1980

The Director of Nursing Service: A Primer

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FERGUSON, MISSOURI
SUMMER 1980

SUMMARY OF CULMINATING PROJECT

THE DIRECTOR OF NURSING SERVICE

A PRIMER

SUBMITTED TO

FACULTY SPONSOR
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FACULTY ADMINISTRATOR
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Chapter One - Administration

This chapter addresses the topic of administration as it pertains to hospitals and nursing. A definition of administration derived from Katz is given and an extrapolation is made from his industrial model to the health care setting. The history of the trend to non medical administrators is explored utilizing both federal and American Hospital Association figures and statistics. The impact of Public Law 89-97 on the hospital is discussed with particular emphasis on the demands made of the nursing staff to care for the millions of chronically ill enrolled under this law. Then manner in which these demands have impacted on nursing administrator in conjunction with the civil rights legislation of the 60 - 70's is explored in detail.

This chapter also deals with the outcome of increasing administrative skills for nursing - the use of power and the involvement in politics. In addition the socio-cultural influences shaping the nurses of today are examined. The type of administrative skill necessary to manage independant professionals at all levels of growth is noted. In summation this chapter attempts to define the changes occurring in the past century that are impacting on the nurse administrator of today. The acute shortage of trained nurse administrators is addressed and examined. A base is established for the following chapters. This base states that nursing and nursing administration is in a transitional phase, that nurses in order to survive must master the skills of administration defined in the opening statements and that power and politics play an integral role.

Chapter Two - Organization

In this chapter the classic organizational models are discussed and their relationship to the health care field. Organizational charts are given. These discussions are the background for examining the complexities

of organizing various levels of autonomous or semi-autonomous professionals into a functioning whole. The possibilities of having organization within organizations is examined, and the difficulties inherent in both the size and complexity of the nursing department, and the size and complexity of the patient population for which it cares. Future trends in organizational structures are discussed, particularly in reference to growing labor activity in the health care field. Participative and democratic organizational styles are discussed in detail. Management by objectives as an organizational style is examined with sample objectives written.

Methods of delivery of care, functional team and primary nursing are discussed as they impact on the organizational model of the nursing department. The chapter concludes with an examination of the matrix organization. It is postulated that the matrix shows promise as the organizational model for the 1980 - 90's. The summary for this chapter concludes that the primary responsibility for the nursing administrator is to design a viable organization, that without this foundation she will not have a department to administer.

Chapter Three - Philosophy, Goal Setting, and Systems Analysis

In this chapter the definition, scope and purpose of a philosophy is discussed. Values as a prerequisite of philosophy writing is examined. The importance of philosophy as the foundation of a nursing service is postulated. Sample philosophies are given.

Goal setting as a derivative of a working philosophy is examined. Analysis, problem definition and problem solving as part of the goal setting is defined. Management by Objectives is introduced, as so is the concept of organizational change occurring as the natural outcome of managing by objectives. Examples of data analysis and goal setting for specific areas of the hospital are given.

Chapter Three - Philosphy, Goal Setting, and Systems Analysis (continued)

This introduction to goal setting and problem analysis is then incorporated into a discussion of systems analysis. Theories of Kast and Rosenweig are utilized in this segment. Adaptation of the systems theory to nursing by Claus and Bailey is introduced. A cybernetic model of the nursing process is given.

In summary this chapter has dealt with the premise that all parts of management and supervision, goals, philosophy and problem solving are inter related and flow from a value system. This chapter has also demonstrated that long range planning is essential, is a systematic method of affecting change and is an invaluable tool for the nursing service administrator. This chapter concludes with some exercises for the student to perform that will reinforce the concepts taught.

Chapter Four - Budgets and Cost Containment

This chapter examines the financial base of the hospital, the methods of obtaining money and the types of budgets to account for the money spent. The role of nursing administration in the budgetary process is delineated and emphasis is placed on the need for further involvement in the future. Budget terms are defined and both traditional and Zero Base budgets are examined. Informational systems necessary to nursing administration are discussed particularly in relation to capitol, supply and personnel budgets. The need to place budgetary control with lower levels of management is emphasized as a form of participative management. Control and evaluation of the budget is discussed and the idea of a nurse internal auditor utilizing a "Sunset Budget" is discussed. The chapter concludes with a section devoted to the government's cost containment emphasis and the fifteen points raised by the government. The main items were identified and discussed.

In summary the chapter has attempted to provide a broad overview of the budgeting process and concludes with a list of questions the student should find useful for assessment of her own situation.

Chapter Five - Staffing

In this chapter both the mechanics of staffing and the human side of staffing are addressed. Under mechanics of staffing, the system of classifying patients according to the acuteness of their needs is explained in detail. The formulas for determing hours of nursing care per patient are given. A flow chart depicting the systems approach to the staffing concept is given with interpretations. A sample nursing budget proposal demonstrating patient acuity and nursing hours is written.

Under staffing - the human side, an analysis of the present situation of labor unrest in nursing is undertaken. Using recently published statistics from both hospital associations and the federal government, an attempt is made to define some major problems resulting in massive turnover, personnel problems and nursing "drop out". The "burn out" syndrome is identified and discussed, and some alternatives offered. The appendix attached to this chapter demonstrates a modified Warstler Scale for Acuity classification and a position control from.

These five chapters represent 40% of a text book. Subsequent chapters would include the following subjects.

1) Policies and Procedures
2) Dual Career Ladders within a nursing department, provision for specialization.
3) Job Descriptions and Performance Review
4) Nurse - Physician relationships - dealing with other professionals and para professionalism.
5) Quality Assurance in Nursing
6) Nursing administration and health planning at local, regional and national levels.

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MAY, 1980

CULMINATING PROJECT

FOR

M. SCIENCE IN HEALTH CARE ADMINISTRATION

MAY, 1980

LINDENWOOD COLLEGE

ST. CHARLES, MISSOURI

SUBMITTED

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PREFACE

My motivation for writing this book stems from conversations with many nurses, all of whom reflect in greater or lesser degree their frustration and stress in coping with the role of nursing administrator. Current pressures whether social medical or federal have placed constraints and challenges on health care systems unheard of a decade ago. Nursing service is frequently the focus of many of these constraints and pressures as it is the largest provider of health care in the hospital. It is hoped that this book will provide an understanding and a base of knowledge for the estimated 25% of new administrators who yearly enter the field of nursing administration.* Many of the ideas expressed in this book are the author's own, based on experience and dialogue with fellow nurses. If inadvertently, credit for concepts has not been given it is due to the Author's inability to correctly remember all sources of ideas and thoughts.

*1977 Survey of Nursing Service Administrators in Hospitals
American Society for Nursing Service Administrators
Chicago, Illinois March 1980 p. 2

CONTENTS

CHAPTER ONE

In order to write a book concerned with nursing administration it is necessary to start with a definition of an administrator.

The following discussion of the basic skills needed by an administrator is derived from Katz's analysis of these skills. An administrator is one who (a) directs the activities of other persons, and (b) undertakes the responsibility for achieving certain objectives through these efforts. He also identifies three basic skills - technical human and conceptual - which he states are not necessarily inborn but can be developed. Technical skill implies an understanding of, and proficiency in, a specific kind of activity, particularly one involving methods, processes, procedures, or techniques. Human skill is the executive's ability to work effectively as a group member and to build cooperative effort within the team he leads. Conceptual skill, according to Katz, involves the ability to see the enterprise as a whole; it includes recognizing how the various functions of the organization depend on one another and how changes in any one part affect all the others and it extends to visualizing the relationship of the individual business to the industry, the community, and the political, social and economic forces of the nation as a whole.[1]

Although Katz was referring to the industrial model, his remarks could easily be applied to that of the hospital. The hospital administrator needs strong technical skills in budgeting, accounting, and program planning, human skills in dealing with a labor intensive institution, and conceptual skills in assimilating and adapting to the rapid changes occurring in the health care field.

In the last thirty-five years hospital administrators have emerged as a separate and distinct management profession. Prior to the end of World War II most administrators

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[1] Katz, Robert L., Skills of an Effective Administrator Howard Business Review on Management, 1975 pp. 19-30.

were physicians in traditional hospital settings. The rapid increase in technology, information, and clinical expertise changed the hospital as an institution and brought into being the non-physician administrator.

At the same time (1946), that the new breed of hospital administrators was first managing and influencing major hospitals on a wide scale, federal money through the Hill-Burton Act (Hospital Survey and Construction Program 1946) was freely available for building of new facilities and expansion of old. Frequently, the measure of success of an administrator was the amount of building in process. Statistics show that by 1967 a net increase of 12% per capital rise in the availability and use of hospital facilities took place.[2] The mood of the 50's and early 60's in the health care field was one of expansion and optimism. Suburban hospitals were being built to match the influx of young people in new housing developments fleeing from the overcrowded cities.

Medical technology was also expanding, allowing physicians seeking alternate career paths to branch into many new medical areas and to ignore administration. The non-physician administrators found that the bulk of their management energies was expended on physical plants, medical staff, and acquiring medical technology. Nursing service, other than to staff the new hospitals and units, was left alone.

In the 60's the trend towards experienced qualified non-physician hospital administrators was firmly established with approximately 17,000 non-physician administrators reported for 7,100 hospitals by 1971.

University courses and internships for hospital administrators were becoming commonplace, and an academic

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[2] American Medical Association: Hospital Services in the United States, Journal of the American Medical Association 149;13-16 1952.

discipline of Health Care Administration was recognized.

The American College of Hospital Administrators report 74% of the members holding a Masters degree or above in 1978, a steadily increasing figure.[3] In 1967 the association of University Programs in Health Administration (AUPHA) reported 24 graduate programs in Health Administration in the U.S.A. By 1976 the number was 47.[4]

At the same time that these changes were occuring in hospital administration, a change in the federal approach to health care was evolving. This change would have a profound impact on nursing administration as the full impact of the accompanying laws, guidelines, rules and regulations became evident.

This change was a law known as Public Law 89-97 Medicare/ Medicaid. At the time the law was passed, Wilbur J. Cohen, then Secretary for Health Education and Welfare and principal author of the bill, stated that the law was a sleeper.[5] And sleeper it turned out to be indeed. Intended to be a stopgap measure prior to National Health Insurance under President Johnson, it was underfunded for a misjudged number of potential clients. "H.E.W. cheerfully estimated a cost of $238 million for 1968; in actual fact the cost was $2.27 billion for that year."[6]

The design of the program was intended to move the poor and the needy into the mainstream of American medicine thus

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[3]Commission of Education for Health Administration (The Dixon Commission) as quoted in "Hospital Administrators Face Stiff Competition in Job Market". Journal of the American Hospital Association. Oct. 1978 Vol. 52 p. 61-62.

[4]Fellowships offer Expanded Views of the Health Care World. Hospitals JAHA March 1, 1979 p. 65-66.

[5]Medicaid: The Primrose Path; E. Friedman. Hospitals. Aug. 16, 1977. Vol. 51. p. 51.

[6]Ibid. p. 54.

making maximum use of the new facilities planned and funded under the Hill-Burton Act. "It was estimated by the plan's authors that a very small percentage of America population would be covered since most Americans, they believed, were covered already by some form of private insurance. In actual fact some 10 million people entered the American Health care system in a group."7 This group of poor citizens who became eligible in 1965 under the program were not in the best of health. "In areas such as dental care, eye care, and chronic illness these people were probably more in need of care than people who had access to health care all along. Inpatient hospital care was then and is now the single largest cost component of Medicaid."[8]

This influx of chronically and acutely ill patients into hospitals produced a challenge for nursing service in the following manner.

1) It increased the demand for nurses
2) It focused nursing research on the health needs of minorities and chronically ill poor
3) It demanded maximum use of nursing resources and accountability for same.

Another factor influencing the growth of nursing administration in the late 60's and early 70's was the social changes occurring in America.

"Nursing has traditionally been a semi-profession suffering from a very elusive or ambiguous character. Semi-profession referring to the fact that the majority of nurses did not possess a baccalaureate degree, generally accepted as a basis for professional service."[9] Nursing students of the late 60's and 70's demonstrated a desire for role definition. "The old

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[7] Ibid. p. 53.

[8] Medicaid: A Garden Soon with Dragon's Teeth. E. Friedman, C. Weindof. Hospitals. Sept. 1, 1977. Vol. 51. p. 60.

[9] Progress in Professional Service: Nurse Leadership Queried, J. Lysaught, M. Choist, G. Hagopian. Hospitals. Aug. 16, 1978. Vo. 52. p. 120.

values, the traditional views of nursing, no longer received much attention in the literature, in the classroom or in the practice of nursing... Nursing leadership styles were questioned as being relevant to the needs of the nurse workers."[10] The introduction of electronics and bio-medical engineering into the average hospital required many new skills of the nurses. The nurse specialist became a reality as also did the nurse practitioner. The management of highly trained and much in demand nurse specialists also posed challenges for nursing administration. A recent article in U.S. News and World Report stated "nurse practitioners are a new breed in an old profession in the process of transition; the most important trend in nursing is being independent."[11]

The third factor contributing to the change occurring in nursing administration is also a spin-off from P.L. 89-97, the integration into the nursing work force of hundreds of marginal employees. These employees were persons from low income groups affected by the following legislation.

1) The Area Redevelopment Act of 1961
2) The Manpower Development and Training Act of 1962 (as amended)
3) The Vocational Education Act of 1963 (as amended)
4) The Equal Opportunity Act of 1964 (as amended)
5) The Vocational Rehabilitation Act of 1965
6) The 1967 amendments to the Social Security Act

"This legislation was an attempt to correct the imbalance existing between worker trait requirement demands of public and private organizations and the actual abilities of the unemployed work force."[12] As hospitals became the recipients of large sums of money from the Government in t he form of Medicaid/Medicare reimbursement, they were also required to participate in federal programs such as those listed above. Frequently participation in these programs required nursing administration to expand their inservice departments as not only occupational job skill training was given but also remedial training in the three R's.

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[10] Humanistic Leadership in a Pragmatic Age. S. Fuller. Nursing Outlook. Dec. 1979. Vol 27. pp. 771-

[11] U.S. News & World Report. Jan 14, 1980. p. 59.

[12] Dunn J.D., Stephens E. Management of Personnal. McGraw-Hill. St. Louis. 1972. p. 388

Programs leading to G.E.D. completion became the norm in large urban hospitals. As trained nurses became more specialized, on the job trained workers became more numerous in all areas of hospital employment. These employees then became targets for union activity. Unionization in federal service became a reality with Executive order No. 10988 in the early 60's and the public or quasi-public sectors of the economy-secondary schools, colleges, universities, city and state government soon followed.[13]

Nursing administration has had to adjust to the previously identified problems very rapidly, too rapidly to accumulate a wealth of knowledge, assimilate it and establish norms and methods of coping. Because of the nature of the health care field more change and pressures generated by the changes are occuring daily. Only a very small segment of the nursing profession is alert to the changes and pressures; frequently the nursing service employees see their own nursing administration as the cause of their problems rather than a buffer or facilitater. This then adds another dimension in the management of nursing professionals. Recent surveys of nursing administrators demonstrate rapid turnover and "burnout". A burnout is caused in part by the factors identified in the preceding pages and in part by pressures generated by nurses against their own administration.

In a recent editorial Corona discusses this lack of support, stating "Hospital nursing leaders leave their positions frequently at the suggestion of hospital administrators . . . These nursing leaders were exercising constructive change-oriented leadership considered undesirable not only by doctors and hospital administrators but by nurses who were determined to uphold the status quo".[14] Rank and file nurses are frequently apolitical with all excess energies devoted to raising families and homemaking roles; therefore, they are not aware of larger issues in health care. Nursing education in an effort to include all necessary aspects of clinical practice into their curriculums, provide almost no management training.

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[13] Ibid. p. 392.

[14] Nursing Leadership. Editorial. Dec., 1979, Vol. 2. p. 4.

As a consequence the nursing administrator finds herself in a difficult situation. A situation where she is being forced into a major management role, far removed from patient care, criticized by some as not being a nurse any more and a traitor to nursing, criticized by others as failing to understand administration because she only knows patient care. Nursing administrators have struggled with these challenges, frequently in a setting that raised barriers to effective management. Some of these barriers, that were identified at the American Hospital Association Special Committee on Nursing in October, 1978, were listed as "failure of hospital administrators, physicians, and some nurses to recognize and acknowledge a nurse's capability to fulfill a top management role; reluctance on the part of nursing service directors to accept and implement their roles in top management and long standing difficulties in interprofessional collaboration."[15]

These barriers are real and exist all too frequently but never the less, the growth and expertise of nursing administration continues, albeit very slowly. In recognition of this there have been several studies carried out on the availibility of graduate programs in nursing administration and indeed, of what was needed to be studied.

