as equals within the organization in a two-way exchange of information with management generally will support the goals of that organization in good times and bad (Smith 3).

Many management/union relationships still contain restrictive work rules-another force that hinders individualizing the management of people. Although there is no doubt that managers are faced with constant challenges, nevertheless the need to manage the changing work force differently is more pressing than ever. A new model is needed-and needed soon-before the work force becomes even more discouraged, potentially creating further declines in productivity. In these times of slower labor force growth, competent, high demand workers are choosing their individuality through the work itself, through policies and systems that support their lifestyle requirements, and through management practices that enhance their dignity (Jamieson and O'Mara 162).

The changes needed to put American companies on the leading edge of the competitive world will not come without pain, but that pain can be minimized through sensitive management and attention to the human details. There is no way to eliminate all the human hardships of change, but the pain of not making the required corporate and management changes to adapt the new environment is likely to be much greater. The bottom line for this worker-management partnership then, is communications. The relationship must be built on a solid, factual understanding about the company's position (Potts and Behr 115).

As a manager, the most effective role may be that of a teacher; it is also the most challenging. In working to develop others, a manager may choose to mentor, coach, delegate, train, or be a role model as discussed by Jamieson in the book Managing Workforce 2000 (185):

1. Mentoring is a one-on- one, often intense development process that usually extends over a period of time. The

mentor may be the supervisor or someone else inside or outside the organization.

2. Coaching consists of providing suggestions, advise, and support on the job. A coach may hold career discussions that question and focus interests, preferences, and goals, as well as identifying organizational opportunities.
3. Delegating provides an opportunity to give increasingly difficult assignments in areas that are to be developed. It allows employees to use new skills or to strengthen old ones. For example, if one-to-one career discussions reveal that an employee would like to move into a managerial position, provide that employee with opportunities to chair task forces and manage portions of projects.
4. Training consists of either direct, on the job instruction or internal or external training programs for employees.
5. Managers who are role modeling behave in the same way that they would like employees to behave. For example, to

encourage employees to arrive on time, the manager should consistently be on time (185).

It is very important to understand the managerial role within health services, contributing factors which influence that role, and skills required to meet the challenges of changing environments and organizations. The alternate roles of conceptions of management are defined as the traditional, the political-personal, and the organizational conceptions. The traditional or functional model of the managerial role is best described as representing the basic activities of management: planning, organizing and staffing, directing, and controlling. This classic model assumes that these basic management functions will be performed in any organization, and that they represent the key contribution of management. A key missing ingredient in the traditional model is the human relations perspective which has as its central theme the motivation of individuals to the achievement of organizational ends. To build this motivational force, management tactics have included leadership processes, development of intrinsic rewards, team

building, participative decision making, and communication processes. The disadvantage of the functional model and the human relations perspective is they tend to be prescriptive in nature, specifying what managers ought to do. The model also ignores the external environment, focusing solely on the internal workings and processes of organizations (Zuckerman and Dowling 38-39).

The political-personal conception emphasizes the centrality of power and personal tactics in understanding the managerial role. This endearing view stresses the importance of the leadership and the resources of the individual manager and is framed in terms of the "heroic manager" and centers around the charisma of individuals or the politics of power. Large, complex organizations often contain multiple influential decision makers who have their own interests, values, and goals that often, and perhaps inevitably, conflict. Not all groups are created equal, and some will be more powerful than others. Thus managers must understand the sources of power (including that of managers) and the

circumstances under which power might be used, withheld, or transferred (Zuckerman and Dowling 39-40).

The organizational conception produces a different and more complex view of the manager by taking into account factors both within the organization and its environment and considering their respective effects. Organizations may be viewed as having several subsystems of activities necessary to their organizational survival: the productive system, the supportive system, the maintenance system, and the adaptive system. The production system involves those activities that produce the products or services of the organization, emphasizing technical proficiency and efficient production methods. The supportive system aids the production system by securing necessary resources, allocating resources, and disposing of the organization's outputs. The maintenance system centers on the human organization and is focused on maintaining stability and predictability of behavior among individuals and groups. The adaptive system faces outward,

focusing on the organization's ability to adapt to its environment (Zuckerman and Dowling 40-42).

These authors further state that the managerial role will change as organizations and the environments within which they operate change, thereby affecting the role of the health care manager (40-42).