In May, 1978, the W. K. Kellogg Foundation published a collection of papers derived from three conferences held to discuss "The Education and Role of Nursing Service Administrators".[16] In this collection of papers Barbara Stevens discusses a 1975 study conducted by the University of Iowa in which it was found "the nursing administration major seems to attract a fair proportion of non-aggressive, non-intellectual people."[17] Also in the same study it was found that a graduate major in

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[15] "Health Care Leaders Examine Role of Nursing Service Administrators". Gugenheim A. "Hospitals". J.A.H.A. Vol. 53. No. 2. Jan. 16, 1979. p. 109.

[16] The Education and Role of Nursing Service Administration. W. K. Kellogg Foundation, Battle Creek, Michigan. May 1978, p. 37.

[17] Stevens, B. Education in Nursing Administration, p. 26

administration could be granted with as little as 24% of the time spent on management studies. Stevens goes on to say that across the country less than 20% of nursing service administrators have masters degrees of any sort, 22% have baccalaureates, and the rest are functioning with the best they have to offer.

National League for Nursing Data Digest of 1976 states that nationally only 14-15% of 1966 B.S.N. graduates had completed master's degrees, with only 3-9% engaged in study at the time.[18] Is it any wonder then, that a leading hospital journal can print an article in which the following statement is heavily emphasized, by underlining and placing in a box at intervals throughout the article "The most that can be said for the traditional nursing supervisor-head nurse hierarchy in the administration of patient care activity is that the structure is relatively inexpensive.[19] The authors went on to state further that management of patient care units should be in the hands of non-nursing managers who can make administrative decisions. The implication was that nurses make poor managers. It is unfortunate for nursing that these authors, by both the examples they provided and their experience, have reached these conclusions. When reading the article it was very difficult to disagree.

In order for nursing to retain control of their practice and profession it is essential that administrative control is in the hands of nursing. Nursing is the single largest department in a hospital, with a correspondingly large budget, therefore nursing will not be allowed an extended "growing" period. Nursing must accept the challenges very fast and make few mistakes. There is a great need for the limited but growing number of nursing administration programs in the country to be expanded and supported and a dynamic internship program built into the standard acedemic nursing program. The professional speciality organization

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[18] Nurse Career-Pattern Study, "Hospital Topics", May/June, 1979. Vol I. No. I, p. 8.

[19] Reece D., Boissareum, R., Wolters, E. "Division Management System Replaces Unit Management", "Hospital Topics", Jan./Feb., 1979, Vol 57, No. I, p. 33.

in nursing need to be requested to support nursing administration programs so that polarization of speciality groups within a nursing service does not occur.

Before closing this chapter on the definition of an administrator and the preparation of the hospital and nursing administrator there is an additional topic of interest to the nursing administrator. The name of the topic is Power in Nursing.

Most of today's nursing administrators are receiving on-the-job training interspersed with going to school in the evening, attending workshops and seminars, and frantic reading of journals. Many of these same nurses are also attempting to establish their departments and their positions as major forces in the hospital organizations. Their department lacks the weight and established traditional base of power of the comptroller and the chief executive officer.

Frequently lacking the ability to communicate effectively in management terms the nurse administrator is at a distinct disadvantage in dealing with these members of the hospital organization.

In recognition of this disadvantage, there is a growing trend for nursing journals to address this topic. Peterson says that "Power . . .

> is a positive force. While power may seem incongrous in relation to an institution whose goal is care of the sick, a hospital is an organization, and as such, the hospital staff relate to one another and use strategies in an effort to promote or protect their interest. Politics, or the promotion of an interest group and the use of available resources to protect and advance that interest is no stranger to the hospital environment. Power and politics are closely allied: power is the ability and willingness to influence behavior and politics is the promotion and protection of a vested interest. 20

Poulin in an article with the same theme also addresses the role of power. She says, "In the arena of power and authority, nurses - women - have been "programmed for failure". Authority to make decisions may be anxiety producing, for it means

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20 Peterson, G. "Power-A Perspective for the Nurse Administrator", "Journal of Nursing Administration", Vol. IX, No. 7, July, 1979, p. 7.

breaking out of dependency roles. It also involves the need for understanding the nature of power and the values of shared power . . . We must, however, avoid the trap of acquisition of power solely as a struggle for prestige and control."[21]

While a recognition of the lack of power in nursing administration is long overdue, what also needs to be examined is how does power accrue.

The study of the psychology of power is valid for nursing, but in addition to, not in place of, the basics of organizational administration.

Gaining power in an organization although lacking formal education and background in management can be done but the nurse administrator should realize that power is a management tool as defined by Katz in the opening statement of this chapter. Power can be derived from expert knowledge, i.e. clinical skills, from human skills in managing the largest department in the hospital, and from the ability to plan and forecast the conceptual skills. It is a mistake for nurses to see politics and power as a substitute for administrative expertise.

In a February 1979 release the American Society for Nursing Administrators of the American Hospital Association states,

> The skills and knowledge for a nursing service administrator begin with the basic preparation for practice as a professional nurse. Preparation for nursing service administration should be obtained through a program in nursing administration. This preparation should include an organized plan of study to acquire knowledge of such subjects as:
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> Principles of Organization
> Theories of Management
> Human Resource Management
> Strategies of Nursing Management
> Financial Management
> Foundations of Health Law
> Statistics and Research Methodology
> Theories of Nursing

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[21] Poulin, M. The Nurse Administrator & Survival in the Executive Jungle. "Nursing Digest", Vol. V., No. I, Spring 1977, p. 24.

The release ends with the statement that the authors of the paper "acknowledge the difficult task being accomplished by our colleagues who have been unable to gain advanced preparation in nursing administration due to lack of access to education for personal or other reasons."

It is primarily towards those colleagues identified in the release that this book is directed.

In summary then, nursing administration has had to adapt to changes occurring from the following sources:

1) The influx of millions of medically needy into the nation's hospitals and subsequent increased demand for nurses;
2) The change in nurses themselves, both individually and collectively as the profession responds to a changing society and increased technology;
3) The increasing usage of minority or untrained workers in the health care field requiring skilled personnel;
4) The rise in union activity in hospitals across the nation;
5) Pressure from the government and third party payors to cut costs.

Nursing administrators can rise to meet these challenges. In doing so they will create a new role and new dimensions both in nursing, and in the business world as a whole. For hospitals are big business. It is hoped that the following pages will provide some assistance to those embarking on this task.

Listed at the close of the chapter are organizations that through their publications and newsletters help to keep the nursing administrator aware of current issues. It is highly recommended that all nursing service administrators become members of at least one professional organization. A nursing administrator is also directly responsible for the establishment of a clinical library for her staff and for management training for her assistants. Subscription to the journals listed is a good beginning.

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[22] Bulletin for Release to Hospitals. American Hospital Association. February, 1979.

Professional Organizations for Nursing Service Administrators

American Society for Nursing Service Administrators of the American Hospital Association
840 North Lake Shore Drive, Chicago, Illinois
Telephone: 312-280-6410

American Nurses Association*
2420 Pershing Road, Kansas City, Missouri 64108
State Organization of ANA

*Due to indefinite status of ANA as a collective bargaining agent and the management role of ANA members, some hospitals prefer not having nursing service administrators enrolled in ANA.

National League for Nursing - A,A, AN
10 Columbus Circle
New York, New York 10019

American Management Society
135 West 50th Street
New York, New York 10020

Administrative Management Society
Willow Grove, Pennsylvania 19090

Journals for the Nursing Administrator

Journal of Nursing Administration
Box 5-78, 12 Lakeside Park, Wakefield, Massachusetts 61880

Nursing Digest, a quarterly magazine published by Contemporary Publications
12 Lakeside Park, Wakefield, Massachusetts 61880

Hospitals - Journal of the American Hospital Association
840 North Lake Shore Drive, Chicago, Illinois 60611

Hospital Topics
3807 Bond Place, Sarasota, Florida 33582

Supervisor Nurse
3734 Glenway, Cincinnati, Ohio 45205

American Journal of Nursing
555 West 57th Street, New York, New York 10019

R.N.
P.O. Box 411, Westwood, New Jersey 07675

Nursing 79
132 Welsh Road, Horsham, Pennsylvania 19044

Suggested Reading

The Nurse As Executive, B. Stevens, Contemporary Publishing, Inc., Massachusetts, 1975.

Nursing Administration in the Hospital Health Care System, E. Alexander Mosby, St. Louis, 1972, chapters one through four.

This book is an excellent text book for the reference shelf of the nurse administrator. The first two chapters deal with the history of hospital nursing and professional organizations. Chapters three and four deal with the need for better nursing care and the role of nursing research.

"How to Become a Witch", Lorraine A. Thomas,"Nursing Outlook", January 1974, Vol. 22, No. 1, p. 40.

This article sub-titled "Everything you always wanted to know about nursing service administration but were afraid to ask" should be read weekly for the first year of your life as a director of nursing service. It will provide you with the necessary courage and conviction to pursue your course.

Chapter Two

Organization

What is an organization? An organization is defined by Dunn & Stephens as "being made up of two basic components: parts and relations. These parts are integrated so that their relation to one another is intended to be governed by the relation to the objectives of the whole."[23]

In a hospital, individual nursing employees are related by both their skill levels and their objectives. The objectives of providing safe, humane, and theraputic nursing care to patients can be achieved by organizing the various levels of care providers in the most effective manner. For example, specific areas such as operating rooms and intensive care units require specific types of nurses and skill levels which may be quite different and yet are related by their common nursing background. Although quite different both units subscribe to the overall objective of the nursing service department: safe, humane and theraputic nursing care.

Each of a nursing service department's units are designed for the particular needs of the patient using them. The skills of the nurse, combined with her educational background, i.e. R.N., L.P.N., must be matched to needs of the patient. How this is done is the basis for the nursing organization chart. A nursing organization chart is a schematic representation of the entire nursing service. Because of the large size of most departments of nursing, it is possible to have organization within organization. For example, the hospital organization may be represented by one style of structure - the nursing service by another and yet the nursing service is still part of the overall organizational chart.

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[23]Dunn, J., and Stephens, E. Management of Personnell. McGraw-Hill Book Company of St. Louis, 1972, p. 34.

The Joint Committee on Accreditation of Hospitals, in this section devoted to nursing, is placing increased emphasis on the development of organizational styles that allow for participation by staff nurses in decision making in nursing.[24]

Of the hospital desiring accreditation, administration will expect the nursing service to meet these standards. Consequently the nursing service director may be designing a structure that is different from the overall hospital structure. Another factor to be considered, is the growing tendency to recognize that the size and diversity of the nursing department requires a shifting of management responsibilities. Management in industry has traditionally outlined 3 management levels, first, second and third line management position. A line position is one that fits precisely in a vertical relationship with others in an organization chart. "The line functions and authority derive from the scalar principle of relationships in which a superior exercises direct supervision over a subordinate."[25] Donovan says "The department head is a key member of middle management within the health care delivery field."[26] He further states "that middle managers are the integrators which make the organizations work" and are "funnels for the 1% which is top administration and 94% which is bottom administration. 5% being middle management." Therefore according to Donovan the nursing service director is a middle or second level manager with supervisors becoming first level. Head Nurses, charge nurses, and team leaders are not seen as management positions.

Increasingly this view is changing to reflect the increased awareness of the cost, complexity and size of nursing service departments.

The Head Nurse is being viewed as a first line manager now and may in the future be seen as a department head, and the supervisor's title are changed to "Assistant Director's." These Assistant Directors are viewed as middle management, and the Director as top level management. The official title of the Director of Nursing becomes

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[24] Standards, etc.

[25] Alexander, L. Nursing Administration in the Hospital Health Care System. C.V.Mosby, St. Louis, 1972, p. 193.

[26] The Department Head & Health Care Delivery. E. Donovan. Journal of Nursing Administration, Jan., 1976, Vol I #1, p. 32.

that of Vice President for Patient Care, Associate Administrator for Nursing, etc. In these situations the nursing departments would more properly be called a division that is divided into departments of obstetrics, medicine, surgery, etc. It is possible that each of these specialized nursing areas may require a different organizational structure from that of the overall nursing organization just as the overall nursing organization needs that of the parent hospital. Organizational design for nursing must take into account the unique characteristics of hospitals, particularly in reference to the complex psycho-social system. Kast/Roseweig state that

> The general hospital has diverse goals. Although the primary goal is the patient's welfare, there are many additional objectives such as medical and nursing education, research, and economic viability...
>
> There is a unique relationship between the formal authority of position, as represented by the administrative hierarchy, and the authority of knowledge as represented by the medical practitioners and other professionals. This creates a diffused and distinctive structure. Although the ideas of the various participants are defined, there are substantial conflicts. The psycho-social system is strongly influenced by the norms and values of professionalism, which are internalized by the various participants. Therefore the managerial system is difficult to define. The diversity of the authority structure creates a dispersal of the planning and control functions. [26]

In the nursing service the planning and control function is of vital importance and is the responsibility of the Director of Nursing Service. In order to assume these responsibilities intelligently she needs to be aware of the choices available. In a discussion of organizational structure written in 1938 and now in its twentieth printing, Chester Barnard says that "3 elements are necessary for an organization: (1) communication; (2) willingness to serve; and (3) common purpose. For the continued existence of an organization either effectiveness or

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[27] Ibid.

[26] Kast, F., Rosenweig, J., Organization and Management, McGraw-Hill, St. Louis, 1974, p. 536.

efficiency is necessary and the longer the life, the more necessary both are".[29] He also states that "the vitality of the organization lies in the willingness of individuals to contribute forces to the cooperative system". If we look at these three elements and also recall the characteristics required of the administrator as identified earlier by Katz we can see how they dovetail.

(1) Communication - the conceptual human skill needed to see and communicate the organization's goals and overall purpose. the parts and their relation;

(2) Willingness to serve - the human skills needed to work effectively as a team and build a cooperative effort;

(3) Common Purpose - the technical and conceptual skills needed to provide a base of proficiency in the desired work.

These elements can be found in several different styles of organizations. The challenge facing the nursing administrator is in choosing the style which will provide the level of care needed in the most efficient and cost effective manner.

Historically nursing services have been characterized by rather rigid, traditional, bureaucratic organizational styles that were slow to change. Kast and Rosenweig quote Max Weber as stating that "bureaucracy is the most efficient form, that which could be used most effectively for complex organizations -- business, government, etc. -- arising out of the needs of modern society."[30] The view of rational, legal authority was crucial to Weber's idea of bureaucarcy. He said

> In the case of legal authority, obedience is owed to the legally established impersonal order. It extends to the persons exercising the authority of office under it only by virtue of the formal legality of their commands and only within the scope of the authority of the office. [31]

Kast & Rosenweig further define Weber's views by stating

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[29] Barnard, Chester I., The Functions of the Executive, 30th Anniversary Edition, Harvard University Press, Mass., 1971, p. 83.

[30] Weber, Max, The Theory of Social & Economic Organization, translation by A.M. Henderson & Talcott Parsons, The Free Press of Glencoe, New York, 1964, p. 328. quote by Kast & Rosenweig in Organization & Management, McGraw-Hill, St. Louis, 1974, p. 62.

[31] Ibid., p. 62.

"Rational - legal authority is based upon position within the organization, and when it evolves into an organized administrative staff it takes the form of a bureaucratic structure. Within this structure each member of the administrative staff occupies a position with a specific delineation of power, compensation is in the form of salary, the various positions are organized in a heirarchy of authority, fitness for the office is determined by technical competence and the organization is governed by rules and regulations."[32]

The rational legal viewpoint is very easily adapted to a hospital model. Authority is now and always has been established with the physician through federal and state laws as well as traditional social customs. "Hospitals deliver medical care only through physicians. The most effective health care management in the country is useless without a physician component as part of the total available controllable resources."[33] However as hospitals grew in size and complexity, organized administrative staff endured, carrying with them the rational-legal authority reflected from their positions of authority in a physician serving institution. The authoritative stance of the physician, enlarged by federal & state laws was incorporated into the posture of the institution. The authoritative posture of the institution then imbued the members of the staff. Because doctors were considered moral and infallible, hospitals and their staff were also perceived as moral and infallible.

Many hospitals both then and now were owned by religious organizations therefore, there was a combination of the authoritative, infallible and religious ethic influencing the provision of patient care. Religious hospital institutions also were frequently combined with schools of nursing. The graduates from these schools helping to perpetuate the learned managerial style which was the traditional bureacratic or heirarchical model.

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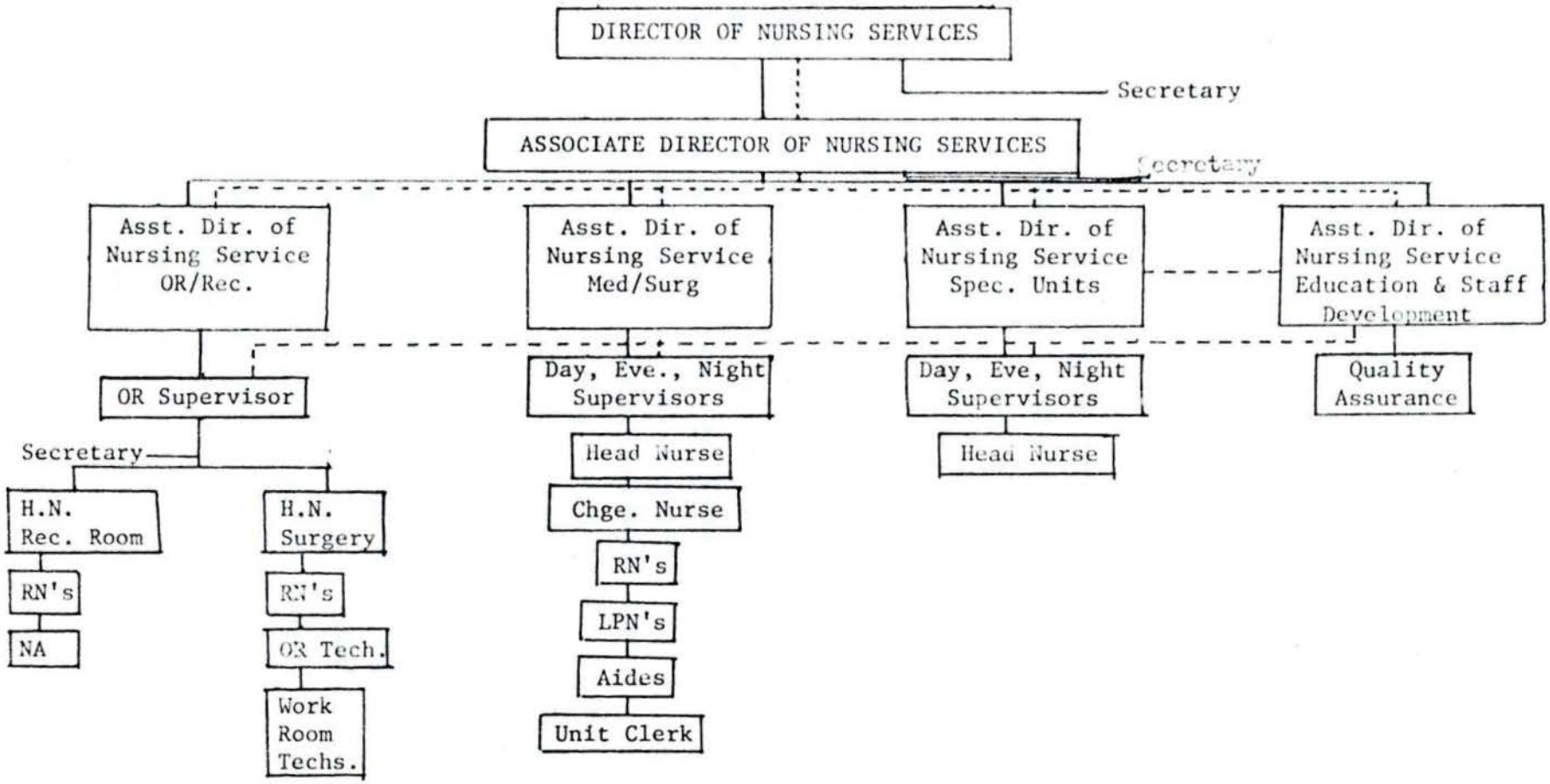
[32] Ibid.

[33] Johnson, B., Giving the Consumer Advice in the Hospital Business in the "Consumer & the Health Care System". Ed. by Rosen H., Hetsch, J., Levey, S., Halsted Press, John Wiley & Sons, New York, 1977, p. 193.

Figure

Example of part of a nursing service organizational chart using the hierarchical method



In nursing services the heirarchical chart clearly shows the level of skills of the nurses, the aide being at the bottom and the director at the top. An example of this is given in Figure 1. Due to the number of positions under her command the director may never be able to communicate personally with large numbers of her staff. In this model delineation of authority tends to be sharply defined and power tends to be concentrated at the top of the pyramid. Communication is usually poor, the design facilitating downward channels but inhibiting upward channels for feedback. Due to the distance between the top and bottom of the pyramid what communication does take place tends to be subject to distortion.

The heirarchial model appeared to work relatively well when there was little need to change and therefore communication needs were less. As long as the workers at the bottom of the heirarchy felt that their supervisors were protecting their best intrests; and that this structure was not only necessary, but provided security both in role definition and job tenure, the workers appeared content.

One major drawback with the heirarchical model was the frequent lack of grievance procedures. Grievance procedures became important concerns of the hospital employees, particularly in the 60's and 70's. As the social and medical changes outlined in chapter one impacted on the hospitals, frustrations and concerns erupted. Without a channel for communicating these concerns. a great deal of unrest was created.

At the same time (60's) the new breed of "worker was emerging. These workers demanded good pay, sensitive bosses, meaningful work and satisfying careers," [34] said a national news magazine. David Ewing of Harvard Business School was quoted in this article as asking why workers should leave their constitutional rights on the doorstep when they go to work. Workers were quoted as stating they wished to be treated as a person rather than a number, they wished to be listened to.

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[34]"New Breed of Workers", U.S. News & World Report, Sept. 3, 1979, page 35

Whether or not these concerns have contributed to the downfall of the heirarchical model can be debated but these concerns did contribute to the increase in unionization of hospitals.

Stanton says (1972) . . .

> the professional and white collar employee today is a rather troubled and frustrated individual. Inflation and rising living costs have seriously eroded his position as compared to that of the unionized blue collar worker and the already unionized white collar worker. Furthermore, Society's activism, militancy, and confrontations have convinced people that the respectable, patient, and trusting yet politically weak, relatively impotent, and unorganized professional white collar employee will regress more and more in the near future. Many are convinced . . . that their status will continue to deteriorate unless they take dramatic, assertive and unified action by seeking the protective umbrella of a powerful union. [35]

Nurses and nursing staff were and are a prime target of union organizers including those activities of the American Nurses Association. As a consequence of these changes nursing organizations have evolved from heirarchical to participative or decentralized models. Inherent in the change to this model was the understanding that nurses are "knowledge workers" and that "worker alienation is the cost of administrative failure to manage work so that it is productive, to demand responsibility of employees for contributions towards desired goals and to create a climate in which it is possible to achieve."[36] The author of the above statement goes on to say "The successful administration of knowledge intensive institutions basically involves a fundamental change in traditional notions about administration."[37]

The participative management system is, according to Marriner,

> associated with the most effective performance. Superiors have complete confidence in their subordinates.

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[35] Stanton, E., Unions & the Professional Employee in "A Guide to Employer-Employee Relations" Ed. by Kobs, D. Catholic Hospital Association, St. Louis, 1974, p. 80.

[36] Schaefer, M.J. "The Knowledge Worker", "Journal of Nursing Administration", April, 1977, Vol. VII #4, p. 8.

[37] Ibid., p. 9.

> Subordinates ideas are always sought, and they feel completely free to discuss their jobs with their superior. Goals are set at all levels. There is a great deal of communication, up, down, and sideways -- which is accurate and received with an open mind. Superiors are very well informed about the problems faced by their subordinates and decision making is well integrated throughout the organization with full involvement of subordinates. Because goals are established through group action, there is little or no resistance to them. Control is widely shared through the use of guidance and problem solving. [38]

Participative organizations are also known as democratic, decentralized or flattened. The participative organization is based on the premise that nurses are knowledgable workers, professionals, adults, and capable of self-guidance and of guiding the ancillary workers with whom they work.

Participative management requires large numbers of nursing staff who prefer minimally structured situations. While this may be the norm in some areas and specialities, it may not in others. This situation supports the need to have one organizational structure in an I.C.U. which typically employs assertive, independant, autonomous nurses and perhaps another more structured organization for traditional medical/surgical units.

Figure 2 demonstrates the following relationships. The Director of Nursing is taking direct responsibility for staffing and budget, secretarial staff, Quality Assurance which includes audits, staff development, and infection control. Her associate assumes direct control of the clinical areas. The Head Nurses have twenty-four hour responsibility and report directly to the Associate Director. The Evening and Night Assistant Directors are in advisory and consultant capacity to the Head Nurses but have only line authority over the evening and night employees. This line authority relates to the actual events of the day, not to long range goals or planning. This is the prerogative of the Associate Director and the Head Nurse. There are no day supervisors on this chart. There would, however, have to be either charge nurses or assistant head nurses for evening and

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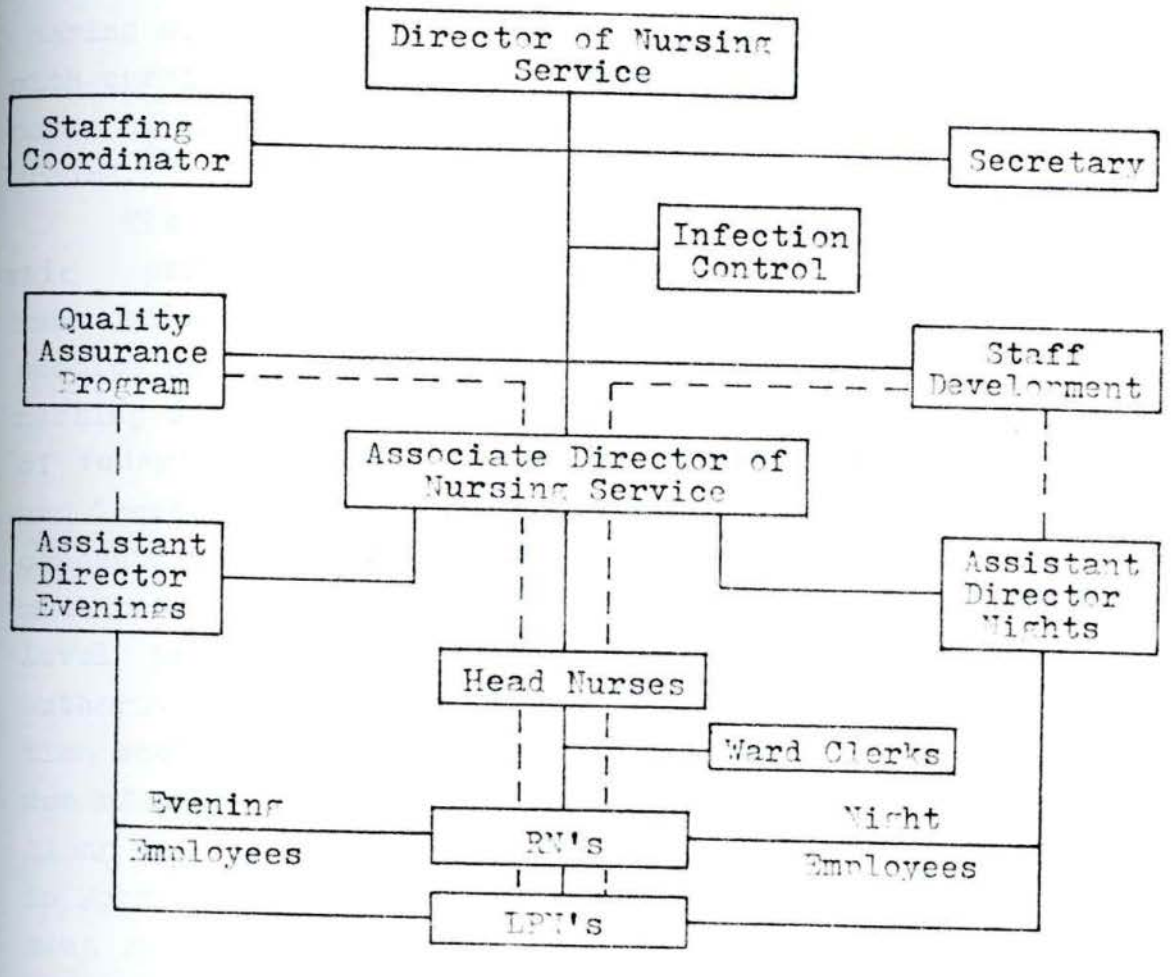
[38] Marriner, A., "Development of Management Thought", Journal of Nursing Administration, Sep., 1973, Vol IX #9, p. 20.

Figure 2

Example of part of a nursing organizational chart using the flattened method



nights. These positions can be utilized as training areas for Head Nurses. The staffing coordinator is not a nurse.

This kind of structure is cost effective inasmuch that many high paying jobs are eliminated. Participation and decentralization do not mean complete autonomy. As a management method, "decentralization is a way of organizing work by sharing authority and decisions among semi independent units with carefully devised controls to make certain that all subparts of the system are working towards the same established goals".[39]

The major problem in changing from a traditional bureaucratic organizational model to a decentralized model is how much authority should be concentrated or dispersed. This problem directly relates also to the communication needs of nursing director and employee. The increasing complexities of today's health field make it imperative that decision making and therefore the information necessary to make decisions, be concentrated at lower levels on the organization than possible with previous models. The director must designate at which levels problems may be solved and allow those levels the authority and autonomy to proceed to do so. "Thus decentralization encompasses all areas of management control involving the use of human and material resources within the total system.[40] Along with participative management there has been an increase in Management by Objective as an organizational tool. Management by Objectives is also seen "as a possible means of optimizing nursing effectiveness, efficiency and job satisfaction while minimizing frustration."[41]

Management by Objectives was introduced by Peter Drucker as a method for management to manage managers. Consequently

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[39] Alexander, L. Ibid., p. 186.

[40] Ibid.

[41] Cain, C., and Luchsinger, V., "Management by Objectives--Applications to Nursing", "Journal of Nursing Administration", Jan., 1978, Vol. VIII #1, p. 35.

when it became obvious to hospital administrators that the nursing service budget accounted for 40-60% of the hospital budget with each individual nursing unit managing thousands of dollars, it was felt that management by objective would be ideal in a large decentralized nursing service. By the setting of goals and objectives for individual nursing units that contributed to overall goals of the nursing department and hospital a certain degree of structure missing in decentralization was replaced. Furthermore Management by Objectives is a management tool that can be adapted to a clinical setting without changes in methodology. One of the complaints of nurses concerning the administration of hospitals has been that the wholesale adoption of management theories effective in product oriented institutions are not applicable to service oriented institutions.

Maritz says "The basic difference a product and a service have is the one element that needs consideration when making the application. Patients are not products and cannot be regimented into management patterns that work in product oriented industries . . ."[42]

The advantage of a M.B.O. (Management by Objectives) approach is that it incorporates the service orientation into its methodology. Nursing administration can write goals and objectives for designing absenteeism control methods, supervisors can write goals and objectives for planning the introduction of new technology or systems into a patient care unit and staff nurses can write goals and objectives for individualized nursing care plans. Thus a decentralized nursing department becomes more efficient by the use of M.B.O. Another advantage of M.B.O. is that there is built into its system an evaluation process, the use of the results of the evaluations enable the organization to remain dynamic and growing. An example of M.B.O. in a nursing organization is given.

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[42] Maritz, D. "Management Principles & Nursing - The Inefficiency of Efficiency","Supervisor Nurse", March 1980, Vol. II #3, p. 40.

XYZ Nursing Service will be reviewed by Joint Commission on Accreditation of Hospitals in six months. New standards for nursing have been written since the last accreditation -- full compliance for all standards is anticipated, in addition the department had several areas of non-compliance cited at the last review.

The objective in this situation is easy to write:

XYZ Nursing Service will be granted two years approval by J.C.A.H. with no exceptions on the next visit in six months.

How can this goal be achieved? In this instance the nursing management group examines the various ways this goal can be reached, what problems can occur, and what are the possible solutions. The resulting suggestions should then be divided into those that should be discussed within an immediate time frame and those that can, by their nature, wait. These are then called short and long term goals.

In this instance a short term goal might be to (1) review the previous recommendations and examine present practice to see if defaults were remedied and documented; (2) obtain and examine copies of new J.C.A.H. standards; (3) make nursing middle management aware of one and two with a request to discuss these issues with staff.

The nursing management committee, in order to divide the six months time into working periods most likely to help them succeed, would divide short term goals one and two into segments that can be handled by sub or specialty committees and establish a four-week time frame for reporting back. By this time each member of the nursing service should be aware of what is going on.

Completion of long term goals follows. Having established a firm data base, members of the nursing management team move towards completion of their goal, coordinating the sub-committees that are composed of nursing staff from all levels of patient care and job descriptions. The role of the director becomes that of coordinator, teacher, and counselor in that the

successful accreditation of the nursing service department reflects the work of the entire staff, that the process has been a growing, sharing, and learning one, and that each member of the nursing staff now has a better understanding of her role and contribution to the whole.

In keeping with the evolution of organizational structures in nursing has been the change occuring in the methodology of delivery of hands on patient care. The three most widely used methodologies have been functional, team and primary. The functional method was in use at the same time (1900-1950's) that the traditional staff were divided and assigned to staff members in the most economical and efficient manner. Each staff member became proficient at a limited number of tasks. In this method a patient could have 10 nursing staff members carryout 10 different functions concerning his care in an 8 hour period. Many times nursing rules and regulations forbade discussing any aspect of the patients desire for knowledge concerning his illness.