Although we think of the top managers of a health care organizations as master strategists who envision and lead their organizations to a new and better future, in reality that view of the management role greatly overstates the case. This is because most of what health care organizations do is determined not by management but by fundamental external factors and trends. Some of the factors and trends are the aging of the population, advances in technology, changing societal expectations, tightening reimbursement, the growth of managed care, and the shift to outpatient settings. These are fundamental and pervasive forces that health care organizations cannot realistically envision or strategize

direction or roles that are inconsistent with them, if they want to survive (Zuckerman and Dowling 45).

The manager of the 90s and beyond will need to manage organizations in new ways and focus attention on the external environment and its relation to the organization, while attending simultaneously to the internal needs as well. The managerial role is a "trinity," requiring managers to serve as designers, as strategists, and as leaders (Zuckerman and Dowling 58).

Managers must address such matters as organizational structure, innovation, and change, managing the productive functions, information systems, continuous quality improvement, managing human resources, and changing roles and relationships with professionals and governance. In designing organizations for the future, structures must be flexible and adaptive (Zuckerman and Dowling 48).

In their role as strategists, managers must view the relationship between their organization and its environment as two-way; that is, managers seek not only to react to, but also

influence, the environment. They will employ a variety of strategies in light of changing environmental forces and seek to understand the characteristics, needs, and demands of the various populations that the organizations serves (Zuckerman and Dowling 46).

As leader, the manager may well seek to transform the organization to meet the realities of this decade and beyond. They will play key roles in ensuring that members of the organization know and understand, and accept the core values of the organization, showing their relevance in decision making and integrating them into the organizations reward system. The extent to which managerial decision making reflects the basic values of the organization is of fundamental importance to its long-term viability (Zuckerman and Dowling 49).

Fifty one percent of nursing administrators surveyed expressed the need for budgeting to be an area to be included in a management education program for nursing administrators in long-term care facilities (Vaughan-Wrobel 36). Steven A.

Finkler and Christine T. Kovner in Financial Management for Nurse Managers and Executives provides a broad, inclusive text that could serve to cover the many aspects of financial management that are of growing interest to nurses--an introduction to financial management.

Nursing managers must be able to determine the resources they will need and then argue convincingly to get their share of resources from a limited total amount available to the organization. The nurse executive is the senior nurse responsible for managing nursing in the entire organization. The nurse manager is responsible for an area or program within the organization. In almost all health care organizations, the chief nurse executive (CNE) has the authority and responsibility for the expenses incurred by the nursing department. Responsibility for expenses means that the CNE is the person who is ultimately answerable for all expenses incurred by the department. The CNE is directly involved in the negotiating process that establishes the level of resources that will be available for the department and is

accountable for any spending above or below the planned level (Finkler and Kovner 57-58).

As a member of the senior management team, the chief nurse executive (CNE) must have the financial skills of equivalent senior managers. The CNE should have a through grounding in applied economics, be familiar with basic accounting principles, and have the skills to analyze financial statements. In addition to these basic skills, the CNE must be highly competent in cost management. To effectively manage costs it is also necessary for the CNE to be effective at strategic planning and controlling operating results (58).

Another important aspect of management is effective communication. Responsible communication is a tool that supports the flex management strategies of informing and involving people and management and rewarding performance. Empathetic listening and requests for information accord respect and dignity to the individual and reinforce involvement at work. Tips for communicating are listed below:

- Develop skills in active listening

- Be attentive to mood changes among employees. Acknowledge these emotional states in a supportive way.
- When employees are experiencing a difficult personal situation, such as a divorce or death in the family, talk to them privately and find out what support may be useful and to express your concern.
- Ask for ideas to help individuals meet performance standards.
- Always make sure you are understood, whether you are communicating in writing or verbally. Have employees repeat or respond in some way to show they understand a new perspective.
- Identify key cultural differences in the use of language and train the staff to recognize these differences.
- Create a pocket reference that lists guidelines for giving and using feedback. Add variations applicable to the various populations in your organization.
- Keep the praise-to-criticism ratio at roughly three to one. Notice and acknowledge the positive things people do, and

set criteria for evaluating positive achievements. Recognize even small steps along the way as valuable accomplishments.

- Ask employees about contributions that group members have made. Acknowledge these people in a meeting or write a note expressing your appreciation.
- Don't hesitate to give rewards for intelligent mistakes. Recognize thoughtful performance that rises above simple adherence to rules.
- Establish a system to warn employees when there has been a serious breach of conduct or a marked lack of performance.
- Communicate and reinforce your expectations concerning performance or development and show that you care (Jamieson and O'Mara 178-179).

Jane Koeckeritz, Eleanor Stockbridge and Cally Zann, authors of the article "A Leadership Development Series" recommend avoiding duplication of programs already in place; leadership educational offerings elsewhere need to be

identified. The next step to begin a leadership development program is to identify the expectations of the managers. The modules that were developed for a nurse management group are as follows:

Module 1: Self Esteem and Professional Image

- Fundamental to all content
- Career track content Dress for success
- Accepting recognition
- Self/other criticism analyzed

Module 2: Assertive Communication

- Clear Communication under stress
- Power/politics/verbal abuse
- Gender impact on communication
- Effective feedback
- Setting standards for honest interaction
- Asking for peer critiques

Module 3: Collaboration

- Independent and interdependent nursing practice

    Understanding the legal expectations

- Fiscal accountability
- Interfacing with other disciplines harmoniously
- Assisting ancillary services in problem solving
- Organizational loyalty/team building/team work

Module 4: Problem Solving

- Problem-solving methodologies/nursing process
- Effecting change through chain of command
- Conflict management style assessment
- Problem solving as a route to empowerment/self esteem
- Recognizing legitimate problems and ownership
- Adaptation versus problem solving
- Research as problem solving

Module 5: Coaching/Mentoring

- Assessing leadership style
- Describing a positive learning relationship
- Recognizing novice to expert
- Creating atmosphere for sharing knowledge and expertise
- Upholding organization and unit standards
- Immediate effective feedback with peer review

Module 6: Time management/resource Utilization

- Daily organization and response to stress
- Prioritizing
- Communicating changes from routine
- Delegating effectively
- Time management tool/log
- Unit organization/avoid overloading effective people
- Problem solving as time management tool (Koeckeritz et al. 62).

Leadership is different from management; they are two distinctive and complementary systems of action. Management is about coping with complexity. Its practices and procedures are largely a response to one of the most significant developments of the twentieth century: the emergence of large organizations. Without good management, complex enterprises tend to become chaotic in ways that threaten their very existence (Kotter 3-4).

Leadership, by contrast, is about coping with change. Part of the reason it has become so important in recent years

is that the business world has become more competitive and more volatile. Major changes are more and more necessary to survive and compete effectively in this new environment. More change always demands more leadership (Kotter 4).

Leadership is an observable, learnable set of practices. The belief that leadership cannot be learned is a far more powerful deterrent to development than is the nature of the leadership process itself. The ten behavioral commitments in leadership are:

Challenging the process

1. Search for Opportunities
2. Experiment and Take Risks

Inspiring a Shared Vision

3. Envision the Future
4. Enlist Others

Enabling Others to Act

5. Foster Collaboration
6. Strengthen Others

Modeling the Way

7. Set the Example

8. Plan Small Wins

Encouraging the Heart

9. Recognize Individual Contribution

10. Celebrate Accomplishments (Kouzes and Posner 14)

Research shows we are capable of moving our own leadership style closer to the ideal by:

1. Developing a work climate that encourages trust, candor and open communication with a free sharing of work related information.

2. Adopting the belief that the best motivation is self-motivation and that if the proper climate and leadership are provided, most employees will want to be productive and efficient.

3. Involving employees in problem-solving and improvement planning when they are in a position to make a contribution.

4. Listening to employees and trying to see merit in their needs.

5. Setting clear goals and helping employees understand organizational objectives.
6. Rearranging jobs to allow a greater degree of responsibility and self-direction.
7. Recognizing that conflicts between the needs of individuals and the organization are inevitable, but should be confronted openly using problem-solving strategies.
8. Using mistakes as a learning opportunity rather than concentrating on placing blame.
9. Having high expectations of others while providing them support and encouragement in attaining their objectives.
10. Providing recognition for superior performance (Fritz 20).

Leadership is an interpersonal process involving influence and role modeling that inspires people to achieve personal and group goals (Sullivan 4). To understand and gain mastery of leadership requires uncovering its most fundamental natural laws. Such laws are valuable if they meet four criteria:

1. They precisely define what it means to be a leader across the complexity and range of leadership in all contexts. The pattern represented by the laws would apply as much to a single leader and follower as to a leader of a nation.
2. They clearly differentiate leaders from non-leaders and other organizational roles.
3. They effectively identify the common source of all leadership capability.
4. They suggest practical action ideas that provide useful choices for those who take the lead in their organizations (Blank 9-10).