Team nursing (1950's to present) was and is an attempt to individualize the care of patients and present a more unified approach. Team nursing was the result of recommendations of a research project funded by W. K. Kellogg and undertaken by the Department of Nursing at Teachers College New York in 1949 under the direction of Eleanor C. Lambertson. Team nursing was incorporated into the curriculum of schools of nursing and was utilized by most hospitals in the last 25 years.

The third method of delivery of care is the Primary Care Model designed by Manthey and colleagues at the University of Minnesota in 1970. They state

> Primary nursing establishes a one to one nurse patient relationship in a highly complex care context. It is a design concept that embodies an arrangement of nurse and patient that facilitates professional practice and the delivery of nurse care. It is an organizational pattern for nursing units in acute care hospitals which calls for

> nurses to assume a new role . . . it incorporates the strong components of responsibility and accountability into the role of the hospital nurse . . . admitting to only one constant, top quality care. [43]

The growing interest in primary nursing has developed an equal interest in the organizational format necessary to support this model of delivery of care. Anderson and Choi state "Our intent is to show that primary nursing consists not only of activities propelled by nursing initiatives but also depends upon the degree of nursing autonomy provided through the organization.[44]

Necessary Primary Nursing Characteristics
Organizational Autonomy[45]

Nursing Initiative		
High	X	O
Low	O	X

X = high percentage

O = low percentage

Anderson and Choi go on to examine in detail the necessary characteristics for a receptive milieu in which to practice primary nursing. They conclude with the following statement:

> The definition of primary nursing reflects what would be considered by some an ideal evolution for nursing... for primary nursing to succeed, we would expect a high level of initiative from the nurses and from the organization that provides structural autonomy to the nurses. In effect, the organization legitimates primary nursing activities by providing professional latitude. Such latitude is in large measure achieved through decentralized decision making authority from, for example, the director of nurses to the primary nurse.[46]

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[43] Manthorn, M., Cisko, K., Robertson, P., & Harris, I., "Primary Nursing: Return to the Concept of "My Nurse", "My Patient"" Nursing Forum Writer, 1970, Vol 9 #1, p. 35.

[44] Anderson, M., and Choi, U., "Primary Nursing in an Organizational Context", Journal of Nursing Administration, Vol. X #3, March, 1980, p. 28.

[45] Ibid.

[46] Ibid., p. 30.

The situation cited by Anderson & Choi may be answered by the emergence of a new form of organization, that of the Matrix.

Matrix Organization

A matrix organization is a very new concept that owes its conception to the space industry. It is an organizational theory based on the equality of role and contribution to product effectiveness of all members of th organization. Line authority is on a peer level and demonstrates communication rather than a superior/subordinate role. Matrix recognizes that each person or group in their own spheres are the authority in that sphere. Matrix organizations may also be known as function and project organizations. Kast and Rosenweig quote Hage, Aiken and Marriett as saying that

> as organizational structures become more diversified, and in particular, as personal specialization increases, the value of communication increases because of the necessity of co-ordinating the diverse occupational specialists. The major direction of this increased flow of information is horizontal, especially cross-departmental communication at the same status level.[47]

Figure 3 depicts a Matrix Model for a nursing service.

In this organizational model the director of nursing service would assume a program manager role, super-imposed upon a functional organization of complicated and specialized departments requiring the development of "horizontal and diagonal information-decision networks."[48]

Some hospitals are adopting a Matrix System of organization in response to mergers of institutions mandated by regional health (Marian Health Center)[49] planning groups. In these cases a project manager manages and integrates the merging of two complex organizations into one institution without loss of the definition, authority and accountability on the part of individual department heads of both hospitals.

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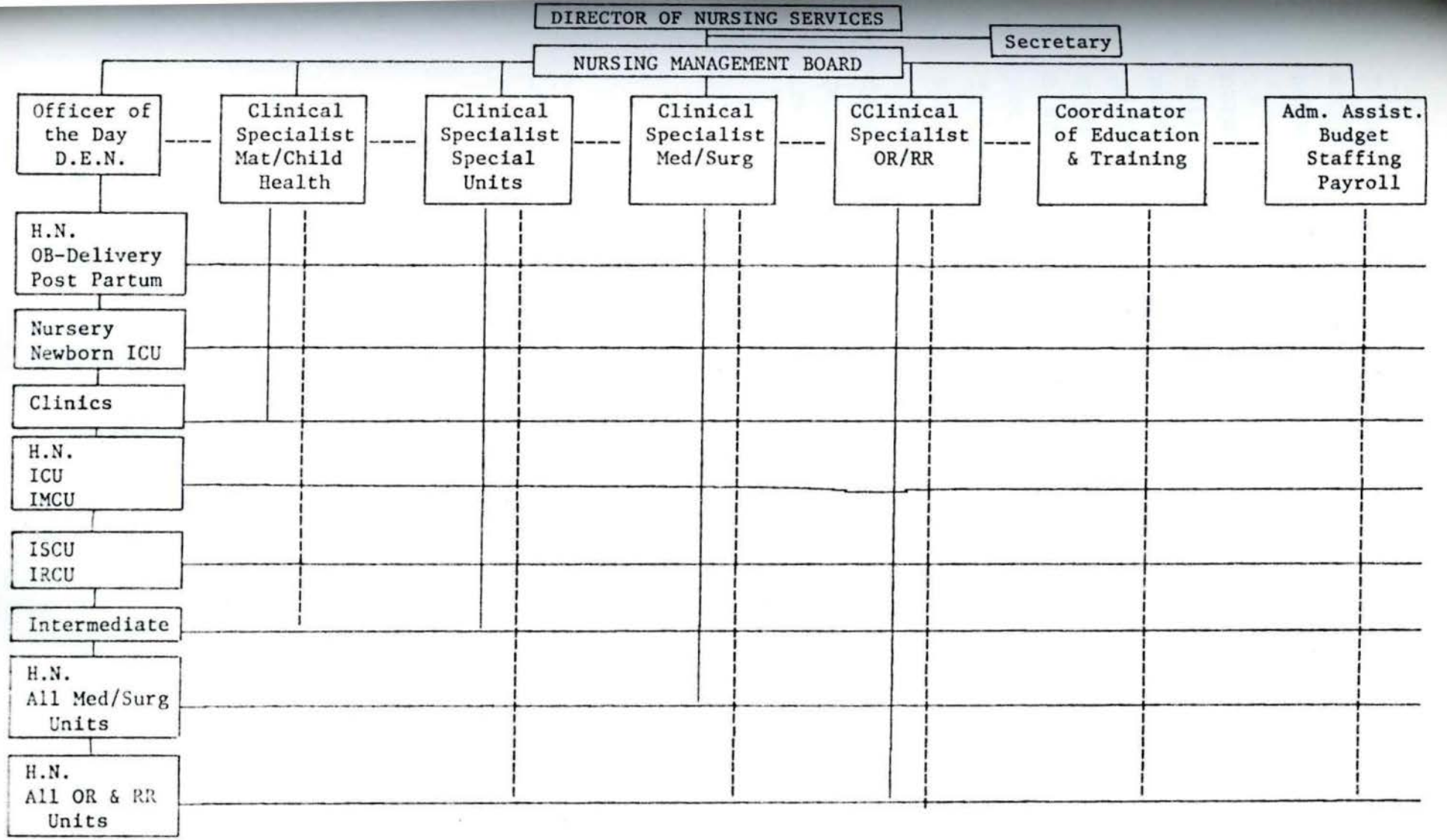
[47] Jerald Hage, Michael Aiken, and Cora Dagley Marrett, "Organization Structure and Communication", American Sociological Review, Oct. 1971, p. 869 as quoted by Kast, F., & Rosenweig, J., Organization & Management, McGraw-Hill, St. Louis, 1974, p. 230.

[48] Ibid. p. 223.

[49] Matrix Organizational Chart to Marian Health Center, Sioux City, Iowa, Dr. Colarelli & Associates, St. Louis, Mo., 1976.



This diagram is not intended to represent a total nursing service, only the concept of matrix.

_____ Line of authority
------- Line of support

Adapted from Matrix Model for Unification of Nursing Effort

In other large hospitals the Matrix is evolving as the design of the future as more and more patient care areas become highly specialized.

In summary then the primary responsibility of the nursing administrator is the creation of an organizational setting conducive to quality care in the institution in which she is employed. Depending on the contingencies, pressures and needs she will develop a model which is congruous to her own style and that of the predominate style and needs of her employees. The administrator must have a firm background in theories of management, an understanding and feeling for the needs of nursing service employees and the ability to conceptualize, communicate and implement the program of her design. She must also possess the confidence to delegate the decision making role to the levels at which the problems occur. The director must learn to become the integrator of the nursing service department -- a tall order.

Suggested Readings on Organization and Management

Management, Tasks, Responsibilities, and Practices, Peter Drucker, Harper & Row, 1974, New York.

This book is a revelation for the humanistic manager.

Nursing Administration, Edyth Alexander, C.V. Mosby, St. Louis, 1972. Chapter 10.

Very good overview that gives excellent example of organization charts, job descriptions, and internal workings of a large nursing service.

Organization and Management, F. Kast, J.E. Rosenweig, 2nd Edition, McGraw-Hill, St. Louis, 1974.

This book is for the serious student of organization theory and contains an excellent chapter on behavioral aspects of group decision making, an essential component of the participative management method.

Managing by Objectives, P. Hall, Wiley Interscience, New York, 1972. In chapter 2, the author concentrates on the problems of a growing technological society and the perils of crisis management. Although not health oriented, this book is valuable for the nurse administrator because it deals with stress in management.

Journal Articles of Exceptional Interest

"Responsibility and Authority Must Match in Nursing Management", Adelius, R., Hospitals, J.A.H. , February 1979, p. 69.

This article is excellent in that it clearly defines the accountability factor in management.

"Nursing Management and the Sense of Structure", Stevens, B.J., Journal of Nursing Administration, July/August 1974, p. 57.

This article clearly outlines the personnel element in matching the nursing managers to the type of organization structure and the resulting productivity.

"A Nonstrike for Patient Care", Cleary, D., Modern Health Care, June 1975, p. 43.

This article reflects the growing tendency of professional nurses to get involved in patient care issues especially in what they perceive as an autocratic situation.

Chapter Three

A hospital is a service oriented institution, consequently it is expected to be able to clearly identify its manner and type of service and its statement of belief concerning that service. This statement of purpose is known as a philosophy. The nursing service is expected to have a corresponding philosophy that reflects the thinking and value systems of the nurses comprising that department. A nursing service philosophy is not only a requirement for accreditation[50] but should be a widely circulated document known to all staff members. More importantly the values stated in that document should be observed to be practiced daily in all nursing transactions.

Bergevin states that a philosophy has the purpose of "establishing a common point of reference, an integrated viewpoint, towards certain beliefs, ideas, attitudes and practices.[51] A philosophy implies a value system; only people can have values or beliefs. Nursing philosophy is a statement made by a group of nurses concerning what they believe about their work. It also must reflect the management style if it is a true statement. A management that develops meaningless philosophies and policies demonstrates a lack of understanding. A philosophy that suggests care for the psychological as well as social needs of the patient and is written by a management that ignores the same needs in its staff is a paper of little meaningful value.

Philosophies can be trite and insipid or they can be dynamic. They should at all times make a statement about what is believed in, aimed for, and supported.

Sample Nursing Philosophy

> "The XYZ nursing service, by group determination, has stated its belief that nursing as a service goes beyond the administration of drugs and treatments. It believes that nursing involves a personal commitment

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[50] Bergevin, P., A Philosophy for Adult Education. Seabury Press, New York, 1967, p. 5.

[51] Standard No. of Joint Commission on Accreditation of Hospitals.

for fellow humans who are in need of support whether physical or emotional. It believes that professional nursing makes a significant contribution to the wellness of individuals by use of varied nursing techniques and interventions either alone or in conjunction with other members of the health care team.

The XYZ Nursing service further believes that it is essential that the nursing staff provide support and add strength to each other in such a way that the practice of nursing provides enrichment rather than depletion of self. It further believe that all patients, family, and fellow staff members are entitled to skillful, empathetic, courteous and caring attention.[52]

The writing of a philosophy can be a very rewarding experience. It should be the occasion for offering intellectual stimulation and response from the management group. The philosophy is inextricably wound up with the organization plan, in that they should complement each other. If primary nursing is a major part of your organizational plan, then a statement to that effect would be placed in your philosophy; "X Nursing Service believes that implementation of primary nursing provides for the most therapeutic and cost effective use of nursing resources." A philosophy is a working statement, it must reflect accurately the prevailing attitude within the department. In order for a philosophy to be written, the nursing staff needs a certain degree of sophistication. A study of nursing literature reveals that this is a neglected topic with few authors addressing this subject. Alexander does, however, discuss this issue by exploring the impact of the technologies evolving from physical and life sciences on the practice of medicine and related disciplines.

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[52] Ibid.

She states, "As new scientific knowledge and skills are applied in the treatment and prevention of disease and new social theories are initiated in the delivery of health services, the traditional philosophies... of good intentions, adjusts its new principles values and expections."[57] She also states," The old values and attitudes of nurses towards new roles and functions of nursing service personnel are not acceptable if today's and tommorrow's nursing service system is to be an integral part of the total patient care system.[54]"

Upon completion of a philosophy for nursing service the nursing department should address itself to goals both short and long term. If the organizational format encompasses the M.B.O. management tool then this is automatic. If M.B.O. is not used, the setting of goals to be pursued is still the next step in design of a nursing administration.

In order to set goals an analysis of existing departmental strategies, future plans of the hospital and planned happenings needs to be made. Without the analysis necessary for goal setting, objectives designed to solve problems cannot be written. Each speciality area within nursing will have different dimensions and perspectives in meeting the overall goals of the nursing department and the hospital. Therefore an analysis of each subdepartment of nursing needs to be undertaken on a frequent ongoing basis. This analysis needs to establish the following data.

(1) The existing level of care provided
(2) The relation of the existing level of care to the desired level of care.
(3) The impact upon this level of any planned or foreseen changes.
(4) The steps necessary to implement any identified needed changes.

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[53] Alexander M. Ibid p. 157
[54] Ibid p. 153

(5) The method by which the subdepartments relate to the department and the hospital.

(6) The support services necessary to maintain or implement the designed level of care.

With the above data assembled nursing administration is able to identify certain areas in which organizational change is needed. Broad goals to effect that change can then be written, which in turn are rewritten as short and long term goals. As the goals are established, so then can objectives be written.

An example of data analysis and goal setting from examining the performance of the Operating and Recovery room follows.

Examination of XYZ O.R. has revealed:

(1) The existing level of nursing care provided has resulted in four documented patient complaints, numerous physician complaints, and one malpractice claim in the past six months.

(2) Comparison of American Operating Room Nurses Association standards to XYZ practiced standards reveal several areas of non compliance.

(3) Addition of fifty new surgical beds and a neuro-surgery I.C.U. unit requires specific new skills, equipment and techniques in O.R. and R.R. nursing staff.

(4) Present O.R. and R.R. staff lack experience and skills needed to change behaviors without outside help.

(5) Communication concerning problems in the O.R. and R.R. is not taken to other supportive areas in the hospital.

(6) The Staff Development Department and overall nursing administration have been identified as having little input into the O.R. and R.R.

Following the assembly of this data the nursing administration writes this goal.

"XYZ O.R. and R.R. nursing service plans to increase the level of nursing care to patients and gain specific technical skills though a program of staff development which will be reflected in a decrease in patients' incidents and an increase in the ability to interact and communicate effectively with all staff and patients utilizing the O.R. and R.R."

This broad goal can then be written as short and long range goals. A long range goal would be to, "within the calendar year examine the results of changes implemented in the O.R. and R.R. by measuring the quality of nursing care delivered."

A short range goal would be to "reduce immediately all practices that negatively impact on patient safety and perception of care."

From these goals specific objectives may be written that are addressed in the issues identified in the data analysis. An example of an objective for this situation follows.

(1) The O.R. and R.R. nursing staff will adapt, integrate, and emplement the published standards of the A.O.R.N. into the policies and procedures of the XYZ O.R. and R.R. by January 1st.

The preceding example of goal setting and objective writing reflect a basis in problem solving and the systems approach. "The system is an organized unitary whole composed of two or more into dependant parts components or subsystem, and delineated by identifiable boundaries from its environmental suprasystem."[55] A nursing service with its many subparts fits the category described above very well.

A systems theory provides an approach to analysis of a couplex and dynamic organization. Kast and Rosenweig define an organization in the content of the systems theory as:

(1) A subsystem of its broader environment, and
(2) Goal-oriented people with a purpose; including
(3) A technical sub-system - people using knowledge, techniques equipment and facilities.
(4) A structural subsystem - people working together on integrated activities.

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[55] Kast and Rosenweig, Ibid p. 29

(5) A pychosocial subsystem - people in social relationships and coordinated by

(6) A managerial subsystem - planning and controlling the overall endeavour.