Warren Blank also defines the nine natural laws of leadership which draw from the most compelling insights of many thoughtful practioners and scholars. The nine natural laws of leadership are as follows:

1. A leader has willing followers-allies. Action idea: Focus on gaining followers. When you choose to take initiative on a particular task, ask yourself, "Who do I need to follow or align themselves with me?" or Whose support is

necessary?" Then concentrate on gaining the backing of these people.

2. Leadership is a field of interaction-a relationship between leaders and followers-allies. Action idea: Build solid work relationships with others. The quality of relationships you have with others is central to leadership. Others are more likely to follow when you step forward to lead if they know you and trust you. Building solid work relationships is an ongoing activity.

3. Leadership occurs as an event. Action Idea: Concentrate on the leadership event. Accept the variable duration and scope of your ability to gain followers. Take initiative when action is needed to gain followers-allies. Create the field when necessary. Share leadership power by reinforcing others as willing followers-allies.

4. Leaders use influence beyond formal authority. Action idea: Develop influence beyond authority. Take on tasks relevant to the organization's core mission Gain access to critical information networks (knowledge is power) and

mentor other people; develop task expertise, attend training or formal education programs, and support others' work projects. All of these actions will increase your ability to influence people.

5. Leaders operate outside the boundaries of organizationally defined procedures. Action idea: Fix your sights on nonprescribed areas. Look for opportunities and seek ways to resolve problems beyond your job descriptions and outside the prescribed organizational boundaries set by rules, regulations, policies, and procedures. Pay attention to projects or responsibilities that are not fully defined and have few established requirements. Focus on what is not working. Ask questions to identify possibilities and challenge assumptions. Ask yourself each day: What more can I do to move the organization forward.

6. Leadership involves risk and uncertainty. Action idea: Embrace risk and uncertainty as a challenge. Risk is an interpretation. View risk as a challenge, just as you might be energized to solve a knotty mathematical

problem, succeed in a difficult negotiation or perform well in a tough tennis match. Transform the tension created by uncertainty into the productive energy needed to take action. Then enjoy the action without being attached to the unpredictable fruits of action.

7. Not everyone will follow a leader's initiative. Action idea: Attend to those who will follow. Since not everyone will always follow, focus on those who will support your lead. Pay attention to those who acknowledge your lead as useful, and give consideration to anyone who offers you positive support. Align with the critical followers by asking yourself, "Who must I get to follow to achieve this initiative?" A few key allies can bring success to your initiative. Seek them out, but remember that sometimes no one will follow. The reasons are explained in the final two leadership laws.

8. Consciousness-Information processing capacity-creates leadership. Action ideas: Develop greater self-awareness. Greater self-awareness means knowing the strengths and

limitations of your consciousness. Become aware of how you restrict or overload your information reception process. Explore the assumptions and judgments you make when you interpret information. Are your assumptions based on information or derived from what you suppose exists? Do your judgments represent old mental programs, or are they formed through a dialectic learning process of thesis-antithesis synthesis? Think about how you respond to information. Are you overly cautious and unwilling to commit to action; do you move to the other extreme and act without thinking; or do you balance analytical with intuitive analysis? Continually update your information base. Explore alternative ways to evaluate ideas.

9. Leadership is a self-referral process. Action idea: Clarify expectations. Expectations reveal one filter people use to interpret reality. What we expect is what we get. To lead requires continually exploring what matters to others, how they interpret events, and the meaning they assign to

a situation. To discover the self- referral identity people use to define their world, hold meetings in which expectations are clarified. Ask participants, "What is important to you about...?" The answers will help you meet the followers at their level of consciousness. Clarify your expectations to make it easier for others to understand and accept you position. The potential to manifest the leadership field increases when leaders and followers understand each other's self-referral frame of reference (Blank 10-25).

Blank notes in his preface that the action ideas provide choices designed to increase the arsenal of potential ways to succeed. There will be situations when it is not possible to try certain action ideas; focus on those that can be used and do not get mired in what cannot be done. Some ideas may be easier to apply than others; work on implementing a range of actions from easy to difficult so that you stretch your capacity (4).