Systems theory is in its infancy in its application in nursing. Claus and Bailey have devised a "step by step procedure conceptualized within a system framework to train nurses to systematically approach problems and to make rational and defensible decisions."[57]

A goal is essentially a statement of either a solution to an existing problem or an outcome designed to prevent a problem in the future. The information needed to state goals can be obtained through the systems theory process. Flow charts are a derivative of systems theory. The nursing service director can facilitate the goal setting process by the use of flow charts. A simple flow chart is shown by Figure #4.

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[57] Bailey, J. Claus R., Decision Making in Nursing C.V. Mosby, St. Louis, 1975 p. 7

Figure 4
Outcome Measurable Care

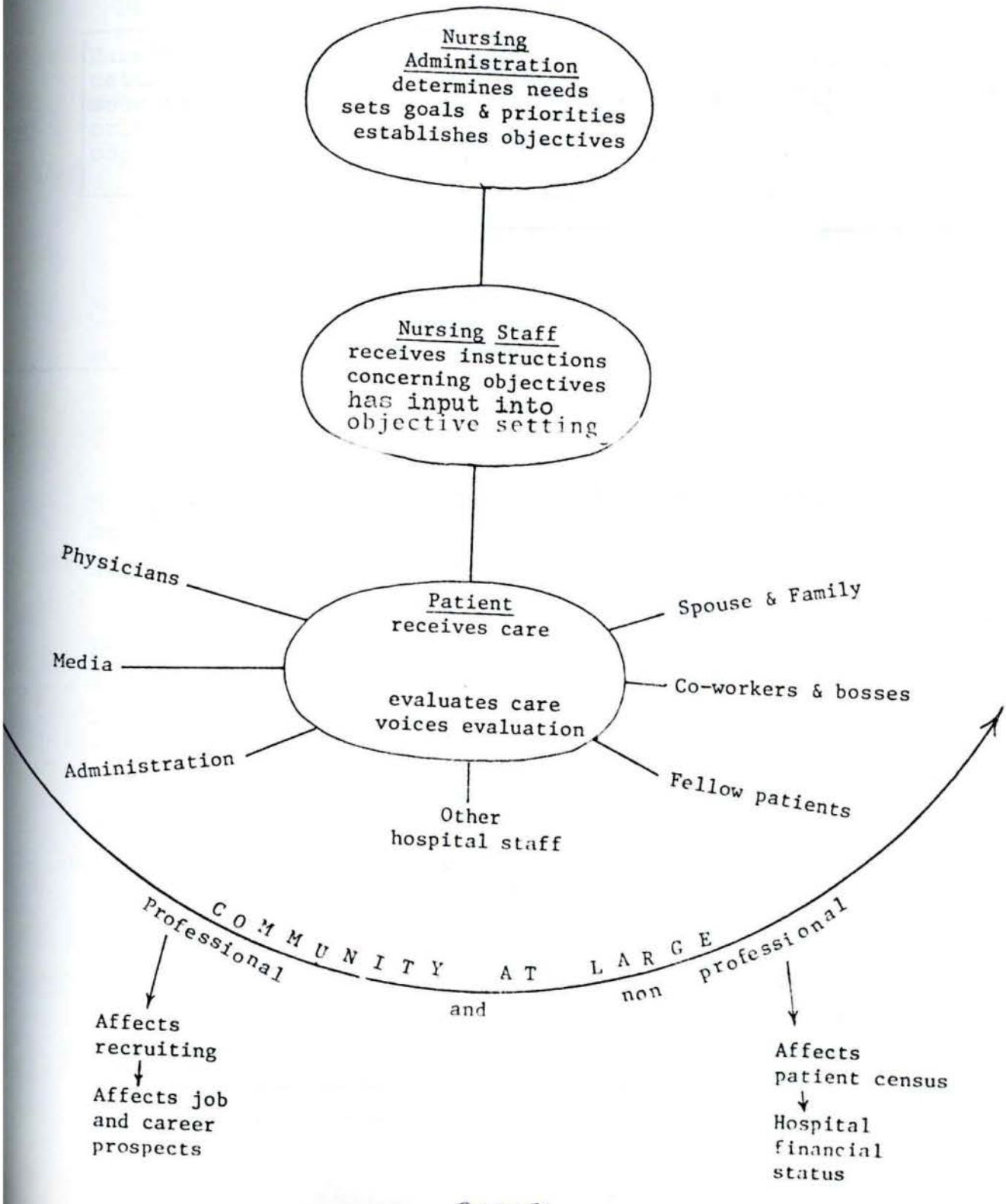
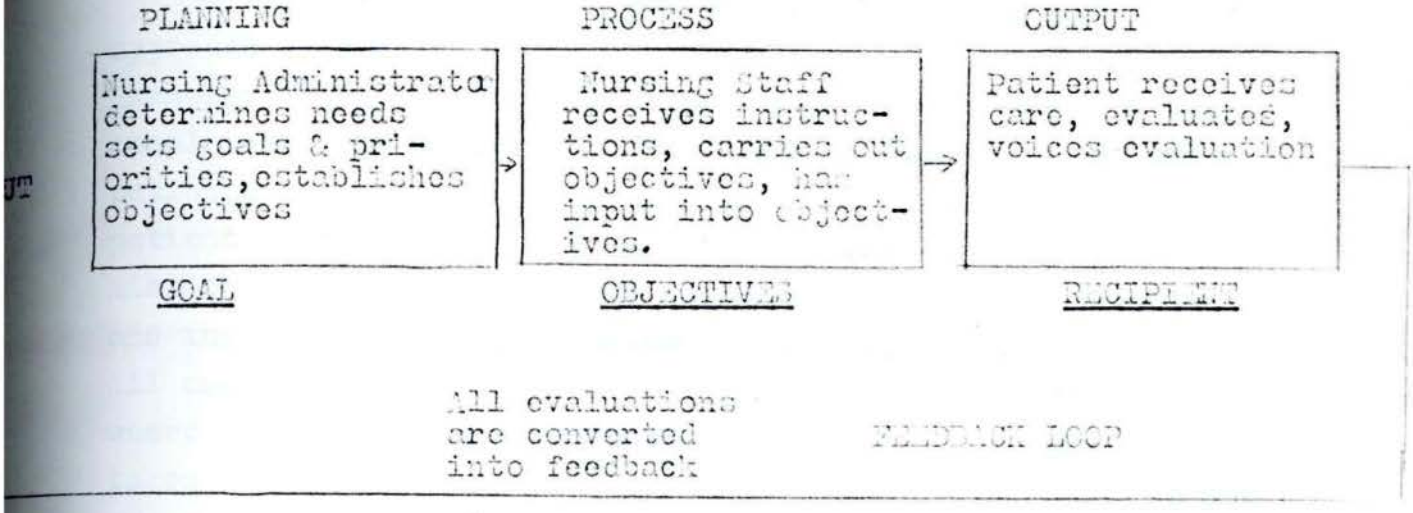


Figure #4 can also be shown as a cybernetic model see Figure #5.

Figure 5



This diagram, or schema, based on "General Model of Organization as an Open System,"[50] clearly demonstrates how evaluation of care received by the patient should provide input into the goal selection.

The nursing administrator can see the planning, process, output, evaluation and input of goal setting and the effectiveness of the systems approach in clarifying issues. The practice of goal selection and clarification leads the administrator away from crises management. Nurses have, for too long, equated crises management skills with good administrative skills. The two are not synonymous. A crisis is an unforeseen problem of some magnitude. If this occurs daily, then obviously little planning is taking place. Crises in a hospital will always occur but most events should be routine, expected and handled by established protocols. A good nursing service administrator needs to have both sets of skills, crises and organizational.

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[50] Kast, F. Rosenweig, J. Ibid p. 110

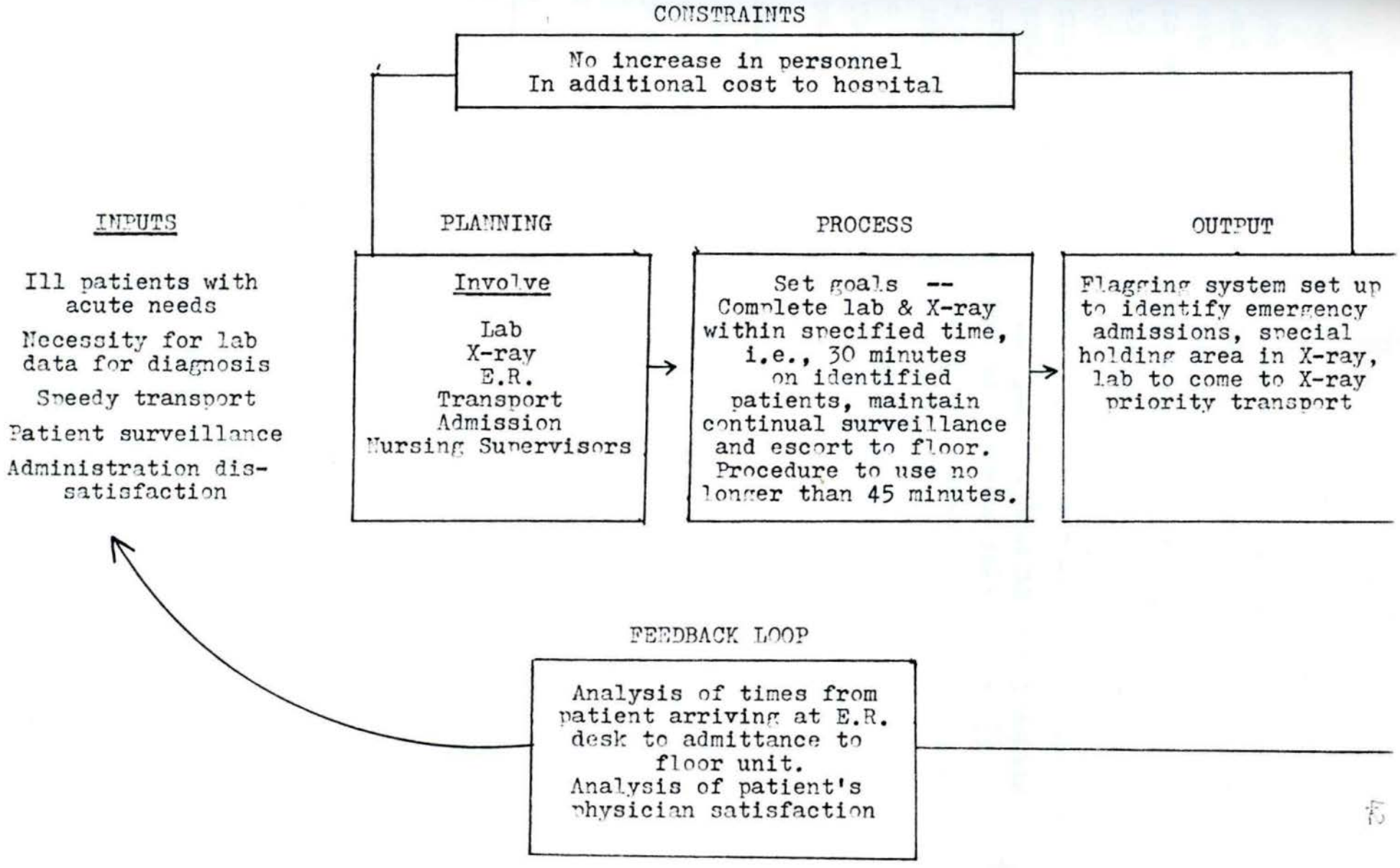
Many organizational goals can be achieved by analyzing the goal, defining problems in the way of reaching the goal and then solving these problems permanently by writing policies and procedures designed to prevent the problems reoccurring.

A further example of goal setting utilizing the problems approach follows.

Example: The Director of Nursing Service has received many complaints from physicians about the confusion in admitting patients through the Emergency Room, delay in getting the patient through X-ray and lab, and getting emergency admissions to the floor. This problem has been longstanding and improvements only temporary. Recently, a critically ill emergency admission had a cardiac arrest in X-ray where he had been inadvertently left instead of being taken directly to his room. The Director feels that another "temporary improvement" after reprimands is totally inadequate but feels overwhelmed at the task of overhauling the emergency admission process. A crises approach would be to counsel and discipline everyone involved immediately and regardless of their actual role in the problem. An organizational approach would be to establish a goal she would like to reach and find out how she can get there. If she looks at the system model she might come up with a scheme such as Figure 6, page 42.

This diagram has an additional box labelled constraints -- in this case, financial. This addition of constraints completes the model of a system approach to problem solving. How does this help the director of nursing service? She knows the inputs; she has gained these from interviews with physicians and patients, and her direct observations.

Figure 6


CONSTRAINTS
No increase in personnel
In additional cost to hospital
INPUTS
Ill patients with acute needs
Necessity for lab data for diagnosis
Speedy transport
Patient surveillance
Administration dissatisfaction
PLANNING
Involve
Lab
X-ray
E.R.
Transport
Admission
Nursing Supervisors
PROCESS
Set goals -- Complete lab & X-ray within specified time, i.e., 30 minutes on identified patients, maintain continual surveillance and escort to floor. Procedure to use no longer than 45 minutes.
OUTPUT
Flagging system set up to identify emergency admissions, special holding area in X-ray, lab to come to X-ray priority transport
FEEDBACK LOOP
Analysis of times from patient arriving at E.R. desk to admittance to floor unit.
Analysis of patient's physician satisfaction

She plans to invite all concerned parties to problem solve and identify a goal. What is the problem? Why are these events occurring? How can they be changed for the better? Is merely affecting change enough or can a goal, i.e., 45 minutes total time, be achieved? What is the output of setting this goal? In this case, the output is a flagging system to identify acutely ill patients; a special area set aside for flagged patients that is equipped with crash cart equipment and under surveillance at all times; a method whereby lab personnel come to the holding area, thus utilizing time spent waiting for X-rays; and, finally, a top priority given to flagged patients by transportation. These outputs or outcomes can then be translated into policies or procedures.

Sample Policy

Example: All patients identified in the Emergency Room as in need of emergency admission are to have a red sticker placed both on their chart and x-ray and lab requests. Personnel will consider all red stickers as top priority to be superceded only by stat requests.

Sample Procedure

Example: Obtain red stickers from Central Purchasing using form AB-15.
Place red sticker on top left corner of x-ray requisition, bottom left of lab requisition.
Place red sticker on patient's chart back and on patient's armband.
Notify transportation of red sticker priority.
Alert admitting office of red sticker admission.
Remove red stickers from patients armband following admission to floor.
Remove red sticker from E.R. chart back following closure of E.R. chart.

Sample Policy

All patients wearing a flagged red armband and having a flagged x-ray request will be kept in holding room "A". X-ray personnel will keep these patients under direct surveillance at all times.

Sample Procedure

Receive patient and place in holding room "A", process request.
Proceed with examination ahead of all others unless "stat" orders are received.
Return patient to holding area "A"
Alert transportation of red sticker patient when x-ray completed.
Repeat transportation request every five minutes until patient is sent to floor.

In order for the director of nurses to feel that she is reaching the organizational goal established, she will need to have feedback. How will she achieve this? A very simple way is to check with those physicians who have complained in the past. Another simple way is to log the time involved. An analysis of this data will then be added to the next input cycle and the model recommences producing refinements to the system.

The preceding have been examples of goal setting addressed to typical problems within a nursing service department. Frequently, the administration and management of a nursing service is the solution of problems on a continuing basis due to enormous pressures from society directed at the health care field. These pressures make it imperative that a nursing administrator utilize the executive management tools in order to assist her department to meet the demands placed upon it. Marriner says, "By studying the development of

management thought, the nursing administrater can define her management role, develop her philosophy of management learn tools and techniques for implementing her responsibilities, and gain an increased understanding of how to work with others towards accomplishing goals."[59]

Bryan states "The nursing service director in an acute care center, is responsible for assisting the staff in the decision making process. Leadership and decision making skill as well as skill in the use of problem solving models can greatly enhance the directors managerial ability through approaching problems in a systematic way before choosing and emplementing a major change."[60]

The use of the general system theory approach to th management of a nursing department is strongly advocated by this author. A systems approach minimizes crisis management and allows for innovative problem solving in a flattened decentralized organizational structure. Alexander says, "With the implementation of the system concept, the nursing service system, are an integral part of the patient care system, becmes a crucial and pivotal point through which the production of the departments in other systems can be translated into effective service to patients, their families, and others."[61]

Finally, when the nurse administrater solves complex and compound problems involving several departments, she has achieved several things that frequently are not perceived or capitalised upon.

The first thing that has occurred is that several aspects of the problem solving process have become inter-

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[59] Marriner A., Ibid p. 31

[60] Bryan, E., A Nursing Service Director in an Acute Health Care Center, Edited by J. Bailey & K. Claus in Decision Making in Nursing, C.V. Mosby Comapny, St. Louis, 1975, page 137

[61] Alexander, E., IBID page 129

nalized. She has absorbed the process and can now use energy to solve even more complex problems.

Secondly, and very importantly, she has demonstrated her ability to both the administrator and other department heads. This leads to the acquisition of power through recognition of expertise and concomitant respect. This type of power, power which stems from expertise, is totally necessary to the nursing administrator, not for reasons of esteem or ego but because nursing, legally and in reality, is the department most responsible for patient care.

Thirdly, out of an acute verbalized problem has come written policies and procedures that can relieve anxieties and tensions in many members of the hospital staff. Staff members do not want to see patients come to harm; they do not want to work in a chaotic environment. They want to see their department heads exert a leadership role. Therefore, the nursing administrator who takes definitive action to solve ongoing problems becomes recognized as a leader. When a strong leader is present, morale rises.

The fourth aspect of problem solving is probably the least capitalized on, particularly by nurses. And that is documentation and management information that reflects on the nursing administrator's performance. The nurse administrator today is being evaluated on her management skills and management skills are those of achievement rather than knowledge. Drucher says, "Achievement rather than knowledge remains, of necessity, both proof and aim. Management is a practise... it means taking action to make the desired results come to pass."[62] Nurse administrators though written reports need to document their growing management skills.

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[62] Druches, P. The Practice of Management, Harper and Bros. N.Y. 1954 p. 11.

Summary

This chapter has dealt with the premise that all parts of management and supervision-goals, philosophy, and problem solving-are interrealted and flow from a value system. In a nursing service they flow from the objective value system of that nursing service. A nursing service should subscribe to a nursing philosphy that incorporates an equal value to the providers of that nursing service.

This chapter also attempts to demonstrate that long range planning is essential, is a systematic method of affecting change, and is an invaluable tool for the nursing service administrator. Diagrams are given which demonstrate a simple system involving use of inputs, processes, outputs, constraints, and feedback loops. Case studies are given which demonstrate how this system can be used in problem solving.

Following are examples given so that the reader may gain self-assurance in carrying through the suggested steps and exercises in this chapter.

(1) Write a philosophy that reflects your value system as it pertains to nursing. Why did you become a nurse? What does nursing mean to you? What do you want your impact on others to be?

(2) Write a departmental goal for a nursing service based on your nursing and personal values.

(3) Write an organizational goal for an Intensive care Unit, a department of nursing education (staff development), and an emergency room, using your experience and projecting a six-month frame for achievement.

(4) Using the system approach to solve the following problem. From the solution develop policies and procedures.

Problem - Six cases of staphlococci wound infection have been reported on 3E in past month. Yesterday two cases were reported, one on 3W and one on 4E. Three months ago 3E was closed and terminally cleaned due to a similar outbreak. Closing this mixed medical/surgical floor caused

both interruption of service, physician complaints, and financial loss. In solving this problem you can give your imagination free rein. Provide as many inputs as you like from a housekeeper with a carbuncle to incorrect O.R. procedure. Whichever inputs you decide to start with follow through to completion with the writing of policies or procedures or the implementation of the existing ones.

Suggested Readings

Criteria for Appraisal of Departments of Nursing, National league for Nursing, New York, 1970.
This small book succinctly states updated standards for departments of nursing. It should be read and be available for all Directors of Nursing Service.

"Value Analysis," Executive Action Series #104, Bureau of Business Practice, Waterford, Connecticut.
This chapter on value analysis, although industry oriented, is invaluable in my opinion to tie together the rather abstract "value" to the concrete commercial product. It can be extrapolated very readily to the nursing situation, and, in fact, I recommend not only the whole book but the series itself to the new nursing administrator.

Riordan, M.L., "The Untraditional Nurse Manager," Hospitals, J.A.H.A., January 1, 1970, Vol. 52.

Manez, J., "The Untraditional Nurse Manager," Hospitals, J.A.H.A., January 1, 1970, Vol. 52.

A Luther Christman Anthology, Edited by J.P. Wysaught, Nursing Digest, Vol. VI, No. 2, Summer 1970.
This book represents selected works of a controversial nursing and human leader. Whether or not you subscribe to his views, reading this book can only add to your

preparation for the role of nursing administrator. I consider this book a must on the reference shelf.

Stevens, B.J., The Delicate Art of Nursing Supervision and Leadership, Edited by B.J. Stevens, Nursing Digest Vol. V, No. 3, Fall 1977.

This book is a very informative reference book, which contains some major articles on institutional politics, management of continuity and change and organization.

Periodicals and Pamphlets

American Journal of Nursing, 555 West 57th Street, NY 10019.

Cost Containment, fortnightly newsletter, Raven/White Publications.

Ganong, Joan and Warren; "HELP -- with Annual Budgetary Planning, "Help No. 7, P.O. Box 2727, Chapel Hill, NC 27514.

Hospitals - Journal of the American Hospital Association, 840 North Lake Shore Drive, Chicago, Illinois 60611.

Hospital Topics, 3807 Bond Place, Sarasota, Florida 33882.

Journal of Nursing Administration, Box 5-78, 12 Lakeside Park, Wakefield, Massachusetts 61880.

Nursing Digest, Contemporary Publication, 12 Lakeside Park, Wakefield, Massachusetts 61880.

Nursing 79, 132 Welsh Road, Horsham, Pennsylvania 19044.

R.N., P.O. Box 411, Westwood, New Jersey, 07675.

Supervisor Nurse, 3734 Glenway, Cincinnati, Ohio 45205.

Journal of Nursing Administration, Vol. VII, No. 2, February 1977. This edition relates entirely to staffing and is good background material.

"Staffing Should be Spelled $taffing," Eswina McConnell, Nursing 77, November issue.

"A System for Determining Appropriate Nurse Staffing," T. Ryan, B. Barber, and A. Marcierate, Journal of Nursing Administration, Vol. 5, No. 5, June 1975.

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Stevens, B.J., The Delicate Art of Nursing Supervision and Leadership, Nursing Digest, Fall 1977.

Stevens, B.; The Nurse as Executive; Contemporary Publishing Inc., Massachusetts, 1975.

CHAPTER FOUR

Budgets

What is a budget? Swanburg says that "A budget is an operational management plan, stated in income and expense terms, covering all phases of activity for a future division of time. In the department of nursing it sets the limits of finanical support, therby controlling the extent and quality of nursing programs. The budget will determine the number and kinds of all personal, material and money resources available to the care for patients and to achieve the stated nursing objectives...It is a finanicial statement of policy."[63]

Guntley says the most essential factor in developing "a succesful budgeting philosophy is that all members of the organisation understand that the budget is a plan of operations for the organisation for a particular period in the future."[64] Guntley believes that it is not possible to devise a successful budget for a hospital without guidelines, issued by the board and written established goals. He provides the following sample guidelines:

"To give competent, personalized compassionate care to our patients without respect to race, color, creed, social status or ability to pay and have the good of our patients as the primary consideration in any decision making."[65]

This philosophy then provides administration with clear but broad guidelines. Guntley feels that a philosophy of an organisation is the "umbrella underwhich a budget may be developed."[66]

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[63] Swansburg, Russell, The Nursing Budget, Supervisor Nurse Vol. 9, No.6, June 1978, page 40.

[64] Guntley, Gregory, You Can't Have a Good Budget Without a Budget Philosophy in Financial Management of Health Care, Facilities Ed. by William O. Cleverley, Aspen Systems Corp., Maryland, 1976, page 140.

[65] IBID

[66] IBID

In most hospitals the administrator and the comptroller work jointly on the preparation of the data and guidelines which will be provided to the various department heads. Included in this data should be administrative projections, goals and objectives for the coming fiscal year. The comptroller will project income and expenses for the same period. An example of some projections might include new patient care areas, new diagnostic services or remodelling of existing facilities. Administration and the comptroller also decide the type of budget, the definition of various items in a budget and the format to be used. Once all of this information is assembled it is ready to be given to department heads for discussion, planning, formalising and implementation. The data to be given includes the following, projected daily census - this is the number of patients in the hospital on a given date multipled by 365 = total census or patient days for the coming financial year. In order to do this one needs to take into account seasonal swings in average daily census (historically low at holidays and summer months), projected increase or decrease in available beds, increase or decrease in services and equipment offered, and anticipated increase or decrease of admitting physicians.

Once it is known approximately how many patient days are anticipated multiplication of patient days by anticipated room rates provide the largest figure of operating revenue. Other sources of operating revenue come from "educational program tuition, cafeteria sales, rental of hospital space to others, T.V. and other equipment rentals, income derived from operation of concessions, medical record transcript sales and other non patient related items."[67] Non-operating revenue comes from donated services and commodities and philanthropy.

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[67] Wood, Jack, Operating Revenues, Topico in Health Care Financing Fall 1974, Aspen Systems Corp., Maryland, page 82

It should be understood that more departments spend money than earn it in a hospital.

Income Producing Departments

Laboratories - routine
Radiology
Emergency Rooms
Operating Rooms
C.S.S.
Diagnostic testing laboratories that are disease specific, i.e., Cardiopulmonary - Neurology - Oncology
Respiratory Therapy
Nursing
Physicial Therapy
Pharmacy
All other patient care areas

Non-Income Producing Departments

Housekeeping
Maintenance
Transportation Services
Business Office
Medical Records
Dietary
Food Service
Public Relations
Administration
Security
Clerical Services
Medical Executive Offices
Training and Development
Printing Department
Grounds
Laundry
Utilization & Quality Assurance
Infection Control
Employee Health
Personnel
Engineering
Communication (telephone, mailroom

The need of the non-income producing department to be paid for by the income producing departments is the crux of the budgeting problem.

All hospitals are labor intensive, i.e., they are staffed with people, some of whom are highly paid professionals, a good proportion are para-professionals, and a relatively small number minimally trained.

It has been already stated that income is derived from patients, presuming that all patients pay their bills as soon as they are discharged. In fact this doesn't happen.

What actually occurs is that some patients pay their bills in cash and on time, some pay by way of commerical pre-hospitalization plans such as Blue Cross, Mutual, Aetna Travelers, etc., and some are covered by Medicare and Medicaid. Some patients are indigent, they are not covered by Medicaid or Medicare, and their bills are then written off by the hospital as bad debts. Each hospital has a certain amount of money budgeted for charity cases, which is separate from bad debts.

The hospital is not paid according to what they bill in the same way as other transactions are carried out. Mrs. Brown enters the hospital under a commercial third party plan. She is discharged owing $3000.00. Her insurance company will be billed this amount. In acutal fact, however, the third party carrier, if a major carrier in the community, will have arranged to deposit with the hospital certain sums of money on a regular basis. This money is allocated according to the past history of this insurance company's clients' usuage, average length of stay, and the hospital prices or rates for room., board, and tests, etc.. Thus, the hospital administration projecting the earnings of the hospital for the future year must take into account the projected dollar amount plus inflationry factors and the possible rate increases planned by the hospital. Because of the system of allocating lump sums to a hospital based on usage and past history--this is called P.I.P., provided interim payment--the hospital cannot raise its rates arbitrarily. In the vast majority of communities the Blue Cross-Shield Plan is the agency responsible for the P.I.P. and negotiates the rates for most third party payors. Federal reimbursement or Medicare and Medicaid have varied reimbursement rates that in the case of Medicaid are different in each state. Nevertheless, the total earnings for the financial year can be estimated. This estimate is the money referred to in the hospital budget.

the hospital is talking about in the budget.

The name for the overall projection of revenue and expense is usually the operational or organisational budget. A hospital, for ease in accounting, assigns each department a number which is part of a "chart of account." Each department then has subaccounts. Budgets are then set up for each number on the chart of accounts or cost centers.

Nursing departments usually have the largest budgets of any department in the hospital, therefore a nurse administrator must have a knowledge of budgets and the budgetting process. She must be aware of the hospital's chart of accounts and how many subaccounts she has. She must receive information of the activity generated for each account number for which she is responsible.

In the past nursing has frequently responded to the mention of budgets with variations of the following statements.

"Patient care comes first with me. My job is to get the patient well. Let administration worry about the money."

"The patient's insurance is paying anyway."

"The hospital can afford it."

"I didn't go into nursing to be a bookkeeper."

"I don't understand budgeting and I don't want to."

Understandably this is no longer possible. Standard V of the 1973 revised Standards for Nursing Services of the American Nurses Association state, "Nursing Administration determines the budget necessary to carry out the nursing care program and administers the approved budget."

Guidelines;

A. The objectives of nursing care are utilised as the determinants in forecasting the nursing service budget.

B. Nursing personnel directly involved in practice provide estimates of projected budgeting needs.

C. Nursing administration reviews and analyses reports of its financial operation on an ongoing basis and share information with nursing staff.

D. The budget is evaluated and revised as necessary by the nursing administrator on the basis of available resources and program priorities."[68]

Fulles states "Nursing administrators are finding that budgeting has become one of the most important duties. For the cost of nursing programs has to be integrated into the financial structure of the entire health care institution. Thus, in order to sustain and revitalise their departments, nursing leaders must acquire the skills needed to grapple with sophisticated financial planning." [69]

Nurses must therefore be aware of the following;

A. Methods of budget computation, i.e., traditional, zero base.

B. Control and evaluation of the budget, (sunset budgeting).

C. Information systems necessary for the budget process.

D. Types of budgets-capital, supply, personnel.

1. Budget Computation

Budget computation include two main methods, traditional and zero base. Traditional budgets are relatively simple and consist of knowing what was spent in previous years, deciding whether or not there would be any major changes in the spending, adding numbers for projected increase in expenses and totaling. This budget has been replaced in recent years by the Zero Base Budget. Impetus for this occured largely due to "the goverments insistance on budgets for revenue expenses and capital items for all Medicare/Medicaid participants."[70] Traditional budgets did not give either private or government auditors the information needed.

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[68] Stevens, Barbara, A.N.A. Standards for Nursing Service, How do They Measure up?, Journal of Nursing Administration, Vol. VI, No. 4, page 29

[69] Fulles, Mary, "The Budget", Journal of Nursing Administration, Vol.VI, No.4, page 36.

"Zero base budgeting was introduced locally by Texas Instruments in 1970 and subsequently adpoted by the Governer of Georgia, Jimmy Carter, it has subsequently been adopted by major corporations throughout the country and the world."[71] Zero base budgets eliminate accross the board layering of expenses by percentage increases or decreases. It requires a "formal justification to support from base zero each operational activity and function; and systematically reviews and prioritize all departmental decision packages into one consolidated ranking so that organizational funding is determined by priority, and reflects the net contribution and conceptual importance of each activity to the total enterprise."[72] Most articles addressed to budgeting in the nursing literature are addressed to the method of zero base budgeting, as so are the standards of both the Joint Commission on Accreditation of Hospitals and the American Nurses Association. Scrutiny of each operational activity and function of the nursing department and the delineation of goals and objectives are a required function of this perferred budgeting procedure.

2. Types of Budgets

A hospital has three kinds of budgets as a rule; Capital, Personnel, and Supplies.

Capital budgets are those budgets which project spending for large, substantial non-disposable items of considerable value and length of use. Included in this budget would be a building addition, cat scanner, and other major technological equipment. In some hospital major O.R. equipment and new furniture for patient use comes under this budget. Any item requiring a major ezpenditure and a long time in which to recover costs is sonsidered a capital item.

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[70] Whittaker, A., Holmes, S., Man Hour Budgeting: A Refinement of Managerial Control, Hospital Topics, Vol. 54, No. 1, Jan/Feb, 1976, page 14.

[71] Phyrr, Peter, Zero Base Budgeting: Where to use it and How to Begin, S.A.R.E., Advanced Management Journal, Summer 1976, page 5, quoted in "Zero Base Budgets": A Hospital Application, Calamaji, Frank & Others, Hospital Topics, Vol. 57, No. 2 page 26

[72] IBID

Personnel budgets are those budgets which project the amount of money to be spent on people--employees of the hospital. It includes the actual wages paid, the fringe benefits, the federal and state taxes, overtime and on-call payments. "It is the largest single budget, comprising 60 to 75 percent of the monies available."[73] Also included in this budget are education and tution reimbursement.

Supply budgets are for supplies used by departments in the performance of their functions and usually are not reimbursable by the patient. Supply budgets include paper goods, housekeeping and lab supplies as well as x-ray film, O.R. sponges, paint and plaster, Supply budgets are calculated on the projected increases or decrease in patient days if used for patient care, on square footage if used in building maintenance or on activity in service departments.

3. Information Systems

Nursing administration in order to design a budget requires an information system. Depending on the hospital size and complexity it may be computerised or manual. Information necessary for the formulation of a capital budget requires a nursing department to have:

A. Inventory of all equipment owned by nursing,
B. Date of purchase and anticipated life cycle of equipment,
C. Anticipated cost of repair/replacement,
D. Projected need for new equipment,
E. An understanding of the hospitals definition of what is a capital item and if revenue producing, who gets the revenue.