Chapter III

SELECTIVE REVIEW AND EVALUATION OF RESEARCH

The resource material provides very good information about the expectations and responsibilities for effective and efficient nursing management. Many health care managers view management responsibilities as unique and not typical of other businesses. However, in reality the responsibilities and requirements of managers in all industries are pretty much the same.

The major impact of external factors on nursing administrators in the long term care arena will be the aging population, tightening reimbursement and the growth of managed care in the Medicare population. Internal problems will continue to be the recruiting and retention of nursing staff, especially personnel educated and experienced in Geriatrics.

Another great disadvantage for nurse administrators in nursing homes is a limited number of resources, especially if

the facility is not part of a multi-system operation. A large corporation gives increased access to experts and consultants. However the disadvantage would be the imposition of new programs and or procedures that the local staff may not necessarily agree with or perceive as necessary (Mercer et al. 34).

Directors of nursing in hospitals have more resources than those in long term care facilities. Frequently the DON in long term care facilities has direct responsibility for the quality improvement activity, staffing, hiring and firing and all the other management activities. If she/he is lucky, there might be an assistant director or at least one other manager. In addition she/he usually have responsibilities for other departments such as social services, admissions, medical records, etc.

As stated before nursing homes are a highly regulated industry. The new nursing home enforcement regulation issued by the Health Care Financing Administration(HCFA) entails the imposition of a fine up to $10,000 a day for violations of

federal nursing facility standards mandated by the Omnibus Budget Reconciliation Act of 1987 (OBRA '87) (Stahl 17).

In addition to state surveys to assess compliance with regulations, there are three major areas that skilled nursing facilities must address if they want to be Joint Commission on Accreditation of Health Care (JCAHO) accredited. These major areas are patient outcomes, physical plant, and physician credentialing. It is important for SNF's to develop and implement a system of outcomes measurement that will satisfy JCAHO requirements (17). Compliance with all regulations, especially clinical compliance, is the responsibility of the nurse administrator.

There is no question in the author's mind that the DON's role is principally a managerial one. However competition for managed care patients will require that DONs make thorough, accurate admissions assessment with unprecedented speed, working closely with the admissions director, administration, and the nursing staff (Warden15).

Making these rapid assessments, and making them accurately, will require sharpened clinical skills, similar to skills of those who began their nursing careers in such areas as critical care. In general though, for many DONs improving clinical skills has taken a back seat to issues related to reimbursement, Medicare/Medicaid rules and regulations and so on. These topics are important, but they are only part of what DONs need to learn in order to survive the coming changes in long term care (15).

DONs will need to increase both managerial skills and clinical skills. There are numerous college programs offering undergraduate and graduate degrees in nursing, management and business. It is hard to imagine how nursing leaders can survive without further education. But for some nursing administrators, college is not an immediate option. One suggestion the author offers for meeting these requirements is networking (Strasen 284).

Networking is the process of creating linkages to obtain information, influence, and power. It is the process of

exchanging information between strategically placed individuals who have access to ideas and other people. It is defined as the process of developing and utilizing your contacts for information, advice, and moral support as you pursue your career (284).

Strategies for successful networking are broad guidelines for managers to obtain long term career goals in specific areas. Additional strategies to develop a broader base of network contacts and increased access to information and personal power to accomplish one's goals could include the following:

- Subscribe to a non-nursing business magazine for women. Nurses need to broaden their perspectives by using strategies for success that other women have already identified.
- Subscribe to at least one motivational and or business magazine. The nurse leader can learn many things from other business disciplines. A handy method of developing a reference of all network contacts is to maintain a business

card file. The manager should ask all colleagues or professional contacts for a business card. This request flatters the contact and results in a method of keeping track of the contact in the future.

- Investing in oneself and one's future is a key networking strategy. This strategy means that the manager invests money to further academic education or take specific courses that provide the technical skills to reach future goals.
- The rules of the health care game are changing so quickly, it is very important to keep informed. Knowledge is power, and if one is viewed as knowledgeable and current in her field of expertise, others will want to network with her to broaden their information base.
- After developing a strong self-image, it is important to develop good active listening skills. It is important for the net working professional to work hard at becoming a good listener to implement the give and take philosophy.

- The development of good communication skills is also a key networking skill. Professionals evaluate other individuals based on their ability to communicate their skills and expertise to others. The ability to communicate verbally, be assertive, and be outgoing is important in making personal network contacts.
- Another verbal communication skill to develop is the ability to make formal presentations to groups of all sizes. The process of making a presentation to a group of professionals allows the nurse to make numerous network contacts in a single effort. (Adapted from Strasen 288-290).

An excellent way to network is to join a professional organization. The National Association of Directors of Nursing Administrators in Long Term Care (NADONA/LTC) is the organization for long term care nursing administrators as the name implies. There are local and state chapters of the organization.

NADONA sponsors clinical and management workshops for NAs. The quarterly journal The Director features topics on a wide variety of subjects to help educate and update the members knowledge about the field.

The Sixteenth Annual Convention of the local chapter, cosponsored by the Missouri Association Directors of Nursing was held recently in St. Louis, Missouri. The topics presented were Wound Care, Medicare Documentation Part A, and Managed Care.

There are other organizations which present workshops on topics pertinent to nursing leaders in long term care. A recent program presented by the Missouri League for Nursing was "Director of Nursing in Long Term Care: A Survival Course." The information presented covered the following:

1. Review of State Regulations
2. Surviving as the DON
   - A. Leadership Style
   - B. Managing Staff Problems
   - C. Communication Skills

3. Providing Quality Care

   A. Organization of Nursing Services

   B. Conducting Business With Physicians and other facilities

4. Quality Assurance programs (Missouri League for Nursing).

Belonging to professional organizations, networking, attending college and or pertinent educational sessions will assist the nurse leader in developing the necessary skill and expertise. In addition, another option available for career advancement is that of a mentor relationship. Mentoring is a process whereby a seasoned businessman takes a young inexperienced executive "under his wing and shows him the ropes." The mentoring process can be formal or informal (Strasen 295).

Specific benefits of the mentor relationship include professional career planning, leadership development, professional advancement, increased creativity, risk taking, and personal satisfaction.

Chapter IV

DISCUSSION

The United States health care system has undergone major restructuring since the early 1980s as a result of scientific and technological breakthroughs, market forces, cost containment efforts, and radically different payment policies for Medicare patients. These forces, combined with the growth of managed care in recent years, have had a major impact on the organization, financing, delivery of health care, and on the clinicians and technicians in acute care and long-term care facilities (Wunderlich 19).

The boundaries between hospitals and nursing facilities are beginning to blur, and the walls around them are moving outward into the community where community based home health services and other alternatives to nursing facilities are developing (Shortell 131). The typical nursing home of the past provided custodial care for the elderly needing assistance; persons with acute conditions were treated in hospitals. Today, the demand for nursing home care is shifting

from the traditional care model toward one that often has a rehabilitative component. Nursing facilities are beginning to provide a wide array of services to individuals who are disabled with an increasing number of unstable chronic conditions. The type of care provided is also changing with the increasing severity of illness and disability of some of the residents; it includes rehabilitative care, ventilator assistance and care for residents with an emerging acute crisis and respite care (Wunderlich 42-43).

The committee on the adequacy of nurse staffing in hospitals and nursing homes recommends that, in view of the increasing case-mix acuity of residents and the consequent complexity of the care provided, nursing facilities should place greater weight on educational preparation in the employment of new directors of nursing (Wunderlich 18).

Directors of nursing in long term facilities will need to acquire advanced education in order to succeed in a rapidly changing environment. The first order of business is for the directors of nursing to recognize that change is inevitable.

Change is like a car coming down the street toward you. It has no driver that you can see, but it is moving surely and steadily in your direction. You have three options:

1. Reactive: Jump out of the way. The car will pass you by. You may realize too late that it was going in the direction you hoped to follow.
2. Nonactive: Stand still. The car will run over you and leave you behind, probably in worse condition than before the encounter.
3. Proactive: Start to move along with the car. Match speed, then jump into the driver's seat so that you can steer the car where you want to go (Wilson 5).

Whenever we are faced with any of the conditions of change (technology, prosperity pockets, competition, human capital or individual responsibility) and perceive them as threats in any way, we will deal with them through a five step process. These steps lead us finally to accept and integrate the change into our lives (39).

Step one is resistance which comes from fear. When we feel that the change will affect our comfort zone in any way, we immediately begin to fear it. What we fear, we resist. Our resistance can take the form of loud vocal protests, specific activities aimed against the change (either open or subversive) or passive non-participation in the change (40-41)

Step two is uncertainty. As we deal with change, this is probably the most uncomfortable step. The fear that we felt in the resistance stage provided an impetus that kept us going, but in the stage of uncertainty we experience stress (42-43).