Information necessary for the formulation of a supply budget requires the following:

A. Knowledge of all items used by nursing that are not capital expense items,
B. Whether or not items are patient reimbursable items,
C. What is the usage of items and is the usage level acceptable, (e.g., pensfor nursing stations).

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[73] Durbin, R.L. and Springall, W.H., Organisation and Administration of Health Care, St. Louis: The Mosby Copr., 1974, page 28

D. Anticipated changes in supply items or policies and procedures, e.g., from alcohol prop sponges to betadine prep sponges.

Information systems needed to formulate the personnel budget is much more complex due to the size of the budget involved.

Although the importance of having objectives and goals for the nursing department is essential for both supply and capital budgets, it is vital for the personnel budget. A zero base personnel budget will require the nursing manager to exercise all managerial and organisational skills by utilising the following information as outlined by Porter-O'Grady:

"A. The goals and objectives of the nursing department,
B. The system of nursing care delivery and patient classification,
C. The number of full time equivalents (i.e. a person working 8 hours per day, 5 days per week),
D. Classes of nursing personnel (i.e. R.N.'s, L.P.N., etc.),
E. Salary benefit program for each class,
F. Speciality nursing services,
G. Budgeted positions on master staffing plan,
H. Position control and unit assignments,
I. Scheduling pattern for staffing,
J. Management information reporting,
K. Nursing hours of care by category,
L. Evaluation of manpower control system."[74]

In addition distinction must be made between the amount of personnel needed for direct patient care and that needed for administration. Also all projected salary increases and benefits must be incorporated into the budget.

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[74] Porter-O'Grady, T., Budgeting for Nursing Part II, Supervisor Nurse, Vol. 10, No. 9, Sept. 79, page 26

A large budget for many nursing divisions is a difficult task for one person; therefor, in line with flattened or decentralised management is the trend to get budget making at the level where it will be utilised.

Standards for nursing service indicate that those persons involved in the physical care of the patient should have input into the budgeting decisions. Therefore if each head nurse is involved in budget making the following will be achieved:

A. Compliance with national standards,

B. Participative management,

C. Continuing management growth of head nurses.

Swansburg suggests the following steps in writing a personnel budget for a nursing unit.

"A. Determine total number of full time employees needed,

B. List each employee filling a position, their hourly wages, possible or planned wage increases and/or benefits,

C. Design a calendar from first month month to last month of fiscal year, calculate payroll expense utilising the figures from letter B multiplied by the number of working days in each month,

D. Calculate shift differental, overtime and holiday pay based on either prediction or historical data. Comptroller may be able to supply a percentage figure from historical data,

E. Calculate cost of educational programs, travel and expenses. Total each monthly column and overall total. If each unit of the nursing department is done in this manner an aggregate total will be achieved. Nursing administration, education and other departments not directly associated with patient care should be handled the same way, but not included in patient care total."[75]

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[75] Swansburg, Russell, The Nursing Budget, Supervisor Nurse, Vol. 9, No. 6, June 1978, page 44

4. Control and Evaluation of the Budget

Each cost center in nursing should have had a budget formulated which in turn generates some type of information which can be analysed. Some analysis can be performed on figures obtained by scrutiny of staffing patterns, some by figures generated from stores and material management.
In analysing feedback it is necessary to note if increases or decreases noted in both expenses and revenues, has delay in purchasing capitol items caused a change in quoted prices? What has happened in the community effecting the labor market, i.e., cost of living, competition for labor amongst neighboring hospitals? Have seasonal fluctuations in census and staff utilisation of benefits been greater than anticipated?

Many hospitals are now utilising the "sunset" form of budget auditing. 'In this process the monitoring componet assumes priority. The objective of this process is to monitor the effectiveness. the efficiency, and the cost related factors of any management activity.' [76] Frequently this is done by internal auditors. The use of an internal nurse auditor in large nursing departments is an idea which should be given great thought.
Fulles in discussing nursing budgets makes the following statement, "nurses often respond...by feeling guilty about expenditures. They should realise that patients are in the health care organisation primarily because they cannot provide self care, or require nursing as a support service, relevant to their medical regimen . Nursing should be perceived as the major "earner" of the per diem rate paid by the patient, and, rather than feeling guilty, nursing administrators should realise that expenditures backed by sound budgeting will contribute to better patient care." [77]

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[76] Porter-O'Grady, page 29

[77] Fulles, Mary, page 38

Cost Containment

A chapter dealing with money in hospitals would not be complete without a discussion concerning the current emphasis on voluntary cost containment.

In the fall of 1977 the goverment subcommittee on health of the Committee on Ways and Means challenged the health care community to cut the rate of acceleration in health care costs or have laws passed that would do it for them. The American Hospital Association prepared a fifteen point program under the title of Voluntary Effort. Each local chapter had to prepare a plan for compliance of member hospitals and all providers of health care, physicians, insurers, and consumers or face mandatory caps placed on them by the Carter Administration.

The stated goal of the Voluntary Effort was to reduce the rate of increases in hospital expenditures by 2% in 1978 and again in 1979. The reader will realize the difficulty of the task while appreciating present inflation rates. The National Steering Committee for Voluntary Effort is made up of the chairmen of the Board of Trustees of the American Hospital Association, the American Medical Association, Association of Health Insurance of America, Blue Cross, and the president of the Health Industry Manufacturers Association.

Of the fifteen points in the program some of the most significant are: (1) Reduction of new capital investments by hospitals; (2) No increase in number of beds available; (3) Improvement in productivity by 2%; (4) Tighter utilization review controls in hospitals; (5) Acceleration of trends towards multi hospital systems and shared services; (6) Improving health delivery systems; (7) Making the general public cost conscious re: health care; (8) Raising the cost containment consciousness of physicians, medical students, and nursing administration; (9) Materials Management.

Cost containment in capital expenditures might mean denial of the new O.R. table this last budgeting session,

the hospital only bought one major item this year and it wasn't in nursing, or the parking garage wasn't built, or all the older beds weren't replaced with the new electric ones.

Reduction in beds or refusal to grant permission to increase the total number is now commonplace throughout the country, partly through Voluntary Effort, partly through the Certificate of Need legislation now in effect in every state.

Of the major points raised in the cost containment issue all affect nursing to some degree but number three will proably have the greatest impact. It is always comfortable to read a sentence which implies someone else is going to have to do something. Unfortunately, if the nursing service is going to become more productive, then administration will have to become doubly so to hasten this occurrence! This factor appears to be contributing greatly to the slow to change nursing administrator's demise.

Summary

This chapter has attempted to make the nursing administrator aware of the factors involved in the budgeting process. It has not provided actual budgets, forms, or figures. It is the author's contention that each hospital develop its own method of budgeting and once the nurse is able to conceptualize the budgeting process, and has access to the pertinent information and data she will be able to proceed with minimal help. It is recognized, however, that in order to design a personnel budget it is necessary to have an indepth understanding of the staffing process. This will be given in chapter five.

The following is a list of questions the reader should ask herself concerning her own situation.

(1) If I had to do a capital budget starting tomorrow what do I, or any others in the nursing office, know about nursing equipment? What do we need to replace?
(2) Do I know in terms of capital items what I am responsible for?
(3) Do I know the current cost of major nursing equipment?
(4) Have I access to catalogs and equipment files?
(5) Do I know what is needed in each unit?
(6) Do I receive information on a regular basis concerning how much nourishments are sent to the nursing stations. Is this being abused by hospital staff?
(7) Do I receive information concerning stationery and supplies sent to nursing stations?
(8) Has an effort been made to conserve all supplies throughout the nursing service?
(9) Who has access to the xerox?
(10) Do I get payroll analysis sheets and copies of overtime payments?
(11) Do I meet regularly with the administrator and comptroller to discuss budgetary concerns?
(12) Do I get year-to-date summary sheets?

If the reader answers in the negative for most of these questions, she needs to assess the demands being made of her in her position, analyze the difficulties placed in her path by failure to have adequate information, and request that these issues be clarified. There is, sometimes, a reluctance on the part of the hospital administration to part with what is considered top management information. If the nurse is to be a manager, she must have this information. Each reader will have to address her own situation and endeavor to become as competent as possible in the budgeting process. Trusted competency then becomes the entry point into top management.

Suggested Readings

Schmied, Elsie, Maintaining Cost Effectiveness, The Management Anthology Series, Nursing Resources Inc., 1979. This book is a new book in a new series for nurse administrators that is devoted to the same concepts as this author. It should be considered a must reading item for all new and old nursing administrators who are updating their financial knowledge. The conceptual model for the anthology series on page xii is a model that could serve for the profession of nursing and alone is worth the price of the book.

"Voluntary Effort-Cost Containment," Hospitals, J.A.H.A., July 1, 1978, Vol. 52 No. 13. This issue is devoted to cost containment and gives good overview and background information.

"Cost Containment," Hospitals, J.A.H.A., May 1, 1979, Vol. 53, No. 9. This issue updates previous year and shows what hospitals are doing to cut costs.

"Can Hospitals Survive Payment Shortfalls?" Steinert, J., Hospitals, J.A.H.A., June 16, 1978, Vol. 52, No. 12. This article describes very clearly the methods of Medicare-Medicaid reimbursements and some of the problems connected with this. It should be required reading for nursing staff.

"Help--with Annual Budgetary Planning," Joan & Warren Ganong, Help No.7, a Management Guide, 1976, P.O. Box 2727, Chapel Hill, N.C. 27514. This pamplet is one of the HELP series and is also a valuable reference and teaching tool. It incorporates work sheets and a type of programmed learning format.

CHAPTER FIVE

In the preceding chapter the subject of budgets was discussed. It could be argued that this chapter should have come first. In actual practice one cannot be done without a knowledge of the other and be both cost effective and provide safe levels of care at the same time.

As with budgets, nursing hours have earned themselves a reputation they don't deserve. Nursing hours are actually simple and non-time consuming if put in proper perspective. Staffing on the other hand is a different proposition. The subject of staffing in a hospital is complex and, for eaiser understanding, will be divided into two parts; the numbers part, the cold statistics which look efficient and easy to achieve when viewed objectively; and the human part, a constant source of tension when the numbers are translated into humans with babysitting problems and car trouble.

How does a nursing administrator find out what nursing hours are necessary for her organisation? How do you incorporate the numbers of nursing hours projected into the budget and how will these figures indicate the actual number of persons needed?

A nursing hour (or manhour) is the amount of time a member of the nursing staff will spend providing care to a patient in a 24 hour period. The nursing hours are the aggregate of the numerous small amounts of time spent performing a service for the patient by many different members of the nursing staff. How do you find out what the patients in each institution need?

Vaughan and Macleod estimate that "hospitals spend $15,000,000.00 yearly on nurse staffing studies. They feel that much of this money is spent reinvesting the wheel." [78]

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[78] Vaughn, R. G., and Macleod, V., Nurse Staffing Studies: No Need to Reinvest the Wheel, Journal of Nursing Administration, March 1980, Vol. X, No. 3, page 9

Nurses and administrators have, over the past 20 years, conducted numerous studies to find how many nurses are needed to provide good nursing care within sound financial constraints. These studies are based on classifying patients according to the need for care of the patient. Acuity means the acuteness of the patient's needs. A patient in the Surgical Intensive Care Unit following open heart surgery has acute needs. A patient having a series of x-rays and otherwise healthy is low on the acuity scale, since he is able to perform many functions for himself. Acuity may change in the space of two hours, however, if the patient undergoes major abdominal surgery.

Many hospital associations, hospital chains, and large institutions have conducted studies showing the average time spent on performing nursing functions, e.g., making an unoccupied bed takes four minutes; making an occupied bed, twelve minutes; pouring one medication, one-half minute. These studies detailing all nursing procedures were typical of that institution. For example, the one-half minute of pouring one medication correctly in XYZ hospital might reflect their unit dose system. Another hospital might be using a different system. Nevertheless, it can be predicted that a patient with certain acute needs is going to require in twenty-four hours a certain number of nursing procedures. These procedures will take approximately the same time in most hospitals. Add the time spent on the procedures and you have a total amount of time that someone in nursing service will be physically providing a service to the patient. Example-Mr. Brown receives in twenty-four hours the following:

1 bed bath and shave	25 minutes
4 changes of bed linen	40 (10x4)
1 enema	15
3 IV's with admixtures	15 (5x3)
1 IV dressing change	10
3 wound dressings	45 (15x3)
12 position changes	60 (5x12)
4 backrubs	12 (3x4)
12 percussion treatments	60 (5x12)
12 suctionings	24 (2x12)

6	nasal feedings	60 (6x10)
8	intravenous piggyback medications	40 (5x8)
2	intravenous push medications	10 (5x2)
10	nasal tube medications	50 (5x10)
12	B/P readings	18 (1½x12)
12	temperature, pulse, and respiration readings	18 (1½x12)
3	complete nursing assessments	45 (15x3)
1	family teaching conference	20
	Total	567 minutes" [79]

567 minutes divided by 60 = 9.45 hours of nursing time needed to care for Mr. Brown in direct hands on contact. Add to this the telephone calls, reports, orders transcribed and this patient will need close to twelve nursing hours per day if he remains stable. If his condition fluctuates, he might need fifteen nursing hours. Obviously a person this ill will be in a Special Care Unit.

If 10 patients of this acuity were in a 12 bed unit you would need

15 nursing hours per 24 hours per patient,
10 patients x 15 = 150 nursing hours per 24 hours,
150 nursing hours ÷ 8 hour shifts (if nurses are working 10 hour or 12 hour shifts divide by that number) = 18.75 nurses each 24 hours.

Since 18.75 is not practical 19 nurses are needed for each 24 hour period divided into 3 shifts.

Day shift = 6 nurses and 1 clerk (7)
Evening shift = 5 nurses and 1 clerk (6)
Night shift = 6 nurses and no clerk (6)

These figures reflect a total of 19 nurses per 24 hours providing 15 nursing hours per patient. To calculate nursing hours multiply number of employees by 8 hours and divide by number of patients. 19 x 8 = 152 ÷ 10 = 15 nursing hours.

Patient acuity systems rely on a nursing workload

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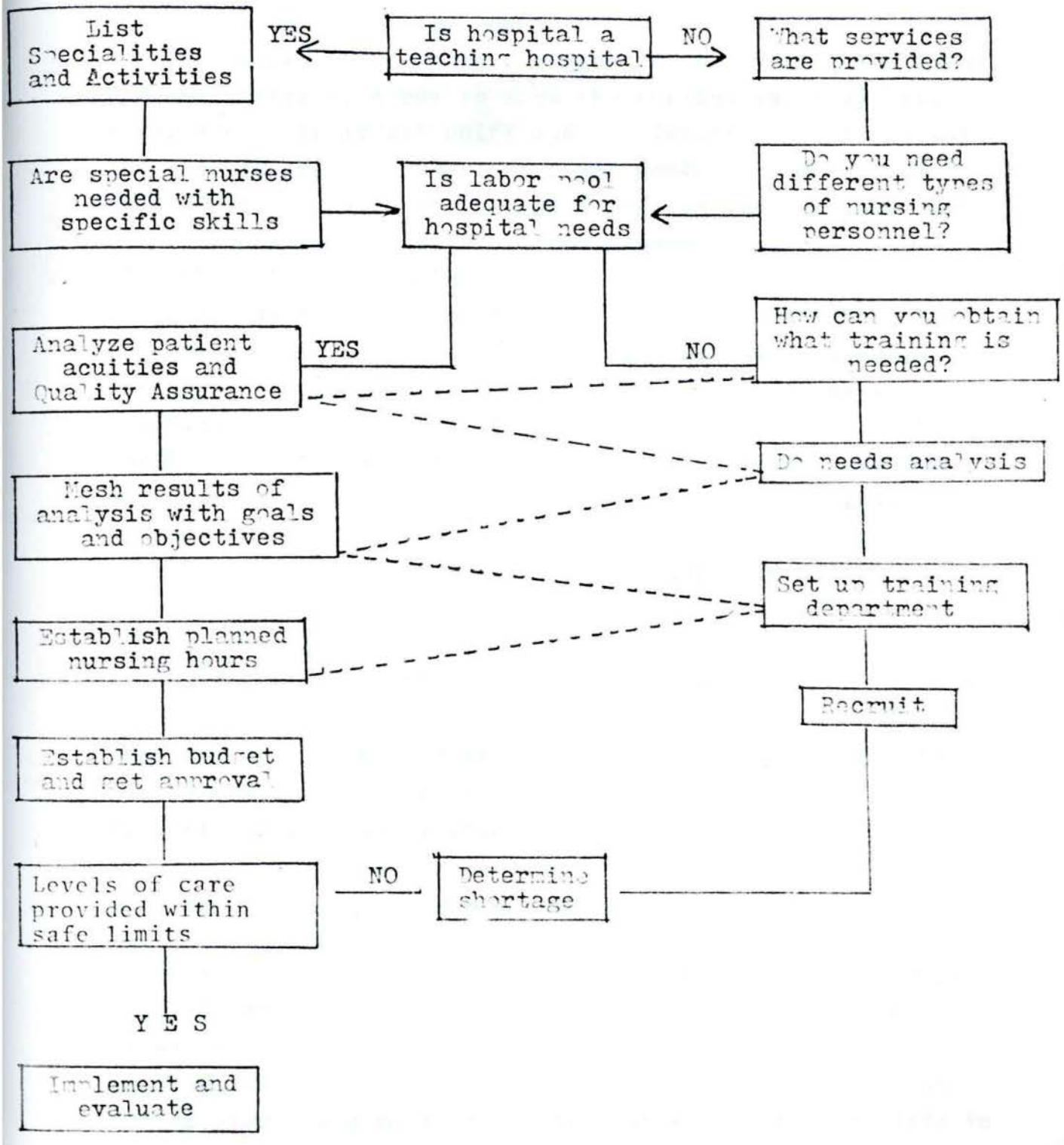
[79] Adapted from "A Nurse Staffing Sustem Based upon Assignment Difficulty, Narby, Ronald S. and Others, Journal of Nursing Administration, November 1977, Vol. VII, No. 9, page 5.