Step three is assimilation. Our state of uncertainty is replaced by a gradual assimilation of the new condition. The same tension that we experience steering an unfamiliar vehicle down the expressway affects us during the assimilation of change. There is always the underlying fear that we'll crash or fail and have to suffer the consequences. Slowly our confidence builds as we learn how to drive the unfamiliar vehicle or use the change condition to our advantage (43-44).

Step four is transference. Eventually, as we continue to assimilate the change condition, we enter into the transference stage. The new technology, thoughts, processes and procedures replace the old. We still feel a sense of uneasiness and discomfort as we learn to make this replacement or transference. Part of us still longs to return to the old way because we felt comfortable and in control, but we know that there is no turning back (44).

Step five is integration. In the integration stage, we have finally accepted the change and work with it comfortably. In fact, we hardly can remember what it was like before the change. Sometimes we wonder how we ever put up with "the old way." We feel confident and once again in control as we use the change daily (45)

The information explosion in today's world means that we never can sit back and announce that we have learned all we need to know. In fact, that same information explosion compels us to embrace the concept of life long learning. Every day, the change condition challenges us because:

- There is always something new to be learned.
- What you learned yesterday may be out of date already
- Only continual learning will keep you in the game.
- Lifelong learning must become a daily habit.

As you work through the changes in your organization, these predictable realities are the touchstones for your own successful change management. Empowering yourself to move into areas outside your comfort zone of your former work expectations will create a heightened sense of personal responsibility (75).

Tom Peters in his book Crazy Times Call for Crazy Organizations asks the following questions:

> (1) Just what have you learned in the last three months, six months, year, eighteen months? (Prove it-to yourself, anyway). (2) Are you taking classes, company-sponsored or not, right now? If not, why not? (3) Do you have a personal skills-development program? (4) As a boss, is every employee engaged in a self-designed learning/ homework program with specific goals, reviewed at least twice a year? (5) Is the end product "improvement" or reinvention? (if reinvention, are you sure) ? Are you enroute to towering competence? (115)

Effective self-development must proceed along two parallel streams. One is improvement to do better what you already do reasonably well. The second is change to do something different. Both are essential. It is a mistake to focus only on change and forget what you already do well. One works constantly on doing a little better, identifying the little step that will make the next step possible. But it is equally foolish to focus on improvement and forget that the time will inevitably come to do something new and quite different (Drucker 223).

Listening for the signal that it is time to change is an essential skill for self-development. Change when you are successful-not when you are in trouble. Look carefully at your daily work, your daily tasks, and ask: Would I go into this today knowing what I know today? Am I producing results or just relaxing in a comfortable routine, spending effort on something that no longer produces results (223).

Leah Curtin discusses the components necessary to make a successful manager:

> Natural endowment helps, as does the appropriate education and skill set. Experience in the field and knowing what it takes to produce the product or intended result is crucial. In the 1980s, contemporary management pundits taught that the manager, administrator, or chief executive officer did not have to know the field or the product. Time proved them wrong as huge conglomerates went belly-up and high-tech firms run by marketers lost their vision and with it their market share (8).

Never before have competent, creative, and flexible nurse leaders been more important. These leaders are accountable for ensuring the appropriate structure and resources for patient care (Beyers 37). In today's environment, desired characteristics of managers are shifting along with shifts in services. Competent, creative, and flexible nurse leaders must shine up all of the competences they have and make them part of the day-to-day repertoire of collaboration, cooperation, and decision-making. Now is the time to be present when decisions are made. Data about healthcare delivery, patient-

and community care requirements, and the resources needed to match the care, are critical (38).

Nursing administrators have expressed a need for further education in management development. Professional preparation has long been an entry to a career in health care. There is the opportunity to take those skills, focus on other existing, emerging fields and opportunities and, always, to work on the best of your talents as you grow. In some respects, we can think of a career as an operational vehicle for personal growth in which one's values and competencies are the currency for job security (25).

Nurses who know what they are doing, who can communicate effectively and who have developed the competencies for team playing, for facilitative leadership and the ability to balance fiscal and quality aspects of care have a bright future indeed. Fundamental values, a strong knowledge base, and adaptability are the keys to making a success of nursing management in the future (25). Nursing administrators can close the gap by pursuing further education in advanced

degrees and by actively participating in continuing education. The successful nursing administrator will proactively maintain and upgrade their knowledge in the fast changing arena of health care.

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