Figure 7

A Systems Approach to the Concept of Staffing



a teaching hospital and should be documented. This feature is often down played by an administration that does not understand the havoc and confusion, however well intended, that can exist on a teaching floor. In a community hospital where only one physician writes orders and visits once a day, this confusion is greatly lessened, thus requiring less clerical and nursing staff.

(2) What services are provided? List every area utilizing nursing personnel from operating rooms to emergency room, med/surg to pediatric. Do not miss out on any area. Describe what types of nursing personnel are needed, and start to rough out on paper what is needed.

(3) What is available in the area? Are adequate training facilities in the area, for both advanced and basic health care professionals?

(4) What can your hospital provide? Analyze what your hospital can currently provide and what appears to be a community need.

(5) Analyze patient acuities.

(6) Quality Assurance-do audits and questionnaires reflect patients and physician satifaction with care? Are the nurses frustrated in the level of care they are able to provide?

(7) Goals and Objectives-answers, facts and figures from the previous questions should enable the formulation of definite goals and objectives within the overall philosophy of care. e.g. A goal might be to change a functional traditional obstetrics department to a family centered birthing center utilizing nurse midwives within the next fiscal year.

(8) Training Needs- Some hospitals now have training departments which meet the needs of all hospital employees. In these departments the nurse educators do not report to the nurse administrator. Nevertheless, it is vital that the goals and philosophies of both nursing education and nursing service mesh. When the nurse administrator designs the

budget for nursing education, she has a distinct advantage in that she can plan to increase or decrease the size of the department due to her needs. For instance, XYZ Hospital cannot find Critical Care Unit nurses in the community. They must train their own. Their one and only instructor has spent twenty years teaching nurse assistants and provides orientation. The Director of Nursing demonstrates the advantages of having an experienced clinical instructor for not only Critical Care Unit but the recovery and emergency room also.

(9) Established Nursing Hours-the nursing administrator now has a good working knowledge of the nursing service. She has identified every unit for which she is responsible and averaged the patient acuities for those units. By using the census prediction methods outlined in Chapter Four she is ready to staff the department, unit by unit.

In order to understand staffing it is necessary to understand an F.T.E. (full time equivalent). An F.T.E. is usually a person working forty hours a week, i.e., five eight-hour shifts. An F.T.E. may be made up of several people, i.e., eight hours equals two-tenths of an F.T.E. (Five R.N.'s working one eight-hour shift each together make one R.N., F.T.E.). Budgets are made up utilizing F.T.E.'s. A nursing service may be budgeted for 200 F.T.E.'s. Two hundred and sixty-five people may be on the actual payroll due to several people combined into one F.T.E.

An F.T.E. is called working (productive) F.T.E. or paid but non-working (non-productive) F.T.E. The W.F.T.E. is the number of F.T.E. actually at work. The P.F.T.E. is the number of people being paid but on sick, holiday, or vacation time which has been earned. Usually these fringe benefits require ten to twelve percent more staff than the actual needs of the patients.

In order to justify staffing needs the nursing administrator needs to develop a short narrative describing each unit and those peculiarities of the unit that alter nursing needs.

XYZ HOSPITAL
NURSING BUDGET PROPOSAL

Study of Patient Acuity and Nursing Hours on A-Wing

At present we have to allocate extra nursing staff to work with bedridden patients on the A Wing. Our current budget shows an increase of .5 nursing hours for these units due to lack of bathroom facilities and adequate floor space in the small rooms. Nursing care is hampered due to lack of oxygen and suction in wall units. The rooms are small and designed for ambulatory patients. (Built 1947) The hospital statistical index shows that the patients are consuming more ancillary services, i.e., x-ray, lab, EKG, and EEG even though length of stay is decreasing. This means that the patients are more acutely ill, requiring more nursing care. The present patient accomodations on the A Wing do not allow quality care to be given safely, economically, and to patient satification, as reflected by a sharp increase in complaints recorded in the past fiscal year.

Present ventilation systems are inadequate and very old. Window air conditioners do not adequately cool the area, causing patient discomfort. Temperatures in excess of 80 degrees are recorded every day during the summer months by the engineering department. This requires frequent sponging of patients, extra rounds with ice water and providing other comfort measures. It has also contributed to patients' elevated temperatures requiring more nursing care.

At present we estimate from our various studies that a high percentage (25%) of nursing time is spent walking the corridors to the utility rooms obtaining supplies and emptying utensils, time that could be better utilized at the bedside. A three-month study of patient acuities reflect

a steadily increasing number of patients requiring an excess of four nursing hours per day. Due to the A Wing accomodations being less than desirable from clinical or personal comfort reasons, we have a high transfer activity. Each transfer, admission, or discharge takes one nursing hour.

Any attempt to modify delivery of patient care to meet new standards is almost impossible under the described conditions. Large "teams" are the only way to provide the manpower needed. Lack of audio intercom systems also pose a manpower problem.

A-Wing-capacity of forty-five beds medical/surgical. Study shows present occupancy rate for past three months is 70 % (31.5), 2835 patient days against 4050 possible patient days.

1865 patient days required minimum of 3.5 nursing hours per day. 2185 patient days required minimum of 5.5 nursing hours per day.

Combined average required using WARSTLER* scale was 4.5 nursing hours per patient day.
Due to inadequacies in ward facilities, it is actually necessary to staff for 5.5 nursing hours per day to provide patient safety.
Nursing budget is predicated on 70% occupancy or 31.5 patients per day (32 x 7 =224 weekly patient days).

Staffing Computation Sheet

A Wing

Nursing hours		Weekly Patient Days		Average Weekly Hours
5.5	X	224	=	1232

1232 weekly hours are changed into F.T.E.'s (40 hours = 1 F.T.E. by dividing by 40 = 30.8 F.T.E. (31 F.T.E.). Therefore it is known that thirty-one full time nurses or a mix of part and full time not exceeding 31 forty-hour workers is allowable.

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*See Appendix

The preceding formula has provided the number needed for the worked hours. If the fringe benefits provided by the hospital are computed as a percentage of the time worked, multiply the W.F.T.E.'s by the percentage to obtain the P.F.T.E.'s or the total number of nurses needed to provide holidays, vacations, etc.

(10) Establish Budget-the budget is established by determining how many nursing employees of the total F.T.E.'s allowed will be needed in each category and job description. By computing the average hourly salary of each level of worker, and multiplying by the total numbers of hours allowed that category, an overall figure can be obtained.*

A newer method of establishing a position control, or budgeted salary for that position and predicted salary increase for each position enables a more accurate total figure.

(11) Levels of Care provided within safe limits-have circumstances altered, requiring an increase in patient care? Does the method of determining acuity need revising? Is the method being implemented correctly by nursing staff or is the patient being shortchanged?

(12) Implement and Evaluate-implementation of a nursing budget, position control and patient classification systems require:

A. A coordinated well planned effort
B. Education of personnel concerning these processes. This education should involve all members of the nursing service and be designed for each level of sophistication.
C. A member of the nursing staff assigned to monitor the process, and depending on the size of the organization a department to handle the paperwork. A budget of several millions cannot be handled on a part-time basis.

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*See Appendix

D. A method of coordinating the numbers of budgeted hours to the number of patients in the hospital on any given day

E. A method of evaluation to see if the nursing payroll reflects the budgeted expenses within the anticipated variances.

Staffing - Human Issue

The human side of staffing provides the administrator with different challenges. The administrator is caught between the need to cut costs and the need to maintain morale and support systems amongst the staff.

Very recently a great deal of attention has been placed on the growing nurse shortage. Methodologies of staffing are academic if there is no nursing staff available.

A recent (1979) American Hospital Survey of its 6100 members hospitals indicated that "between 90,000 and 100,000 R.N. positions are now vacant." [80] An examination of the results of the survey indicate the following reasons for the shortage.

Working conditions-including salary, hours, workload and stress.

Lack of career mobility.

Overwork

Low professional image and recognition.

Barbara Nichols, the president of the American Nurses Association is quoted in the same editorial as saying "The employment climate, salaries and job related stress must be thoroughly examined to encourage nurse employment," [81] She further states in another article that "the proliferation of speciality units is a major factor contributing to stresses on the nursing profession. At the start of 1970 there were 16,000 critical care beds, at the end of the 70's there were 40,000." [82]

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[80] The Nurse Shortage - A National Dilemma, Editorial, Federation of American Hospitals Review, April/May 80, Vol. 13, No.2, Page 1

[81] ANA heads reveals goals of Nurses in delivery System

[82] IBID, page 17

Barbara Nichols goes on to state that "We anticipate that our political activity will gain momentum in the 1980's. In this way we believe that we can make nursing a more intergral part of the health delivery system." [83] Anzalone writing in the same issue also discusses the impact of the temporary nurse agency and the hospital situation. She points out that nurses today want to be flexable. Predicting a demand for 800,000 nurses by 1985 she states

> "Clearly, the only way we are going to be able to come anywhere near the demand is to find ways to tap into that huge and difficult to measure supply of nurses who are licensed to work but don't choose to do so. And the only way we are going to be able to do that is by responding creatively, engineering job situations where a nurse can conveniently work part-time and stay up to date in the profession. In this way the nurse can be a viable resource in the community and yet still have time for other demands and responsibilities in an increasingly changing and independant life style." [84]
>
> "The huge and difficult to measure supply of nurses who are licensed to work but don't" identified by Anzalone has been estimated at 350,000 by the Dept. of H.E.W.'s Bureau of Health Professions". [85]

The problem facing nurse administrators in the future will be the design of nursing organisations that will allow for the independance and creativity that the new nurses need.

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[83] Supplemental Staffing: Trying to help fill the void in Nurse Shortage, Anzalone, C. IBID., page 32

[84] H.E.W. official says enough nurses available for needs. Editorial comment Federation of American Hospital Review IBID page 13

[85] IBID page 16

This author sees a conflict that is becoming more marked between the rigid constraints of cost containments and the demands of nurses for the ability to practice nursing as they preceive it needs to be practiced. A nursing research study recently completed provided statistics on subjective and objective measures of staffing adequacy. The summation concluded "that nurses made subjective evaluations of staffing adequcay in relation to patient care based on a complex interplay of factors...these factors were personality motivation, supervision, morale, and the daily minor and major emergencies."[86] The study also showed that nurses tended to give more tranquilizers and pain shots to patients when they perceived themselves to be short-staffed. When short-staffed, nurses prioritised all physician's orders and provided little nursing care. This in turn gave rise to frustration with their inability to function fully as nurses. In the actual studies, the objective workload analysis and staffing contrasted with the subjective perceived adequacy of staffing by non-quantifiable variables that appeared unrelated to the original workload.

Baldonado states "in a recent survey 17,000 nurses indicated that job staisfaction is directly related to adequate staffing, agreeable working hours, a pleasant enviroment, supervisory support and a feeling of accomplishment. On the other hand job dissatisfaction was attributed to conditions resulting in unsafe practise, communication breakdown and poor leadership."[87]

Communication breakdowns and poor leadership in nursing has contributed to the flattened organization chart. If, by using the flattened, decentralised and participative approach the budget design, workload analysis and staffing patterns are designed by the nurses both working with and

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[86] Williams, M. & Murphy, L., Subjective and Objective Measures of Staffing Adequacy, Journal of Nursing Administration, Nov., 1979, Vol. 9, No. 11, page 29

[87] Baldonado, Ardelina, Making Job Satification a Reality for Nurses-Supervisor Nurse, May 1980, Vol, 11, No, 5 page 39

Appendix One

Modified Warstler Scale,

Adapted from, Mary Ellen Warstler, "Cyclic Work Schedules and a non-nurse Coordinator of Staffing, Journal of Nursing Administration, November/December 1973, Vol. 3, No.6, pages 45-51.

CATEGORIES OF NURSING CARE NEEDS OF PATIENTS

gory	Medical & Surgical (Adult & Child) Patient	Psychiatric Patient
Intensive Care 14 hours age 12 hours	1. Acutely ill, requires constant or frequent observation; not necessarily terminal 2. Activity must be rigidly controlled 3. Requires continuous or very frequent treatment	1. Acutely ill mentally and physically and requiring constant attention 2. Any new patient for first 24 hours
Modified intensive care 8 hours age 7.5 hours	1. Acutely ill; requires frequent observation; may or may not be a terminal case 2. Limited activity; is dependant on others for basic needs 3. Requires frequent treatments	1. Receiving IVs or requiring frequent observation or treatments 2. Motivation is limited; needs frequent supervision in ADL
Intermediate care 6 hours rage 5.5 hours	1. Extreme symptoms have subsided or have not yet appeared; usually moderately ill 2. Behavior pattern deviates moderately yet does not require close observation 3. Activity must be partially controlled; or requires periodic treatment	1. Behavior pattern deviates moderately requires moderate control of activity 2. Requires only pe iodic observation a treatment
Minimal care 4 hours rage 3.5 hours	1. Mildly ill or convalescent 2. Activity is controlled requiring little treatment or observation 3. Needs very little help with personal hygiene	1. Awaiting dischar or transfer 2. Needing only sli control or little c no treatment

Self-care 2 hours age 1.5 hours	1. Usually ambulatory; activities are not limited; requires a minimum of observation 2. In hospital for x-rays and/or treatment or physical therapy
Special condition	Patients having one or more of the following conditions shall be classified as above but at one higher step of nursing care need. 1. Isolation for communicable or infectious disease 2. Handicap (blind, deaf, dumb, amputee) 3. Senility, confusion, or general debility of age 4. Incontinent or semicomatose or paraplegic 5. Continuous temperature above 102° or nonstable blood pressure

The Warstler *3 Scale which was the first real attempt to categorize levels of care is still widely used, though becoming in need of updating as there is a general trend for more acutely ill patients requiring more nursing hours. This reflects the shortened hospital stay and the increased usage of tests and procedures in one or two days instead of several.

Appendix Two

Calculation of overall nursing budget for a unit.

Utilising methods given in body of chapter it is determinded that 35 F.T.E.'s are needed to provide the required number of nursing hours every 24 hours for a specific unit. How are these F.T.E.'s to be distributed? An analysis of the nursing workload should be undertaken for days, evenings, and nights. Taken into consideration should be the activity generated by admission, discharges, transfers, diagnostic tests, physicians rounds and ancillary department's requests. In a tertiary care hospital the analysis frequently shows little difference in activity between day and evening shifts. Therefore 40% of staff on days, 40% on evenings and 20% on nights.

40% of 35 = 14 persons on days number of hours

40% of 35 = 14 persons on evenings number of hours

20% of 35 = 7 person on nughts number of hours

35 persons

If your unit had an average of 50 patients with delivered nursing hours of 5.6 you would then have adequate staffing,

35 x 8 = 280, 280 ÷ 50 = 5.6 nursing hours.

Community hospitals frequently find that they can manage with less staff on the evening shift and may choose a 50%, 30%, 20% format.

Finding the cost of one weeks nursing salaries, utilise the position control sheet, enter the name and salary of each employee, allow for any projected salary increase and tabulate.

POSITION	POSITION NUMBER	NAME OF EMPLOYEE NOW HOLDING POSITION	FTE's	PAYROLL			STARTING DATE
				Hourly	Pay Pd.	Yr'ly	

PARED BY: DEPARTMENT:

HOSPITAL SALARY BUDGET

NURSING SERVICE POSITION CONTROL FORM

TERMINATED	TRANSFER/PROMOTION	HIRE
Position Control #	Position Control #	Position Control #
Has	Is being transferred to	Is being Hired
Effective	Position Control #	Effective Date
Salary	Effective date	Salary
This position needs to be	Previous salary	Reference Checked
Filled Now	New salary	Pre Employment Physical
At a later date	Reason	Remarks
Put on Hold		
Dept. Head	Dept. Head	Dept. Head
Approved	Approved	Approved
Date	Date	Date

ADDITIONAL COMMENTS:	ADDITIONAL COMMENTS:	ADDITIONAL COMMENTS: