Effective Leadership and Management in NURSING

Ninth Edition

Eleanor J. Sullivan

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Cover Printer: Phoenix Color/Hagerstown

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Library of Congress Cataloging-in-Publication Data

Names: Sullivan, Eleanor J., 1938- author.
Title: Effective leadership and management in nursing / Eleanor J. Sullivan, PhD, RN, FAAN.
Description: Ninth edition. | Boston : Pearson, [2017] | Includes index.
Identifiers: LCCN 2016021687 | ISBN 9780134153117 | ISBN 0134153111
Subjects: LCSH: Nursing services—Administration. | Leadership.
Classification: LCC RT89 .S85 2017 | DDC 362.17/3068—dc23
LC record available at https://lccn.loc.gov/2016021687

1 17

ISBN-10: 0-13-415311-1
ISBN-13: 978-0-13-415311-7

About the Author

Eleanor J. Sullivan, PhD, RN, FAAN, is the former dean of the University of Kansas School of Nursing, past president of Sigma Theta Tau International, and previous editor of the *Journal of Professional Nursing*. She has served on the board of directors of the American Association of Colleges of Nursing, testified before the U.S. Senate, served on a National Institutes of Health council, presented papers to international audiences, been quoted in the *Chicago Tribune, St. Louis Post-Dispatch,* and *Rolling Stone Magazine*, and named to the "Who's Who in Health Care" by the *Kansas City Business Journal*. She earned nursing degrees from St. Louis Community College, St. Louis University, and Southern Illinois University and holds a PhD from St. Louis University.

Dr. Sullivan is known for her publications in nursing, including this award-winning textbook, *Effective Leadership & Management in Nursing*, and *Becoming Influential: A Guide for Nurses*, from Pearson Education. In addition, Dr. Sullivan has authored numerous professional articles, book chapters, and books, including *Creating Nursing's Future: Issues, Opportunities and Challenges*, among others.

Today, Dr. Sullivan is also active in the mystery writing field. She served on the national board of Sisters in Crime, chaired an award committee for the Mystery Writers of America, and is published in *Mystery Scene Magazine* and *Ellery Queen Mystery Magazine*.

She has published five mystery novels. Her first three mysteries (*Twice Dead, Deadly Diversion,* and *Assumed Dead*) feature nurse sleuth Monika Everhardt. The latter two were bought by Harlequin, reissued in paperback, and are still available as e-books (*Deadly Diversion, Assumed Dead*).

Her latest series, the Singular Village Mysteries, features 19th century midwife Adelaide Bechtmann and her cabinetmaker husband, Benjamin. Two books in the series (*Cover Her Body* and *Graven Images*) are available in print, e-book, and audio formats. The third book, *Tree of Heaven*, will be released in the fall of 2017. The series is set in the Ohio village of Dr. Sullivan's ancestors. Dr. Sullivan's blog, found on her website, reveals the history behind her historical fiction.

Connect with her at EleanorSullivan.com, Facebook, and LinkedIn.

This book is dedicated to my family
for their continuing love and support.

—Eleanor J. Sullivan

Thank You

Our heartfelt thanks go out to our colleagues from schools of nursing across the country who gave generously of their time, expertise, and knowledge to help us create this exciting new edition of our text. We have reaped the benefit of your collective experience as nurses and teachers, and this edition is vastly enriched due to your efforts.

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Preface

Never have nurses been more important to healthcare organizations than they are today. Passage of the Affordable Care Act (ACA) in 2010 reversed decades of focus on providing *quantities* of care to emphasize *quality* of care. Preventing illness and coordinating care are the cornerstones of the ACA, and nurses are key to its success.

In addition, leading and managing are essential skills for all nurses in this radically changed healthcare environment. New graduates find themselves managing unlicensed assistive personnel, and experienced nurses are managing groups of healthcare providers from a variety of disciplines and educational levels. All need to know how to manage.

This text is designed to provide new graduates or novice managers with the information they need to become effective managers and leaders in healthcare. In addition, a sidebar in each chapter illustrates how nurses can lead at the bedside. More than ever before, today's rapidly changing healthcare environment demands highly developed management skills and superb leadership.

Features of the Ninth Edition

Effective Leadership and Management in Nursing has made a significant and lasting contribution to the education of nurses and nurse managers in its eight previous editions. Used worldwide and translated into numerous languages, this award-winning text is now offered in an updated and revised edition to reflect today's healthcare arena and in response to suggestions from the text's users. The ninth edition builds upon the work of previous contributors to provide the most up-to-date and comprehensive learning package for today's busy students and professionals.

Features of the ninth edition include the following:

- Implementation of the Affordable Care Act
- Evolving models of healthcare organizational structures and relationships
- Expanded content on cultural and gender diversity
- Emphasis on quality management
- Addition of emotional leadership concepts
- Use of social media in management
- Harassing, bullying, and lack of civility in healthcare
- Emergency preparedness for terrorism, disasters, and mass shootings
- Prevention of workplace violence

Two new chapters have been added to this award-winning text. Chapter 7, *Understanding Legal and Ethical Issues*, encompasses the myriad of issues confronting nurses and managers today. Chapter 28, *Imagining the Future*, helps readers contemplate the possibilities inherent in a fast-evolving environment.

Most notably, this text is available for the first time with a suite of digital resources to enhance your learning. This digital program includes the MyLab Nursing program

that lets you review the chapter materials, decision-making cases that allow you to apply your learning, and the E-Text 2.0 digital text that is easy to navigate and gives you tools for highlighting, note taking, and more.

Student-friendly Learning Tools

Designed with the adult learner in mind, the text focuses on the application of the content presented and offers specific guidelines on how to implement the skills included. To further illustrate and emphasize key points, each chapter in this edition includes these features:

- A chapter outline and preview
- A complete audio version of each chapter
- Key terms in pop-up boxes linked to their first appearance and defined in the glossary at the end of the text
- Flashcards to self-test knowledge of new vocabulary
- What You Know Now summaries at the end of each chapter
- A Tool Box with a list of tools, or key behaviors, for using the skills presented in the chapter
- Questions to Challenge You in an interactive journal format to help students relate concepts to their experiences
- Up-to-date references
- Case Studies to demonstrate application of content, with discussion board questions

Organization

The text is organized into five sections that address the essential information and key skills that nurses must learn to succeed in today's volatile healthcare environment and to prepare for the future.

Part 1. Understanding Nursing Management and Organizations

Part 1 introduces the context for nursing management, with an emphasis on changing organizational structures, ways that nursing care is delivered, the concepts of leading and managing, how to initiate and manage change, providing quality care, and how to use power and politics—all necessary for nurses to succeed and prosper in today's chaotic healthcare world. A new chapter addresses how to weigh legal and ethical issues,

Part 2. Learning Key Skills in Nursing Management

Part 2 delves into the essential skills for today's managers, including thinking critically, making decisions, solving problems, communicating with a variety of individuals and groups, delegating, working in teams, resolving conflicts, and managing time.

Part 3. Managing Resources

Knowing how to manage resources is vital for today's nurses. They must be adept at budgeting fiscal resources; recruiting and selecting staff; handling staffing and scheduling; motivating and developing staff; evaluating staff performance; coaching, disciplining, and terminating staff; managing absenteeism, reducing turnover, and retaining staff; and handling disruptive staff behaviors, especially harassing and bullying behaviors. In addition, collective bargaining, preparing for emergencies and preventing workplace violence are included in Part 3.

Part 4. Taking Care of Yourself

Nurses are their own most valuable resource. Part 4 shows how to manage stress and to advance in a career.

Part 5. Looking Toward the Future

New to this edition, this chapter provides ways to consider the future, societal predictions about the future, the future of healthcare, and the future of nursing.

Instructor Resources

The assignable and gradable assessments in MyLab Nursing provide educators with insight into students' preparation for class, students' understanding of the material, and clarity around areas in which additional instruction may be needed.

Additional Instructor Resources can be accessed by registering and logging in at www.pearsonhighered.com/nursing and include the following:

- TestGen Test Bank
- Lecture Note PowerPoints
- Instructor's Resource Manual

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Acknowledgments

The success of previous editions of this text has been due to the expertise of many contributors. Nursing administrators, management professors, and faculty in schools of nursing all made significant contributions to earlier editions. I am enormously grateful to them for sharing their knowledge and experience to help nurses learn leadership and management skills.

I am especially grateful to the contributors to this edition. They revised and updated content in the following chapters: Chapter 2: Michael Bleich, Chapters 10 and 12: Debbie Ford, Chapters 15 and 17: Rachel Pepper, and Chapters 19 and 20: Pamela Triolo. All are excellent writers, and this edition would not exist without their contributions. In addition, Michael Bleich lent his expertise to a review of the eighth edition, and Rachel Pepper reviewed the previous edition and added specific examples to demonstrate content for this edition as well.

At Pearson Education, I am grateful to continue to work with Executive Editor Pamela Fuller, who has supported this text through many editions. For this edition, Program Manager Erin Rafferty facilitated all aspects of the text's progress, and Development Editor Pamela Lappies's expertise and fine attention to detail ensure that the text will continue to be the first choice of faculty and students worldwide.

To everyone who has contributed to this fine text over the years, I thank you.

Eleanor J. Sullivan, PhD, RN, FAAN
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Chapter 1
Introducing Nursing Management

Changes in Healthcare
Paying for Healthcare

Changes in Society
Cultural, Gender, and Generational Differences
Violence, Pandemics, and Disasters

Changes in Nursing's Future
Current Status of Nursing
Institute of Medicine's Recommendations for Nursing
Adapting to Constant Change

Learning Outcomes

After completing this chapter, you will be able to:

1. Explain changes to healthcare over the past decade, including those resulting from implementation of the Affordable Care Act; demands to reduce errors and improve patient safety; and evolving medical and communication technology.
2. Describe how nursing management is influenced by changes in society.
3. Identify the changes and challenges that nurses face now and in the future.

Key Terms

accountable care organization (ACO)
Affordable Care Act (ACA)
benchmarking
Centers for Medicare & Medicaid Services (CMS)
electronic health records (EHRs)
evidence-based practice (EBP)
health home
Leapfrog Group
Magnet Recognition Program

medical errors
medical home
Quality and Safety Education for Nurses (QSEN)
quality management
robotics
telehealth

Introduction

Today, all nurses are managers. And leaders. And followers. Whether you work in an urgent care center, an ambulatory surgical center, a critical care unit in an acute care hospital, or in hospice care for a home care agency, you interact with staff, including other nurses and unlicensed assistive personnel, who work with you and for you. You must be able to collaborate with others, as a leader, a follower, and a team member. More than ever before, today's rapidly changing healthcare environment demands highly refined management skills and superb leadership.

Changes in Healthcare

Healthcare continues to change at a rapid rate. Reimbursement for care, demands for safe care, and evolving technology are affecting every aspect of care. In addition, societal changes, including cultural, gender, and generational differences, as well as an increase in violence, pandemics, and disasters force the healthcare system to adapt quickly. In turn, these changes challenge nursing and nurses to adapt.

Paying for Healthcare

In the past, healthcare providers were paid for the amount of care they gave patients. The more care they provided, the more money they received. There was no provision for the effectiveness of that care. Also, if mistakes were made, healthcare organizations were reimbursed for whatever care they provided to ameliorate those mistakes. That system is being replaced by reimbursement for the quality of the care provided and not reimbursing healthcare organizations for the cost of correcting mistakes.

AFFORDABLE CARE ACT Implementation of the **Affordable Care Act (ACA)** in 2010 radically changed how healthcare is delivered and compensated in the

Leading at the Bedside: Management Skills

You may think you don't need this text. After all, you're a staff nurse. You take care of patients in a hospital or clinic. You're neither a designated manager nor an identified leader.

But you would be wrong.

For every plan you make, every time you instruct an assistant, every interaction with a patient or family member, you use management skills. Don't you manage patient safety? Solve problems? Handle conflict? And—my favorite—manage time? These are just a few of the skills you will learn in this text. Good luck!

United States. Such healthcare reform was desperately needed to fix a system that rewarded more care and discouraged preventive care. In addition, the cost of medical care continued to soar while many Americans lacked access to basic care (Centers for Medicare & Medicaid Services [CMS], 2015). Although the ACA has undergone numerous court challenges that remain unsettled, implementation is proceeding.

The ACA was designed to provide quality, affordable healthcare for all Americans (Emanuel, 2015). Its emphasis is on preventing disease and coordinating care, and it provides mechanisms for the uninsured to acquire health insurance by enrolling in state or federal exchanges of health insurance companies (Blumenthal & Collins, 2014). Through incentives and penalties, the ACA encourages healthcare organizations to establish **accountable care organizations (ACO)**, consisting of hospitals and healthcare providers who agree to provide care to a designated population.

Also changed is how primary care providers offer care via a **health home** (previously called a **medical home**) (U.S. Department of Health and Human Services, 2015a). Instead of serving as gatekeepers to specialty care in order to contain costs, primary care providers facilitate access to specialty care when needed and monitor that care using electronic health records (Russell, 2014). Regular follow-ups by care providers monitor chronic health conditions and reinforce treatment regimens. Patients, too, have access to their medical records and are encouraged to participate in decisions about their care.

Whether the ACA will remain as it is, be changed by legislation, or be repealed entirely remains to be seen. What is apparent, however, is that access, cost, and quality of care will continue to concern providers, insurers, state and federal governments, and the American people.

COST OF MEDICAL ERRORS Another factor affecting the healthcare system is the cost of **medical errors** (Andel, Davidow, Hollander, & Moreno, 2012). Since the Institute of Medicine (IOM) reported that 98,000 deaths occur each year from preventable medical mistakes (Institute of Medicine, 1999), both healthcare providers and insurers have mounted efforts to prevent such errors, including falls, wrong site surgeries, avoidable infections, pressure ulcers, and adverse drug events. In spite of numerous efforts to prevent mistakes, the cost of medical errors has continued to climb. In addition to loss of life or diminished quality of life, actual dollar estimates put such costs at $17.1 billion annually (Den Bos et al., 2011).

To incentivize hospitals to reduce medical mistakes, the **Centers for Medicare & Medicaid Services (CMS)**, the agency that oversees government payments for care, changed its reimbursement policy to no longer cover costs incurred by medical mistakes. If medical mistakes occur, the hospital must absorb the costs. Thus, pay for performance became the norm, and performance is now measured by the quality of care (Milstein, 2009).

DEMAND FOR QUALITY In an effort to ameliorate medical mistakes, a number of quality initiatives have emerged. These include quality management, the Leapfrog Group, benchmarking, evidence-based practice, the Magnet Recognition Program, and Quality and Safety Education for Nurses.

Quality Management. **Quality management** is a preventive approach designed to address problems before they become crises. Although quality management was

originally designed for manufacturing, the healthcare industry has adopted various quality management strategies from the airline industry and other fields. Good management techniques can often be transferred from one use to another.

Leapfrog Group. The **Leapfrog Group** is a consortium of public and private purchasers that uses its mammoth purchasing power by rewarding healthcare organizations that demonstrate quality outcome measures. Today, the Leapfrog Group compares hospitals' performance on preventing errors, accidents, injuries, and infections. In 2014, the Leapfrog Group assessed 1,501 hospitals (Leapfrog Group, 2015).

Benchmarking. **Benchmarking** is a comparison of an organization's data with similar organizations. Outcome indicators are compared across disciplines or organizations. Once the results are known, healthcare organizations can address areas of weakness and enhance areas of strength (Nolte, 2011).

Evidence-based Practice. **Evidence-based practice (EBP)** has emerged as a strategy to improve quality by using the best available knowledge integrated with clinical experience and the patient's values and preferences to provide care (Houser & Oman, 2010).

Similar to the nursing process, the steps in EBP are as follows:

1. Identify the clinical question.
2. Acquire the evidence to answer the question.
3. Evaluate the evidence.
4. Apply the evidence.
5. Assess the outcome.

Research findings with conflicting results puzzle consumers daily, and nurses are no exception, especially when they search for practice evidence. Hader (2010) suggests that evidence falls into several categories:

- Anecdotal—derived from experience
- Testimonial—reported by an expert in the field
- Statistical—built from a scientific approach
- Case study—an in-depth analysis used to translate to other clinical situations
- Nonexperimental design research—gathering factors related to a clinical condition
- Quasi-experimental design research—a study limited to one group of subjects
- Randomized control trial—uses both experimental and control groups to determine the effectiveness of an intervention

While all forms of evidence are useful for clinical decision making, randomized control design and statistical evidence are the most rigorous (Hader, 2010).

Magnet Recognition Program. More than 25 years ago, the **Magnet Recognition Program** was designed to recognize excellence in nursing. The purpose was to improve patient care by focusing on nurses' qualifications, work life, and participation within the organization. The program designated 14 factors that indicated a culture of

excellence, resulting in an environment for quality patient care. Institutions that met the stringent guidelines for nurses were credentialed by the American Nurses Credentialing Center (ANCC) as Magnet-certified hospitals.

In 2007, the Magnet program was redesigned to provide a framework for the future of nursing practice and education (American Nurses Credentialing Center, 2008). To focus on outcome measures, the 14 factors from the original program were reconfigured into five components:

- Transformational leadership
- Structural components
- Exemplary professional practice
- New knowledge, innovations, and improvement
- Empirical outcomes

Magnet hospitals are those organizations that are recognized for "quality patient care, nursing excellence and innovations in professional nursing practice." (American Nurses Credentialing Center, 2016). To qualify for recognition as a Magnet hospital, the organization must demonstrate that they are achieving the following:

- Promoting quality in a setting that supports professional practice
- Identifying excellence in the delivery of nursing services to patients/residents
- Disseminating "best practices" in nursing services (ANCC, 2015)

In 2013, the US News Best Hospitals in America Honor Roll included 15 medical centers of the 18 recognized as holding Magnet certification (ANCC, 2015).

Quality and Safety Education for Nurses. Based on recommendations of the Institute of Medicine (IOM, 2003), a national advisory board of experts developed quality and safety competencies, designating targets of knowledge, skills, and attitudes (KSAs) for nursing education known as **Quality and Safety Education for Nurses (QSEN**; Cronenwett et al., 2007).

The six prelicensure KSAs are as follows:

- Patient-centered care
- Teamwork and collaboration
- Evidence-based practice
- Quality improvement
- Safety
- Informatics (Quality and Safety Education for Nurses Institute, 2015)

These competencies are being used as guides for nursing education, to assist nurses transitioning to practice, and for nurses continued lifelong learning (Amer, 2013).

EVOLVING TECHNOLOGY Rapid changes in technology seem, at times, to overwhelm us. Hospital information systems (HIS); electronic health records (EHRs); computerized physician/provider point-of-care data entry (CPOE); barcode medication administration; dashboards to manage, report, and compare data across platforms; telehealth provided from a distance; and robotics—to name a few of the many

evolving technologies—both fascinate and frighten us simultaneously. At the same time, communication technology—from smartphones to social media—continues to march into the future. It is no wonder that people who work in healthcare complain that they can't keep up! The rapidity of technological change promises to continue unabated (Huston, 2013).

Electronic Health Records. **Electronic health records (EHRs)** reduce redundancies, improve efficiency, decrease medical errors, and lower healthcare costs. Continuity of care, discharge planning and follow-up, ambulatory care collaboration, and patient safety are just a few of the additional advantages of EHRs. Furthermore, fully integrated systems allow for collective data analysis across clinical conditions and between and among healthcare organizations, and they support evidence-based decision making. Federal incentives (e.g., reimbursement and grants) encourage the expanded use of EHRs, which is expected to continue (Amer, 2013).

Telehealth. **Telehealth** has evolved as technologies to assess, intervene, and monitor patients remotely continue to improve. The technology to diagnose and treat patients from a distance, along with patient-accessible EHRs and mobile devices such as smartphones, enables providers to interact with patients regardless of their location.

Nurses, for example, can watch banks of video screens miles away from the hospital monitoring ICU patients' vital signs. Electronic equipment, such as a stethoscope, can be accessed by a healthcare provider in a distant location. Such systems are especially useful in providing expert consultation for specialty care (Zapatochny-Rufo, 2010). This technology, too, is expected to grow (Amer, 2013).

Robotics. Another technological advance is **robotics**. In the hospital, supplies can be ordered electronically. Next, laser-guided robots fill orders in the pharmacy or central supply and deliver them to nursing units via dedicated elevators—and do so more efficiently, accurately, and in less time than individuals can. Robot functionality will continue to expand, limited only by resources and ingenuity.

Communication Technology. Communication technologies are evolving just as rapidly as clinical and data technology, changing forever the ways people keep informed and interact (Sullivan, 2013). Information (accurate or inaccurate) is disseminated with lightning speed, while smartphones capture real-time events and broadcast images instantaneously.

Social media have revolutionized communication beyond the realm of possibilities of just a few years ago. Social media connect diverse populations and encourage collaboration by way of the exchange of images, ideas, and opinions in online forums, blogs, wikis, podcasts, RSS feeds, Instagram, Pinterest, YouTube, Twitter, Facebook, and LinkedIn, among others (Sullivan, 2013).

Like other enterprises, most healthcare organizations maintain a website as well as a presence on social media sites such as Facebook, Twitter, and blogs. Units within the organization may maintain Facebook pages as well, with staff designated to post on those sites. These opportunities for information sharing and relationship building also come with risks. Patient confidentiality, the organization's reputation, and recruiting efforts can be enhanced or put in jeopardy by posts to the site (Sullivan, 2013).

Changes in Society

Societal change is occurring as rapidly as healthcare is changing. Changes include differences in the composition of today's population, including the nursing population, as well as demands on the healthcare system resulting from increasing violence, threats of pandemics, and challenges of potential disasters.

Cultural, Gender, and Generational Differences

The population mix in the United States, the number of men entering nursing, and the average age of practicing nurses all affect nursing. All require nursing to adjust and adapt.

CULTURAL DIFFERENCES According to the U.S. Census Bureau (2013), the minority population in the United States is projected to rise to 56% of the total by 2060, compared with 38% in 2014 (U.S. Census, 2015). This includes Hispanic, Asian, and African American populations, but the fastest growing minority group in the United States are people who identify themselves as two or more races (U.S. Census, 2015). In addition, the recognition that lesbian, gay, bisexual, and transgender (LGBT) populations are part of communities across the United States challenges healthcare providers to offer appropriate care and services (Budden, Zhong, Moulton, & Cimiotti, 2013).

The nursing profession, however, does not reflect the cultural diversity seen in the general population. A 2013 survey of registered nurses found that only 17% are minorities (Budden et al., 2013). Efforts to increase diversity in nursing are recommended (IOM, 2010).

GENDER DIFFERENCES The gender mix found in nursing also differs from the general population, with men greatly outnumbered by women. While only 7% of the nursing population is male, only 5% in the profession were male in 2000 (Budden et al., 2013). Cultural and gender diversity challenge nurses to consider such differences when working with staff, colleagues, and administrators as well as mediating conflicts between individuals.

GENERATIONAL DIFFERENCES Generational differences in the nursing population challenge interactions and relationships between workers and patients alike. Three generational cohorts (baby boomers, generation X, and generation Y) are currently working together (Keepnews, Brewer, Kovner, & Shin, 2010) and a fourth (generation Z) will soon join them (Levit, 2015).

Each generational group has different expectations in the workplace. Baby boomers value professional and personal growth and expect that their work will make a difference. Generation X members strive to balance work with family life and believe that they are not rewarded given their responsibilities. Generation Y (also called millennials) are technically savvy and expect immediate access to information electronically. Generation Z, born in the mid-1990s to early 2000s, will soon graduate and join their older coworkers. Generation Z members are curious, passionate, and diverse, and willing to pursue nontraditional options in their futures (Levit, 2015).

The challenge for nurses in dealing with different generations is similar to that of dealing with cultural and gender differences: to avoid stereotyping within the

generations, to value the unique contributions of each generation, to encourage mutual respect for differences, and to leverage these differences to enhance team work (Murray, 2013).

Violence, Pandemics, and Disasters

Sadly, violence invades today's workplaces, and healthcare is no exception. Verbal threats, physical attacks, and violent assaults can and do occur in healthcare settings (Papa & Venella, 2013). As those who work closely with patients, nurses are vulnerable to attack from patients, family members, coworkers, or others. To reduce the incidence and impact of workplace violence, the organization must establish clear guidelines to prevent it, and staff must be adequately trained to respond to incidents of violence.

A pandemic is a disease outbreak that spreads rapidly, usually because the infecting virus is new, and humans have little or no immunity to it. The H1N1 virus of 2009 is an example (U.S. Department of Health and Human Services, 2015b). Pandemics are public health emergencies that require healthcare organizations to have in place the necessary protocols to respond rapidly in the event of a pandemic (Fineberg, 2014).

Both natural and human-caused disasters have increased in recent years and require healthcare organizations to prepare for the influx of mass casualties that may occur. Natural disasters, such as earthquakes, floods, and tornadoes, may damage not only communities but hospitals as well (e.g., the 2012 tornado in Joplin, Missouri). Human-caused disasters may occur accidentally (e.g., industrial accidents, bridge collapses, power outages), but intentional harm from acts of terrorism are unfortunately common today. All hospitals and other healthcare organizations must have emergency plans in place and have staff adequately trained to respond to these all-too-common events.

Changes in Nursing's Future

As healthcare organizations are restructuring to implement the ACA, scrambling to improve outcomes to meet safety and quality benchmarks, and struggling to adapt to constantly evolving technology, nurses ask, "What does this mean for our future?"

Current Status of Nursing

Slightly more than 3 million nurses are currently licensed as registered nurses in the United States, with 2.6 million practicing in the profession (U.S. Bureau of Labor Statistics, 2014). To meet both anticipated increases in population and an aging populace (U.S. Census Bureau, 2015), more than 500,000 additional nurses will be needed by 2022 (U S. Bureau of Labor Statistics, 2014). Unfortunately, as the population ages, nurses, too, are growing older (Budden et al., 2013). The average age of nurses practicing today is 50 years or older, up from 45 a few years ago (Health Resources and Services Administration [HRSA], 2013).

Institute of Medicine's Recommendations for Nursing

The IOM's report on the future of nursing makes sweeping recommendations for the profession, including that "nurses should be full partners, with physicians and other healthcare professionals, in redesigning healthcare in the United States" (IOM, 2010, p. 3). Also, the IOM posits that today's healthcare environment necessitates better-educated nurses and recommends that 80% of nurses be prepared at the baccalaureate or higher level by 2020.

In addition, the report recommends that barriers limiting the scope of practice for advanced practice nurses be eliminated, and that racial, ethnic, and gender diversity among the nursing workforce should be increased to better care for a diverse patient population. While nurses are consistently ranked as the most trusted profession in the United States (Gallup, 2014), few nurses hold positions of leadership in healthcare, and the IOM recommends an increase in their numbers. Progress on meeting the recommendations of the IOM report is substantial and ongoing (Hassmiller & Reinhard, 2015).

Adapting to Constant Change

What does the future hold for nursing? Change is the one constant! The challenge for nurses is how to manage in this continually fluctuating system.

Nurses are charged with monitoring and improving the safety and quality of care, managing with limited resources, participating in organizational decision making, working with teams of professionals and nonprofessionals from various generations and cultures, adapting to technological advances, and preparing for constant environmental changes. This is no small task. It requires that nurses be committed, involved, enthusiastic, flexible, and innovative; above all else, it requires that they have good mental and physical health. The nurse of today must be a coach, a teacher, and a facilitator. Most of all, the nurse must be able to live with ambiguity and be flexible enough to adapt to the changes it brings.

That is a tall order, but nurses are up to the challenge. This text is designed to prepare you to meet that challenge.

What You Know Now

- The Affordable Care Act, which may be changed or repealed, altered how healthcare is provided and compensated.
- Reducing medical errors is a priority, and organizations are scrambling to achieve outcomes better than benchmarks.
- The Magnet Recognition Program certifies hospitals that meet rigorous standards and provide excellent nursing.
- Electronic health records, robotics, and telehealth are just a few of the many technologies continuing to evolve.

- Communication technologies will continue to evolve, offering opportunities and challenges to healthcare organizations.
- Cultural, gender, and generational diversity will continue to shape the nursing workforce and patient populations.
- Threats of natural disasters, terrorism, and pandemics require all healthcare organizations to plan and prepare for mass casualties.
- More than a half million new nurses will be needed in the near future.
- The Institute of Medicine recommends that nurses be better educated to participate as full partners in redesigning healthcare.
- Nurses must be able to adapt to rapid and ongoing changes in healthcare.

Questions to Challenge You

1. Name three changes that you would suggest to reduce the cost of healthcare without compromising patient safety. Specify how you could help make these changes.
2. What mechanisms could you suggest to improve and ensure the quality of care? (Don't just suggest adding nursing staff!)
3. How could you help reduce medical errors? What can you suggest that a healthcare organization could do?
4. What are some ways that nurses could take advantage of emerging technologies in healthcare and information systems? Think big.
5. Have you participated in a disaster drill? Did you notice ways to improve the organization's readiness for mass casualties? Name at least one.
6. What steps can you take to transfer the knowledge and skills you learn in this text into your work setting?

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Chapter 2
Designing Organizations

Reductive and Adaptive Organizational Theories
Reductive Theory
Humanistic Theory as a Bridge
Adaptive Theories

Organizational Structures and Shared Governance
Functional Structure
Service-line Structure
Matrix Structure
Parallel Structure
Shared Governance

Healthcare Settings
Primary Care
Acute Care Hospitals
Home Healthcare
Long-term Care

Ownership and Complex Healthcare Arrangements
Ownership of Healthcare Organizations
Healthcare Networks
Interorganizational Relationships
Diversification
Managed Healthcare Organizations
Accountable Care Organizations

Redesigning Healthcare
Organizational Environment and Culture

Learning Outcomes

After completing this chapter, you will be able to:

1. Differentiate between reductive and adaptive organizational theories.
2. Describe traditional and emerging structures in healthcare organizations.
3. Choose a practice setting based on a preferred professional practice model.
4. Explain how the ownership of and complex relationships among healthcare organizations impact nursing.
5. Discuss how the organizational environment and culture affect workplace conditions.

Key Terms

accountable care organization (ACO)
bureaucracy
capitation
chain of command
diversification
Hawthorne effect
health home
horizontal integration
integrated healthcare networks
line authority
medical home
mission
organization
organizational culture
organizational environment
philosophy
redesign
retail medicine
service-line structures
shared governance
span of control
staff authority
throughput
values
vertical integration
vision statement

Introduction

When individuals come together to fulfill a common aspiration, **organizations** are formed. Some organizations are as small as two individuals with simple structures guiding the business relationship. Others may be large and complex. In healthcare, individuals form organizations to care for the ill and infirm or to advance health and well-being, yet they use different approaches to achieve these aims. A home care organization may focus less on the use of diagnostic technologies in favor of delivering hands-on and psychosocial support services where the patient resides. Other organizations may prefer to focus on technology usage, such as outpatient imaging services where patients go for care. Still other organizations may combine the two and add other aims, such as teaching future health providers. For these reasons, individuals studying to be healthcare providers will benefit from realizing early on that they will choose not only an area of clinical interest for a career but also a practice setting that aligns with their beliefs about organizations.

Organizations almost always begin small, with structures that are easy to navigate. A nurse practitioner with a rural independent practice may provide clinic services with one or two others, but most organizations tend to grow in size and complexity. If the clinic grows in volume and scope of services offered, the time comes when more care providers are needed. At some point, a business manager is needed to specialize in billing and collecting revenues to offset the cost of providing services. Leaders begin to differentiate organizations into functions, divisions, and service lines, among other ways of structuring work discussed later in this chapter.

In the earliest stages, especially during in an era when a business plan is needed to establish an organization in order to gain needed capital, organizational partnerships have a defined mission, purpose, and goals. Leaders shape their organizational structure based on what they want the organization to achieve.

The **philosophy** is a sometimes written statement that reflects the organizational values, vision, and mission (Conway-Morana, 2009). **Values** are the beliefs or attitudes

one has about people, ideas, objects, or actions that form a basis for the behavior that will become the culture. Organizations use value statements to identify those beliefs or attitudes esteemed by the organization's leaders.

A **vision statement** is often written; it describes the future state of what the organization is to become through the aspirations of its leaders. The vision statement is designed to keep stakeholders intent on why they have come together and what they aspire to achieve. "Our vision is to be a regional integrated healthcare delivery system providing premier healthcare services, professional and community education, and healthcare research" is an example of a vision statement for a healthcare system.

The **mission** of an organization is a broad, general statement of the organization's reason for existence. Developing the mission is the necessary first step to forming an organization. "Our mission is to provide comprehensive emergency and acute care services to the people and communities within a 200-mile radius" is an example of a mission statement that guides decision making for the organization. Purchasing a medical equipment company, therefore, fails to meet the current mission, nor does it contribute to the vision of improving the community's health.

Reductive and Adaptive Organizational Theories

The purpose of a theory-derived organization is to design work and optimize human talent in a manner that best accomplishes the aspirational goals of the organization. Most healthcare organizations have theoretical foundations stemming from the late 1800s to the early to mid 1900s, an era during which family-based industries such as farming were replaced with manufacturing plants developed in urban settings to accommodate mass production. Building on management principles derived from Adam Smith in 1776, who studied how organizations specialize and divide labor into piecework, new theories emerged. On analysis, these theories began to address work design, individual and group motivation to improve performance outputs, and the hypothesis that different situations may require adaptive strategies for the organization to remain viable.

Reductive Theory

Reductive theory, or classical approaches to organizations, focuses heavily on (a) the nature of the work to be accomplished, (b) creating structures to achieve the work, and (c) dissecting the work into component parts. The premise is to enhance people's efficiency through thoughtfully designed tasks. Leaders who use this model aim to subdivide work, specify tasks to be done, and fit people into the plan. Reductive theory has four elements: division and specialization of labor, organizational structure, chain of command, and span of control.

DIVISION AND SPECIALIZATION OF LABOR Dividing work reduces the number of tasks that each person carries out, with the intent to increase efficiency by assigning repetitive tasks to dedicated workers and improve the organization's product. This concept ties proficiency and specialization together such that the division of work and specialization economically benefit the owner. When work is designed in such a standardized manner, managers exert greater control over productivity expectations.

ORGANIZATIONAL STRUCTURE Organizational structures delineate work group arrangements based on the concept of departmentalization as a means to maintain command, reinforce authority, and provide a formal communication network.

Stated earlier, structures evolve over time, especially as organizations grow in size. The term **bureaucracy** is defined as the ideal, intentionally rational, most efficient form of organization. Today this word has a negative connotation, suggesting long waits, inefficiency, and red tape, yet its tenets continue to serve a purpose.

CHAIN OF COMMAND The **chain of command** is depicted on a table of organization (called the organizational chart) through job titles listed in magnitude of authority and responsibility. Those jobs that ascend to the top reflect increased authority and represent the right or power to direct the activities of those of lesser rank. Those depicted at the lower end of the chart have the obligation to perform certain functions or responsibilities and yield less authority and power.

The organizational chart gives the appearance of orderliness and clarity around who is in charge. Positions with **line authority** are depicted in boxes on the organizational chart, with the person holding supervisory authority over other employees located at the top. In Figure 2-1, line authority is illustrated by the chief nurse executive holding supervisory authority over nurse managers and the acute care nurse practitioner. Another type of authority is known as **staff authority**, in which individuals yield considerable expertise to advise and influence others; they possess influence that, without supervisory power, provides important direction and persuasion, minus supervisory status. In Figure 2-1, the nurse managers and acute care nurse practitioner possess staff authority with one another. This means that no nurse is responsible for the work of the others, yet they respect and collaborate to improve the efficiency and productivity of the unit for which the nurse manager bears responsibility.

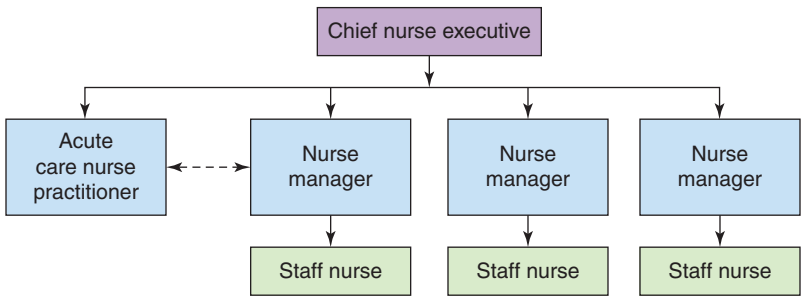

Figure 2-1 Chain of authority.

SPAN OF CONTROL **Span of control** addresses the issue of effective supervision expressed by the number of direct reports to someone with line authority. Complex organizations have numerous highly specialized departments; centralized authority results in a tall organizational structure with small differentiated work groups. Less complex organizations have flat structures; authority is decentralized, with several managers supervising large work groups. Figure 2-2 depicts the differences.

Reductionist theory uses the mission of the organization to structure and design work, which is then subdivided into parts. The traditional design of medicine is based on this model, where a primary care physician oversees the holistic concerns of the patient, but specialists are called in to detail each subcomponent part of medical

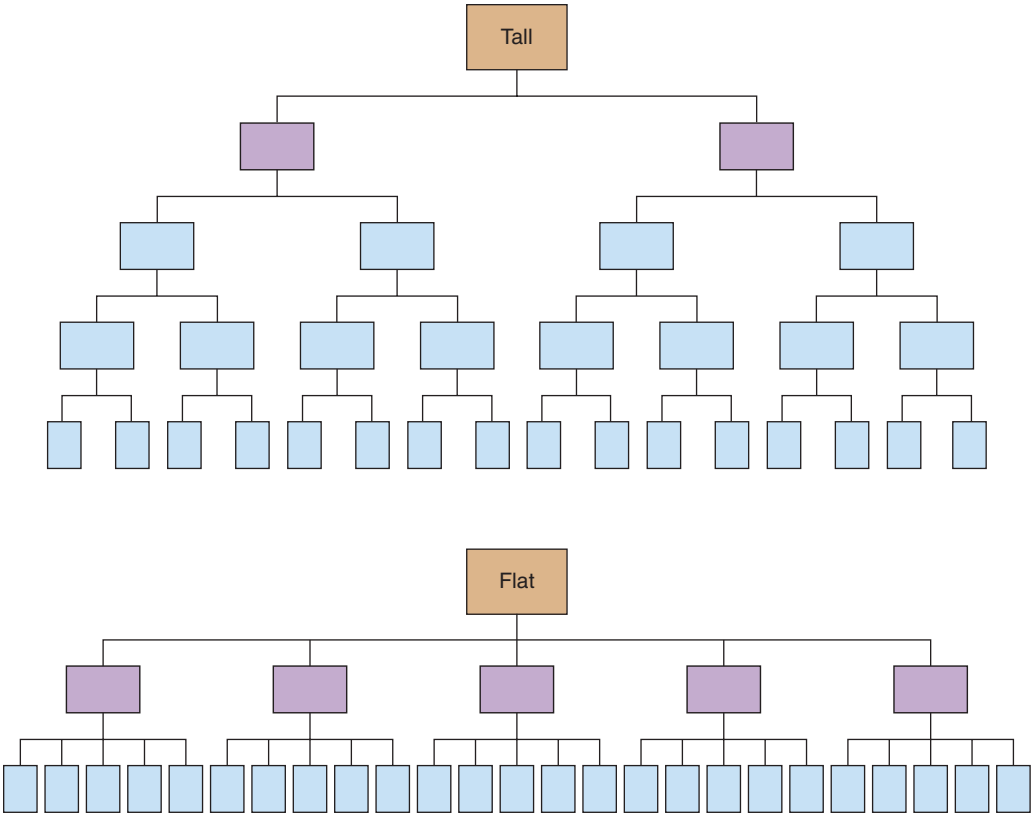

Figure 2-2 Contrasting spans of control.

From Longest, B. B., Rakich, J. S., & Darr, K. (2000). *Managing health services organizations and systems* (4th ed.). Baltimore: Health Professions Press, p. 124. Reprinted by permission.

treatment. Similarly, most hospital organizations still orchestrate their clinical services and departments using this model. This classical view of organizations has strength, but also real limitations. The way clinical work is carried out is dependent upon bureaucratic work design, yet clinicians often create work-arounds when necessary to achieve patient care objectives.

Humanistic Theory as a Bridge

Between reductive and adaptive organizational theory development is a movement from the 1930s that addresses how people respond to working in large organizations brought on by the industrial revolution. A major premise of humanistic theory is that people desire social relationships, respond to group pressure, and search for personal fulfillment in work settings. A series of studies conducted by the Western Electric Company at its Hawthorne plant in Chicago unexpectedly advanced knowledge about human responses to the workplace. The first study coexamined the effect of illumination (improved or diminished) on productivity but failed to find any relationship between the two extremes. In most groups, productivity varied at random, and in one study productivity actually rose as illumination levels declined. These contradictory results led researchers to conclude that unforeseen psychological factors could be at play.

Further studies of working conditions, such as varied positive and negative experiences linked to rest breaks and workweek length, similarly failed to impact

productivity. The researchers concluded that the social attention and interactions created by the research itself—that is, the special human attention given to workers participating in the research—met a social need that enhanced productivity. This tendency for people to perform in an expected manner because of special attention and focused, unintentional interactions became known as the **Hawthorne effect**, a term now used most commonly in research but which emanated from organizational science.

Although the findings are controversial, organizational theorists shifted focus to the social aspects of work and organizational design. One important assertion of this theory was that individuals cannot be coerced or bribed to do things they consider unreasonable; formal authority does not work without willing participants.

Adaptive Theories

During the great social changes that occurred following World War II and Vietnam, organizational theorists began to observe ways that organizations adapt to change. The interplay among structure, people, technology, and environment led to perceiving organizations as adaptive systems; consequently, rules developed about how organizations thrived or were challenged.

SYSTEMS THEORY Concurrent thoughts about biologic and nursing science also led to breakthrough knowledge known as systems theory (Mensik, 2014).

An open-system organization draws on resources—known as *inputs*—from outside its boundary. Inputs can include materials, money, and equipment as well as human capital with particular expertise. These resources are transformed when processes are designed, animated, and coordinated with the mission of the organization in mind—a process known as *throughputs*—to create the goods and services desired, which are called *outputs*. Each healthcare organization—whether a hospital, ambulatory surgical center, home care agency, or something else—requires human, financial, and material resources. Each also designs services to treat illness, restore function, provide rehabilitation, and protect or promote wellness, thereby influencing clinical and organizational outcomes.

Throughput today is commonly associated with access to care and how patients enter and leave the healthcare system. Hospitals measure the throughput of patients, beginning with emergency department services and, if necessary, patients diverted away from the hospital based on resource availability; how long a patient has to wait for a bed; and the number of readmissions (Handel et al., 2010). Readmissions that occur within fewer than 120 days from discharge create financial penalties for hospitals as a measure of inadequate discharge planning. Using information technology, bed management systems are a tool to monitor patient throughput in real time (Gamble, 2009). The Joint Commission accreditation, a national accreditation program, requires hospitals to show data on throughput statistics (Joosten, Bongers, & Janssen, 2009).

CONTINGENCY THEORY Another adaptive theory is contingency theory, which was developed to explain that organizational performance is enhanced when leaders attend to and interact directly with the unique characteristics occurring in a changing environment. Through these interactions leaders match an organization's human and material resources in creative ways to respond quickly to social and clinical needs. The environment defined here includes the people, objects, and ideas outside the

organization that influence or threaten to destabilize the organization. Although some environmental factors are easily identified in healthcare organizations (regulators, competitors, suppliers of goods, and so on), the boundaries become blurred when a third-party payer or a physician controls a patient's access to care. In these cases, the physician or payer appears to be the customer, or gatekeeper.

CHAOS THEORY The final adaptive theory, known as chaos theory, is linked to the field of complexity science, inspired by quantum mechanics. Chaos theory challenges us to look at organizations through a lens that strips away notions of the command and control structures found in reductive theories. Complexity scientists observe in nature that nonlinear problems cannot be solved with the linear approaches tied to reductionism. The concept of cause and effect is rarely predictable in work settings where the stakes are high, multiple variables interact, and predictive outcomes are not feasible. Complexity science informs organizational leaders that all systems will self-regulate over time, that change is plausible from the bottom-up or through the organization, and that leadership aims to establish simple rules that promote adaptation in concert with environmental agents, rather than believing that the command and control methods found in reductionist models are sufficient (Ray, Turkel, Cohn, 2011).

Chaos theory and complexity science refute permanent organizational structures as useful. Rather, principles that ensure flexibility, fluidity, speed of adaptability, and cultural sensitivity are emerging, such as those found in virtual organizations (Norton & Smith, 1997). In social media, Facebook is an example of a leaderless organization, created and managed by its communities of interests, serving its users through a broad set of principles that are self-monitored.

Organizational Structures and Shared Governance

Implementing organizational theory is best accomplished with guiding principles to orchestrate roles and responsibilities linked to the mission, purpose, and goals of the organization; accommodate its size; and consider technology and other environmental factors. The structures named in the following sections are used in healthcare organizations today.

Functional Structure

In functional structures, employees are grouped in departments by specialty, and groupings of similar tasks are performed by groups of like-minded or trained individuals operating out of the same department along with similar types of departments reporting to the same manager. In a functional nursing structure, all nursing tasks fall under nursing service. Functional structures tend to centralize decision making because the functions converge at the top of the organization.

A functional nursing structure enjoys the benefit of having like individuals performing common work close together, but coordination between and among other functional areas, such as the pharmacy or laboratory, may be limited. Decision making can become too centered on a single manager who may lack a broad perspective of organizational dynamics.

Service-line Structure

More common in healthcare organizations today are **service-line structures** (Nugent, Nolan, Brown, & Rogers, 2008). Service-line structures also are called product-line or service-integrated structures. In a service-line structure, clinical services are organized around patients with specific conditions (see Figure 2-3). For instance, there may be an oncology, cardiac, or mother–infant service line.

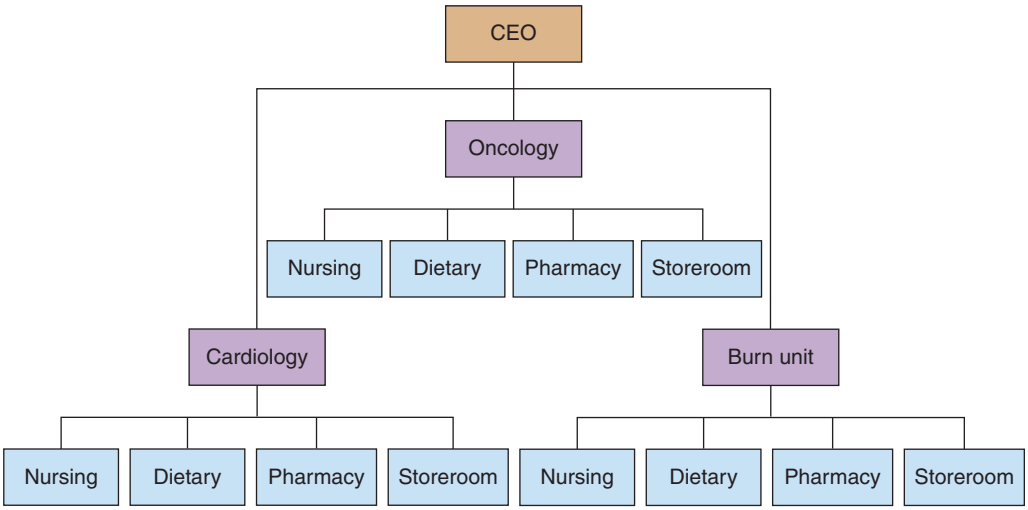

Figure 2-3 Service-line structure.

Service-line structures are sometimes preferred in large and complex organizations because the same activity (e.g., hiring) is assigned to several self-contained units. In theory, service lines respond rapidly to the service's patient populations because nursing, pharmacologic, diagnostic, and other services work in tandem. This structure is appropriate when environmental uncertainty is high, the populations serviced are high volume and have specific needs, and the organization requires frequent adaptation and innovation to distinguish itself.

A service-line structure designs its resources for rapid response in a changing environment. Because each service line specializes and strategically aligns resources, its outputs can be tailored to keep patient satisfaction high.

Service lines coexist with functional structures. A nurse may work in a service line as an oncology nurse but also have ties to the functional area of nursing. This requires coordination across function settings (nursing, dietary, pharmacy, and so on) and takes effort among leaders to ensure that functional and service goals are achieved. Service goals receive priority under this organizational structure because employees see the service outcomes as the primary purpose of their organizational position.

As in all structures, organizations with multiple service lines face challenges, including possible duplication of resources (such as duplicating advertisements for new positions), lack of identity with one's professional discipline, and inconsistent or duplicative process design across services, creating multiple demands on support service areas, such as pharmacy or environmental services where expectations can differ enough to create confusion and inefficiencies in those areas. In addition, some service

Leading at the Bedside: Organizational Structures

What does it matter how your unit or practice or institution is structured? You can't do anything about that, you say. However, nursing doesn't exist in isolation; it is part of a larger entity—from your organization to your state (e.g., licensing of nurses and institutions) to your country (e.g., healthcare policies). All of those components affect your practice.

Also, are you career minded? Do you want to advance in your profession? You may be undecided about that. After all, you're still a student or a beginning staff nurse. Wouldn't you like to have that option available to you? If so, pay attention to the reporting relationships between and among various departments, divisions, or service lines in your organization, especially when something goes wrong. Errors identify problems in either the person in the position or the structure. Sometimes both the individual and structure are unworkable. Notice, too, when everything goes smoothly.

You are correct; you can't change your organization's structure. Paying attention to how it works, though, offers you a learning experience that you can tuck away for the future. Remember it!

lines (e.g., pediatrics, obstetrics, bariatric surgery, and transplant centers) present special challenges due to low usage or the need for specialized personnel (Page, 2010).

Service-line structures are the most common structures found in academic health science centers and larger urban organizations (Kaplow & Reed, 2008). As noted, this type of structure can present a challenge to nurse leaders to maintain nursing standards across service lines (Hill, 2009).

Armstrong, Laschinger, and Wong (2009) found that improved patient safety in Magnet hospitals was related to nurses' perception of empowerment. This can be explained, possibly, by Magnet standards that encourage staff participation in decision making.

Matrix Structure

The matrix structure integrates both service-line and functional structures into one overlapping structure. In a matrix structure, a manager is responsible for both the function and the product line. For example, the nurse manager for the oncology clinic may report to the vice president for nursing and the vice president for outpatient services.

Matrices tend to develop where there are strong outside pressures for a dual organizational focus on product and function. The matrix is appropriate in a highly uncertain environment that changes frequently but also requires organizational expertise (Galbraith, 2009).

A major weakness of the matrix structure is its dual authority, which can frustrate and confuse departmental managers and employees. Respect and strong interpersonal skills are required from the leaders in this structure, who will spend extra time in joint problem solving and conflict resolution. These leaders must share organizational vision beyond their individual functional areas and be willing to act based on this broader vision. If this does not happen, one function may become more dominant.

Parallel Structure

Parallel structure is unique to healthcare. The field of medicine contends that it requires its own organizational structure because of the complexity of its field and the desire to self-monitor its own members. Most hospitals today continue to have

hospital structures while the medical staff has its own structural unit, with its own leaders and departments that coexist with the hospital's structures, with both structures reporting to the board of trustees. For a department like nursing, this poses the dilemma of being exposed to two lines of authority—to the hospital and the medical governance structure. Parallel structures are becoming less successful as healthcare organizations integrate into newer models that incorporate physician practice under the organizational umbrella.

Shared Governance

Shared governance is a nursing response to organizational structures that represents the voice of the nursing profession in healthcare agencies. It can be considered a modified parallel structure to that of medicine, ensuring that matters of clinical practice are influenced by those who are closest to care delivery. One key difference in shared governance is that its structures complement organizational design.

Shared governance gives nurses a forum in which to shape nursing practice within the healthcare organization. Shared governance requires nurses to be accountable to the latest standards and knowledge in the field. Nurses gain experience in using their voice in decision making at the organizational level. So important is this structure that Magnet standards require shared governance and—as part of its review process, including peer review—examine the influence of nursing in organizational decision making. Nurses participate in unit-based councils that interface with divisional councils, specialty councils, and a leadership council, consisting of nurse managers and administrators (Hafeman, 2015).

In this structure, decisions are made by consensus rather than by the manager's order or majority rule, allowing staff nurses an active voice in problem solving. Unit councils make decisions for that unit, while divisional councils address issues impacting multiple units, with a hospital-wide council addressing profession-wide issues linked to patient care standards. Appropriate councils address clinical quality and safety issues, professional competencies and development, and the implementation of evidence-based practices into the organization.

Although nursing practice councils have operated for several decades, changes in healthcare and in organizational structures have led to council modifications, a process not without difficulty (Moore & Wells, 2010). Staffing shortages, patient demands, and unfamiliarity with shared governance concepts or its benefits may discourage participation. In addition, not all shared governance models are successful (Ballard, 2010). Human factors—such as lack of leadership, lack of staff or manager understanding of shared governance, or the absence of knowledgeable mentors—can impede implementation of the model. Structural factors—such as a known structure for decision making, time available for meetings, and staffing support for attendance—also affect the success of shared governance. Still, as a Magnet standard, shared governance will continue into the future (McDowell et al., 2010).

Healthcare Settings

Settings for the delivery of healthcare include primary care, acute care hospitals, home healthcare, and long-term care organizations. While these are the most common, note that nursing care is also provided in schools, rehabilitation, hospice, correctional, and other settings not addressed in this section.

Primary Care

Primary care is considered to be the location where the patient goes for preventive and basic care services and is the gatekeeper for access to specialized services. Primary care is delivered in neighborhood clinics, provider offices, ambulatory care, emergency departments, public health clinics, and some sites found in retail shopping.

Retail medicine is now available in many pharmacies and large retail chains as a convenient walk-in clinic for treating low-acuity illnesses, immunizations, or school physicals. Staffed heavily by nurse practitioners with physician backup, these clinics address the ease that consumers want outside of traditional bureaucratic agencies. While groups such as the American Medical Association have questioned the quality of care provided in these clinics (Costello, 2008), other studies refute this claim, revealing comparable levels of care (Bauer, 2010; Rohrer, Augstman, & Furst, 2009).

Acute Care Hospitals

Hospitals are frequently classified by length of stay and type of service. Most hospitals are acute (short-term or episodic) care facilities, and they may be classified as general or special care facilities, such as pediatric, rehabilitative, and psychiatric facilities. Many hospitals also serve as teaching institutions for nurses, physicians, and other healthcare professionals; these are known as academic health centers.

The term *teaching hospital* commonly designates a hospital associated with a medical school that maintains physician or medical resident availability on-site 24 hours a day. Nonteaching hospitals, in contrast, have private physicians (not medical students) on staff. Both academic teaching and nonteaching hospitals have made greater use of a new physician specialty known as hospitalists. A hospitalist manages the care of hospitalized patients on behalf of the primary care provider while that patient is hospitalized or works to complement the private physician by being available for emergency care. Whatever the model, the role of the nurse shifts based on physician availability. Likewise, some hospitals are employing acute care nurse practitioners to support the clinical management of hospitalized patients. These specialty-trained nurses have the authority to manage clinical incidents and write orders to manage clinical events (Hravnak, 2014).

Home Healthcare

Home healthcare is the intermittent, temporary delivery of healthcare in the home by skilled (nurses) or unskilled providers (home health aides). With the expanded use of minimally invasive and adjunctive treatments, coupled with safety concerns, today patients are rapidly discharged to recuperate at home. The primary service provided by home care agencies is nursing care, yet physical or occupational therapists and durable medical equipment technicians who support ventilators, hospital beds, home oxygen equipment, and other medical supplies are also on the team, along with social workers.

Long-term Care

Long-term care facilities constitute a range of service levels known as assisted living services. Included in these services are professional nursing care and rehabilitative services. Most long-term care facilities are freestanding, but it is not uncommon for them to be part of a hospital or aligned with a hospital system. Assisted living services

used to be almost exclusively for residential care. Today, many long-term care facilities maintain both apartment-like living for those who are independent and more clinically oriented facilities to accommodate the aging process. Many of these facilities are now a bridge from acute care to home, with a limited length of stay.

Given the range of services provided, the long-term care industry is heavily regulated. There are exemplars for outstanding senior services, but some facilities lack professional staff and adequate support staff. Thus, many patients with conditions of aging may require resources beyond what is available. Particularly vulnerable are the frail elderly. Challenges in providing care to the elderly include addressing the tendency to stigmatize older, frail adults and to provide continuity of care across settings.

Ownership and Complex Healthcare Arrangements

As federal regulations and payment shifts from a fee-for-service model to population health management systems, hospitals are consolidating or becoming part of larger systems that cover geographic expanses. Further, health systems are restructuring to provide a range of pre- and post-acute care services.

Ownership of Healthcare Organizations

Ownership can be either private or government, voluntary (not for profit) or investor owned (for profit), and sectarian or nonsectarian (see Figure 2-4). Private organizations are usually owned by corporations or religious entities, whereas government organizations are operated by city, county, state, or federal entities, such as the Indian Health Service. Voluntary organizations are usually not-for-profit, meaning that surplus monies are reinvested into the organization. Investor-owned, or for-profit, corporations distribute surplus monies back to the investors, who expect a profit. Sectarian agencies have religious affiliations.

Healthcare Networks

Integrated healthcare networks originally emerged as organizations sought to survive in today's cost-conscious environment. The results of the Affordable Care Act have led to even further integration as the health of populations must not be managed across the continuum of care services (Soto, 2013). The earliest definition for population health was based on health outcomes distributed over a group of individuals. Today this includes interventions around lifestyle, prevention, and risk avoidance, all aimed at reducing the need for acute care services. Integrated systems encompass a variety of model organizational structures, but certain characteristics are common. Network systems provide the following:

- A continuum of care
- Geographic or population coverage for the buyers of healthcare services
- Acceptance of the risk inherent in taking a fixed payment in return for providing healthcare for all persons in the selected group, such as all employees of one company

To provide such services, networks of providers evolved to encompass hospitals and physician practices. Most important, the focal point for care is primary care

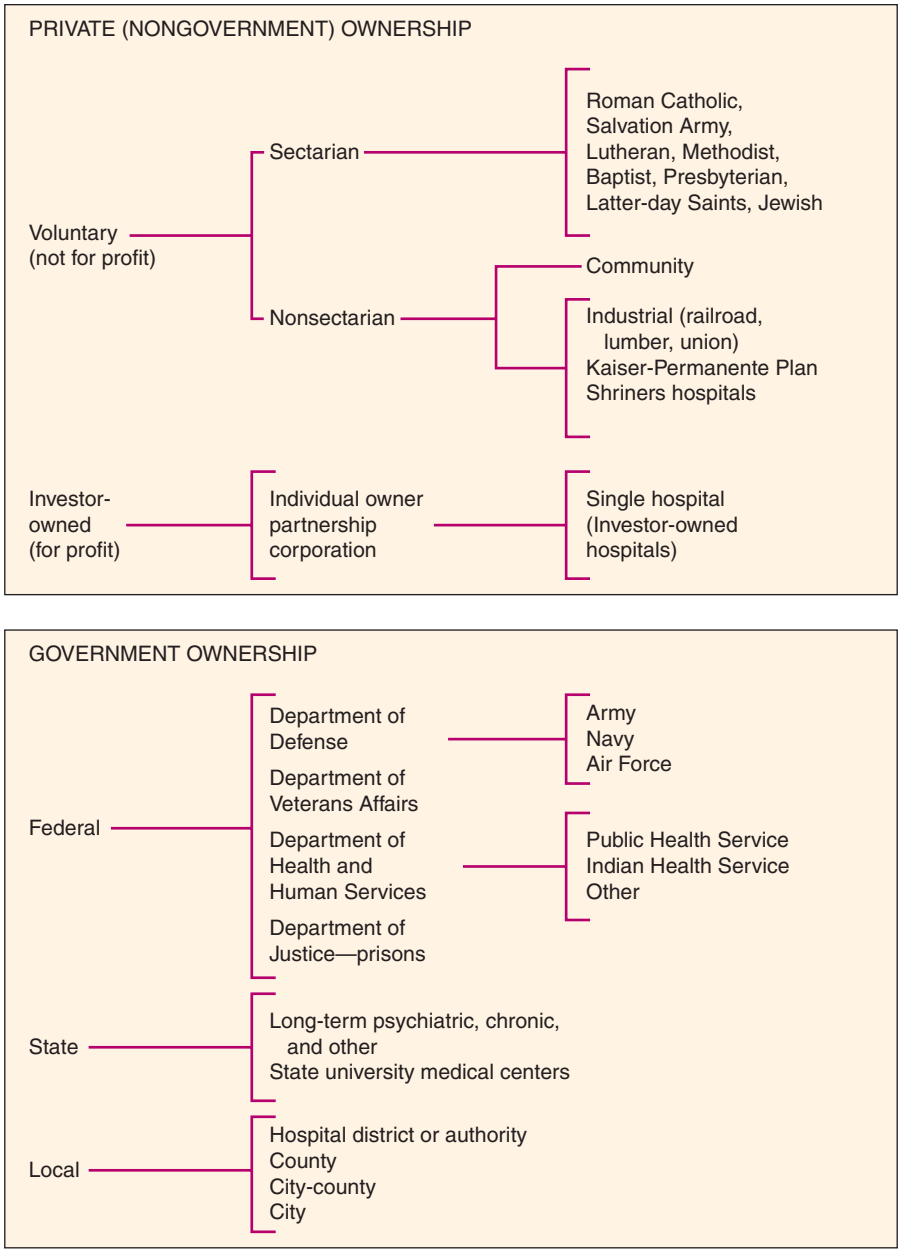

Figure 2-4 Types of ownership in healthcare organizations.

From Longest, B. S., Rakich, J. S., & Darr, K. (2000). *Managing Health Services Organizations and Systems* (4th ed.). Baltimore: Health Professions Press, p. 173. Reprinted by permission.

and care management rather than using the hospital for the continuum of services. The goal is to interact with and keep patients in the setting that incurs the lowest cost, promotes health, and reduces expensive hospital stays. A variety of other arrangements have emerged, varying from loose affiliations or collaborations between hospitals and hospital systems to complete mergers of hospitals, clinics, and physician practices. As changes in healthcare reimbursement unfold, nurses are playing expanded roles in primary care, transitional care, and community-based wellness initiatives.

Interorganizational Relationships

At the onset of this chapter, the reasons why organizations form and re-form were addressed. With increased competition for resources and public and governmental pressures for better efficiency and effectiveness, organizations are choosing to establish expanded relationships with one another for their continued success. Multihospital systems and multiorganizational arrangements, both formal and informal, are exploring their mission, purpose, and goals, and whether or not alignments through new mechanisms are beneficial.

Arrangements between or among organizations that provide the same or similar services are examples of **horizontal integration**. For instance, all hospitals in the network provide comparable services (see Figure 2-5).

Figure 2-5 Horizontal integration.

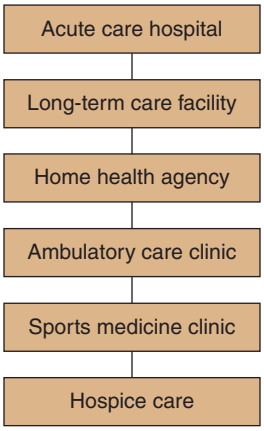

Figure 2-6 Vertical integration.

Vertical integration, in contrast, is an arrangement between or among dissimilar but related organizations to provide a continuum of services. An affiliation of a health maintenance organization with a hospital, pharmacy, and nursing facility represents vertical integration (see Figure 2-6).

Numerous arrangements using horizontal and vertical integration can be found today. Examples of such arrangements include affiliations, consortia, alliances, mergers, consolidations, and agencies under the umbrella of a corporate network (see Figure 2-7).

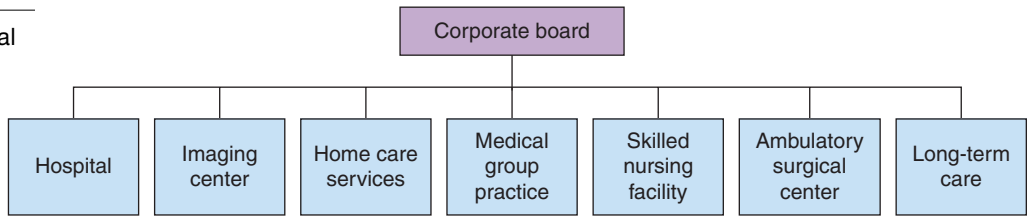

Figure 2-7 Corporate healthcare network.

Diversification

Diversification is the expansion of an organization into new arenas. It provides another strategy for survival in today's economy. Two types of diversification are common: concentric and conglomerate.

Concentric diversification occurs when an organization complements its existing services by expanding into new markets or broadening the types of services it currently has available. For example, a children's hospital might open a daycare center for developmentally delayed children or offer drop-in facilities for sick child care.

Conglomerate diversification is the expansion into areas that differ from the original product or service. The purpose of conglomerate diversification is to obtain a source of income that will support the organization's product or service. For example, a long-term care facility might develop real estate or purchase a company that produces durable medical equipment.

Another type of diversification common to healthcare is the joint venture. A joint venture is a partnership in which each partner contributes different areas of expertise, resources, or services to create a new product or service. In one type of joint venture, one partner (general partner) finances and manages the venture, whereas the other partner (limited partner) provides a needed service. Joint ventures between healthcare organizations, physicians, researchers, and others are becoming increasingly common. Integrated healthcare organizations, hospitals, and clinics seek physician and/or practitioner groups they can bond (capture) in order to obtain more referrals. The healthcare organization as financier and manager is the general partner, and physicians are limited partners.

Managed Healthcare Organizations

The managed healthcare organization is a system in which a group of providers is responsible for delivering services (that is, managing healthcare) through an organized arrangement with a group of individuals (e.g., all employees of one company, all Medicaid patients in the state). Different types of managed care organizations exist: health maintenance organizations (HMOs), preferred provider organizations (PPOs), and point-of-service plans (POS).

An HMO is a geographically organized system that provides an agreed-on package of health maintenance and treatment services provided to enrollees at a fixed monthly fee per enrollee, called **capitation**. Patients are required to choose providers within the network.

In a PPO, the managed care organization contracts with independent practitioners to provide enrollees with established discounted rates. If an enrollee obtains services from a nonparticipating provider, significant copayments are usually required.

Point-of-service (POS) is considered to be an HMO—PPO hybrid. In a POS, enrollees may use the network of managed care providers to go outside the network as they wish. However, use of a provider outside the network usually results in additional costs in copayments, deductibles, or premiums.

Accountable Care Organizations

Effective January 2012, accountable care organizations have been able to contract with Medicare to provide care to a group of Medicare recipients (Ansel & Miller, 2010). Strong incentives to reduce cost, share information across networks, and improve quality are included in the provisions for reimbursement.

An **accountable care organization (ACO)** consists of a group of healthcare providers that provide care to a specified group of patients. Various structures can be used in ACOs, from loosely affiliated groups of providers to integrated delivery systems. An ACO is more flexible than an HMO because consumers are free to choose providers from outside the network. Cognizant of the potential for Medicare contracts and, later, reimbursement by other third-party payers, healthcare providers and organizations are scrambling to establish collaborative arrangements and networks.

Redesigning Healthcare

Healthcare is a dynamic environment with multiple factors impinging on continuity and stability. Implementation of ACOs, demands for safe, quality care, Magnet standards that promote decentralized organizational structures, and an aging population with multiple chronic conditions are among the factors that make redesigning healthcare a reality today.

A **redesign** includes strategies to better provide safe, efficient, quality healthcare. Some examples of redesign strategies include adopting a patient-centered care model, focusing on specific service lines, applying lean thinking to the system, and establishing a flat, decentralized organizational structure.

A report entitled *Crossing the Quality Chasm* (Institute of Medicine, 2001) recommended ways to improve healthcare. One of those was to adopt a patient-centered care model. Success in implementing a patient- and family-centered care model has been reported in the literature (Zarubi, Reiley, & McCarter, 2008).

Another patient-centered model is the **health home** or **medical home** (Berenson et al., 2008). Centered by a primary care provider (primary care physician or nurse practitioner), a health home considers the population it serves and designs its services to attract patients to a "home" where they are known over time as a co-partner in maintaining health. The goal is to provide continuous, accessible, and comprehensive care. Challenges for coordinating care in a health home include the lack of training for health professionals in this model, poor communication between and among providers and patients (e.g., absence of electronic medical records for all providers), the multiple demanding needs of patients with chronic health problems, and fair compensation for primary care services. These challenges are offset by implementing electronic health records, expanding nurse practitioners' coverage to include managing patients with chronic conditions, encouraging patients to self-manage chronic conditions, and persuading providers to use electronic communication with patients (Berenson et al., 2008).

Within organizations, individual behavior is greatly influenced by how systems and processes are designed. As integrated systems form, it becomes an imperative to ensure that systems and processes are designed for the patient and family experience and for the provider intersection with these work flow designs. Regardless of whether a health home or a transitional care program is being designed, lean thinking principles should be employed (Joosten, Bongers, & Janssen, 2009). Lean thinking focuses on the system rather than on individuals, concentrates on interventions that improve outcomes, and disregards those that have little or no effect. If it is determined that a flat, decentralized organizational structure that centers decision making closest to the point of care is most desirable, lean thinking principles should guide the design. Lean principles promote unit-based decision making and empower staff to create and implement process improvements in a timely manner (Kramer, Schmalenberg, & Maguire, 2010). Furthermore, a decentralized structure encourages communication and collaboration and provides a quality improvement infrastructure.

Nurse leaders at all levels should be key players in health system redesign efforts. They are expected not only to initiate change while reducing costs, maintaining or improving quality of care, coaching and mentoring, and team building, but also to do so in an ever-changing environment full of ambiguities while their own responsibilities are expanded (Bleich, 2011).

Organizational Environment and Culture

As organizations grow and evolve in responding to and meeting the needs of those for whom it was created, a working environment and culture emerge. How decisions get made, how the values live out through individual and group behavior, how the organization responds to shifts in the marketplace, and how it recognizes and rewards innovative or ritualized behavior together shape the feel or tone of the setting. Individuals are well served if their personal style aligns with the community of peers that match the organization.

The terms organizational environment and organizational culture, then, describe the internal conditions in the work setting. **Organizational environment** is the systemwide conditions that contribute positively or counterproductively to fulfilling the stated mission, purpose, and goals of the organization within the work setting. In 2005, the American Association of Critical-Care Nurses (AACN) identified the following six characteristics of a healthy work environment, characteristics that the organization continues to promote (AACN, 2011):

- Skilled communication
- True collaboration
- Effective decision making
- Appropriate staffing
- Meaningful recognition
- Authentic leadership

Organizations should not be personified. One way to assess the organizational environment is to evaluate the qualities of those leading the organization. An organization in which nursing leaders are innovative, creative, and energetic will tend to move and/or operate in a fast-moving, goal-oriented fashion. If humanistic, interpersonal skills are sought in candidates for leadership positions, the organization will focus on human resources, employees, and patient advocacy (Hersey, 2011).

Organizational culture, on the other hand, comprises the basic assumptions and values held by members of the organization (Sullivan, 2013). These are often known as the unstated "rules of the game." For example, who wears a lab coat? When is report given? To whom? Is tardiness tolerated? How late is acceptable?

Like environment, organizational culture varies from one institution to the next, and subcultures and even countercultures—groups whose values and goals differ significantly from those of the dominant organization—may exist. A subculture is a group that has shared experiences or like interests and values. Nurses form a subculture within healthcare environments. They share a common language, rules, rituals, and dress, and they have their own unstated rules. Individual units also can become subcultures. Countercultures, if unrecognized and/or tolerated, can distract from organizational success. Subcultures, in and of themselves, may or may not stray from the organizational mission, purpose, and goals.

Systems involving participatory management and shared governance create organizational environments that reward decision making, creativity, independence, and autonomy (Kramer, Schmalenberg, & Maguire, 2010). These organizations retain and recruit independent, accountable professionals. Organizations that empower

nurses to make decisions have expanded potential to exceed consumer needs. As the healthcare environment continues to evolve, more and more organizations are adopting consumer-sensitive cultures that require accountability and decision making from nurses.

What You Know Now

- The schools of organizational theory can be clustered into reductive, humanistic, and adaptive schools of thought, all useful in framing organizations as they exist.
- Organizations can be viewed as social systems consisting of people working in a predetermined pattern of relationships who strive toward a common mission, purpose, and goals. The mission of healthcare organizations is to provide a particular mix of health services.
- Traditional organizational structures include functional, hybrid, matrix, and parallel structures.
- Service-line structures organize clinical services around specific patient conditions.
- Shared governance provides the framework for empowerment and partnership within the healthcare organization.
- Accountable care organizations are expanding as population health is considered in healthcare design. They can contract with a payer to provide care to a specific group of patients.
- The health home is one of the patient-centered models where all services are provided by a group of healthcare professionals.
- Organizational environment and culture affect the internal conditions of the work setting.

Questions to Challenge You

1. Secure a copy of the organizational chart from your employment or clinical site. Would you describe the organization the same way the chart depicts it? If not, redraw a chart to illustrate how you see the organization.
2. What organizational structure would you prefer? Think about how you might go about finding an organization that meets your criteria.
3. Organizational theories explain how organizations function. Which theory (or theories) describes your organization's functioning? Do you think it is the same theory your organization's administrators would use to describe it? Explain.
4. Using the six characteristics of a healthy work environment listed in this chapter, evaluate the organization where you work or have clinicals. How well does it rate? What changes would improve the environment?

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Chapter 3
Delivering Nursing Care

Traditional Models of Care
Total Patient Care
Functional Nursing
Team Nursing
Primary Nursing

Integrated Models of Care
Practice Partnerships
Case Management
Critical Pathways

Evolving Models of Care
Patient-centered Care
Synergy Model of Care
Patient-centered Medical Home

Learning Outcomes

After completing this chapter, you will be able to:

1. Differentiate the models of nursing care delivery systems and the disadvantages of each.
2. Describe the attributes of integrated models of care.
3. Compare three evolving models of care and explain why care delivery systems will continue to evolve.

Key Terms

critical pathways
patient-centered care
patient-centered medical home (PCMH)
practice partnership
synergy model of care

Introduction

The core business of a healthcare organization is providing nursing care to patients. The purpose of a nursing care delivery system is to provide a structure that enables nurses to deliver nursing care to a specified group of patients. Wherever nursing care is delivered—whether in a hospital, an outpatient clinic, or a primary care practice—it must be organized to ensure quality care in an era of cost containment.

Over the years, nursing care delivery systems have undergone continuous and significant changes (see Box 3-1). Various nursing care delivery systems have been tried and critiqued. Debates regarding the pros and cons of each method have focused on identifying the perfect delivery system for providing nursing care to patients with varying degrees of need.

Box 3-1 Job Description of a Floor Nurse in 1887

Developed in 1887 and published in a magazine of Cleveland Lutheran Hospital.

In addition to caring for your 50 patients, each nurse will follow these regulations:

1. Daily sweep and mop the floors of your ward, dust the patients' furniture and window sills.
2. Maintain an even temperature in your ward by bringing in a scuttle of coal for the day's business.
3. Light is important to observe the patient's condition. Therefore, each day fill kerosene lamps, clean chimneys, and trim wicks. Wash windows once a week.
4. The nurse's notes are important to aiding the physician's work. Make your pens carefully. You may whittle nibs to your individual taste.
5. Each nurse on day duty will report every day at 7 a.m. and leave at 8 p.m., except on the Sabbath, on which you will be off from 12 noon to 2 p.m.
6. Graduate nurses in good standing with the Director of Nurses will be given an evening off each week for courting purposes, or two evenings a week if you go regularly to church.
7. Each nurse should lay aside from each pay a goodly sum of her earnings for her benefits during her declining years, so that she will not become a burden. For example, if you earn $30 a month you should set aside $15.
8. Any nurse who smokes, uses liquor in any form, gets her hair done at a beauty shop, or frequents dance halls will give the Director of Nurses good reason to suspect her worth, intentions, and integrity.
9. The nurse who performs her labor, serves her patients and doctors faithfully and without fault for a period of five years will be given an increase by the hospital administration of five cents a day providing there are no hospital debts that are outstanding.

In addition, a delivery system must utilize specific nurses and groups of nurses, optimizing their knowledge and skills and at the same time ensuring that patients receive appropriate care. It is no small challenge. In fact, researchers have found that a better hospital environment for nurses is associated with lower mortality rates (Aiken, Clarke, Sloane, Lake, & Cheney, 2008) and nurse satisfaction (Spence-Laschinger, 2008).

Traditional Models of Care

Various models of care have been designed both to meet the needs of patients and to use nurses effectively. Unfortunately, no one model has been shown to fit every patient population and every care facility. Total patient care, functional nursing, team nursing, and primary nursing all offer advantages and disadvantages.

Total Patient Care

The original model of nursing care delivery was total patient care, in which an RN was responsible for all aspects of the care of one or more patients. During the 1920s, total patient care was the typical nursing care delivery system. Student nurses often staffed hospitals, whereas RNs provided total care to the patient at home. In total patient care, an RN works directly with the patient, family, physician, and other healthcare staff in implementing a plan of care. Continuity of care is assured, and communication with the patient, family, physician, and staff from other departments is fostered.

The disadvantage of this system is that RNs spend some time doing tasks that could be done more cost-effectively by less skilled persons. This inefficiency adds to the expense of using a total patient care delivery system.

Functional Nursing

In functional nursing, the needs of a group of patients are separated into tasks that are assigned to registered nurses (RNs), licensed practical nurses (LPNs), or unlicensed assistive personnel (UAPs) so that the skill and licensure of each caregiver is used to his or her best advantage. Under this model an RN assesses patients, whereas others give baths, make beds, take vital signs, administer treatments, and so forth. As a result, the staff become very efficient and effective at performing their regularly assigned tasks.

Because of problems with continuity, difficulties with follow-up, and the lack of an understanding of the total patient, functional nursing care is used infrequently in acute care facilities and only occasionally in long-term care facilities.

Team Nursing

In team nursing, a team of nursing personnel provides total patient care to a group of patients. The team is led by an RN, and other RNs, LPNs, and UAPs provide patient care to all patients under the direction of the team leader. The team, acting as a unified whole, has a holistic perspective of the needs of each patient.

A key aspect of team nursing is the nursing care conference, where the team leader reviews each patient's plan of care and progress with all team members. Skills in delegating, communicating, and problem solving are essential for a team leader to be effective. Open communication between team leaders and the nurse manager is also important to avoid duplication of effort, overriding of delegated assignments, or competition for control or power.

Primary Nursing

Conceptualized by Marie Manthey and implemented during the late 1960s after two decades of team nursing, primary nursing was designed to place the RN back at the patient's bedside (Manthey, 1980). Decentralized decision making by staff nurses is the core principle of primary nursing, with responsibility and authority for nursing care allocated to staff nurses at the bedside. Primary nursing recognized that nursing was a knowledge-based professional practice, not just a task-focused activity.

In primary nursing, the RN maintains a patient load of primary patients. A primary nurse designs, implements, and is accountable for the nursing care of patients in the patient load for the duration of the patient's stay on the unit. Actual care is given by the primary nurse and/or associate nurses (other RNs).

When primary nursing was first implemented, many organizations perceived that it required an all-RN staff. This practice was viewed as not only expensive but also ineffective because many tasks could be done by less skilled persons. As a result, many hospitals discontinued the use of primary nursing. Other hospitals successfully implemented primary nursing by identifying one nurse who was assigned to coordinate care and with whom the family and physician could communicate, and other nurses or UAPs assisted this nurse in providing care. (See Leading at the Bedside: Do Care Delivery Systems Matter?)

Leading at the Bedside: Do Care Delivery Systems Matter?

You may think it doesn't matter what care delivery system is in place where you work. You have a job description and assigned duties. Your focus is on the patient.

What if you have questions? Do you know whom to ask? How about when others don't do their jobs? Or supplies or equipment don't show up? Or meds fail to appear when needed? Answers to these and other questions can be found in the structure of the delivery system at your workplace. Don't be caught without knowing it!

Integrated Models of Care

In an attempt to better integrate disparate care, new models of care were designed. As with the earlier designs, these models—practice partnerships, case management, and critical pathways—had both positive and negative aspects.

Practice Partnerships

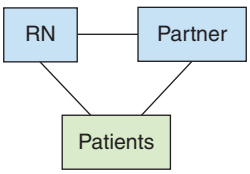

Figure 3-1 Practice partnerships.

The **practice partnership** (see Figure 3-1) was introduced by Marie Manthey in 1989 (Manthey, 1989). In the practice partnership model, an RN and an assistant—UAP, LPN, or less experienced RN—agree to be practice partners. The partners work together with the same schedule and the same group of patients. The senior RN partner directs the work of the junior partner within the limits of each partner's abilities and within the limits of the state's nurse practice act.

The relationship between the senior and junior partner is designed to create synergistic energy as the two work in concert with patients. The senior partner performs selected patient care activities but delegates less specialized activities to the junior partner.

When compared to team nursing, practice partnerships offer more continuity of care and accountability for patient care. When compared to total patient care or primary nursing, partnerships are less expensive for the organization and more satisfying professionally for the partners.

Practice partnerships can be applied to primary nursing and used in other nursing care delivery systems, such as team nursing, modular nursing, and total patient care. As organizations restructured in the 1990s, practice partnerships offered an efficient way of using the skills of a mix of professional and nonprofessional staff with differing levels of expertise.

Case Management

Case management emerged after payment for care changed from cost-based reimbursement to a prospective payment model (Scott, 2014). Case management (see

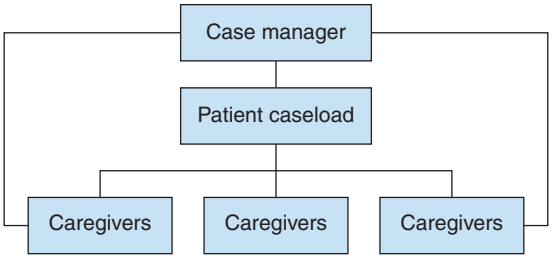

Figure 3-2 Case management.

Figure 3-2) is a model for identifying, coordinating, and monitoring the implementation of services needed to achieve desired patient care outcomes within a specified period of time. Nursing case management organizes patient care by major diagnoses or diagnosis-related groups (categories used by Medicare for reimbursement) and focuses on attaining predetermined patient outcomes within specific time frames and resources.

To initiate case management, specific patient diagnoses that represent high-volume, high-cost, and high-risk cases are selected. High-volume cases are those that occur frequently, such as total hip replacements on an orthopedic floor. High-risk cases include patients or case types who have complications, stay in a critical care unit longer than two days, or require ventilatory support, for example. Whatever patient population is selected, baseline data must be collected, including length of stay, cost of care, and potential complications. These data are analyzed and provide the information necessary to measure the effectiveness of case management.

Once a patient population is selected, a collaborative practice team is established, which includes clinical experts from appropriate disciplines (e.g., nursing, medicine, physical therapy). Each member of the team helps determine appropriate interventions and decides on specific, measurable outcomes within a specified time frame. All professionals are equal members of the team; thus, one group does not determine interventions for other disciplines.

All members of the collaborative practice team agree on the final draft of the critical pathways, take ownership of patient outcomes, and accept responsibility and accountability for the interventions and patient outcomes associated with their discipline. The emphasis is on managing interdisciplinary outcomes and building consensus with physicians. In an acute care setting, the case manager has a caseload of 10 to 15 patients and follows patients' progress through the system from admission to discharge, accounting for variances from expected progress.

Critical Pathways

The term **critical pathways**—also known as critical paths, care pathways, milestone maps, and progression of care—refers to the expected outcomes and care strategies developed by the collaborative practice team (Schrijvers, van Hoorn, & Huiskes, 2012). Again, interdisciplinary consensus must be reached and specific, measurable outcomes determined.

Critical paths provide direction for managing the care of an individual patient during a stipulated time period. Critical paths are useful because they accommodate the unique characteristics of the patient and the patient's condition. Critical

paths use resources appropriate to the care needed and thus reduce cost and length of stay.

A critical path quickly orients the staff to the outcomes that should be achieved for the patient for that day. Nursing diagnoses identify the outcomes needed. If patient outcomes are not achieved, the case manager is notified and the situation analyzed to determine how to modify the critical path.

Altering time frames or interventions is categorized as a variance, and the case manager tracks all variances. After a time, the appropriate collaborative practice teams analyze the variances, note trends, and decide how to manage them. The critical pathway may need to be revised, or additional data may be needed before changes are made.

Some features are included on all critical paths, such as specific medical diagnosis, the expected length of stay, patient identification data, appropriate time frames (in days, hours, minutes, or visits) for interventions, and patient outcomes. Interventions are presented in modality groups (medications, nursing activity, and so on). The critical path must include a means to determine whether the outcome has been met and to easily identify variances.

Evolving Models of Care

Recognizing the need for improving patient care, the Robert Wood Johnson Foundation and the Institute for Healthcare Improvement established a program titled Transforming Care at the Bedside (Lavizzo-Mourey & Berwick, 2009). The goal was, and continues to be, to help hospitals achieve affordable and lasting improvements to care. One of its premises is the use of a patient-centered care model.

Patient-centered Care

Patient-centered care is a model of nursing care delivery in which the role of the nurse is broadened to coordinate a team of multifunctional unit-based caregivers. In patient-centered care, all patient care services are unit based, including admission and discharge, diagnostic and treatment services, and support services such as environmental and nutrition services and medical records. The focus of patient-centered care is decentralization, the promotion of efficiency and quality, and cost control.

Using this model of care, the number of caregivers at the bedside is reduced, but their responsibilities are increased so that service time and waiting time are decreased. A typical team in a unit providing patient-centered care consists of the following:

- Patient care coordinators (RNs)
- Patient care associates or technicians who are able to perform delegated patient care tasks
- Unit support assistants who provide environmental services and can assist with hygiene and ambulation needs
- Administrative support personnel who maintain patient records, transcribe orders, coordinate admission and discharge, and assist with general office duties

Success using a patient-centered care model continues to be reported in the literature (Miles & Vallish, 2010; Schneider & Fake, 2010). Furthermore, lower mortality in

patients with acute myocardial infarctions has been found (Meterko, Wright, Lin, Lowy, & Cleary, 2010). Patients with chronic conditions are appropriate candidates for patient-centered care approaches, including the use of complementary and alternative medicine therapies (Maizes, Rakel, & Niemiec, 2009).

The nurse manager's role in patient-centered care requires considerable time. No longer is the manager doing rounds and assisting with patient care. Instead, being responsible for a staff that is more diverse with fewer professional RN staff demands a strong leader proficient to interview, hire, train, and motivate staff. Some organizations share assistive staff between units, also increasing the need for coordination and cooperation with other managers.

Synergy Model of Care

Developed by the American Association of Critical Nurses (AACN), the **synergy model of care** conceptualizes nursing practice based on the needs and characteristics of patients (American Association of Critical Care Nurses, 2011). These characteristics drive nurse competencies. Patient characteristics include the following:

- Resiliency
- Vulnerability
- Stability
- Complexity
- Resource availability
- Participation in care
- Participation in decision making
- Predictability

These characteristics are then matched with nurse competencies, including the following:

- Clinical judgment
- Advocacy and moral agency
- Caring practices
- Collaboration
- Systems thinking
- Response to diversity
- Facilitation of learning
- Clinical inquiry (AACN, 2011)

When patients' characteristics and nurses' competencies match, synergy is the outcome. The model is useful to nurses by delineating job descriptions, evaluation formats, and advancement criteria. Furthermore, a synergy model helps meet the standards for Magnet certification (Kaplow & Reed, 2008).

Patient-centered Medical Home

The newest addition to a care delivery system is the **patient-centered medical home (PCMH)**, a model for delivering primary care to ensure that adequate and appropriate care is provided to a population of patients. The concept of a medical home,

or health home, however, is not new. The American Academy of Pediatrics first proposed the medical home concept in the late 1960s, and by the mid 2000s, the concept had been adopted by the American Academy of Family Physicians and the American College of Physicians.

The goal of a PCMH is as follows:

- Coordinates care across settings and providers
- Supervises transitions between providers and hospitals
- Monitors care given by a variety of providers
- Develops personal relationships with individual patients
- Adapts care to unique patient needs
- Follows up each encounter of care and revises or refers as necessary (Henderson, Princell, & Martin, 2012)

Unlike previous reimbursement policies, the Affordable Care Act of 2010 supports integrating and coordinating primary care services (Henderson et al., 2012). This change prompted reorganization of healthcare systems. Accountable care organizations (ACO) emerged to encompass a wide range of providers and care services, including, for example, hospitals, physician practices, and ambulatory clinics (Hart, 2012). PCMH may be one component of an ACO, such as a primary care practice, or it may be an organizational entity itself—that is, the primary care practice is its own "medical home."

Coordinating care for today's population of chronically ill patients is essential to ensure patients' safety across a multitude of providers and settings, care that often is duplicated or left undone (Henderson et al., 2012). The PCMH model includes the following:

- Provides comprehensive care
- Is patient centered
- Delivers coordinated care
- Ensures accessible services
- Includes quality and safety measures (Agency for Healthcare Research & Quality, 2015)

Advanced practice nurses are especially suited to lead a PCMH team. In fact, the definition of primary care in the Affordable Care Act specifically refers to primary care *providers*, who, depending on the state's scope of practice, may be nurse practitioners. In addition, the Centers for Medicare & Medicaid Services (2014) included nurse practitioners and clinical nurse specialists as primary care providers, thus making them eligible for direct reimbursement (Amara et al., 2013; Centers for Medicare & Medicaid Services, 2014). What effect this will have on the healthcare system, in general, and primary care practice, in particular, remains to be seen.

No delivery system is perfect—or permanent. As healthcare adapts to changes in reimbursement, demands for quality, and technological advances, models for delivering care will continue to evolve.

What You Know Now

- Nursing care delivery systems provide a structure for nursing care.
- Traditional care models include functional nursing, team nursing, total patient care, and primary nursing.
- Integrated models of care include practice partnerships, case management, and critical pathways.
- Evolving models of care include patient-centered care, a synergy model of care, and the patient-centered medical home.
- In patient-centered care, the nurse coordinates a team of multifunctional unit-based caregivers.
- The synergy model matches patients' characteristics with nurses' competencies.
- The patient-centered medical home is a model of delivering primary care to ensure that adequate and appropriate care is provided to a population of patients.
- As healthcare adapts to changes in reimbursement, demands for quality, and technological advances, models for delivering care will continue to evolve.

Questions to Challenge You

1. Describe the patient care delivery system(s) at your place of work or clinical placement site. How well does it work? Can you suggest a better system?
2. Pretend that you are designing a new nursing care delivery system. Select the system or combination of systems you would use. Explain your rationale.
3. Why have different systems been used in earlier times? Would any of them be useful today? Explain what characteristics of the healthcare system today would make them appropriate or inappropriate to use.
4. As a manager, which system would you prefer? Why?
5. If you were a patient, which system do you think would provide you with the best care?

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Chapter 4

Leading, Managing, Following

Leaders and Managers
Leadership

Leadership Theories
Traditional Leadership Theories
Contemporary Leadership Theories

Followership: An Essential Component of Leadership

Traditional Management Functions
Planning
Organizing
Directing
Controlling

Nurse Managers in Practice
Nurse Manager Competencies
Staff Nurse
First-level Management
Charge Nurse
Clinical Nurse Leader

Learning Outcomes

After completing this chapter, you will be able to:

1. Differentiate between leaders and managers.
2. Evaluate different theories that explain leadership.
3. Explore how followership is essential to leadership.
4. Explain why nurses need to learn management skills.
5. Describe the management roles that nurses fill in practice.

Key Terms

charge nurse
clinical nurse leader (CNL)
controlling
directing
emotional intelligence
first-level manager
followership
formal leadership

informal leadership
leader
manager
organizing
planning
quantum leadership
servant leadership
shared leadership
transactional leadership
transformational leadership
staff nurse

Introduction

Managers are essential to any organization. A manager's functions are vital, complex, and frequently difficult. They must be directed toward balancing the needs of patients, the healthcare organization, employees, physicians, and self. Nurse managers need a body of knowledge and skills distinctly different from those needed for nursing practice, yet few nurses have the education or training necessary to be managers. Frequently, managers depend on experiences with former supervisors, who also learned supervisory techniques on the job. Often a gap exists between what managers know and what they need to know.

Today, all nurses are managers, not in the formal organizational sense but in practice. They direct the work of nonprofessionals and professionals in order to achieve desired outcomes in patient care. Acquiring the skills to be both a leader and a manager will help the nurse become more effective and successful in any position.

Leaders and Managers

The terms *manager*, *leader*, *supervisor*, and *administrator* are often used interchangeably, yet they are not the same. A **leader** is anyone who uses interpersonal skills to influence others to accomplish a specific goal. The leader exerts influence by using a flexible repertoire of personal behaviors and strategies. The leader is important in creating connections and forging links among an organization's members to promote high levels of performance and quality outcomes.

The functions of a leader are to achieve a consensus within the group about its goals, maintain a structure that facilitates accomplishing the goals, supply necessary information that helps provide direction and clarification, and maintain group satisfaction, cohesion, and performance.

A **manager**, in contrast, is an individual employed by an organization who is responsible and accountable for efficiently accomplishing the goals of the organization. Managers focus on coordinating and integrating resources, using the functions of planning, organizing, supervising, staffing, evaluating, negotiating, and representing. Interpersonal skill is important, but a manager also has authority, responsibility, accountability, and power defined by the organization. The manager's job includes the following:

- Clarify the organizational structure.
- Choose the means by which to achieve goals.
- Assign and coordinate tasks, developing and motivating as needed.
- Evaluate outcomes and provide feedback.

All good managers are also good leaders—the two go hand in hand. However, one may be a good manager of resources and not be much of a leader of people. Likewise, a person who is a good leader may not manage well. Both roles can be learned; skills gained can enhance either role.

Leadership

Leadership may be formal or informal. For example, **formal leadership** is practiced by a nurse with legitimate authority conferred by the organization and described in a job description (e.g., nurse manager, supervisor, coordinator, case manager). Formal leadership also depends on personal skills, but it may be reinforced by organizational authority and position. Insightful formal leaders recognize the importance of their own informal leadership activities and the informal leadership of others who affect the work in their areas of responsibility.

Informal leadership is exercised, for example, by a staff member who does not have a specified management role. A nurse whose thoughtful and convincing ideas substantially influence the efficiency of work flow is exercising leadership skills. Informal leadership depends primarily on one's knowledge, status (e.g., advanced practice nurse, quality improvement coordinator, education specialist, medical director), and personal skills in persuading and guiding others.

Leadership Theories

Research on leadership has a long history, but the focus has shifted over time from personal traits to behavior and style, to the leadership situation, to change agency (the capacity to transform), and to other aspects of leadership. Each phase and focus of research has contributed to managers' insights and understandings about leadership and its development.

The most effective leadership style for a nurse manager is the one that best complements the organizational environment, the tasks to be accomplished, and the personal characteristics of the people involved in each situation.

Traditional Leadership Theories

Traditional leadership theories include trait theories, behavioral theories, and contingency theories. In the earliest studies, researchers sought to identify inborn traits of successful leaders. Although inconclusive, these early attempts to specify unique leadership traits provided benchmarks by which most leaders continue to be judged.

Research on leadership in the early 1930s focused on what leaders do. In the behavioral view of leadership, personal traits provide only a foundation for leadership; real leaders are made through education, training, and life experiences.

Contingency approaches suggest that managers adapt their leadership styles in relation to changing situations. According to contingency theory, leadership behaviors range from authoritarian to permissive and vary in relation to current needs and future probabilities. A nurse manager may use an authoritarian style when responding to an emergency situation such as a cardiac arrest but use a participative style to encourage development of a team strategy to care for patients with multiple system failure.

Contemporary Leadership Theories

Leaders in today's healthcare environment place increasing value on collaboration and teamwork in all aspects of the organization. They recognize that as health systems become more complex and require integration, personnel who perform the managerial and clinical work must cooperate, coordinate their efforts, and produce joint results. Leaders must use additional skills, especially group and political leadership skills, to create collegial work environments.

QUANTUM LEADERSHIP **Quantum leadership** is based on the concepts of chaos theory. Chaos theory posits that reality is constantly shifting, and levels of complexity are constantly changing. Movement in one part of the system reverberates throughout the system. Roles are fluid and outcome oriented. It matters little what you did; it only matters what outcome you produced. Within this framework, employees become directly involved in decision making as equitable and accountable partners, and managers assume more of an influential facilitative role, rather than one of control (Porter-O'Grady & Malloch, 2015).

Quantum leadership demands a different way of thinking about work and leadership. Change is expected. Informational power, previously the purview of the leader, is now available to all. Patients and staff alike can access untold amounts of information. The challenge, however, is to assist patients uneducated about healthcare in learning how to evaluate and use the information they have. Because staff members have access to information that only the leader had in the past, leadership becomes a shared activity, requiring the leader to possess excellent interpersonal skills.

TRANSACTIONAL LEADERSHIP **Transactional leadership** is based on the principles of social exchange theory (Yukl, 2013). The primary premise of social exchange theory is that individuals engage in social interactions expecting to give and receive social, political, and psychological benefits or rewards. The exchange process between leaders and followers is viewed as essentially economic. Once initiated, a sequence of exchange behavior continues until one or both parties finds that the exchange of performance and rewards is no longer valuable.

The nature of these transactions is determined by the participating parties' assessments of what is in their best interests—for example, a staff member responds affirmatively to a nurse manager's request to work overtime in exchange for granting special requests for time off. Leaders are successful to the extent that they understand and meet the needs of followers and use incentives to enhance employee loyalty and performance. Transactional leadership is aimed at maintaining equilibrium, or the status quo, by performing work according to policy and procedures, maximizing self-interests and personal rewards, emphasizing interpersonal dependence, and routinizing performance (Matson, 2014).

TRANSFORMATIONAL LEADERSHIP **Transformational leadership** goes beyond transactional leadership to inspire and motivate followers (Marshall, 2010). Transformational leadership emphasizes the importance of interpersonal relationships. Transformational leadership is not concerned with the status quo but, rather, with effecting revolutionary change in organizations and human service. Whereas traditional views of leadership emphasize the differences between employees and managers, transformational leadership focuses on merging the motives, desires, values, and goals of leaders and followers into a common cause. The goal of the transformational leader is to generate employees' commitment to the vision or ideal rather than to themselves.

Transformational leaders appeal to individuals' better selves rather than these individuals' self-interests. They foster followers' inborn desires to pursue higher values, humanitarian ideals, moral missions, and causes. Transformational leaders also encourage others to exercise leadership. The transformational leader inspires followers and uses power to instill a belief that followers also have the ability to do exceptional things.

Transformational leadership may be a natural model for nursing managers because nursing has traditionally been driven by its social mandate and its ethic of human service. In fact, Weberg (2010) found that transformational leadership reduced burnout among employees, and Grant, Colello, Riehle, and Dende (2010) reported that transformational leadership positively affected the practice environment in one medical center. Transformational leadership can be used effectively by nurses with patients or coworkers at the bedside, in the home, in the community health center, and in the healthcare organization.

SHARED LEADERSHIP Reorganization, decentralization, and the increasing complexity of problem solving in healthcare have forced administrators to recognize the value of **shared leadership**, which is based on the empowerment principles of participative and transformational leadership (Everett & Sitterding, 2011). Essential elements of shared leadership are relationships, dialogues, partnerships, and an understanding of boundaries. The application of shared leadership assumes that a well-educated, highly professional, dedicated workforce is comprised of many leaders. It also assumes that the notion of a single nurse as the wise and heroic leader is unrealistic and that many individuals at various levels in the organization must be responsible for the organization's fate and performance.

Different issues call for different leaders, or experts, to guide the problem-solving process. A single leader is not expected always to have knowledge and ability beyond that of other members of the work group. Appropriate leadership emerges in relation to the current challenges of the work unit or the organization. Individuals in formal leadership positions and their colleagues are expected to participate in a pattern of reciprocal influence processes. Kramer, Schmalenberg, and Maguire (2010) and Watters (2009) found shared leadership common in Magnet-certified hospitals.

Examples of shared leadership in nursing include the following:

- ***Self-directed work teams.*** Work groups manage their own planning, organizing, scheduling, and day-to-day work activities.
- ***Shared governance.*** The nursing staff are formally organized at the service area and organizational levels to make key decisions about clinical practice standards, quality assurance and improvement, staff development, professional development, aspects of unit operations, and research.
- ***Co-leadership.*** Two people work together to execute a leadership role. This kind of leadership has become more common in service-line management, where the skills of both a clinical and an administrative leader are needed to successfully direct the operations of a multidisciplinary service. Co-leadership also occurs in a matrix organizational structure. For example, a nurse manager provides administrative leadership in collaboration with a clinical nurse specialist, who provides clinical leadership. The development of co-leadership roles depends on the flexibility and maturity of both individuals, and such arrangements usually require a third party to provide ongoing consultation and guidance to the pair.

SERVANT LEADERSHIP Founded by Robert Greenleaf (Greenleaf, 1991), **servant leadership** is based on the premise that leadership originates from a desire to serve and that, in the course of serving, one may be called to lead (The Greenleaf Center for Servant Leadership, 2015). Servant leaders embody three characteristics:

- Empathy
- Awareness
- Persuasion

Servant leadership appeals to nurses for two reasons. First, our profession is founded on principles of caring, service, and the growth and health of others (Anderson, Manno, O'Connor, & Gallagher, 2010). Second, nurses serve many constituencies, often quite selflessly, and consequently bring about change in individuals, systems, and organizations.

EMOTIONAL LEADERSHIP **Emotional intelligence** (Goleman, Boyatzis, & McKee, 2013) has gained acceptance in the business world and in healthcare (Veronsesi, 2009). Emotional intelligence involves personal competence, which includes self-awareness and self-management, and social competence, which includes social awareness and relationship management that begins with authenticity. (See Table 4-1.)

Goleman et al. (2013) assert that attachment to others is an innate trait of human beings. Thus, emotions are "catching." Consider a person having a pleasant day. Then an otherwise innocuous event turns into a negative experience that spills over into

Table 4-1 Emotional Intelligence Domains and Associated Competencies

PERSONAL COMPETENCE: These capabilities determine how we manage ourselves.	
Self-Awareness	• *Emotional self-awareness:* Reading one's own emotions and recognizing their impact; using "gut sense" to guide decisions • *Accurate self-assessment:* Knowing one's strengths and limits • *Self-confidence:* A sound sense of one's self-worth and capabilities
Self-Management	• *Emotional self-control:* Keeping disruptive emotions and impulses under control • *Transparency:* Displaying honesty and integrity; trustworthiness • *Adaptability:* Flexibility in adapting to changing situations or overcoming obstacles • *Achievement:* The drive to improve performance to meet inner standards of excellence • *Initiative:* Readiness to act and seize opportunities • *Optimism:* Seeing the upside in events
SOCIAL COMPETENCE: These capabilities determine how we manage relationships.	
Social Awareness	• *Empathy:* Sensing others' emotions, understanding their perspective, and taking active interest in their concerns • *Organizational awareness:* Reading the currents, decision networks, and politics at the organizational level • *Service:* Recognizing and meeting follower, patient, or customer needs
Relationship Management	• *Inspirational leadership:* Guiding and motivating with a compelling vision • *Influence:* Wielding a range of tactics for persuasion • *Developing others:* Bolstering others' abilities through feedback and guidance • *Change catalyst:* Initiating, managing, and leading in a new direction • *Conflict management:* Resolving disagreements • *Building bonds:* Cultivating and maintaining a web of relationships • *Teamwork and collaboration:* Cooperation and team building

Source: Goleman, Boyatzis, & McKee. (2013).

future interactions. Or the reverse: A positive experience lightens the mood and affects the next encounter. When people feel good, they work more effectively.

Emotional intelligence has been linked with leadership (Antonakis, Ashkanasy, & Dasborough, 2009; Cote, Lopes, Salovey, & Miners, 2010). One study, however, found no relationship between emotional intelligence and transformational leadership (Lindebaum & Cartwright, 2010).

Nurses, with their well-honed skills as compassionate caregivers, are aptly suited to this direction in leadership that emphasizes emotions and relationships with others as a primary attribute for success. These skills fit better with the more contemporary relationship-oriented theories as well. Thus, the workplace is a more complex and intricate environment than previously suggested.

Healthcare environments require innovations in care delivery and therefore innovative leadership approaches. Quantum, transactional, transformational, shared, servant, and emotional leadership make up a new generation of leadership styles that have emerged in response to the need to humanize working environments and improve organizational performance. In practice, leaders tap a variety of styles culled from diverse leadership theories.

Followership: An Essential Component of Leadership

Leaders cannot lead without followers in much the same way that instructors need students in order to teach. Nor is anyone a leader all the time; everyone is a follower as well. Even the hospital CEO follows instructions from the board of directors.

Followership is interactive and complementary to leadership, and the follower is an active participant in the relationship with the leader (Crawford & Daniels, 2014). A skilled, self-directed, energetic staff member is an invaluable complement to the leader and to the group. Most leaders welcome active followers; they help leaders accomplish their goals and the team succeed.

Followers are powerful contributors to the relationship with their leaders. Followers can influence leaders in negative ways, as in government cover-ups, Medicare fraud, and corporate law-breaking attest. The reverse is also true. Poor managers can undermine good followers in direct and indirect ways, such as criticizing, belittling, or ignoring positive contributions to the team (Arnold & Pulich, 2008). In fact, Crawford and Daniels (2014) found that poor interactions between leaders and followers led to an increase in nurse burnout, resulting in a decrease in the quality of care and, in some cases, causing nurses to leave the profession.

Followership is fluid as well. The nurse may be a leader at one moment and become a follower soon afterward. In fact, the ability to move along the continuum of degrees of followership is a must for successful teamwork. The nurse is a leader with subordinate staff and a follower of the nurse manager, possibly at the same time.

An effective follower must maintain credibility and trust with the leader. Furthermore, the follower can improve the relationship with the leader, point out flaws in proposed plans, and help leaders be more successful (Yukl, 2013). Box 4-1 offers guidelines for effective followership.

Box 4-1 Guidelines for Followers

- Find out what you are expected to do.
- Take the initiative to deal with problems.
- Keep the boss informed about your decisions.
- Verify the accuracy of information you give the boss.
- Encourage the boss to provide honest feedback to you.
- Support efforts to make necessary changes.
- Show appreciation and provide recognition when appropriate.
- Challenge flawed plans and proposals made by bosses.
- Resist inappropriate influence attempts by the boss.
- Provide upward coaching and counseling when appropriate.
- Learn to use self-management strategies.

Source: Yukl, G. (2013). *Leadership in organizations*. Upper Saddle River, NJ: Pearson, p. 239.

Traditional Management Functions

In 1916, French industrialist Henri Fayol first described the functions of management as planning, organizing, directing, and controlling.

Planning

Planning is a four-stage process to achieve the following:

- Establish objectives (goals).
- Evaluate the present situation and predict future trends and events.
- Formulate a planning statement (means).
- Convert the plan into an action statement.

Planning is important on both an organizational and a personal level and may be an individual or group process that addresses the questions of what, why, where, when, how, and by whom. Decision making and problem solving are inherent in planning, and computer software programs and databases are available to help facilitate it.

Organization-level plans, such as determining organizational structure and staffing or operational budgets, evolve from the mission, philosophy, and goals of the organization. The nurse manager plans and develops specific goals and objectives for her or his area of responsibility.

Antonio, the nurse manager of a home care agency, plans to establish an in-home phototherapy program, knowing that part of the agency's mission is to meet the healthcare needs of the child-rearing family. To effectively implement this program, he would need to address the following:

- *How the program supports the organization's mission*
- *Why the service would benefit the community and the organization*
- *Who would be candidates for the program*
- *Who would provide the service*
- *How staffing would be accomplished*
- *How charges would be generated*
- *What those charges should be*

Planning can be contingent or strategic. Using contingency planning, the manager identifies and manages the many problems that interfere with getting work done. Contingency planning may be reactive in response to a crisis or proactive in anticipation of problems or in response to opportunities.

What would you do if two registered nurses called in sick for the 12-hour night shift? What if you were a manager for a specialty unit and received a call for an admission but had no more beds? What if you were a pediatric oncology clinic manager and a patient's sibling exposed a number of immunocompromised patients to chickenpox? Planning for crises such as these are examples of contingency planning.

Strategic planning refers to the process of continual assessment, planning, and evaluation to guide the future (Fairholm & Card, 2009). Its purpose is to create an image of the desired future and design ways to make those plans a reality. A nurse manager might be charged, for example, with developing a business plan to add a time-saving device to commonly used equipment, presenting the plan persuasively, and developing operational plans for implementation, such as acquiring devices and training staff.

Organizing

Organizing is the process of coordinating the work to be done. Formally, it involves identifying the work of the organization, dividing the labor, developing the chain of command, and assigning authority. It is an ongoing process that systematically reviews the use of human and material resources. In healthcare, the mission, formal organizational structure, delivery systems, job descriptions, skill mix, and staffing patterns form the basis for the organization.

> *In organizing the home phototherapy project, Antonio develops job descriptions and protocols, determines how many positions are required, selects a vendor, and orders supplies.*

Directing

Directing is the process of getting the organization's work done. Power, authority, and leadership style are intimately related to a manager's ability to direct. Communication abilities, motivational techniques, and delegation skills also are important. In today's healthcare organization, professional staff are autonomous, requiring guidance rather than direction. The manager is more likely to sell the idea, proposal, or new project to staff rather than tell them what to do. The manager coaches and counsels to achieve the organization's objectives. In fact, it may be the nurse who assumes the traditional directing role when working with unlicensed personnel.

> *In directing the home phototherapy project, Antonio assembles the team of nurses to provide the service, explains the purpose and constraints of the program, and allows the team to decide how to staff the project, giving guidance and direction when needed.*

Controlling

Controlling involves comparing actual results with projected results. This includes establishing standards of performance, determining the means to be used in measuring performance, evaluating performance, and providing feedback. The efficient

manager constantly attempts to improve productivity by incorporating techniques of quality management, evaluating outcomes and performance, and instituting change as necessary.

When Antonio introduces the home phototherapy program, the team of nurses involved in the program identifies standards regarding phototherapy and individual performances. A subgroup of the team routinely reviews monitors designed for the program and identifies ways to improve the program.

Planning, organizing, directing, and controlling reflect a systematic, proactive approach to management. This approach is used widely in all types of organizations, healthcare included, but today's rapidly changing healthcare environment makes it more difficult to control events and predict outcomes.

Nurse Managers in Practice

Putting nursing management into practice in the dynamic healthcare system of today is a challenge. Organizations are in flux, structures are changing, and roles and functions of nurse managers become moving targets.

Managers are essential to any organization. A manager's functions are vital, complex, and frequently difficult. They must be directed toward balancing the needs of patients, the healthcare organization, employees, physicians, and self. Nurse managers need a body of knowledge and skills distinctly different from those needed for nursing practice, yet few nurses have the education or training necessary to be managers. Frequently, managers depend on experiences with former supervisors, who also learned supervisory techniques on the job. Often, a gap exists between what managers know and what they need to know.

Titles for nurse managers vary as widely as do their responsibilities. The first-level manager may be titled first-line manager or unit manager. A middle manager might be deemed a department manager. The top-level nursing administrator could be named executive manager, chief nursing officer, or vice president of patient care. In addition, clinical titles might include professional practice leaders who are clinical nurse specialists or nurse practitioners. Regardless of their titles, all nurse managers must hold certain competencies.

Nurse Manager Competencies

The American Organization of Nurse Executives (AONE), an organization for the top nursing administrators in healthcare, identified five areas of competency necessary for nurses at all levels of management (American Organization of Nurse Executives, 2011). Nurse managers must be skilled communicators and relationship builders, have a knowledge of the healthcare environment, exhibit leadership skills, display professionalism, and demonstrate business skills (see Box 4-2). These characteristics intersect to provide a common core of leadership competencies (see Figure 4-1).

Staff Nurse

Although not formally a manager, the **staff nurse** supervises LPNs, other professionals, and assistive personnel and thus is also a manager who needs management

Box 4-2 AONE Five Areas of Competency

AONE believes that managers at all levels must be competent in the following:

Communication and Relationships-Building Competencies Include:

- Effective communication
- Relationship management
- Influence of behaviors
- Ability to work with diversity
- Shared decision making
- Community involvement
- Medical staff relationships
- Academic relationships

Knowledge of the Health Care Environment Includes:

- Clinical practice knowledge
- Patient care delivery models and work design knowledge
- Health care economics knowledge
- Health care policy knowledge
- Understanding of governance
- Understanding of evidence-based practice
- Outcome measurement
- Knowledge of and dedication to patient safety
- Understanding of utilization/case management
- Knowledge of quality improvement and metrics
- Knowledge of risk management

Leadership Skills Include:

- Foundational thinking skills
- Personal journey disciplines
- The ability to use systems thinking
- Succession planning
- Change management

Professionalism Includes:

- Personal and professional accountability
- Career planning
- Ethics
- Evidence-based clinical and management practice
- Advocacy for the clinical enterprise and for nursing practice
- Active membership in professional organizations

Business Skills Include:

- Understanding of health care financing
- Human resource management and development
- Strategic management
- Marketing
- Information management and technology

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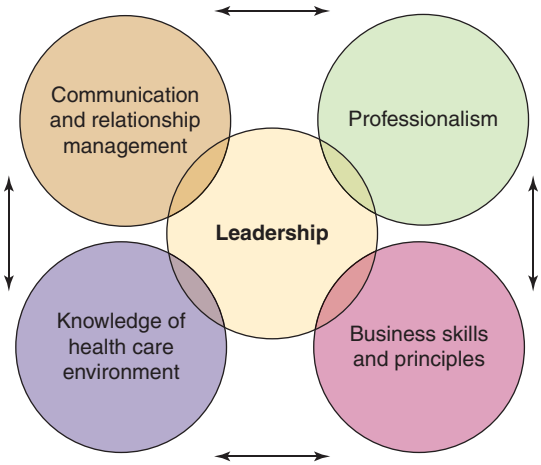

Figure 4-1 Core of leadership competencies.

Source: Copyright © 2005 by the American Organization of Nurse Executives. Address reprint permission requests to aone@aha.org.

and leadership skills. Communication, delegation, and motivation skills are indispensable.

In some organizations, shared governance, which gives staff nurses more control over their practice, has been implemented, and traditional management responsibilities are allocated to the work team. In this case, staff nurses have considerable involvement in managing the unit.

Many staff nurses, however, find delegating and supervising other staff challenging, often insisting the unit needs more nurses and/or support staff. By reviewing exactly what tasks the staff nurse is doing, the manager may find the nurse doing baths, vital signs, and toileting despite having aides who could help. The manager must teach the nurse how to delegate so all roles are adequately utilized. (See Leading at the Bedside: Practicing Leadership.)

First-level Management

The **first-level manager** is responsible for supervising the work of nonmanagerial personnel and the day-to-day activities of a specific work unit or units. With primary responsibility for motivating the staff to achieve the organization's goals, the first-level manager represents staff to upper administration, and vice versa. Nurse managers have 24-hour accountability for the management of a unit(s) or area(s) within a healthcare organization. In the hospital setting, the first-level manager is usually the head nurse, nurse manager, or an assistant manager. In other settings, such as an ambulatory care clinic or a home healthcare agency, a first-level manager may be referred to as a coordinator.

As healthcare becomes more complex, the responsibilities and tasks that fall to this role continue to grow. Hours are longer, the role is stressful at times, and time management skills, as well as training charge nurses and others to be extensions of the manager, are more important than ever before. Box 4-3 describes one first-level manager's day.

Charge Nurse

Another role that does not fit the traditional levels of management is the **charge nurse**. The charge nurse position is an expanded staff nurse role with increased responsibility. The charge nurse functions as a liaison to the nurse manager, assisting in shift-by-shift coordination and promotion of quality patient care as well as efficient use of resources.

Leading at the Bedside: Practicing Leadership

This chapter offers the direct caregiver the most advice for leading and managing in any job designation. Specifically, the staff nurse role explanation, along with descriptions of various managers' duties, can help you understand how your work fits into the larger organization. In addition, descriptions of leadership theories (*theory* is not a dirty word!) help to explain why and how other people do what they do. Or why they don't do what you expect. In fact, you can find explanations of your own choices and behavior in these theories.

Leadership is a learned skill. Like any other skill, it takes practice. Fortunately, working at the bedside gives you many opportunities to practice.

Box 4-3 A Day in the Life of a First-level Manager

As the manager for a surgical intensive care unit (SICU), Jamal Johnson is routinely responsible for supervising patient care, troubleshooting, maintaining compliance with standards, and giving guidance and direction as needed. In addition, he has fiscal and committee responsibilities and is accountable to the organization for maintaining its philosophies and objectives. The following exemplifies a typical day.

As Jamal came on duty, he learned that there had been a multiple vehicle accident and that three of the victims were currently in the operating room and destined for the unit. The assistant manager for nights had secured more staff for days: two part-time SICU nurses and a staff nurse from the surgical floor. However, she had not had time to arrange for two more patients to be moved out of the unit. From their assigned nurses, Jamal obtained an update on the patients who were candidates for transfer from the SICU to another floor and, in consultation with his assistant, made the appropriate arrangements for the transfers.

Other staffing problems were at hand: In addition to the nurse who had been pulled from the surgical floor, there were two orientees, and the staff needed to attend a safety in-service. As soon as the charge nurse came in, Jamal apprised her of the situation. Together, they reviewed the operating room schedule and identified staffing arrangements. Fortunately, Jamal had only one meeting that day and would be available for backup staffing. In the meantime, he would work on evaluations.

After his discussions with the charge nurse, Jamal met with each of the night nurses to get an update on the status of the other patients. Then he went to his office to review his messages and plan his day. Tamera, an RN, had just learned she was pregnant, but stated that she planned to work until delivery. Jamal learned that his budget hearing had been scheduled for the following Monday at 10:00 a.m. A pharmaceutical representative wanted to provide an in-service for the unit. Fortunately, there were no immediate crises.

Jamal called his supervisor to inform her of the status of affairs on the unit and learned that two other individuals in the accident had been transported to another hospital; one had since died. They discussed the ethical and legal ramifications. Jamal would need to review the policies on relations with the press and law enforcement and update his staff.

As the first patient returned from surgery, Jamal went to help admit the patient and receive a report. Learning that the patient was stable, he informed Lucinda, the charge nurse, that the patient they had just received was likely to be charged with manslaughter and reviewed media and legal policies with her. They also discussed how the staff were doing. There were some equipment problems in room 2110; Lucinda had temporarily placed the patient in that room on a transport monitor and was waiting for a biomedical technology staff member to check the monitor. Could Jamal follow up? Jamal agreed and commended Lucinda for her problem solving. She reminded Jamal that they would need backup for lunch and in-services.

As Jamal returned to his office, he noted that the alarms were turned off on one of the patients. He pulled aside the nurse assigned to the patient and reminded her of the necessity to keep the alarms on at all times. Finally, back in his office, he called biomedical technology to ascertain the plans to check the monitor and made notes regarding the charge nurse's problem-solving abilities and the staff nurse's negligence.

He reviewed staffing for the next 24 hours and noted that an extra nurse was needed for both the evening and night shifts because of the increased workload. After finding staff, he was able to finish one evaluation before covering for the in-services and lunch and then attending the policy and procedure team meeting.

The charge nurse often troubleshoots problems and assists other staff members in decision making. Role modeling, mentoring, and educating are additional roles that the charge nurse often assumes. Therefore, the charge nurse usually has extensive experience, skills, and knowledge in clinical practice and is familiar with the organization's standards and practices.

The charge nurse's job differs, though, from that of the first-level manager. The charge nurse's responsibilities are confined to a specific shift or task, whereas the first-level manager has 24-hour responsibility and accountability for all unit activities. Also the charge nurse has limited authority; the charge nurse functions as an

agent of the manager and is accountable to the manager for any actions taken or decisions made.

Although often involved in planning and organizing the work to be done, the charge nurse has a limited scope of responsibility, usually restricted to the unit for a specific time period. In the past, the charge nurse had limited involvement in the formal evaluation of performance, but in today's climate of efficiency, the charge nurse may be involved in evaluations as well. With the trend toward participative management, charge nurses are assuming more of the roles and functions traditionally reserved for the first-level manager.

The charge nurse has considerable power to build or break the culture of the unit. Thus, many organizations have shifted away from the charge nurse being a rotated responsibility or many random staff members taking their turn being in charge. Today, a set group of nurses who demonstrate leadership, are good role models, and have shown they can build a positive work environment may be selected. They are trained to the charge nurse role and compensated appropriately (Normand, Black, Baldwin, & Crenshaw, 2014). In addition, charge nurses can be groomed for future leadership roles in the organization (Patrician, Oliver, Miltner, Dawson, & Ladner, 2012).

Clinical Nurse Leader

The **clinical nurse leader (CNL)** is not a manager, per se, but instead is a lateral integrator of care responsible for a specified group of patients within a unit of the healthcare setting (Schilling-Broderick, 2013). Questions about the differences between a clinical nurse specialist (CNS) and the CNL are often raised. While the CNS is assigned hospital-wide, the CNL is unit based.

The CNL role is designed to respond more effectively to challenges in today's rapidly changing, complex technological environment that can result in dangerously fragmented care (Harris & Roussel, 2009; Schilling-Broderick, 2013). Prepared at the master's level, the CNL coordinates care at the bedside and supervises the healthcare team, among other duties (Sherman, 2010).

Use of the CNL positions in healthcare organizations has improved patient outcomes and reduced costs and is expected to expand as the demand for quality continues (Hix, McKeon, & Walters, 2009; Ignatious, 2010; Stanley et al., 2008).

Problems have emerged, however, as CNLs transition into organizations. These include being drawn into direct patient care, explaining the role to other nurses and healthcare providers, and acceptance by the staff (Sherman, 2010).

Today, all nurses are managers, not in the formal organizational sense but in practice. They direct the work of nonprofessionals and professionals in order to achieve desired outcomes in patient care. Leaders are skilled in empowering others, creating meaning and facilitating learning, developing knowledge, thinking reflectively, communicating, solving problems, making decisions, and working with others. Leaders generate excitement; they clearly define their purpose and mission. Leaders understand people and their needs; they recognize and appreciate differences in people, individualizing their approach as needed. Acquiring the skills to be both a leader and a manager will help the nurse become more effective and successful in any position. See how one nurse described her work in Box 4-4.

Box 4-4 A Leader Describes Her Work

I believe that the most important role of a nurse leader is to live the life and exemplify at all times the qualities that every professional nurse leader should. I also believe the nurse leader/manager must be the person to set the bar high and perform at the highest levels in order to inspire staff to achieve the same.

As a nurse manager, I at all times work to be compassionate, caring, an excellent communicator, vested in my job, willing to go above and beyond and assist people with any task or issue they just need a little extra support on. I feel that by doing this, there is never a question what I expect from them and those around me. I verbally set expectations, then live them as a role model.

For example, at shift change two nights ago, a physician wanted to do a bedside procedure. I was actually planning on leaving soon after a long day. I knew it was shift change, and didn't want the staff to be interrupted, so I volunteered to stay and do the procedure so they could continue with report, and the physician and patient were not kept waiting. The staff were very appreciative, but more important, I think it set the right example of teamwork, being flexible, being patient focused.

I think it is important for the nurse leader to provide feedback at times other than evaluations. The nurse leader should schedule time into the workweek to have informal conversations with staff on the floor about comments a patient or coworker has shared or to send an email to a staff member about feedback the leader has received. I think constructive feedback needs to be timely and supportive and the need for improvement discussed long before an evaluation.

I like starting conversations with questions such as "What are your goals?" or "What can I help you explore or do that you've been dreaming about to enhance your nursing career?" People need to feel comfortable having these conversations with their trusted nurse leader. Building relationships with those you lead is important.

What You Know Now

- A leader employs specific behaviors and strategies to influence individuals and groups to attain goals.
- Managers are responsible for efficiently accomplishing the goals of the organization.
- Contemporary leadership theories emphasize cooperation and collaboration.
- Quantum, transactional, transformational, servant, emotional, and shared leadership are examples of contemporary leadership theories.
- Both leaders and followers contribute to the effectiveness of their relationship.
- Traditional management functions include planning, organizing, directing, and controlling.
- Successful leaders inspire and empower others, generate excitement, and individualize their approach to differences in people.

Tools for Leading, Managing, and Following

1. In any interaction, pay attention to the context: Are you leading, managing, or following in this situation?
2. Notice others whose leadership style you admire and try to incorporate their behaviors in your own leadership if the situation is appropriate.
3. Evaluate yourself at regular opportunities in order to find ways to improve your abilities to lead, manage, and follow.

Questions to Challenge You

1. Think about people you know in management positions. Are any of them leaders as well? Describe the characteristics that make them leaders.
2. Consider people you know who are not in management positions but are leaders nonetheless. What characteristics do they have that make them leaders?
3. Describe the manager to whom you report. (If you are not employed, use the first-level manager on a clinical placement site.) Evaluate this person using the management functions described in this chapter.
4. Imagine yourself as a manager whether you are in a management position or not. What skills do you possess that help you? What skills would you like to improve?
5. Evaluate yourself as a follower. Find at least one characteristic listed in this chapter that you would like to develop or improve. During the next week, try to find opportunities to practice that skill.
6. Assess yourself as a leader. How would you like to improve?

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Chapter 5
Initiating and Managing Change

The Nurse as Change Agent

Change Theories

The Change Process

Step 1: Identify the Problem or Opportunity

Step 2: Collect Necessary Data and Information

Step 3: Select and Analyze Data

Step 4: Develop A Plan for Change, Including Time Frame and Resource

Step 5: Identify Supporters and Opposers

Step 6: Implement Interventions to Achieve Desired Change

Step 7: Evaluate Effectiveness of the Change and, if Successful, Stabilize the Change

Change Strategies

Power–Coercive Strategies

Empirical–Rational Model Strategies

Normative–Reeducative Strategies

Resistance to Change

The Nurse's Role

Initiating Change

Implementing Change

Unplanned Change

Handling Constant Change

Learning Outcomes

After completing this chapter, you will be able to:

1. Explain why nurses have the opportunity to be change agents.
2. Describe how different theorists explain change.
3. Delineate steps in the change process.
4. Differentiate among change strategies.
5. Evaluate ways to handle resistance to change.
6. Describe the nurse's role in planned and unplanned change.

Key Terms

change
change agent
driving forces
empirical–rational model
normative–reeducative strategies
power–coercive strategies
restraining forces
transitions

Introduction

Change is inevitable, if not always welcome. Organizational change is essential for adaptation; creative change is mandatory for growth (Heath & Heath, 2010). Change, though, is a continually unfolding process rather than an either/or event. The process begins when the present state is disrupted, moves through a transition period, and ultimately comes to a desired state. Once the desired state has been reached, however, the process begins again.

Leading change was never needed more than in today's rapidly evolving system of healthcare. Those who initiate and manage change often encounter resistance. Even when planned, change can be threatening and a source of conflict because it is the process of making something different from what it was. There is a sense of loss of the familiar, the status quo. This is particularly true when change is unplanned or beyond human control. Even when change is expected and valued, a grief reaction still may occur.

Although nurses should understand and anticipate these reactions to change, they need to develop and exude a different approach. They can view change as a challenge and encourage their colleagues to participate. They can become uncomfortable with the status quo and be willing to take risks.

The present is a particular fortuitous time for the nursing profession (Nickitas, 2010). The report published by the Institute of Medicine (IOM) on the future of nursing proposes radical change for the profession (Institute of Medicine, 2010). The key messages of the report appear in Box 5-1.

Box 5-1 Key Messages from The Future of Nursing: Leading Change, Advancing Health

- Nurses should practice to the full extent of their education and training.
- Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.
- Nurses should be full partners with physicians and other healthcare professionals in redesigning healthcare in the United States.
- Effective workforce planning and policymaking require better data collection and an improved information infrastructure.

Furthermore, the IOM makes eight recommendations:

- Remove scope-of-practice barriers.
- Expand opportunities for nurses to lead and diffuse collaborative improvement efforts.
- Implement nurse residency programs.
- Increase the proportion of nurses with baccalaureate degrees to 80% by 2020.
- Ensure nurses engage in lifelong learning.
- Prepare and enable nurses to lead change to advance health.
- Build an infrastructure for the collection and analysis of interprofessional healthcare workforce data.

Source: IOM (Institute of Medicine). 2011. *The Future of Nursing: Leading Change, Advancing Health.* Washington, DC: The National Academies Press.

The Nurse as Change Agent

A **change agent** is one who works to bring about a change. Being a change agent is not easy. Although the end result of change may benefit nurses and patients alike, initially it requires time, effort, and energy, all of which are in short supply in the high-stress environment of healthcare.

Several recent reports document nurses' roles in facilitating change. MacDavitt, Cieplincki, and Walker (2011) report that when nurses made small changes in communication on a pediatric inpatient unit, improved patient satisfaction resulted. McMurray, Chaboyer, Wallis, and Fetherston (2010) found that nurse managers played a key role in implementing successful change in bedside handover in two hospitals.

Changes will continue at a rapid pace with or without nursing's expert guidance. Nonetheless, nurses, like organizations, cannot afford merely to survive changes. If they are to exist as a distinct profession that has expertise in helping individuals respond to actual or potential health problems, they must be proactive in shaping the future. Opportunities exist now for nurses, especially those in management positions, to change the system about which they so often complain.

Change Theories

Because change occurs within the context of human behavior, understanding how change does (or does not) occur is helpful in learning how to initiate or manage change. Five theories explain the change process. See Table 5-1 for a comparison.

Lewin (1951) proposes a force-field model, much like a football field (see Figure 5-1). He sees behavior as a dynamic balance of forces working in opposing directions within a field (such as an organization). **Driving forces** facilitate change because they push participants in the desired direction. **Restraining forces** impede change because they push participants in the opposite direction.

To plan change, one must analyze these forces and shift the balance in the direction of change through a three-step process: unfreezing, moving, and refreezing. Change occurs by adding a new force, changing the direction of a force, or changing the magnitude of any one force. Basically, strategies for change are aimed at increasing driving forces, decreasing restraining forces, or both. The image of people's attitudes thawing and then refreezing is conceptually useful. This symbolism helps to keep theory and reality in mind simultaneously.

Table 5-1 Comparison of Change Models

Lewin	Lippitt	Havelock	Rogers	Kotter
1. Unfreezing 2. Moving 3. Refreezing	1. Diagnose problem 2. Assess motivation 3. Assess change agent's motivations and resources 4. Select progressive change objects 5. Choose change agent role 6. Maintain change 7. Terminate helping relationships	1. Building a relationship 2. Diagnosing the problem 3. Acquiring resources 4. Choosing the solution 5. Gaining acceptance 6. Stabilization and self-renewal	1. Knowledge 2. Persuasion 3. Decision 4. Implementation 5. Confirmation	1. Create urgency 2. Form a powerful coalition 3. Create a vision for change 4. Communicate the vision 5. Empower others to act 6. Generate short-term wins 7. Consolidate changes 8. Institutionalize new approach

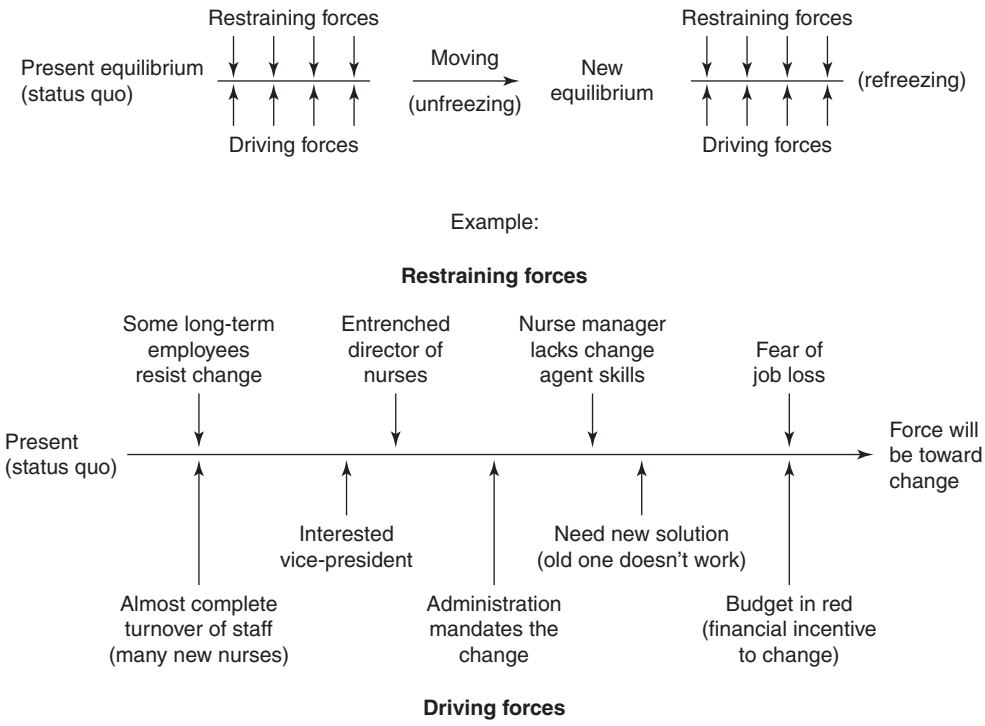

Figure 5-1 Lewin's force-field model of change.

Adapted from *Resolving Social Conflicts and Field Theory in Social Science* by K. Lewin. Copyright © 1997, by the American Psychological Association. Adapted with permission.

Lippitt, Watson, and Wesley (1958) extended Lewin's theory to a seven-step process and focused more on what the change agent must do than on the evolution of change itself. (See Table 5-1.) They emphasized participation of key members of the target system throughout the change process, particularly during planning. Communication skills, rapport building, and problem-solving strategies underlie their phases.

Havelock (1973) described a six-step process, also a modification of Lewin's model. Similar to Lippitt et al., Havelock describes an active change agent as one who uses a participative approach.

Rogers (2003) takes a broader approach than Lewin, Lippitt et al., or Havelock (see Table 5-1). His five-step innovation–decision process details how an individual or decision-making unit passes from first knowledge of an innovation to confirmation of the decision to adopt or reject a new idea. His framework emphasizes the reversible nature of change: Participants may initially adopt a proposal but later discontinue it, or the reverse—they may initially reject it but adopt it at a later time. This is a useful distinction. If the change agent is unsuccessful in achieving full implementation of a proposal, it should not be assumed the issue is dead. It can be resurrected, perhaps in an altered form or at a more opportune time.

Rogers stresses two important aspects of successful planned change: Key people and policy makers must be interested in the innovation and committed to making it happen. Erwin (2009) found that organizational change in hospitals could only be successful and sustained if senior administrators were fully committed to the change.

More recently, Kotter (2012) identifies lessons from organizations that succeeded with change and critical mistakes by those organizations that failed. Successful

organizations created a sense of urgency for the change, formed a powerful coalition to guide the change, created a vision of the desired change, communicated that vision to all, empowered employees to act on the vision, planned for and created short-term wins, consolidated improvements, and institutionalized the new approach. Failed organizations, on the other hand, did not create a sense of urgency, a guiding coalition, or a vision. They did not plan for short-term wins, declared victory too soon, and did not anchor the changes in the organization's culture. Success in using Kotter's eight-step process has been reported in a variety of healthcare organizations (Berger, Conway, & Beaton, 2012; Shirey, 2011).

The Change Process

The steps in the change process are the same whether the change is major (e.g., merging several organizations) or minor (e.g., trying hourly 4P rounding on a unit). (See Box 5-2.)

Box 5-2 Steps in the Change Process

1. Identify the problem or opportunity.
2. Collect necessary data and information.
3. Select and analyze data.
4. Develop a plan for change, including time frame and resources.
5. Identify supporters and opposers.
6. Implement interventions to achieve desired change.
7. Evaluate effectiveness of the change and, if successful, stabilize the change.

Step 1: Identify the Problem or Opportunity

Because change is often planned to close a discrepancy between the actual and desired state of affairs, the first step is to identify the problem. Discrepancies may arise because of problems in reaching performance goals or because new goals have been created.

Opportunities demand change as much as (or more than) problems do, but they are often overlooked. Be it a problem or an opportunity, it must be identified clearly. If the issue is perceived differently by key individuals, the search for solutions becomes confused.

Start by asking the right questions, such as these:

- Where are we now?
- What is unique about us?
- What should our business be?
- What can we do that is different from and better than what our competitors do?
- What is the driving stimulus in our organization?
- What determines how we make our final decisions?
- What prevents us from moving in the direction we wish to go?
- What kind of change is required?

This last question generates integrative thinking on the potential effect of change on the system. Organizational change involves modifications in the system's interacting components: technology, structure, and people.

Introducing new technology changes the structure of the organization. The physical plant may be altered if new services are added and then relationships among the people who work in the system change when the structure is changed. Surveillance cameras, cell phones, magnetic entry cards, bar codes, and communication technology, including social media, have altered the care environment as much as they've changed our personal world. The Affordable Care Act introduced new rules and regulations, suggested new authority structures, and forced new budgeting methods to emerge. These changes, in turn, altered staffing needs, requiring people with different skills, knowledge bases, attitudes, and motivations.

Step 2: Collect Necessary Data and Information

Once the problem or opportunity has been clearly defined, the change agent collects data external and internal to the system. This step is crucial to the eventual success of the planned change. All driving and restraining forces are identified so the driving forces can be emphasized and the restraining forces reduced.

The costs and benefits of the proposed change are obvious focal points as is the need to assess resources—especially those the manager can control. A manager who has the respect and support of an excellent nursing staff has access to a powerful resource in today's climate.

Step 3: Select and Analyze Data

The kinds, amounts, and sources of data collected are important, but they are useless unless they are analyzed. The change agent should focus more energy on analyzing and summarizing the data than on just collecting it. The point is to flush out resistance, identify potential solutions and strategies, begin to identify areas of consensus, and build a case for whichever option is selected.

> *At a not-for-profit hospital in the process of seeking Magnet status, each service line is looking for opportunities to improve standards of care, efficiency, and patient safety. In the ambulatory surgery center, the process of providing preoperative services was often slow and inefficient. The surgery center nurses were charged with finding ways to improve efficiency.*

Step 4: Develop a Plan for Change, Including Time Frame and Resource

Planning the who, how, and when of the change is a key step. What will be the target system for the change? Members from this system should be active participants in the planning stage. The more involved they are at this point, the less resistance there will be later. Lewin's unfreezing imagery is relevant here. Present attitudes, habits, and ways of thinking have to soften so members of the target system will be ready for new ways of thinking and behaving. Boundaries must melt before the system can shift and restructure.

This is the time to make people uncomfortable with the status quo and establish a sense of urgency (Kotter, 2012). Introduce information that may make people feel dissatisfied with the present and interested in something new. This information comes from the data collected (e.g., research findings, quantitative data, and patient satisfaction questionnaires or staff surveys). Couch the proposed change in comfortable terms as far as possible, and minimize anxiety about the new change.

Managers need to plan the resources required to make the change and establish feedback mechanisms to evaluate its progress and success. Establish control points with people who will provide the feedback, and work with these people to set specific goals with time frames. Develop operational indicators that signal success or failure in terms of performance and satisfaction.

Three surgery center nurses designed a flow chart of how the process could be improved. They took it to their administration and were put in charge of its implementation.

Step 5: Identify Supporters and Opposers

Who will gain from this change? Who will lose? Who has more power and why? Can those power bases be altered? How? Who in control may be benefiting now? Egos, commitment of the involved people, and personal likes and dislikes are as important to assess as the formal organizational structures and processes.

Selecting and placing personnel or terminating key people often is used to alter the forces for or against change. When key supporters of the planned change are given the authority and accountability to make the change, their enthusiasm and legitimacy can be effective in leading others to support the change. Conversely, if those opposed to the change are transferred or leave the organization, the change is more likely to succeed.

Step 6: Implement Interventions to Achieve Desired Change

The plans are put into motion (Lewin's moving stage). Interventions are designed to gain the necessary compliance. The change agent creates a supportive climate, acts as an energizer, obtains and provides feedback, and overcomes resistance.

The surgery center nurses worked with physician offices, insurance companies, and other hospital departments to implement the new process for preoperative services.

Step 7: Evaluate Effectiveness of the Change and, if Successful, Stabilize the Change

The change agent determines whether presumed benefits were achieved from a financial as well as a qualitative perspective, explaining the extent of success or failure. Unintended consequences, positive or negative, may have occurred.

The change is extended past the pilot stage, and the target system is refrozen. For example, a nursing unit starts an hourly rounding program. Each hour the nurses or aides check pain, potty, position, and possessions (4P rounding). The goal is to improve patient satisfaction. After trying the rounding for 6 months, fall rates improve and call light usage goes down. The decision is made to continue the rounding (Mitchell, Lavenberg, Trotta, & Umscheid, 2014).

The change agent terminates the relationship by delegating responsibilities to target system members. The energizer role is still needed to reinforce new behaviors through positive feedback.

Over the next 3 months, the preoperative services department was able to show a 90% decrease in duplicate test orders, a 50% decrease in patient waiting time, and an 80% increase in physician satisfaction with the process.

Change Strategies

Regardless of the setting or proposed change, the change process should be followed. Specific strategies can be used, however, depending on the amount of resistance anticipated and the degree of power the change agent possesses.

Power–Coercive Strategies

Power–coercive strategies are based on the application of power by legitimate authority, economic sanctions, or political clout. Changes are made through law, policy, or financial appropriations. Those in control enforce changes by restricting budgets or creating policies. Those who are not in power may not even be aware of what is happening. Even if they are aware, they have little power to stop it. The Affordable Care Act legislation is an example of power–coercive strategy by the federal government.

Power–coercive strategies are useful when a consensus is unlikely despite efforts to stimulate participation by those involved. When much resistance is anticipated, time is short, and the change is critical for organizational survival, power–coercive strategies may be necessary.

Empirical–Rational Model Strategies

In the **empirical–rational model** of change strategies, the power ingredient is knowledge. The assumption is that people are rational and will follow their rational self-interest if that self-interest is made clear to them. It is also assumed that the change agent who has knowledge has the expert power to persuade people to accept a rationally justified change that will benefit them.

The flow of influence moves from those who know to those who do not know. New ideas are invented and communicated or diffused to all participants. Once enlightened, rational people will either accept or reject the idea based on its merits and consequences. Empirical–rational strategies are often effective when little resistance to the proposed change is expected and the change is perceived as reasonable.

The change agent can direct the change. There is little need for staff participation in the early steps of the change process, although input is useful for the evaluation and stabilization stages. The benefits of change for the staff and research documenting improved patient outcomes are the major driving forces.

Normative–Reeducative Strategies

In contrast to the empirical–rational model, **normative–reeducative strategies** of change rest on the assumption that people act in accordance with social norms and values. Information and rational arguments are insufficient strategies to change people's patterns of actions; the change agent must focus on noncognitive determinants of behavior as well. People's roles and relationships, perceptual orientations, attitudes, and feelings will influence their acceptance of change.

In this mode, the power ingredient is skill in interpersonal relationships, not authority or knowledge. The change agent uses collaboration, not coercion or nonreciprocal influence. Members of the target system are involved throughout the change process. Value conflicts from all parts of the system are brought into the open and worked through so change can progress.

Normative–reeducative strategies are well suited to the creative problem solving needed in nursing and healthcare today. This approach can be effective in reducing

resistance and stimulating personal and organizational creativity. The obvious drawback is the time required for group participation and conflict resolution throughout the change process. With their firm grasp of the behavioral sciences and communication skills, nurses are especially well suited to use this model.

Resistance to Change

Resistance to change is to be expected for a number of reasons: lack of trust, vested interest in the status quo, fear of failure, loss of status or income, misunderstanding, and belief that change is unnecessary or that it will not improve the situation (Yukl, 2013). In fact, if resistance does not surface, the change may not be significant enough.

Employees may resist change because they dislike or disapprove of the person responsible for implementing the change or because they may distrust the change process. Regardless, managers continually deal with change—both the change that they themselves initiate and change initiated by the larger organization.

The change agent should anticipate and look for resistance to change. It will be lurking somewhere, perhaps where least expected. It can be recognized in statements such as the following:

- We tried that before.
- It won't work.
- No one else does it like that.
- We've always done it this way.
- We can't afford it.
- We don't have the time.
- It will cause too much commotion.
- You'll never get it past the board.
- Let's wait awhile.
- Every new boss wants to do something different.
- Let's start a task force to look at it; put it on the agenda.

Expect resistance and listen carefully to who says what, when, and in what circumstances. Open resisters are easier to deal with than closet resisters. Look for nonverbal signs of resistance, such as poor work habits and lack of interest in the change.

Resistance prevents the unexpected. It forces the change agent to clarify information, keep interest level high, and establish why change is necessary. It draws attention to potential problems and encourages ideas to solve them. Resistance is a stimulant as much as it is a force to be overcome. It may even motivate the group to do better what it is doing now, so that it does not have to change.

On the other hand, resistance is not always beneficial, especially if it persists beyond the planning stage and well into the implementation phase. It can wear down supporters and redirect system energy from implementing the change to dealing with resisters. Morale can suffer.

To manage resistance, use the following guidelines:

1. Talk to those who oppose the change. Get to the root of their reasons for opposition.
2. Clarify information, and provide accurate feedback.

3. Be open to revisions but clear about what must remain.
4. Present the negative consequences of resistance (e.g., threats to organizational survival, compromised patient care).
5. Emphasize the positive consequences of the change and how the individual or group will benefit. However, do not spend too much energy on rational analysis of why the change is good and why the arguments against it do not hold up. People's resistance frequently flows from feelings that are not rational.
6. Keep resisters involved in face-to-face contact with supporters. Encourage proponents to empathize with opponents, recognize valid objections, and relieve unnecessary fears.
7. Maintain a climate of trust, support, and confidence.
8. Divert attention by creating a different disturbance. Energy can shift to a more important problem inside the system, thereby redirecting resistance. Alternatively, attention can be brought to an external threat to create a bully phenomenon. When members perceive a greater environmental threat (such as competition or restrictive governmental policies), they tend to unify internally.

The Nurse's Role

Contrary to popular opinion, change often is not initiated by top-level management (Yukl, 2013) but rather emerges as new initiatives or problems are identified. Furthermore, Weiner, Amick, and Lee (2008) posit that organizational readiness is the key to initiating change.

Initiating Change

Staff nurses often think that they are unable to initiate and create change, but that is not so.

> *Home health nurses were often frustrated by not having appropriate supplies with them when seeing a patient for the first time. A team of nurses completed a chart audit to identify commonly used supplies and equipment that nurses were using on their home visits. Each nurse was then supplied with a small plastic container to keep in his or her car with these items. Frustration decreased, and efficient use of nursing time was improved.*

The manager, as well, may resist leading change. Fearful of "rocking the boat" or that no one will join the effort, recalling that past attempts at change had failed, or even reluctance to become involved—all may prevent the nurse from initiating change.

Making change is not easy, but it is a mandatory skill for managers. Successful change agents demonstrate certain characteristics that can be cultivated and mastered with practice. (See Leading at the Bedside: Leading Change.) These characteristics include the following:

- The ability to combine ideas from unconnected sources
- The ability to energize others by keeping the interest level up and demonstrating a high personal energy level
- Skill in human relations: well-developed interpersonal communication, group management, and problem-solving skills
- Integrative thinking: the ability to retain a big picture focus while dealing with each part of the system

Leading at the Bedside: Leading Change

Do you think that change always occurs because administrators order it? That may be the case but not always. Change often emerges as new issues or problems are identified. Recall the example of the home health nurses who were frustrated because they didn't have supplies available when they needed them. They followed up to determine a solution. Such initiatives are not uncommon, but they require nurses to pay attention to problems, consider possible solutions, and share the issue with appropriate decision makers.

Don't abdicate your responsibility to improve your workplace to benefit both staff and patients. It's part of your duty as a professional nurse.

- Sufficient flexibility to modify ideas when modifications will improve the change, but enough persistence to resist nonproductive tampering with the planned change
- Confidence and the tendency not to be easily discouraged
- Realistic thinking
- Trustworthiness: a track record of integrity and success with other changes
- The ability to articulate a vision through insights and versatile thinking
- The ability to handle resistance

Energy is needed to change a system. Power is the main source of that energy. Informational power, expertise, and possibly positional power can be used to persuade others.

To access optimum power, use the following strategies:

1. Analyze the organizational chart. Know the formal lines of authority. Identify informal lines as well.
2. Identify key persons who will be affected by the change. Pay attention to those immediately above and below the point of change.
3. Find out as much as possible about these key people. What are their "tickle points"? What interests them, gets them excited, turns them off? What is on their personal and organizational agendas? Who typically aligns with whom on important decisions?
4. Begin to build a coalition of support before you start the change process. Identify the key people who will be affected by the change. Talk informally with them to flush out possible objections to your idea and potential opponents. What will the costs and benefits be to them, especially in political terms? Can your idea be modified in ways that retain your objectives but appeal to more key people?
5. Follow the organizational chain of command in communicating with administrators. Do not bypass anyone to avoid having an excellent proposal undermined.

This information helps you develop the most sellable idea or at least pinpoint probable resistance. It is a broad beginning to the data-collection step of the change process and has to be fine-tuned once the idea is better defined. The astute manager keeps alert at all times to monitor power struggles.

Although a cardinal rule of change is "Don't try to change too much too fast," the savvy manager develops a sense of exquisite timing by pacing the change process according to the political pulse. For example, the manager unfreezes the system during a period of coalition building and high interest, while resistance is low or at least unorganized.

You may decide to stall the project beyond a pilot stage if resistance solidifies or gains a powerful ally. In this case, do whatever you can to reduce resistance. If resistance continues, two options should be considered:

- The change is not workable and should be modified to meet the strongest objections (compromise).
- The change is fine-tuned sufficiently, but change must proceed now and resistance must be overcome.

Implementing Change

In addition to initiating change, nurses and nurse managers are called on to assist with change in other ways. They may be involved in the planning stage, charged with sharing information with coworkers, or asked to help manage the transition to planned change.

Transitions are those periods of time between the current situation and the time when change is implemented (Bridges, 2009). They are the times ripe for a change agent to act. Just as initiating change is not easy, neither is transitioning to changed circumstances.

Letting go of long-term, comfortable activities is difficult. The tendency is to do the following instead:

- Add new work to the old
- Make individual decisions about what to add and what to let go
- Toss out everything done before (Bridges, 2009)

Accepting loss and honoring the past with respect is essential. Passion for the work is based on results, not activities, regardless of their necessity or effectiveness.

> *A large national for-profit healthcare system purchased a new hospital clinical information system. Because all paper charting would be eliminated, nurses would be directly affected. Their participation could spell success or failure for the new system. To help the transition occur smoothly, nurses from each department met together for a demonstration of the new clinical information system and provided feedback to the IT department about nursing process and integrating patient care with the new system. Then a few nurses on each unit were selected to be trained as experts in the new technology, and they in turn trained other staff members, communicating with the IT department when concerns arose.*

A nurse manager in a home healthcare agency used change management strategies to overcome resistance, as shown in Case Study 5-1.

Unplanned Change

So far we have been discussing planned change—change that the organization desires. Unplanned change, by contrast, occurs without warning and challenges the organization to respond. Two recent events are examples: the impact of the Boston Marathon bombing on Massachusetts General Hospital (Erickson, 2014) and what the Texas Health Presbyterian Hospital Dallas learned as a result of treating the first non-healthcare worker for the Ebola virus (Edmonson, 2015).

In the first example, expert preparation and frequent drills enabled the staff of Massachusetts General Hospital, a Magnet-certified hospital, to remain calm and

CASE STUDY 5-1 | Encouraging Change

Peter Beasley is the nurse manager of pediatric home care for a private home healthcare agency. Last year, the agency completed a pilot of wireless devices for use in documenting home visits. With the new devices, charges for supplies and medical equipment are automatically generated as nurses complete the documentation. The agency director informed the nurse managers that all nurses would be required to use the wireless devices within the next 3 months.

Charlene Ramirez has been a pediatric nurse for 18 years, working for the home healthcare agency for the past 5 years. Charlene was active in updating the pediatric documentation and training staff when new paper-based documentation was implemented in the past. Although she was part of the pilot last year, Charlene is very opposed to using the new wireless devices. She complains that she can barely see the text. At a recent staff meeting, Charlene stated that she would rather quit than learn to use the new wireless devices.

Peter empathizes with Charlene's reluctance to use the new technology. He also recognizes how much Charlene contributes in expertise and leadership to the department. However, he knows that the new performance standards require all employees to use the wireless devices. After three mandatory training sessions, Charlene repeatedly tells coworkers, "We've tried things like this before, and it never works. We'll be back on paper within six months, so why waste my time learning this stuff?" The program trainer reports that Charlene was disruptive during the class and failed her competency exam.

Peter meets privately with Charlene to discuss her resistance to the new technology. Charlene again states that she fails to see the need for wireless devices in delivering quality patient care. Peter reviews the new performance standards with Charlene, emphasizing the technology requirements. He asks Charlene if she has difficulty understanding the application or just in using the device. Charlene admits that she cannot read the text on the screen and therefore cannot determine what exactly she is documenting. Peter informs Charlene that the agency's health benefits include vision exams and partial payment for corrective lenses. He suggests that she talk with an optometrist to see if special glasses would help her see the screen. Peter also makes a note to speak with the technology specialist to see if there are aids to help staff view data on the device.

focused during this mass casualty event (Erickson, 2014). In addition to injured patients and their families, the staff also concentrated on the entire hospital community. Some staff had run the race, others had family members or friends in it, and still others watched it. All were affected by this tragedy.

Texas Health Presbyterian Hospital Dallas, also a Magnet-certified institution, was prepared to deal with infectious diseases, but the Ebola virus was unique (Edmondson, 2015). It defied the usual protections, and two nurses became infected. As a result of this hospital's experiences, all hospitals are better prepared today should they need exceptional precautions and protections when facing unanticipated contagions in the future.

The nurse's role in leading unplanned change is to ensure that your team is well-prepared for emergencies, that coordination and collaboration are assured, and that the focus is on patients and their families. During the event and its aftermath, the leader's ability to remain calm and focused will help ensure that the best quality of care is provided (Erickson, 2014). Furthermore, the staff's functioning and emotional health depend on the leader's calm composure.

Handling Constant Change

Change has always occurred; what is different today is both the pace of change and that an initial change causes a chain reaction of more and more change (Bridges, 2009). Rather than being an occasional event, change has become the norm.

Regardless of their position in an organization, nurses find themselves constantly dealing with change. Whether they thrive in such an atmosphere is a function of both their own personal resources and the environment in which change occurs.

If you do not like the current situation, you may look forward to change. As Midwesterners are fond of saying when asked about the weather, "If you don't like it today, just wait until tomorrow. It will change."

What You Know Now

- In today's healthcare system, change is inevitable, necessary, and constant.
- With changes proposed for the nursing profession, nurses are in a pivotal position to initiate and participate in change.
- For change to be positive for nurses, they must develop change agent skills.
- Critical evaluation of change theories provides guidance and direction for initiating and managing change.
- The change process follows the same steps whether the change is major or minor.
- Resistance to change is to be expected, and it can be a stimulant as well as a force to be overcome.
- The nurse may be involved in change by initiating it or participating in implementing change.
- Handling constant change is a challenge in today's healthcare environment.

Tools for Initiating and Managing Change

1. Communicate openly and honestly with employees who oppose change.
2. Maintain support and confidence in staff even if they are resistive to change.
3. Emphasize the positive outcomes from the change.
4. Find solutions to problems that are obstacles to change.
5. Accept the constancy of change.

Questions to Challenge You

1. Identify a needed change in the organization where you practice. Using the change process, outline the steps you would take to initiate that change.
2. Consider your school or college. What change do you think is needed? Explain how you would implement change to make it a better place for learning.
3. Have you had an experience with change occurring in your organization? What was your initial reaction? Did that change? How well did the change process work? Was the change successful?
4. Do you have a behavior you would like to change? Using the steps in the change process, describe how you might effect that change.
5. How do you normally react to change? Choose from the following:
   a. I love new ideas, and I'm ready to try new things.
   b. I like to know that something will work out before I try it.
   c. I try to avoid change as much as possible.
6. Did your response to the previous question alter how you would like to view change? Think about this the next time change is presented to you.

7. Think back to your first time on a clinical unit. How did you feel? Overwhelmed? Afraid of failing? Those are feelings that people have when facing change. When you encounter resistance to change, try to remember how you have felt in the past.

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Chapter 6

Managing and Improving Quality

Quality Management

Total Quality Management
Continuous Quality Improvement
Components of Quality Management
Six Sigma
Lean Six Sigma
DMAIC Method

Improving the Quality of Care

National Initiatives
Evidence-based Practice
Electronic Health Records
Dashboards
Rounding
Reducing Medication Errors

Risk Management

Nursing's Role in Risk Management
Incident Reports
Examples of Risk
Root-cause Analysis
Peer Review
Role of the Nurse Manager
Creating a Blame-free Environment

Learning Outcomes

After completing this chapter, you will be able to:

1. Describe how total quality management, continuous quality management, Six Sigma, Lean Six Sigma, and DMAIC address quality.
2. Delineate efforts to improve the quality of healthcare.
3. Explain how nurses are involved in reducing risks.

Key Terms

continuous quality improvement (CQI)

DMAIC

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

incident reports
indicator
just culture
Lean Six Sigma
outcome standards
pay for performance (P4P)
process standards
quality management
reportable incident
risk management
root-cause analysis
Six Sigma
spaghetti diagram
structure standards
total quality management (TQM)
value-based purchasing (VBP)

Introduction

In today's highly competitive healthcare environment, each member of the healthcare organization must be accountable for the quality, safety, and cost of healthcare. Both quality and cost containment are part of the concept of total quality management (TQM), which has evolved into a model of continuous quality improvement designed to improve system and process performance. Risk management is integrated within a quality management program.

Quality Management

The concept of **quality management** is one in which problems are prevented and improvement of care and quality is sought. The implementation of quality management has moved healthcare from a mode of identifying failed standards, problems, and problem people to a proactive organization. This paradigm shift involves all in the organization and promotes problem solving and experimentation.

A quality management program is based on an integrated system of information and accountability. Clinical information systems can provide the data needed to enable organizations to track activities and outcomes. For example, data from clinical information systems can be used to track patient wait times from admitting to outpatient testing to admission in an inpatient care unit. Delays in the process can be identified so that in the future, appropriate staff and resources are available at the right time to decrease delays and increase efficiency and patient satisfaction. Methods can be devised to discover problems in the system without blaming the "sharp end," the last individual in the chain to act (e.g., the nurse who gives a wrong medication). The system must be accepted and used by the entire staff.

Total Quality Management

Total quality management (TQM) is a management philosophy that emphasizes a commitment to excellence throughout the organization. The creation of Dr. W. Edwards Deming, TQM was adopted by the Japanese after World War II and helped transform their industrial development. Dr. Deming based his system on principles of quality management that were originally applied to improve quality and performance in the manufacturing industry. The principles are now widely used to improve quality and customer satisfaction in a number of service industries, including healthcare.

The following are the four core characteristics of total quality management:

- Focus on customer/patient.
- Involve the total organization.
- Use quality tools and statistics for measurement.
- Identify key processes for improvement.

A common management adage is "You can't manage what you can't (or don't) measure." There are many tools, formats, and designs that can be used to build knowledge, make decisions, and improve quality. Tools for data analysis and display can be used to identify areas for process and quality improvement, and then to benchmark the progress of improvements. Deming applied the scientific method to the concept of TQM to develop a model he called the PDCA (Plan, Do, Check, Act) cycle, which is depicted in Figure 6-1.

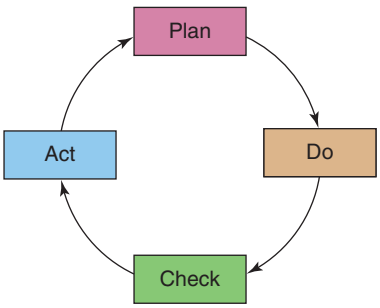

Figure 6-1 PDCA cycle.

Continuous Quality Improvement

TQM is the overall philosophy, whereas **continuous quality improvement (CQI)** is used to improve quality and performance. TQM and CQI often are used synonymously. In healthcare organizations, CQI is the process used to systematically investigate ways to improve patient care. As the name implies, continuous quality improvement is a never-ending endeavor.

CQI means more than just meeting standards and thresholds or solving problems. It involves evaluation, actions, and a mind-set focused on striving constantly for excellence. This concept is sometimes difficult to grasp because patient care involves the synchronization of activities in multiple departments. Therefore, developing and implementing a well-thought-out process is key to a successful CQI implementation.

Components of Quality Management

A comprehensive quality management plan is a systematic method to design, measure, assess, and improve organizational performance. Using a multidisciplinary approach, this plan identifies processes and systems that represent the goals and mission of the organization, identifies customers, and specifies opportunities for improvement. Critical pathways are an example of a quality management plan in that they identify expected outcomes within a specific time frame. Then variances are tracked and accounted for.

The quality management plan includes written statements that define a level of performance or a set of conditions. Standards relate to three major dimensions of quality care:

- **Structure standards** relate to the physical environment, organization, and management of an organization.
- **Process standards** are those connected with the actual delivery of care.
- **Outcome standards** involve the end results of care that has been given.

An **indicator** is a tool used to measure the performance of structure, process, and outcome standards. It is measurable, objective, and based on current knowledge. Once indicators are identified, benchmarking—comparing performance using identified quality indicators across institutions or disciplines—is the key to quality improvement.

In nursing, both generic and specific standards are available from the American Nurses Association (ANA) and specialty organizations; however, each organization and each patient care area must designate standards specific to the patient population being served. These standards are the foundation on which all other measures of quality are based. An example of a standard is "Every patient will have a written care plan within 12 hours of admission."

Six Sigma

Six Sigma is another quality management program that uses, primarily, quantitative data to monitor progress. Six Sigma is a *measure*, a *goal*, and a *system of management*.

- ***As a measure.*** Sigma is the Greek letter (Σ) for standard, meaning how much performance varies from a standard. This is similar to how CQI monitors results against an outcome measure.
- ***As a goal.*** One goal might be accuracy. How many times, for example, is the right medication given in the right amount, to the right patient, at the right time, by the right route?
- ***As a management system.*** Compared to other quality management systems, Six Sigma involves management to a greater extent in monitoring performance and ensuring favorable results.

The system has six themes:

- Customer (patient) focus
- Data driven
- Process emphasis
- Proactive management
- Boundaryless collaboration
- Aim for perfection, but tolerate failure

The first three themes are similar to other quality management programs. The focus is on the object of the service; in nursing's case, this is the patient. Data provide the evidence of results, and the processes used in the system are emphasized.

The latter three themes, however, differ from other programs. Management is actively involved, and boundaries are breached (e.g., the disconnect between

departments). More radically, Six Sigma tolerates failure (a necessary condition for creativity) while striving for perfection.

Lean Six Sigma

Lean Six Sigma focuses on improving process flow and eliminating waste. Waste occurs when the organization provides more resources than are required. Data driven, Lean Six Sigma focuses on identifying steps that have little or no value to patient care and cause unnecessary delays. Furthermore, the method strives to eliminate variations in care and to improve efficiencies and effectiveness. Because the goal of Lean Six Sigma is to identify and reduce waste, it provides tools that can be used with a Six Sigma management system.

Studies have shown Lean Six Sigma to be effective in reducing inappropriate hospital stays, improving the quality of care, and reducing costs at the same time (Yamamoto, Malatestinic, Lehman, & Juneja, 2010). One emergency department reduced nurses' wasted time using Lean methodology (Richardson et al., 2014), and a post-anesthesia unit reported improvement in nurses' working conditions in another study (Haenke & Stichler, 2015). In addition, using the method improved the care of inpatient diabetic patients (Niemeijer, Trip, Ahaus, Does, & Wendt, 2010).

DMAIC Method

DMAIC—an acronym for *define*, *measure*, *analyze*, *improve*, and *control*—is a Six Sigma process improvement method (as shown in Figure 6-2). The following are the steps in the method:

- Define what measures will indicate success.
- Measure baseline performance.
- Analyze results.
- Improve performance.
- Control and sustain performance (DMAICTools.com, n.d.).

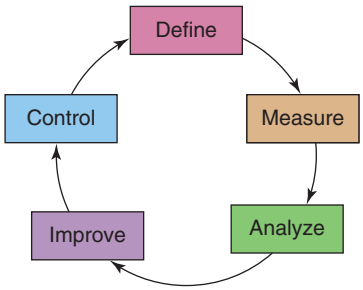

Figure 6-2 DMAIC: The Six Sigma Method.

Adapted from DMAIC tools: Six Sigma training tools. Retrieved October 21, 2011, from www.dmaictools.com

An example of an inexpensive way to monitor efficiency and work flow is a spaghetti diagram (Six Sigma Material, 2015). A **spaghetti diagram** (see Figure 6-3) is a drawing of the actual work flow in a specified area at a point in time. Because nothing moves in a straight line, cooked spaghetti is imagined when visualizing such movements.

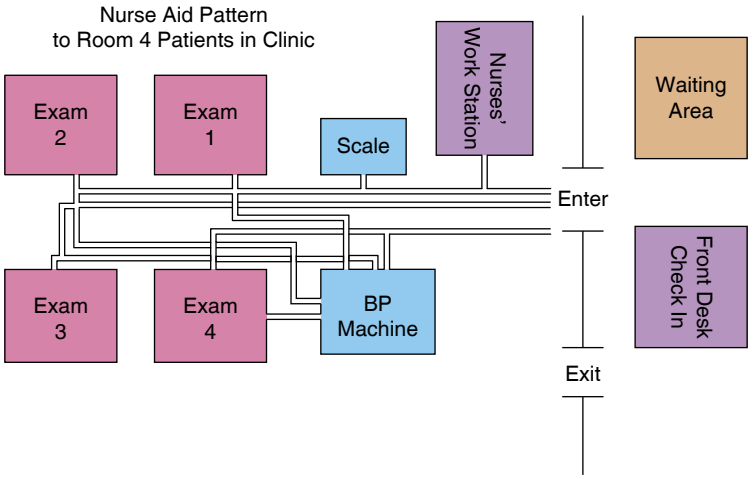

Figure 6-3 Spaghetti diagram.

The spaghetti diagram in Figure 6-3 identifies the movements of a nurse aide trying to room four patients. Current practice for rooming is for the aide to escort the patient from the waiting room to the clinic area, weigh the patient on the scale, and take the patient to an exam room. Then the aide walks from the clinic area to the hallway to fetch the blood pressure machine from its station there and moves it to the patient's room, takes the patient's blood pressure, and returns the machine to the hallway. The aide walks to the nurse station to notify the nurse that the patient is ready to see, then goes to get the next patient and repeats the process.

Blood pressure is done in the room so the patient can be seated and relax. The blood pressure machine is returned to its stationed place in the hallway between patients so it can be readily grabbed if an emergent situation arises. There is a hypothesis that the aide spends excess time walking to get the blood pressure machine for each patient. The spaghetti diagram helps to determine if other options should be evaluated. The following are suggested options:

- Get a blood pressure machine installed in each exam room.
- Place a chair by the blood pressure machine in the hallway, and after weighing the patient on the scale, seat the patient, take the blood pressure, then escort the patient to the room.
- Leave the work flow the way it is.

By tracing the exact movements of a staff member, managers can identify wasted time and energy and put processes in place to reduce this waste.

Improving the Quality of Care

Over many years, numerous efforts have been made to improve the quality of healthcare. The National Quality Forum, the Joint Commission (the organization that accredits hospitals), and more recently changes enacted by passage of the Affordable Care Act (ACA) have moved these efforts into the mainstream of healthcare. Even if legislation changes ACA's provisions, demands for quality care are expected to continue.

National Initiatives

The National Quality Forum is a nonprofit organization that strives to improve the quality of healthcare by building consensus on performance goals and standards for measuring and reporting them (National Quality Forum, 2016). In addition, the Institute for Healthcare Improvement (IHI) offers programs to assist organizations in improving the quality of care they provide (IHI, 2015). The following are their goals:

- No needless deaths
- No needless pain or suffering
- No helplessness in those served or serving
- No unwanted waiting
- No waste
- No one left out

The Joint Commission has adopted mandatory national patient safety goals (Joint Commission, 2016). Hospitals are charged to do the following:

- Identify patients correctly
- Improve staff communication
- Use medicines safely
- Prevent infection
- Check patient medicines
- Identify patient safety risks
- Prevent mistakes in surgery

The Joint Commission recommends that quality measures be based on the following four criteria:

- The measure must be based on research that shows improved outcomes. More than one research study is required for documentation.
- Reports document that evidence-based practice has been given. Aspirin following an acute myocardial infarction is an example.
- The process documents desired outcome. Appropriately administering medications is an example.
- The process has minimal or no unintended adverse effects. (Chassin, Loeb, Schmaltz, & Wachter, 2010)

The ACA has changed the way that healthcare organizations are paid for healthcare. Previously, healthcare organizations were paid for the *volume* of care they provided—that is, the more they did for patients, the more they were paid, regardless of the outcome. The ACA, however, specifies that healthcare organizations be paid for the *value* of their care. One way to assess the value is to measure patient satisfaction. While in the past most healthcare organizations assessed their patients' satisfaction with care, no common instrument existed that could compare those results with other similar organizations. Thus, three federal agencies—the Centers for Medicare and Medicaid (CMS), the Agency for Healthcare Research and Quality (AHRQ), and the Department of Health and Human Services (DHHS)—developed an instrument to measure patient satisfaction across institutions (Hospital Consumer Assessment of Healthcare Providers and Systems, 2015).

The result of their efforts is the **Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)**, a 32-item instrument that identifies patients' perceptions of their care after discharge (HCAHPS, 2015). Hospital scores are publicly reported (Medicare.gov, 2015), and Medicare reimbursement is now linked to hospitals' scores on HCAHPS and is known as **pay for performance (P4P)** or **value-based purchasing (VBP)** (Wolosin, Ayala, & Fulton, 2012). Hospitals are challenged to keep their satisfaction scores high while keeping their costs under control (Dempsey, Reilly, & Buhlman, 2014).

Evidence-based Practice

Evidence-based practice (EBP) stems from the concept that using research to decide on clinical treatments would improve quality of care, and that might be the case. Barriers, however, prevent EBP from being widely used by nurses. Such barriers, consistent across settings, include lack of time, autonomy over their practice, ability to find and assess evidence, and support from administration (Houser & Oman, 2010).

Furthermore, EBP is most reliable when the research study includes a rigorous design (Hader, 2010) and when more than one study has confirmed the results (Chassin et al., 2010). These are not easily surmountable hurdles, due to the fast-paced clinical environment and the barriers previously mentioned.

Electronic Health Records

Also mandated in the ACA is the use of electronic health records (EHRs) that can be shared across providers. Instant access to identical records improves accuracy, reduces redundancies, decreases errors, and speeds communication among care providers. Kutney-Lee and Kelly (2011) found that EHRs improved patient safety, nursing efficiency, and coordination of care. As EHR use expands, more data will be available for comparison with quality (Amer, 2013).

Dashboards

Dashboards are electronic tools that can provide real-time data or retrospective data, known as a scorecard. Both data types are useful in assessing quality. Ease of access and the visual appearance of the dashboard make its use more likely. Dashboards may report on hospital census or patient satisfaction results, for example. Dashboards are also useful to guide staffing and match staffing with patient outcomes (Frith, Anderson, & Sewell, 2010), and to provide accurate financial data on nurse staffing and quality (Anderson, Frith, & Caspers, 2011). As technology advances, widespread use of dashboards to aggregate data and guide decision making is expected.

Rounding

Another quality method to improve patient satisfaction is rounding, a proactive strategy that has been shown to reduce falls and call light occurrences (Petras, Dudjak, & Bender, 2013). Known as 4P rounding, this practice requires the nurse or aide to check pain, potty, position, and possessions every hour (Mitchell, Lavenberg, Trotta, & Umscheid, 2014).

Reducing Medication Errors

Ever since Medicare discontinued payment for hospital-based errors, pressure has increased for hospitals to prevent costly errors. In 2009, the federal government passed the Health Information Technology for Economic and Clinical Health Act (HITECH). The purpose of HITECH is to stimulate technology use in healthcare, including improving technology for medication administration.

Studies have shown that when nurses are interrupted during medication preparation, a 25% rate of injury-causing errors occurs (Westbrook, Woods, Rob, Dunsmuir, & Day, 2010). One strategy to alert others that a nurse should not be interrupted is the use of a sash or vest that the nurse dons to prepare medications (Heath & Heath, 2010).

Other strategies to reduce medication errors include computerized prescriber order entry (CPOE), electronic medication administration record (eMAR), remote order review by pharmacists, automated dispensing at the bedside, bar code administration, smart pumps, and unit doses ready to be administered (Federico, 2010). Despite increased use of these methods, medication errors still occur far too often (Leapfrog Group, 2015).

Quality and safety are challenging and ongoing concerns for everyone who works in healthcare today. Our patients depend on us to continually strive to improve these processes.

Risk Management

Risk management is a component of quality management. Its purpose is to identify, analyze, and evaluate risks and then to develop a plan for reducing the frequency and severity of accidents and injuries. Risk management is a continuous daily program of detection, education, and intervention (Barger, 2014).

A risk management program involves all departments of the organization. It must be an organization-wide program, with the board of directors' approval and input from all departments. The program must have high-level commitment, including that of the chief executive officer and the chief nurse.

A risk management program has these responsibilities:

- Identifies potential risks for accident, injury, or financial loss. Formal and informal communication with all organizational departments and inspection of facilities are essential to identifying problem areas.
- Reviews current organization-wide monitoring systems (incident reports, audits, committee minutes, oral complaints, patient questionnaires), evaluates completeness, and determines additional systems needed to provide the factual data essential for risk management control.
- Analyzes the frequency, severity, and causes of general categories and specific types of incidents causing injury or adverse outcomes to patients. To plan risk intervention strategies, it is necessary to estimate the outcomes associated with the various types of incidents.
- Reviews and appraises safety and risk aspects of patient care procedures and new programs.
- Monitors laws and codes related to patient safety, consent, and care.
- Eliminates or reduces risks as much as possible.

- Reviews the work of other committees to determine potential liability and recommend prevention or corrective action. Examples of such committees are infection, medical audit, safety/security, pharmacy, nursing audit, and productivity.
- Identifies needs for patient, family, and personnel education suggested by all of the foregoing and implements the appropriate educational program.
- Evaluates the results of a risk management program.
- Provides periodic reports to administration, medical staff, and the board of directors.

Nursing's Role in Risk Management

In the organizational setting, nursing is the one department involved in patient care 24 hours a day; nursing personnel are therefore critical to the success of a risk management program. (See Leading at the Bedside: You and Quality Care.) The chief nursing administrator must be committed to the program. Her or his attitude will influence the staff and their participation. After all, it is the staff, with their daily patient contact, who actually implement a risk management program.

High-risk areas in healthcare fall into five general categories:

- Medication errors
- Complications from diagnostic or treatment procedures
- Falls
- Patient or family dissatisfaction with care
- Refusal of treatment or refusal to sign consent for treatment

Nursing is involved in all of these areas, but the medical staff may be primarily responsible in cases involving refusal of treatment or consent to treatment.

Incident Reports

Incident reports are used to analyze the severity, frequency, and causes of occurrences within the five risk categories. Along with medical records, they serve to document organizational, nurse, and physician accountability. For every reported occurrence, however, many more are unreported. If records are faulty, inadequate, or omitted, the organization is more likely to be sued and more likely to lose. Such analysis serves as a basis for intervention.

Accurate and comprehensive reporting on both the patient's chart and in the incident report is essential to protect the organization and caregivers from litigation. Incident reporting is often the nurse's responsibility. Reluctance to report incidents is usually due to fear of the consequences. This fear can be alleviated in the following ways:

- Holding staff education programs that emphasize objective reporting
- Omitting inflammatory words and judgmental statements
- Having a clear understanding that the purposes of the incident reporting process are documentation and follow-up
- Never using the report, under any circumstances, for disciplinary action

Nursing colleagues and nurse managers should not berate an employee for an incident, and never in front of other staff members, patients, or patients' family members.

Leading at the Bedside: You and Quality Care

Quality care requires the efforts of every nurse, regardless of whether that care is in a hospital, a storefront clinic, a free-standing surgical center, or the patient's home. No matter what care the patient receives from other providers, the nurse is the one constant in the patient's world. You are the face of the organization, the staff member called at any time of the day or night, the person charged with maintaining a safe and healthy environment for your patients.

When mistakes are made (and they will be), you must learn how to handle and report such adverse events. This chapter tells you how to do so with dignity for both the patient and the staff.

A **reportable incident** should include any unexpected or unplanned occurrence that affects or could potentially affect a patient, family member, or staff. The report is only as effective as the form on which it is reported, so attention should be paid to the adequacy of the form as well as to the data required.

Reporting incidents involves the following steps:

1. ***Discovery.*** Nurses, physicians, patients, families, or any employee or volunteer may report actual or potential risk.
2. ***Notification.*** The risk manager receives the completed incident form within 24 hours after the incident. A telephone call may be made earlier to hasten follow-up in the event of a major incident.
3. ***Investigation.*** The risk manager or representative investigates the incident immediately.
4. ***Consultation.*** The risk manager consults with the referring physician, risk management committee member, or both to obtain additional information and guidance.
5. ***Action.*** The risk manager should clarify any misinformation with the patient or family, explaining exactly what happened. The patient should be referred to the appropriate source for help and, if needed, be assured that care for any necessary service will be provided free of charge.
6. ***Recording.*** The risk manager should be sure that all records, including incident reports, follow-up, and actions taken, if any, are filed in a central depository.

Examples of Risk

The following are some examples of actual events in the various risk categories.

MEDICATION ERRORS A reportable incident occurs when a medication or fluid is omitted, the wrong medication or fluid is administered, or a medication is given to the wrong patient, at the wrong time, in the wrong dosage, or by the wrong route. Here are some examples:

Patient A. Weight was transcribed incorrectly from emergency department sheet. Medication dose was calculated on incorrect weight; therefore, patient was given double the dose required. Error was discovered after first dose and corrected. Second dose omitted per physician's order.

Patient B. Tegretol dosage was written in Medex as "Tegretol 100 mg chewable tab—50 mg po BID." Tegretol 100 mg given po at 1400. Meds checked at 1430 and

error noted. Fifty mg Tegretol should have been given two times per day to total 100 mg in 24 hours. Doctor notified. Second dose held.

Patient C. During rounds at 1530 found .9% sodium chloride at 75 mLs per hour hanging. Order was written for D5W to run at 75 mLs per hour. Fluids last checked at 1400. Changed to correct fluid. Doctor notified.

DIAGNOSTIC PROCEDURE Any incident occurring before, during, or after such procedures as blood sample stick, biopsy, x-ray examination, lumbar puncture, or other invasive procedure is categorized as a diagnostic procedure incident.

Patient A. When I checked the IV site, I saw that it was red and swollen. For this reason, I discontinued the IV. When removing the tape, I noted a small area of skin breakdown where the tape had been. There was also a small knot on the medial aspect of the left antecubital above the IV insertion site. Doctor notified. Wound dressed.

Patient B. Patient found on the floor after lumbar puncture. Right side rail down. Examined by a physician, BP 120/80, T 98.6, P 72, R 18. No injury noted on exam. Patient returned to bed, side rail placed up. Will continue to monitor patient condition.

MEDICAL–LEGAL INCIDENT If a patient or family refuses treatment as ordered and prescribed or refuses to sign consent forms, the situation is categorized as a medical–legal incident.

Patient A. After a visit from a member of the clergy, patient indicated he was no longer in need of medical attention and asked to be discharged. Physician called. Doctor explained to patient potential side effects if treatment were discontinued. Patient continued to ask for discharge. Doctor explained "against medical advice" (AMA) form. Patient signed AMA form and left at 1300 without medications.

Patient B. Patient refused to sign consent for bone marrow biopsy. States side effects not understood. Doctor reviewed reasons for test and side effects three different times. Doctor informed the patient that without consent he could not perform the test. Offered to call in another physician for second opinion. Patient agreed. After doctor left, patient signed consent form.

PATIENT OR FAMILY DISSATISFACTION WITH CARE When a patient or family indicates general dissatisfaction with care and the situation cannot be or has not been resolved, an incident report is filed.

Patient A. Mother complained that she had found child saturated with urine every morning (she arrived around 0800). Explained to mother that diapers and linen are changed at 0600 when 0600 feedings and meds are given. Patient's back, buttocks, and perineal areas are free of skin breakdown. Parents continue to be distressed. Discussed with primary nurse.

Patient B. Mr. Smith appeared very angry. Greeted me at the door complaining that his wife had not been treated properly in our emergency department the night before. Wanted to speak to someone from administration. Was unable to reach the administrator on call. Suggested Mr. Smith call the administrator in the morning. Mr. Smith thanked me for my time and assured me that he would call the administrator the next day.

Root-cause Analysis

Root-cause analysis is a method to work backward through an event to examine every action that led to the error or event that occurred; it is a complicated process. A simplified method to conduct a root-cause analysis follows:

- Patient—What patient factors contributed to the event?
- Personnel—What personnel actions contributed to the event?
- Policies—Are there policies for this type of event?
- Procedures—Are there standard procedures for this type of event?
- Place—Did the workplace environment contribute to the event?
- Politics—Did institutional or outside politics play a role in the event? (Weiss, 2009)

Peer Review

Used to improve care, the peer review process is not intended to serve as a performance appraisal nor to be punitive (Spiva, Jarrell, & Baio, 2014). The purpose is to review an incident, determine if clinical standards were met or not, and propose an action plan to prevent a future occurrence.

The peer review process is appropriate in the following situations:

- An adverse patient outcome has occurred.
- A serious risk or injury to a patient occurred.
- A failure to rescue incident occurred (Fujita, Harris, Johnson, Irvine, & Latimer, 2009).

A shared governance structure facilitates the peer review process, fostering peer-to-peer accountability (Fujita et al., 2009). Furthermore, the process can help determine if a breach in practice is an isolated incident or a trend occurring across a unit or throughout the organization. In a shared governance environment, unit councils or the nursing council can address unit-wide or system problems. To aggregate trends, peer review cases can be categorized as one of the following:

- Appropriate care with no adverse outcomes
- Appropriate care with adverse/unexpected outcomes
- Inappropriate care with no adverse outcomes
- Inappropriate care with adverse/unexpected outcomes

Role of the Nurse Manager

The nurse manager plays a key role in the success of any risk management program. Nurse managers can reduce risk by helping their staff to view health and illness from the patient's perspective. Usually, a staff's understanding of quality differs from the patient's expectations and perceptions. By understanding the meaning to the patient and the family of the course of illness, the nurse will manage risk better, because that understanding can enable the nurse to individualize patient care. This individualized attention produces respect and, in turn, reduces risk.

A patient incident or an expression of dissatisfaction by the patient or the patient's family regarding care indicates not only some slippage in quality of care but also potential liability. A distraught, dissatisfied, complaining patient is a high risk; a

satisfied patient or family is a low risk. A risk management or liability control program should therefore emphasize a personal approach. Many claims are filed because of a breakdown in communication between the healthcare provider and the patient. In many instances after an incident or bad outcome, a quick visit or call from an organization's representative to the patient or family can soothe tempers and clarify misinformation.

In the examples given throughout this chapter, prompt attention and care by the nurse manager protected the patients involved and may have averted a potential liability claim. Once an incident has occurred, the following are the important factors in successful risk management:

- Recognition of the incident
- Quick follow-up and action
- Personal contact
- Immediate restitution (where appropriate)

The concerns of most patients and their families can and should be handled at the unit level. When that first line of communication breaks down, however, the nurse manager needs a resource—usually the risk manager or nursing service administrator.

HANDLING COMPLAINTS Handling a patient or family member's complaints stemming from an incident can be very difficult. These confrontations are often highly emotional; the patient or family member must be calmed down, yet have their concerns satisfied. Sometimes just an opportunity to release the anger or emotion is all that is needed.

The first step is to listen to the person, to identify concerns, and to help defuse the situation. Arguing or interrupting only increases the person's anger or emotion. After the patient or family member has had his or her say, the nurse manager can then attempt to solve the problem by asking what is expected in the form of a solution. The nurse manager should ensure that immediate patient care and safety needs are met, collect all facts relevant to the incident, and, if possible, comply with the patient or family member's suggested resolution.

Sometimes, a simple apology from a staff member or moving a patient to a different room on the unit can resolve a difficult situation. If the patient and/or family member's requested resolution exceeds the nurse manager's authority, the nurse manager should seek the assistance of a nurse administrator or hospital legal counsel. Offering vague solutions (e.g., "Everything will be taken care of") may only lead to more problems later if expectations as to solution and timing differ.

All incidents must be properly documented. Information on the incident form should be detailed and include all the factors relating to the incident, as demonstrated in the previous examples. The documentation in the chart, however, should be only a statement of the facts and of the patient's physical response; no reference to the incident report should be made, nor should words such as *error* or *inappropriate* be used.

When a patient receives 100 mg of Demerol instead of 50 mg as ordered, the proper documentation in the chart is "100 mg of Demerol administered. Physician notified." The remainder of the documentation should include any reaction the patient has to the dosage, such as "Patient's vital signs unchanged." If there is an adverse reaction, a follow-up note should be written in the chart, giving an update of the patient's status. A note related to the patient's reaction should be written as

frequently as the status changes and should continue until the patient returns to his or her previous status.

The chart must never be used as a tool for disciplinary comments, actions, or expressions of anger. Notes such as "Incident would never have occurred if Doctor X had written the correct order in the first place" or "This carelessness is inexcusable" or "Paged the doctor eight times, as usual, no reply" are wholly inappropriate and serve no meaningful purpose. Carelessness and incorrect orders do indeed cause errors and incidents, but the place to address and resolve these issues is in the risk management committee or in the nurse manager's office, not on the patient chart.

Handling a complaint without punishing a staff member is a delicate situation. The manager must determine what happened in order to prevent another occurrence, but using an incident report for discipline might result in fewer or erroneous incident reports in the future. Learn how one manager handled a situation of this kind in Case Study 6-1.

A CARING ATTITUDE With employees, the nurse manager sets the tone that contributes to a safe and low-risk environment. One of the most important ways to reduce risk is to instill a sense of confidence in both patients and families by emphasizing and recognizing that they will receive personalized attention and that their needs will be attended to with competence. This confidence is created environmentally and professionally.

Examples of environmental factors include cleanliness, attention to patients' privacy, promptly responding to patients and family members' requests, a unit that is orderly in appearance, and engaging in minimal social conversations in front of

CASE STUDY 6-1 | Risk Management

Yasmine Dubois is the nurse manager for the cardiac catheterization lab and special procedures unit in a suburban hospital. The hospital has an excellent reputation for its cardiac care program, including the use of cutting-edge technology. The cath lab utilizes a specialized computer application that records the case for the nursing staff, requiring little handwritten documentation at the end of a procedure.

Last month, a 56-year-old woman was brought from the ER to the cath lab at approximately 1900 for placement of a stent in her left anterior descending coronary artery. During the procedure, the heart wall was perforated. The patient coded and was taken in critical condition to the OR, where she died during surgery.

Two days following the incident, the patient's husband requested a review of his wife's medical records. During his review, he pointed out to the medical records clerk that the documentation from the cath lab stated that his wife "tolerated the procedure well and was taken in satisfactory condition to the recovery area." The documentation was signed, dated, and timed by Elizabeth Clark, RN. The medical records director notified the hospital's risk manager of the error. The risk manager investigated the incident and determined that Elizabeth Clark's charting was in error.

Following her meeting with the risk manager, Yasmine met with Elizabeth to discuss the incident. She showed Elizabeth a copy of the cath lab report. Elizabeth asked Yasmine if she could have the chart from medical records so she could correct her mistake. Yasmine informed Elizabeth that she couldn't correct her charting at this time. But, she could, however, write an addendum to the chart, with today's date and time, to clarify the documentation. Yasmine also told Elizabeth that the addendum would be reviewed by the risk manager and the hospital's attorney prior to inclusion in the chart.

To ensure compliance with the hospital's documentation standards and to determine whether Elizabeth or any other cath lab nurse had committed any similar charting errors, Yasmine requested charts for all patients who had been sent to surgery from the cath lab during the past 12 months due to complications during a procedure. She conducted a retrospective audit and determined that this had been an isolated incident.

patients. One example of portraying professional confidence is to provide patients and families with the name of the person in charge. A sincere visit by that person is reassuring. In addition, a thorough orientation creates independence for the patient and confidence in an efficient unit.

To encourage staff to be open and honest and to contribute to improving care, the manager should be certain to thank staff for reporting adverse incidents. Such reports are opportunities to improve a system or a process rather than to punish an individual. If the nurse manager has developed a patient-focused atmosphere in which patients believe their best interests are a priority, the potential for risk will be reduced.

Creating a Blame-free Environment

The healthcare environment is known to be a blame culture that "is a major source of medical errors and poor quality of patient care" (Khatri, Brown, & Hicks, 2009, p. 320). Such a culture inhibits reporting of inadequate practice, underreporting of adverse events, and inattention to possible safety problems.

A **just culture**, in contrast, allows for reporting of errors without fear of undue retribution. Khatri et al. (2009) suggest that transitioning to a just culture does more than improve reporting mechanisms or initiate training programs. A just culture provides an environment in which employees can question policies and practices, express concerns, and admit mistakes without fear of retribution. A just culture requires organizational commitment, managerial involvement, employee empowerment, an accountability system, and a reporting system (Fanus, Huddleston, Wisotzkey, & Hempling, 2014).

Accountability for errors, however, must be maintained. Errors can be categorized as follows:

- Human errors, such as unintentional behaviors that may cause an adverse consequence
- At-risk behaviors, such as unsafe habits, negligence, carelessness
- Reckless behaviors, such as conscious disregard for standards

A just culture is prepared to handle incidents involving human error. At-risk or reckless behaviors, however, are not tolerated.

Managing and improving quality requires ongoing attention to system-wide processes and individual actions. The nurse manager is in a key position to identify problems and encourage a culture of safety and quality.

What You Know Now

- Total quality management is a philosophy committed to excellence throughout the organization.
- Continuous quality improvement is a process to improve quality and performance.
- Six Sigma is another quality management program that uses measures, has goals, and is a management system.
- Lean Six Sigma provides tools to improve flow and eliminate waste.

- DMAIC is a Six Sigma process improvement method to define, measure, analyze, improve, and control performance.
- Changes mandated by the Affordable Care Act reimburse healthcare providers for the value of their care rather than paying for the volume of care. These changes are expected to continue even if legislation alters the ACA's provisions.
- Electronic health records, dashboards, and rounding can be used to improve and monitor quality.
- Reducing medication errors is a priority for healthcare organizations and policy makers.
- A risk management program focuses on reducing accidents and injuries and intervening if either occurs.
- A caring attitude and prompt attention to complaints help to reduce risk.
- A just culture is more likely to encourage reporting of adverse events, including near misses, as well as to point out unsafe practices.

Tools for Managing and Improving Quality

1. Remember: Quality management is a system. When something goes wrong, it is usually due to a flaw in the system.
2. Become familiar with standards and outcome measures and use them to guide and improve your practice.
3. Strive for perfection, but be prepared to tolerate failure in order to encourage innovation.
4. Be sure that performance appraisals and incident reports are not used for discipline but rather are the bases for improvements to the system and/or development of individuals.
5. Remind yourself and your colleagues that a caring attitude is the best prevention of problems.

Following an incident:

1. Meet with the risk manager and hospital attorney to review documentation and determine which staff will be interviewed regarding the incident.
2. Provide any requested information to administration in a timely manner.
3. Audit documentation and processes to determine if an incident is part of a pattern or an isolated incident.
4. Provide the results of any audits or discussions with staff to appropriate administrators.
5. Educate staff as appropriate.
6. Determine if disciplinary action is required.
7. Follow up with risk management, nursing administration, and human resources as appropriate.
8. Continue to cooperate with the hospital attorney if the incident results in litigation.

Questions to Challenge You

1. Imagine that an organization is debating several quality management programs. What would you recommend? Why?
2. Do you know what standards and outcome measures are used in your clinical setting? How are data handled? Are they shared with employees?
3. What comparable groups, both internal and external, are used for benchmarking performance in your organization?
4. Universities also use benchmarking. What institutions does your college or university use to benchmark its performance? Find out.
5. Have you, a family member, or a friend ever had a serious problem in a healthcare organization that resulted in injury? What was the outcome? Is this how you would have handled it today? What will you do in the future in a similar situation?
6. Have you or anyone you know ever made a mistake in a clinical setting? What happened? Would you assess the organization as a blame-free environment?

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Chapter 7
Understanding Legal and Ethical Issues

Law and Ethics

Ethical Decision Making
Autonomy
Beneficence and Nonmaleficence
Distributive Justice

The Legal System
Sources of Law
Types of Law
Liability

Legal Issues in Nursing
Nursing Licensure
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Management Issues
Employment Issues

Learning Outcomes

After completing this chapter, you will be able to:

1. Differentiate between law and ethics.
2. Analyze the ethical principles of autonomy, beneficence, nonmaleficence, and distributive justice.
3. Examine the sources of law, types of law, and liability in the legal system.
4. Explore legal issues in nursing involving licensure, patient care, management, and employment matters.

Key Terms

administrative law
advance directive
allocation
autonomy
beneficence
common law
confidentiality
corporate liability
distributive justice
durable power of attorney

ethics
informed consent
intentional torts
invasion of privacy
job reassignment
laws
licensure
living will
malpractice
negligence
nonmaleficence
nurse practice acts
personal liability
private law
public law
rationing
respondeat superior
statutory law
tort law
vicarious liability

Introduction

The complexities of today's healthcare system present many ethical and legal issues for nurses. Advanced technology, patient autonomy and privacy, and end-of-life decisions are just a few of the factors posing ethical dilemmas. As the role of the professional nurse expands to include increased expertise, specialization, autonomy, and accountability, so does the number of legal issues involving nurses. Legal protections for patients as well as employees and management liability present additional challenges in healthcare.

Law and Ethics

Laws are rules of conduct, established and enforced by authority, that prohibit extremes in behavior so that one can live without fear for oneself or one's property. **Ethics** is a science that deals with principles of right and wrong, good and bad; it governs our relationship with others. Ethics are based on personal beliefs and values that guide decision making.

Although the definitions of law and ethics may seem clear, there is a fine line between them, and the two may overlap in some healthcare encounters. In some cases, the overlap may be congruent; in others, it may be conflictual. For example, what is ethical may not be legal, and what is legal may not be ethical. Making this distinction between ethics and law is important because the outcomes are very different: When you violate legal principles, you may be held liable for your actions; when you violate ethical principles, you may suffer emotionally due to the results of your actions.

The Code of Ethics of the American Nurses Association (2015), found in Box 7-1, makes explicit the profession's values and standards of conduct. Originally adopted in 1950, this document is revised periodically to reflect changes in the profession and in society. It serves to inform the nurse and the public of the profession's expectations in ethical matters. It also provides a decision-making framework for solving ethical problems. Although the code of ethics is not legally enforceable, violation of these standards often is a violation of laws that have been enacted to ensure protection of the public. For example, breaching a patient's confidentiality also violates the law.

Box 7-1 Code of Ethics for Nurses

1. The nurse, in all professional relationships, practices with compassion and respect for the inherent dignity, worth, and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems.
2. The nurse's primary commitment is to the patient, whether an individual, family, group, or community.
3. The nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient.
4. The nurse is responsible and accountable for individual nursing practice and determines the appropriate delegation of tasks consistent with the nurse's obligation to provide optimum patient care.
5. The nurse owes the same duties to self as to others, including the responsibility to preserve integrity and safety, to maintain competence, and to continue personal and professional growth.
6. The nurse participates in establishing, maintaining, and improving healthcare environments and conditions of employment conducive to the provision of quality healthcare and consistent with the values of the profession through individual and collective action.
7. The nurse participates in the advancement of the profession through contributions to practice, education, administration, and knowledge development.
8. The nurse collaborates with other health professionals and the public in promoting community, national, and international efforts to meet health needs.
9. The profession of nursing, as represented by associations and their members, is responsible for articulating nursing values, for maintaining the integrity of the profession and its practice, and for shaping social policy.

Source: From *Code of Ethics for Nurses with Interpretive Statements* 2015. Reprinted with permission from American Nurses Association. Washington, DC: American Nurses Association.

Ethical Decision Making

Several key principles play a role in solving ethical dilemmas. The principles most directly related to nursing are the principles of autonomy, beneficence, nonmaleficence, and distributive justice.

Autonomy

Autonomy is the right of individuals to take action for themselves. It includes respect for individuals and the right of individuals to make decisions for and about themselves, even if those decisions are not congruent with others' goals. To respect autonomy is to respect others. It requires recognizing the uniqueness of others and listening to and understanding another person in a way that allows you to put yourself in that other person's position. Respecting a terminally ill patient's decision to discontinue treatment is an example.

People engaged in autonomous and self-determining actions must have the capability of self-governance, operate from a stable and internalized set of principles, and view themselves as capable of implementing autonomous decisions. Inherent in this principle is the understanding that a person acts with intention, with knowledge, and without external control or influence. Like most rights, autonomy is not an absolute right: Under certain circumstances, the individual's right does not prevail over the rights of others. Individual autonomy does not prevail when it interferes with the rights, health, or well-being of another. For example, a nurse has the right to refuse to render care to a patient because of personal beliefs. However, if the safety of the patient is jeopardized because of that lack of care, the nurse may suffer legal consequences. Regardless of personal beliefs, the nurse has an ethical obligation to be sure the patient has adequate care.

Beneficence and Nonmaleficence

Beneficence is the duty to help others by doing what is best for them. This belief also implies the principle of **nonmaleficence**, or to "do no harm." One has the duty not only to do good but also not to inflict harm or to risk harm to others. A beneficent nurse acts with empathy for the patient without resentment or malice. A nurse who acts in bad faith or out of ill will or who makes false accusations concerning a patient or employee violates the principle of beneficence.

In many instances, the demands of beneficence and the functions required in a healthcare setting come into conflict. Sometimes, for example, treatment decisions are viewed as harmful from the patient's perspective. When an individual does not desire what others determine to be in that person's best interest—such as when a patient refuses treatment—the principles of beneficence and autonomy conflict. Generally speaking, in conflict situations involving patient care decisions, the principle of autonomy overrides the principle of beneficence.

Distributive Justice

Distributive justice is giving a person that which he or she deserves. It implies that benefits and burdens ought to be distributed equally and fairly, regardless of race, gender (including gender orientation and gender identity), religion, or socioeconomic status so that no one person bears a disproportionate share of benefits or burdens. As healthcare technology advances and healthcare costs continue to climb, nurses may find themselves entrenched in conflicts between cost containment and the equal distribution of finite healthcare resources regardless of the patient's ability to pay.

Allocation (macroallocation) and **rationing** (microallocation) of scarce resources continue to be concerns in healthcare today. Allocation is the decision society makes regarding how many of its resources will be devoted to a particular effort—for example, organ transplants. Rationing is a decision regarding who gets the service or supply and who does not—again using the example of organ transplants. Allocation and rationing decisions require that some societal values take precedence over some individual values. For example, decisions about recipients for heart transplants require consideration of the availability of hearts, the likelihood of the patient to survive, and the patient's age. The societal goal is to implant hearts in people most likely to survive and thrive in the future.

The Legal System

Law comes from a variety of sources. Understanding the sources of law and the various types of laws helps determine their impact on nursing practice. Nurses must understand the changing legal climate and their responsibilities as viewed by the public and the legal system.

Sources of Law

Three branches of government—legislative, judicial, and executive—contribute to the creation of law. They, in conjunction with the Constitution, form the basis of the judicial system of the United States. The Constitution is the supreme law of

the land. It defines the structure, power, and limits of the government and guarantees people certain fundamental rights as individuals. Influences of the three branches of government are reflected in statutory law, common law, and administrative law.

STATUTORY LAW **Statutory law** is enacted by the legislative branch of government. This type of law is designed to declare, command, or prohibit something. Licensing laws for healthcare providers, including nurses, are examples of statutory laws that protect the public from incompetent practitioners. Other statutory laws affecting nursing practice are guardianship codes, statutes of limitation, informed consent, living will legislation, and protective and reporting laws.

COMMON LAW **Common law** is judge-made law. This type of law is derived from earlier decisions made by courts. Common law establishes a custom or tradition by which other similar cases are judged; this custom is referred to as legal precedent. Common law is not absolute. Earlier decisions can be and frequently are overruled. As time and circumstances change, court decisions become obsolete and may require a different opinion. Each state has its own body of common law related to the delivery of healthcare within that state. These laws should be reviewed by health professionals as a basis for accountability, quality, and risk management within their professional practice. Awareness of these laws assists nurses in functioning within the boundaries of their role and advocating for nursing practice when necessary.

ADMINISTRATIVE LAW **Administrative law** is made by administrative agencies. According to certain statutes, administrative agencies are granted authority to enact rules and regulations that will carry out specific intentions of the statute. This allows the legislature to delegate to an administrative agency of experts in the field the authority to create rules and regulations governing a specific area of practice. For example, state boards of nursing are authorized by nurse practice acts (statutory law) to write rules and regulations governing the practice of nursing. These rules and regulations are incorporated into the nurse practice act and are as binding as the statutory law itself. Another example of administrative law is the attorney general's opinion regarding the interpretation of a law, which also is binding.

Types of Law

Law also can be categorized according to specific types. The two basic types of law are **public law** and **private law** (civil law). Public law consists of constitutional law, administrative law, and criminal law. Private law is further classified into tort law, contract law, and protecting and reporting law. All these have an impact on nursing practice, but the most common law affecting nursing practice is tort law.

TORT LAW **Tort law** is divided into two categories—unintentional and intentional. Negligence and malpractice (professional negligence) fall under the category of unintentional torts.

Negligence is defined as the failure of an individual not to perform an act (omission) or to perform an act (commission) that a reasonable, prudent person would or would not perform in a similar set of circumstances. **Malpractice** is professional negligence. It evolves from negligence law and the premise that all individuals are responsible for the consequences of their actions or inactions. It refers to any misconduct or

lack of skill in carrying out professional responsibilities. For malpractice to exist, four elements must be present:

- Duty
- Breach of duty
- Causation
- Injury

If there is no preponderance of evidence that demonstrates negligence, then the malpractice claim may be dismissed.

In **intentional torts**, the intent to harm is present. Assault (including sexual assault), battery, false imprisonment, invasion of privacy, inappropriate disclosure of private information, libel, slander, and defamation of character are examples of intentional torts.

Liability

To understand malpractice, one must understand the various types of liability. As individuals, nurses are responsible and accountable for their own actions or inactions. This is referred to as **personal liability**. In addition, the law ascribes negligence to certain parties who may not be negligent themselves but whose negligence is assumed because of association with the negligent person. This is called **vicarious liability**. It is based on the legal principle of **respondeat superior**, which means "let the master speak." This doctrine allows the courts to hold the employer responsible for the actions of the employee when the employee is performing services for the organization.

All too frequently, nurses have a false sense of security concerning the doctrines of respondeat superior and vicarious liability. Employees sometimes believe that the organization's responsibility protects them from being sued as individuals, but this is not the case. Patients have the right to sue both the employee and the organization when they have suffered an injury as a result of substandard care. Also, the organization has the right to sue the employee for damages incurred as a result of the nurse's substandard care. For these reasons, it is important for nurses to carry their own personal liability insurance.

Nurse mangers are not responsible for the actions of others but are responsible for their own acts of delegation and supervision of others. Failure to delegate and supervise properly can result in liability for the nurse manager. This is not a result of vicarious liability but, rather, an issue of personal liability.

Corporate liability holds that the organization is responsible for its own wrongful conduct. The healthcare organization has the responsibility to maintain an environment conducive to quality healthcare for its consumers. Corporate liability includes the following:

- The duty to hire, supervise, and maintain qualified, competent, and adequate staff
- The duty to provide, inspect, repair, and maintain reasonably adequate equipment
- The duty to maintain safety in the physical environment.

Responsibility to achieve these goals is delegated to managers even though the organization is ultimately responsible. For example, the organization has a responsibility to have a mechanism in place to report incompetent, unethical, and illegal

practice. If the nurse manager is aware of such practice but does not report it, the nurse manager also is liable. Many states have statutory laws regarding mandatory reporting of legal violations.

Legal Issues in Nursing

Legal issues in nursing involve licensure, patients' rights, and management and employment matters. Each of these topics poses challenges for nurses and managers.

Nursing Licensure

Licensure is a credential provided for by state statutes that authorizes qualified individuals to perform designated skills and services. In nursing, these statutes are referred to as **nurse practice acts**. Each state establishes its own board of nursing whose members are granted the authority to set and enforce rules and regulations pertaining to the practice of nursing, including the requirements for licensure in that state. Licensure protects the use of the titles—registered nurse, practical nurse, or advanced practice nurse—and establishes standards for education, examination, and behavior to protect the health, safety, and welfare of the public.

Because each state controls and maintains its own database of licensees, mobility for nurses is hampered. To practice in a state other than the one in which the nurse is already licensed, an RN must apply for a reciprocal license from that state. Although all RNs take the same licensure exam, not all states' policies regarding nursing practice are alike, such as requirements to complete continuing education.

UNIFORM LICENSURE REQUIREMENT One remedy proposed by the National Council of State Boards of Nursing (NCSBN) is to develop uniform licensure requirements among the states that would not only facilitate nurse mobility, but also ensure public access to qualified practitioners (National Council of State Boards of Nursing, 2011).

MULTISTATE LICENSURE Another initiative by the NCSBN is multistate licensure. Multistate licensure is a process similar to obtaining a driver's license, allowing practice in more than one state. As of May 2015, twenty-five states have entered an interstate compact to allow multistate licensure privilege (National Council of State Boards of Nursing, 2015). The state of residence is considered the home state. All other states in the contract are remote states. The nurse is still responsible for meeting the standards set forth by the nurse practice acts in which he or she practices. Disciplinary actions may be taken by both the home and remote states.

MODEL NURSE PRACTICE ACT The NCSBN also has developed a model nursing practice act (National Council of State Boards of Nursing, 2012). The model act defines nursing, its scope of practice, titles, advanced practice nursing standards, educational requirements, and violations and penalties. Improved uniformity among states would result if states adopt the model act.

Patient Care Rights

When individuals enter the healthcare system, they retain the basic fundamental rights ascribed to them by the Constitution and courts of law. Additional rights are designed

to protect the rights of individuals at the times when they are most vulnerable. These include the right to privacy and confidentiality, the opportunity to make informed consent, the right to refuse treatment, and the right to be free from restraint.

PRIVACY RIGHTS **Invasion of privacy** is the violation of a person's right to be left alone without being subjected to unwarranted or uninvited publicity and to make personal choices without interference. Information disclosed by the patient is confidential and as such is available to authorized personnel only. Patients can sue for invasion of privacy when confidential information is revealed to any unauthorized person. Similarly, a patient can sue for invasion of privacy when unauthorized personnel, directly or indirectly, observe the patient without permission. Authorized personnel are those involved in the diagnosis, treatment, and related care of the patient. Generally speaking, these are members of the healthcare team.

Nurses, as well as others, may not use photos, videos, or research data without the explicit permission of the involved patient. Also, the nurse should be discreet about the release of information over the phone regarding the patient's status because it is difficult, if not impossible, to identify the caller accurately over the phone. The nurse must even obtain the patient's permission to release information to family members and close friends.

Other cases regarding invasion of privacy involve the freedom to make choices without interference. Patients have the right to make informed choices, such as contraception use, abortion, and the right to refuse treatment. Furthermore, they should be assured that these decisions will be respected and upheld even if they are not the same decisions or choices the health professional might make. Nurses often serve as advocates to safeguard these rights.

Difficulty arises when the nurses' personal beliefs interfere with their caregiving. Some issues that nurses raise include death with dignity versus extraordinary lifesaving measures, use of medical marijuana, and, not surprisingly, abortion of a nonviable fetus. The manager's role is to support nurses in their personal beliefs while, at the same time, ensuring that all patients receive unbiased care.

The Health Insurance Portability and Accountability Act (HIPAA), implemented in 2003, (U.S. Department of Health & Human Services, 2015a) requires healthcare providers, including individuals and organizations, to take far more stringent measures to ensure their patients' privacy than were required previously. Communication between providers requires a release from the patient. Offices and public places in healthcare agencies must prevent names and identifying information from being overheard or seen. Providers must be certain that mail, fax, email, texts, and voice messages are accessible only by the patient. Complying with the requirement for HIPAA involved a major overhaul of most healthcare systems, but soon protecting patients' privacy became standard nursing practice (Wielawski, 2009).

CONFIDENTIALITY **Confidentiality** is the right to privacy of records. Individuals have the right to believe that information disclosed to health professionals is to be used strictly for the purpose of diagnosis and treatment and will not be released to others without permission of the individual. This is considered protected information by the privilege doctrine. According to this doctrine, people who have protected relationships cannot be forced to reveal communication unless the other person in the relationship agrees to it.

Confidentiality assurances were strengthened with the regulation of HIPAA. Under certain circumstances, the nurse can lawfully disclose confidential information

about the patient, such as when the welfare of a person or a group is at stake or when a personal injury or workers' compensation claim is filed.

INFORMED CONSENT Three basic requirements are necessary for **informed consent**: *capacity*, *voluntariness*, and *information*. Individual *capacity* to consent is determined by age and competence. Generally, one must be an adult in the technical and legal sense in order to consent to treatment. The legal age for adult status is established by state statute and varies from state to state. Based on the state statute, minors may consent to certain types of treatment, such as abortion or substance abuse treatment. Adults are considered competent when they can make choices and understand the consequences of their choices.

Individuals act *voluntarily* when they exercise freedom of choice without force, fraud, deceit, duress, or any other form of coercion. Consent that is compelled by threat or provoked by fraud is legally considered to be no consent at all. Because patients are exceptionally vulnerable when they need medical care, they may believe, or be led to believe, that they must comply with the recommendations of healthcare professionals. Often patients believe that if they do not comply, they may get less than adequate care or no care at all. All too frequently, nurses and other health professionals take it for granted that because a patient is under their care, the patient will agree to whatever care is deemed necessary. Nurses have an obligation to create an atmosphere that avoids any indication of coercion or manipulation. To provide treatment without the patient's consent, except in an emergency situation, could result in liability for unauthorized touching or battery.

The third element of informed consent is *information*. Information must be supplied to patients in a manner that is understandable to them. Lay terminology is preferred to professional jargon. The information must include the following:

- An explanation of the treatment to be performed and the expected results
- A description of the anticipated risks and discomforts
- A list of potential benefits
- A disclosure of possible alternatives
- An offer to answer the patient's questions
- A statement that the patient may withdraw his or her consent at any time

The legal responsibility to provide the necessary information for informed consent rests with the individual who will perform the treatment. When a nurse asks a patient to sign a consent form, the nurse is merely attesting to the fact that there is reason to believe that the patient is informed regarding the impending treatment and is witnessing the signature. If the nurse asks the patient to sign a consent form knowing that the patient has had no prior explanation of the treatment, the consent is invalid.

RIGHT TO REFUSE TREATMENT Just as competent adults have the right to consent to treatment, they also have the right to refuse treatment. In addition, guardians of incompetent adults have the right to refuse treatment for them. The right of competent adults to refuse treatment is guaranteed by the Constitution and has been tested in court with several landmark cases (*Cruzan v. Director, Missouri Department of Health*, 1990; *Quinlan v. New Jersey*, 1976; *Schindler v. Schiavo*, 2005). Most states have adopted statutory laws to protect these rights and to protect the healthcare provider who agrees to not treat even when treatment could be considered medically indicated. The legal

documents that adhere to these laws and protect individuals are referred to as advance directives, living wills, and durable powers of attorney.

As a direct result of the *Cruzan* case, Congress enacted the Patient Self-Determination Act in 1990 (Koch, 1992). This federal law requires every healthcare facility that receives Medicare or Medicaid funds to provide written information to adult patients concerning their right under state law to make healthcare decisions. These decisions include the right to accept or refuse treatment and the right to formulate advance directives.

An **advance directive** is a document that allows a competent patient to make choices prior to the need for medical treatment. Examples include decisions such as refusing nourishment, being placed on a ventilator, or stopping treatment. The two most common advance directives are a living will and a durable power of attorney for healthcare.

With a **living will**, the competent adult signs a form indicating what healthcare the person does and does not want in the event of terminal illness. An individual may want all lifesaving measures continued no matter how dire the prognosis, or a person might want only comfort measures should the need arise. These decisions will be upheld should that adult's decision-making capacity be lost.

Both Case Study 7-1 and Leading at the Bedside: Respecting Patient Directives highlight the importance for nurses to respect the patient's wishes as expressed in these legal documents.

A **durable power of attorney** for healthcare decisions permits a competent adult to appoint a surrogate or proxy to make decisions in the event that the individual becomes unable to do so. The healthcare provider must follow the expressed wishes as stated in these documents. Difficulties arise when the patient is unconscious and does not have an advance directive or the directive is vague. In these cases, the health provider often relies on family members to make these decisions. In most states, however, family members do not have the legal authority to make such decisions unless they are the legally appointed guardians or parents.

FREEDOM FROM RESTRAINT Another potential area of liability is the use of restraints. The Omnibus Budget Reconciliation Act (OBRA) of 1987 provides patients the right to be free from any physical or chemical restraint imposed for the purpose of discipline or convenience and not required to treat medical symptoms. These regulations apply to nursing homes, state and federal agencies, and other healthcare organizations that receive Medicare and Medicaid funds. According to these rules, health professionals are required to assess the need for restraints and consider the use of alternative measures. When restraints are deemed necessary, a physician's order specifying duration and circumstances is required. No order for as-needed (PRN) restraints is permitted. When restraints are used, the patient must be monitored closely and reassessed periodically to evaluate the continued need for restraints. In addition to federal regulations, most states have laws governing the use of restrictive devices.

Federal mandates also call for the judicious use of psychotropic drugs, which are frequently used as chemical restraints. Psychotropic drugs no longer may be used for the purpose of controlling behavior; they may be prescribed only for diagnosis-related conditions. The intention is to prevent indiscriminate use of psychotropic drugs that frequently cause patients to become sedated, agitated, or combative.

Leading at the Bedside: Respecting Patient Directives

As a nurse, you will undoubtedly encounter ethical issues as you care for patients. You may find that your personal beliefs conflict with the patient's decisions or the medical recommendations. You may even face legal issues at some point in your career. Only you can decide if your personal beliefs are such that you cannot care for the patient or that you can provide compassionate care in spite of your views.

Here is an example: Your patient is terminally ill, but both he and his family want to "do everything." You believe in the patient's autonomy, but you also know that continued interventions will cause him pain, reduce his ability to interact with his family, and prolong his inevitable death. Plus, you have watched several of your own family members suffer long and painful deaths. Although you think that you would make a different decision if you were the patient, you continue to care for him and his family with compassion and respect.

CASE STUDY 7-1 | Death with Dignity

For 2 weeks Kristine, an RN on the medical surgical unit, had been caring for a young woman on her shifts. The young woman, Enid, was 36 years old and had been diagnosed with a rare neurological disease. Married with three young daughters, Enid had an extended family that visited her often in the hospital.

During rounds, in which Kristine had participated, the physicians told Enid they would get her through her immediate crisis and work on getting her on some medications to help her symptoms with her newly diagnosed disease. Throughout her hospital stay, Enid learned that her disease was ultimately fatal and that in the next year or two she would likely develop complete paralysis and be unable to communicate or take care of herself, and eventually need a breathing tube and feeding tube to stay alive.

Kristine had been quiet and contemplative in recent days. Then, one morning, Kristine walked in to greet Enid and share that she would be her nurse again that day. Kristine was growing very fond of Enid. Kristine was also a young woman and a mother. She had been thinking about how sad she would be if she developed the condition that Enid had.

That same morning, Enid asked Kristine to sit down and talk with her. Enid shared that she had been thinking for many days about her future and the complications of her disease that would limit her length and quality of life. Enid shared that she did not want her husband caring for her or her children to grow up with a mom who was not taking care of them. Enid told Kristine that one of her worst nightmares was coming true. Kristine tried to comfort Enid. Enid told Kristine she wanted to learn about the death with dignity movement and was considering choosing when her life would end as her disease progressed.

Kristine was devastated and angry. She couldn't believe Enid would want to choose to die and not be a mom to her kids. Kristine did not know what to say to Enid, so she only said that she would tell the doctor and left Enid's room.

Kristine went to find her nurse manager. Kristine cried as she told her manager what Enid had said. Kristine said she did not think she could take care of Enid if she wanted Kristine to help her kill herself.

Kristine's nurse manager listened thoughtfully. When Kristine was finished talking for a moment, her nurse manager helped her sort through her feelings and think about what the present scenario really presented to Kristine.

Enid was not asking Kristine to help her end her life. Enid had only shared her thoughts with Kristine because she trusted her as her nurse. The manager went on to remind Kristine that in their state death with dignity was not offered, and Kristine would need to explore those options after her discharge from the hospital and decide what was right for her. Ultimately, Kristine's role remained to provide good care to Enid during her admission and help her progress to a safe discharge from the hospital. As the nurse manager talked, Kristine began to think about her conversation with Enid differently.

Kristine left her manager's office feeling better. She still did not agree with Enid's thoughts but realized her role was to take care of Kristine in her current healthcare crisis and support a safe discharge when the time came so Enid could move on with her life and decide how she wanted to live.

The use of restraints should be based on the principles of informed consent. If patients are unable to consent, then reliable proxy consent should be obtained with full disclosure of risks and benefits. Restraining patients without consent or sufficient justification may be interpreted as false imprisonment. In additional to legal rights, the use of restraints clearly involves ethical issues such as autonomy and beneficence.

Management Issues

Management includes delegation and supervision, staffing the area of responsibility, reassigning staff as needed, following the organization's policies and procedures, and ensuring that patient privacy is maintained. In addition, management concerns involve identifying and addressing incompetent practice, and familiarity with national records of sanctions against healthcare professionals.

DELEGATION AND SUPERVISION Nursing management encompasses supervision of nursing care and the personnel who provide that care. Nurses are personally liable for the reasonable exercise of the delegation and supervision activities. They must be aware of the staff member's knowledge, skills, and competencies when delegating tasks and should supervise them appropriately. Nurses have a legal duty to ensure that staff members under their supervision are performing in a manner consistent with the accepted standard of practice. If a nurse makes an assignment to an individual who the nurse knows is not competent to perform that assignment, the nurse will be liable if the patient is injured.

STAFFING According to established standards, the organization must provide adequate staffing with qualified personnel (Joint Commission, 2015). The organization that fails to retain the level of nursing personnel required to provide safe, quality care may be held liable under the doctrines of respondeat superior and corporate liability if an injury occurs related to short staffing.

Although retaining appropriate nursing personnel is the responsibility of the organization, if it can be shown that the staff nurse acted unreasonably under the circumstances, the individual nurse also can be held liable for acts of omission or commission. In other words, inadequate staff is no excuse for negligent acts. If the nurse acts reasonably under the circumstances, however, the individual may not be found culpable for malpractice. In addition, if the hospital can demonstrate that it has taken appropriate actions to alleviate the staffing crisis, then it may not be held liable.

Staffing an organization is not as clear-cut as it may seem. Although the organization has some guidelines to follow, such as those mandated by federal and state regulatory bodies, these guidelines are broad and require a certain amount of judgment. Adequate staffing includes not only the number of staff but also their skill level (e.g., RN, LPN, UAP), their experience, and the unit to which the will be assigned (e.g., critical care).

JOB REASSIGNMENT The hospital has a legal duty to ensure that all areas of the hospital are adequately staffed. With fluctuating patient census, this often places the hospital in a position in which reassigning nurses' duties is the only way to balance the needs of the unit and the safety of patients. **Job reassignment** (floating) is the process of pulling nurses from one area of the hospital to another. This practice is

commonplace in today's healthcare organizations, but concerns are raised about it by both staff and administration. Floating nurses to unfamiliar areas, especially specialty areas, increases the chance of error and may increase nurses' anxiety, which in turn may affect job satisfaction and morale.

The nurse who refuses to float may face the possibility of discharge on the grounds of insubordination, although nurses have argued that they do not have the requisite skills to care for patients in the intended unit (Guido, 2014). Nurses have a responsibility to serve in the best interest of the patient. Some solutions to the problem of reassignment are open communication regarding limitations and concerns, creative problem solving, and cross-training.

POLICIES AND PROCEDURES When the nurse is responsible for performing procedures that require judgments beyond the usual scope of nursing practice, a standardized procedure, or protocol, is necessary. These procedures must be written and authorized by the organization. Routinely, the standardized protocol must specify the following:

- Functions the nurse may perform under specific circumstances
- Requirements that must be followed in performing the function
- Education, experience, and training requisites of the nurse performing the procedures
- Method for evaluating the competence of the nurse performing the practice

Policies and procedures are required for all healthcare organizations. These documents serve to standardize care, set standards, and guide practices. They should be well delineated, clearly stated, and based on current and actual practice.

RELEASE OF INFORMATION The same guiding principles regarding release of information about patients also apply to release of information about employees. Information about employees is considered confidential and must not be released outside the organization without the explicit consent of the employee, except to verify employment or to comply with a legal investigation. The Privacy Act of 1974 (1974) outlined the stringent requirements for handling personnel matters related to privacy issues. The nurse manager needs to be familiar with this law, especially as it relates to giving references and recommendations.

INCOMPETENT PRACTICE The "due care" standard requires nurse managers to confront unsafe practice. It is important for the nurse manager to be familiar with both the organization's procedures for addressing safety and professional conduct and the state board of nursing guidelines. Many states have instituted mandatory reporting of unsafe practices to safeguard public health. Mandatory reporting is a complex process involving both legal and ethical parameters. The vast majority of the complaints and disciplinary actions related to mandatory reporting are for impairment or drug diversion.

NATIONAL PRACTITIONER DATE BANK The National Practitioner Date Bank (NPDB) serves as an information clearinghouse regarding adverse actions, such as licensure sanctions against healthcare professionals, including physicians and nurses (U.S. Department of Health and Human Services, 2015b). Federal regulations require healthcare institutions, licensing boards, professional societies, and malpractice payers to report any actions taken against professionals.

Employment Issues

Nurses who serve in management roles are also employees, so they need to be familiar with the growing body of discrimination laws for themselves as well as for those they supervise. Discrimination statutes have a profound effect on hiring, advancement, and termination practices. Matters of employee rights have been pronounced since the passage of the Civil Rights Act of 1964. Today, we continue to see increased activity related to discrimination of various kinds, and many states have enacted laws governing civil rights and discrimination.

CIVIL RIGHTS ACTS Title VII of the 1964 Civil Rights Act (CRA) bars discrimination on the basis of race, color, sex, or national origin (1991). Title VII governs all public and private agencies with 15 or more employees and addresses all aspects of employment (e.g., hiring, promotion, discipline, supervision, performance appraisal, dismissal). The Equal Employment Opportunity Commission (EEOC) is the federal agency that administers and enforces Title VII.

Two exceptions to the law are the bona fide occupational qualifications (BFOQ) and bona fide seniority or merit system. The BFOQ states that it is lawful to make employment decisions on the basis of national origin, religion, and sex (but not race) if this is necessary for the job. Examples include mandatory retirement ages for airplane pilots, required beliefs for teachers in religious schools, or proficiency in a second language (but not national origin) for some nurses.

SEXUAL HARASSMENT In 1991, the Civil Rights Act was amended to expand the definition of sexual harassment in the workplace and to delineate the employer's responsibilities. Specifically, the employer can be held liable for acts of sexual harassment committed by employees, whether or not the employer had any prior knowledge of the reported acts. Employers must establish proactive policies to sensitize employees to the problem and prevent its occurrence.

AGE DISCRIMINATION IN EMPLOYMENT ACT Passage of the Age Discrimination in Employment Act (ADEA) in 1967 made it unlawful for employers to discriminate against older men and women in decisions regarding all phases of employment. Discrimination against individuals over the age of 40 and mandatory retirement for persons at any age are prohibited.

AMERICANS WITH DISABILITIES ACT Title I of the Americans with Disabilities Act (ADA) of 1990 is designed to eliminate discrimination against disabled persons in employment by enforcing equal access to jobs and accommodations. The ADA defines disability as follows:

- A physical or mental impairment that substantially limits one or more major life activities
- A record of such impairment
- Being regarded as having such impairment

These guidelines apply to all phases of the employment process, including hiring, promotion, compensation, training, and termination. Furthermore, the ADA requires employers to provide reasonable accommodations for disabled employees, including those recovering from alcohol or substance abuse. Reasonable accommodations might include providing a leave of absence with or without pay, job reassignment, or job restructuring.

FAMILY AND MEDICAL LEAVE ACT The Family and Medical Leave Act (FMLA) of 1993 provides eligible employees with a leave of up to 12 weeks during any 12-month period for the employee's own serious illness, the birth or adoption of a child, or the care of a seriously ill child, spouse, or parent.

OCCUPATIONAL SAFETY AND HEALTH ACT The Occupational Safety and Health Act of 1970 was established to ensure a safe and healthful work environment for employees. OSHA standards are sets of rules designed to minimize specific on-the-job risks to employees. These risks include exposure to toxic chemicals, infectious agents, hazardous waste, and dangerous equipment.

In 1991, the Occupational Safety and Health Administration (OSHA) published regulations designed to reduce infection from bloodborne pathogens. It applied to all occupations and covered exposure to blood and other body fluids. Then, in 2000, Congress passed the Needlestick Safety and Prevention Act, which required employers to select and use safer medical devices, including needleless systems, to reduce the danger from bloodborne pathogens.

As the world learned from the Ebola outbreak in 2014, the usual protective gear and procedures were not always adequate to protect healthcare workers. Also, as new viruses emerged (e.g., severe acute respiratory syndrome [SARS] in the early 2000s and Middle East respiratory syndrome [MERS] in 2014), healthcare organizations will continue to be challenged to protect both their patients and their employees.

Nurse managers are challenged today to provide quality healthcare, manage employee concerns, and meet legal and ethical standards of the profession. This is no small task. Careful attention to the law and to ethical guidelines will help managers meet their obligations.

What You Know Now

- Both ethical and legal principles guide the practice of nurses and nurse managers.
- Ethics deal with principles of right and wrong, are based on personal beliefs and values, and govern our relationships with others.
- The Code of Ethics for Nurses explicitly defines the profession's values and standards of conduct.
- Laws are rules of conduct, established and enforced by authority, that prohibit extremes in behavior so that one can live without fear for self or property.
- Negligence is the failure of an individual to perform or not perform an act that a reasonably prudent person under the same circumstances would or would not perform.
- Liability may be personal, vicarious, or corporate.
- Liability issues that directly concern nurse managers are delegation and supervision, staffing, floating, policies and procedures, unsafe practice, and employment regulations.
- Nurse managers must be knowledgeable about federal and state laws governing patient care as well as employee supervision and responsibility.

Questions to Challenge You

1. Study the Code of Ethics for Nurses. Do you agree with it? Explain your reasons.
2. Have you been faced with an ethical dilemma? Are you satisfied with the way you handled your part? How did it turn out? Would you handle a similar situation differently now?
3. You are manager of the home care division of a healthcare organization. What regulations might apply in the following situations?
   a. An employee's husband has just been diagnosed with cancer.
   b. An employee who has been on sick leave returns to announce that she's been treated for alcohol dependency.
   c. An employee reports a needlestick injury and you discover the organization is not using the latest needle safety equipment.
4. How would you handle each of the preceding situations?
5. Have you been involved in a legal action or threat of one in healthcare? How was the situation handled and what was the outcome?

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Chapter 8
Understanding Power and Politics

Power and Leadership
Power: How Managers and Leaders Get Things Done

Using Power
Image as Power
Using Power Appropriately

Shared Visioning as a Power Tool

Power, Politics, and Policy
Nursing's Political History
Using Political Skills to Influence Policies
Influencing Public Policies

How Nurses Can Influence the Future

Learning Outcomes

After completing this chapter, you will be able to:

1. Differentiate between power and leadership.
2. Describe how to use power appropriately.
3. Explain how to use shared visioning as a power tool.
4. Explore the relationships among power, politics, and policy.
5. Summarize ways nurses can influence nursing's future.

Key Terms

coercive power
connection power
expert power
information power
legitimate power
personal power
policy
politics
position power
power
power plays
referent power
reward power
shared visioning
stakeholders
vision

Introduction

Power is the potential ability to influence others (Hersey, 2013). Power is involved in every human encounter, whether you recognize it or not. Power can be symmetrical when two parties have equal and reciprocal power, or it may be asymmetrical with one person or group having more control than another (Mason, Leavitt, & Chafee, 2014). Power can be exclusive to one party or may be shared among many people or groups. To acquire power, maintain it effectively, and use it skillfully, nurses must be aware of the sources and types of power that they will use to influence and transform patient care.

Power and Leadership

Real power—principle-centered power—is based on honor, respect, loyalty, and commitment. Principle-centered power is a model congruent with nursing's values. Originally conceived by Stephen Covey (1991), the model is increasingly used by leaders in many fields (Ikeda, 2015). Power sharing evolves naturally when power is centered on one's values and principles. In fact, the notion that power is something to be shared seems to contradict the usual belief that power is something to be amassed, protected, and used for one's own purposes.

Leadership power comes from the ability to sustain proactive influence, because followers trust and respect the leader to do the right thing for the right reason. As leaders in healthcare, nurses must understand and select behaviors that activate principle-centered leadership:

- Get to know people. Understanding what other people want is not always simple.
- Be open. Keep others informed. Trust, honor, and respect spread just as equally as fear, suspicion, and deceit.
- Know your values and visions. The power to define your goals is the power to choose.
- Sharpen your interpersonal competence. Actively listen to others and learn to express your ideas well.
- Use your power to enable others. Be attentive to the dynamics of power and pay attention to ground rules, such as encouraging dissenting voices and respecting disagreement.
- Enlarge your sphere of influence and connectedness. Power sometimes grows out of someone else's need.

Power: How Managers and Leaders Get Things Done

Classically, managers relied on authority to rouse employees to perform tasks and accomplish goals. In contemporary healthcare organizations, managers use persuasion, enticement, and inspiration to mobilize the energy and talent of a work group and to overcome resistance to change.

A leader's use of power alters attitudes and behavior by addressing individual needs and motivations. There are seven generally accepted types of interpersonal power used in organizations to influence others (Hersey, 2013):

1. **Reward power** is based on the inducements the manager can offer group members in exchange for cooperation and contributions that advance the manager's

objectives. The degree of compliance depends on how much the follower values the expected benefits. For example, a nurse manager may grant paid educational leave as a way of rewarding a staff nurse who agreed to work overtime. Reward power often is used in relation to a manager's formal job responsibilities.

2. **Coercive power** is based on the penalties a manager might impose on an individual or a group. Motivation to comply is based on fear of punishment (coercive power) or withholding of rewards. For example, the nurse manager might make undesirable job assignments, mete out a formal reprimand, or recommend termination for a nurse who engages in disruptive behavior. Coercion is used in relation to a manager's perceived authority to determine employment status.
3. **Legitimate power** stems from the manager's right to make a request because of the authority associated with job and rank in an organizational hierarchy. Followers comply because they accept a manager's prerogative to impose requirements, sanctions, and rewards in keeping with the organization's mission and aims. For instance, staff nurses will comply with a nurse manager's directive to take time off without pay when the workload has dropped below projected levels because they know that the manager is charged with maintaining unit expenses within budget limitations.
4. **Expert power** is based on possession of unique skills, knowledge, and competence. Nurse managers, by virtue of experience and advanced education, are often the best qualified to determine what to do in a given situation. Employees are motivated to comply because they respect the manager's expertise. Expert power relates to the development of personal abilities through education and experience. Newly graduated nurses might ask the nurse manager for advice in learning clinical procedures or how to resolve conflicts with coworkers or other health professionals.
5. **Referent power** is based on admiration and respect for an individual. Followers comply because they like and identify with the manager. Referent power relates to the manager's likeability and success. For example, a new graduate might ask the advice of a more experienced and admired nurse about career planning.
6. **Information power** is based on access to valued data. Followers comply because they want the information for their own needs. Information power depends on a manager's organizational position, connections, and communication skills. For example, the nurse manager is frequently privy to information about pending organizational changes that affect employees' work situations. A nurse manager might exercise information power by sharing significant information at staff meetings, thereby improving attendance.
7. **Connection power** is based on an individual's formal and informal links to influential or prestigious persons inside and outside an area or organization. Followers comply because they want to be linked to influential individuals. Connection power also relates to the status and visibility of the individual. If, for example, a nurse manager is a neighbor of an organization's board member, followers may believe that connection will protect or advance their work situation.

Managers have both personal and position power. **Position power** is determined by the job description, assigned responsibilities, recognition, advancement, authority,

the ability to withhold money, and decision making. Legitimate, coercive, and reward power are positional because they relate to the "right" to influence others based on rank or role. The extent to which managers mete out rewards and punishment is usually dictated by organizational policy. Information and legitimate power are directly related to the manager's role in the organizational structure.

Expert, referent, information, and connection power are based, for the most part, on personal traits. **Personal power** refers to one's credibility, reputation, expertise, experience, control of resources or information, and ability to build trust. The extent to which one may exercise expert, referent, information, and connection power relates to personal skills and positive interpersonal relationships as well as employees' needs and motivations. Guidelines for using power are shown in Box 8-1.

Box 8-1 Guidelines for the Use of Power in Organizations

Guidelines for Using Legitimate Authority

- Make polite, clear requests.
- Explain the reasons for a request.
- Don't exceed your scope of authority.
- Verify authority if necessary.
- Follow proper channels.
- Follow up to verify compliance.
  Insist on compliance if appropriate.

Guidelines for Using Reward Power

- Offer the type of rewards that people desire.
- Offer rewards that are fair and ethical.
- Don't promise more than you can deliver.
- Explain the criteria for giving rewards and keep it simple.
- Provide rewards as promised if requirements are met.
- Use rewards symbolically (not in a manipulative way).

Guidelines for Using Coercive Power

- Explain rules and requirements and ensure that people understand the serious consequences of violations.
- Respond to infractions promptly and consistently without showing any favoritism to particular individuals.
- Investigate to get the facts before using reprimands or punishment, and avoid jumping to conclusions or making hasty accusations.
- Except for the most serious infractions, provide sufficient oral and written warnings before resorting to punishment.
- Administer warnings and reprimands in private and avoid making rash threats.
- Stay calm and avoid the appearance of hostility or personal rejection.
- Express a sincere desire to help the person comply with role expectations and thereby avoid punishment.
- Invite the person to suggest ways to correct the problem and seek agreement on a concrete plan.
- Maintain credibility by administering punishment if noncompliance continues after threats and warnings have been made.

Guidelines for Using Expert Power

- Explain the reasons for a request or proposal and why it is important.
- Provide evidence that a proposal will be successful.
- Don't make rash, careless, or inconsistent statements.
- Don't exaggerate or misrepresent the facts.
- Listen seriously to the person's concerns and suggestions.
- Act confidently and decisively in a crisis.

Ways to Acquire and Maintain Referent Power

- Show acceptance and positive regard.
- Act in a supportive and helpful way.
- Use sincere forms of ingratiation.
- Defend and back up people when appropriate.
- Do unsolicited favors.
- Make self-sacrifices to show concern.
- Keep promises.

Adapted from Yukl, G. (2012). *Leadership in organizations* (8th ed.). Upper Saddle River, NJ: Prentice Hall. Reprinted by permission.

Using Power

Despite the increase in pride and self-esteem that comes with using power and influence, some nurses still consider power unattractive. Power grabbing, which has been the traditionally accepted means of relating to power for one's own self-interests and use, is how nurses often think of power. Rather, nurses tend to be more comfortable with power sharing and empowerment: power "with" rather than power "over" others.

Image as Power

A major source of power for nurses is an image of power. Even if one does not have actual power from other sources, the perception by others that one is powerful bestows a degree of power. The same is true for the profession as a whole. If the public sees the profession of nursing as powerful, the profession's ability to achieve its goals and agendas is enhanced.

Images emerge from interactions and communications with others. If nurses present themselves as caring and compassionate experts in healthcare through their interactions and communications with the public, then a strong, favorable image develops for both the individual nurse and the profession. Nurses, as the ambassadors of care, must understand the importance and benefits of positive therapeutic communications and image. Developing a positive image of power is important for both the individual and the profession.

Individual nurses can promote an image of power by a variety of means, such as the following:

1. Appropriately introducing yourself by saying your name, making eye contact, and shaking hands can immediately establish you as a powerful person. If nurses introduce themselves by first name to the physician, Dr. Smith, they have immediately set forth an unequal power relationship unless the physician also uses his or her first name. Although women are not socialized to initiate handshakes, it is a power strategy in male-dominated circles, including healthcare organizations. In Western cultures, eye contact conveys a sense of confidence and connection to the individual to whom one is speaking. These seemingly minor behaviors can have a major impact on how competent and powerful the nurse is perceived.
2. Attire can symbolize power and success (Sullivan, 2013). Although nurses may believe that they are limited in choice of attire by uniform codes, it is in fact the presentation of the uniform that can hold the key to power. For example, a nurse manager needs a powerful image both with unit staff and with administrators and other professionals who are setting organizational policy. An astute nurse manager might wear a suit rather than a uniform to work on the day of a high-level interdisciplinary committee meeting. Certainly, attention to details of grooming and uniform selection can enhance the power of the staff nurse as well.
3. Conveying a positive and energetic attitude sends the message that you are a "doer" and someone to be sought out for involvement in important issues. Chronic complaining conveys a sense of powerlessness, whereas solving problems and being optimistic promote a "can do" attitude that suggests power and instills confidence in others.
4. Pay attention to how you speak and how you act when you speak. Nonverbal signs and signals say more about you than words. Stand erect and move energetically.

Speak with an even pace and enunciate words clearly. Make sure your words are reflected in your body language. Keep your facial expression consistent with your message.

5. Use facts and figures when you need to demonstrate your point. Policy changes usually evolve from data presented in a compelling story. Positioning yourself as a powerful player requires the ability to collect and analyze data. Technology facilitates data retrieval. Remember that power is a matter of perception; therefore, you must use whatever data are available to support your judgment.
6. Knowing when to be at the right place at the right time is crucial for gaining access to key personnel in the organization. This means being invited to events, meetings, and parties not necessarily intended for nurses. It means demanding to sit at the policy table when decisions affecting staffing and patient care are made. Influence is more effective when it is based on personal relationships and when people see others in person: "If I don't see you, I can't ask you for needed information, analysis, and alternative recommendations." Become visible. Be available. Offer assistance. You can be invaluable in providing policy makers with information, interpreting data, and teaching them about the nursing side of healthcare.
7. In dealing with people outside of nursing, it is important to develop powerful partnerships. Learn how to share both credit and blame. When working on collaborative projects, use *we* instead of *they*, and be clear about what is needed. If something is not working well, say so. Never accept another's opinion as fact. Facts can be easily manipulated to fit one's personal agenda. Learn how to probe and obtain additional information. Do not assume you have all the information. Beware of unsolicited commentary. Do not be fearful of giving strong criticism, but always put criticisms in context. Before giving any criticism, give a compliment, if appropriate. Also, make sure your partners are ready to hear all sides of the issue. It is never superfluous to ask "Do you want to talk about such and such right now?" Once an issue is decided—really decided—do not raise it again.
8. Make it a point to get to know the people who matter in your sphere of influence. Become a part of the power network so that when people are discussing issues or seeking people for important appointments of leadership, your name comes to mind. Be sure to deal with senior people. Know who holds the power. Identify the key power brokers. The more contact you have with the power brokers, the more support you can generate in the future should the need arise. Develop a strategy for gaining access to power brokers through joining alliances and coalitions. The more power you use, the more you get. Learn how to question others and how to become part of the organizational infrastructure.
9. There is an art to determining when, what, and how much information is exchanged and communicated at any one time, and to determining who does so. Powerful people have a keen sense of timing. Be sure to position yourself to be at the right place at the right time. Any strategy will involve a good deal of energy and effort. Direct influence and efforts toward issues of highest priority or when greatest benefits are likely to result.
10. Use power appropriately to promote consensus in organizational goals, develop common means to achieve these goals, and enhance a common culture to bind together organizational members. As the healthcare providers closest to the patient, nurses best understand patients' needs and wants. In the hospital, nurses

Leading at the Bedside: Power and Influence

Every nurse has power and influence. Each encounter with a patient or family member—in the hospital, in a clinic, or in the home—is an opportunity to help someone recover, regain health, or experience a dignified death. Your words, your actions, and, most important, your demeanor can help or hinder your patient's future. What could be more powerful?

Beyond the bedside or the exam room, you can influence the unit's functioning, not only by your work but also by how you work with others—colleagues, support staff, and managers. Also, you can use your knowledge to inform others what nurses do and why we are indispensable in healthcare. Who else could do it better?

As a member of a profession more than 3 million strong and continually ranked the most admired profession in the annual Gallup poll, you and your nursing colleagues have both individual and collective power. Use it!

are present from the first patient contact and thereafter for 24 hours a day, 7 days a week. In the clinic, the nurse may be the person the patient sees first and most frequently. By capitalizing on the special relationship that nurses have with patients, they can enhance their position and image as professional caregivers. (See Leading from the Bedside: Power and Influence.)

Nursing as a profession must market its professional expertise and ability to achieve the objectives of healthcare organizations. From a marketing perspective, nursing's goal is to ensure that identified markets (e.g., patients, physicians, other health professionals, community members) have a clear understanding of what nursing is, what it does, and what it is going to do. In doing so, nursing is seen as a profession that gives expert care with a scientific knowledge base.

Nursing care often is seen as an indicator of an organization's overall quality. Regardless of the setting, quality nursing care is something that is desired and valued. Through understanding patients' needs and preferences for programs that promote wellness and maintain and restore health, nurses can show how their work fits the preventive care goals. Marketing an image of expertise linked with quality and cost can position nursing powerfully and competitively in the new healthcare marketplace.

Using Power Appropriately

Using power not only affects what happens at the time but also has a lasting effect on your relationships. Therefore, it is best to use the least amount of power necessary to accomplish your goals. Also, use power appropriate to the situation (Sullivan, 2013). Box 8-2 lists rules for using power.

Box 8-2 Rules for Using Power

1. Use the least amount of power you can to be effective in your interactions with others.
2. Use power appropriate to the situation.
3. Learn when not to use power.
4. Focus on the problem, not the person.
5. Make polite requests, never arrogant demands.
6. Use coercion only when other methods do not work.
7. Keep informed to retain your credibility when using your expert power.
8. Understand you may owe a return favor when you use your connection power.

From Sullivan, E. J. (2013). *Becoming influential: A guide for nurses* (2nd ed.). Upper Saddle River, NJ: Prentice Hall. Reprinted by permission.

Improper use of power can destroy your effectiveness. Power can be overused or underused. Overusing power occurs when you use excessive power relative to the situation. If you fail to use power when it is needed, you are underusing your power. In addition to the immediate loss of influence, you may lose credibility for the future.

Power plays are another way that power is used inappropriately. Power plays are attempts by others to diminish or demolish their opponents. Typical power plays include comments such as these:

"Let's be fair."
"Can you prove that?"
"It's either this or that; which is it? Take your pick."
"But you said . . . and now you say . . . ."

Such statements engender feelings of insecurity, incompetence, confusion, embarrassment, and anger. You do not need to respond directly in these situations; rather, you can simply restate your initial point in a firm manner. Keep your expression neutral, ignore accusations, and restate your position, if appropriate. If you refuse to respond to these thinly veiled attacks, your opponent is unable to intimidate and manipulate you.

Nursing must perceive power for what it really is: the ability to mobilize and focus energy and resources. What better position can nurses be in than to assume power to face new problems and responsibilities in reshaping nursing practice to adapt to environmental changes? Power is the means, not the end, to seek new ways of doing things in this uncertain and unsettling time in healthcare.

Shared Visioning as a Power Tool

Shared visioning is a powerful tool for influencing an organization's future. It is not the same as shared governance, but it sets the stage for shared governance (Berlinger, 2015). Shared visioning is an interactive process in which both leaders and followers commit to the organization's goals (Kantabutra, 2009; Weberg & Weberg, 2014). A **vision** is a mental model of a possible future (Kantabutra, 2008). It should inspire and challenge both leaders and followers to accomplish the organization's goals set forth in the vision.

A shared vision of an organization achieves the following:

- Drives the organization's future
- Determines future goals
- Makes implementing the necessary, and often difficult, changes easier
- Provides a benchmark to evaluate future projects
- Encourages both administrators and staff to accomplish goals
- Inspires and challenges both leaders and followers

If the manager and the staff work together in establishing a shared vision of the unit's future (just like the manager and executives do for the larger organization), then they will work toward the same goals, know what new undertakings to accept or decline, and share in the unit's accomplishments.

Nurse managers often do not realize the power and importance they have in their skill set and knowledge base. To talk to legislators who may not be familiar with

healthcare, for example, the manager should use concise, lay language to convey important points. By doing so, the manager helps legislators acquire information that will help them be more knowledgeable in their conversations with others—a win-win for both the manager and legislators.

> *The chief nursing officer (CNO) approached Tameka, nurse manager of the telemetry unit. The CNO had heard generalized complaints about nurses' dissatisfaction with their schedules and their inability to get their shifts scheduled. Tameka explained that the new upgrade on the scheduling software had created disadvantages for staff on the day shift. The new schedule opens for sign up at 12:00 a.m. rather than the old way at 8:00 a.m. So, night-shift nurses who work that shift are awake and can sign up for their shifts right away. The old system opened at 8:00 a.m., and both night shift nurses just getting off work and day nurses arriving for work had equal opportunity to schedule their shifts, even though it was still first come, first serve.*
>
> *The CNO would not know about this problem, nor would it be in the CNO's job description. By sharing her quick assessment, Tameka alerted the CNO to a situation causing stress among the staff, allowing the CNO to address the problem at the system level.*

Today's leaders recognize that their power must be shared and that integrated leadership styles—bottom up and lateral—are essential for success. Consensus about the organization's future can motivate leaders and employees alike to envision their preferred future and do their best to achieve it. In addition, in a shared vision Kantabutra (2009) posits that the leader is not a passive participant in the visioning process. The leader should be an active group member, leading the group toward the desired vision in a participative fashion. The leader helps guide the group toward consensus.

Power, Politics, and Policy

While power is the potential ability to influence others, **politics** is the art of influencing others to achieve a goal (Mason et al., 2014). The Affordable Care Act, passed in 2010, radically changed healthcare in the United States and such changes are expected to continue regardless of legislative changes. To succeed with this legislation required significant political skills from numerous organizations, legislators, and the public.

Politics encompasses the following:

- It is an interpersonal endeavor—it uses communication and persuasion.
- It is a collective activity—it requires the support and action of many people.
- It calls for analysis and planning—it requires an assessment of the issue and a plan to resolve it.
- It involves image—it hinges on the image people have of change makers.

Nursing's Political History

Nurses' political activities began with Florence Nightingale, continued with the emergence of nursing schools and women's suffrage, and improved with the establishment of nursing organizations and the feminist movement (Sullivan, 2013). Establishing the National Center for Nursing Research in 1985 (in 1993, the name was changed to

the National Institute of Nursing Research) within the National Institutes of Health is an example of nurses' powerful political action.

> *In the early 1980s, after the Institute of Medicine report recommended a federal nursing research entity as part of the mainstream scientific community, nursing leaders in the United States began promoting the establishment of a nursing institute at the National Institutes of Health (NIH). This effort involved lobbying Congress, the Reagan administration, and the other institutes at NIH—a formidable task. A few members of Congress were interested in the potential that nursing science had for improving health, but the administration was not in favor of another institute at NIH, and the other institutes seemed puzzled as to why nursing would need its own institute to do research. Couldn't nurse researchers receive funding through existing institutes? Medicine did so without a separate institute.*
>
> *Step by step, nursing leaders persuaded (harassed?) institute directors and Congress, insisting that nursing research would improve human response to illness and assist in maintaining and enhancing health. A bill was born. Concern about cost and increasing bureaucracy emerged and was overcome. The bill passed, only to be vetoed by President Ronald Reagan. Then a funny thing happened. Nursing made an unprecedented move. The profession came together, united with one goal: to override President Reagan's veto (none had been successfully overridden before).*
>
> *One by one, across the United States, nurses called their senators and congressional representatives, urging support for a nursing institute, explaining that nurses were represented only among a few funded researchers at other institutes who did not understand the impact of nursing interventions on health and recovery. A modest investment, they explained, would yield exponentially greater results. Thanks to a few persuasive members of Congress, a compromise was negotiated, and the National Center for Nursing Research was established in 1985. Through a statutory revision in 1993, the Center became an Institute.*

Similarly, Georgia nurses successfully changed that state's practice act to include prescriptive authority for advanced practice nurses, overcoming fierce opposition from the medical association. Working in concert with each other and with consumers and the media, they generated a letter-writing campaign that countered every obstacle the medical association tried. Georgia became the last state to grant prescribing privileges to nurse practitioners.

Policy, on the other hand, is the decision that determines action. Policies result from political action.

Using Political Skills to Influence Policies

Political skill, per se, is not included in nursing education (nor is it tested on state board exams), yet it is a vital skill for nurses to acquire. Being political is not negative; it's the way to make a difference for your patients, your profession, and yourself.

Adhere to the following to improve your political skill:

- Learn self-promotion—report your accomplishments appropriately.
- Be honest and tell the truth—say what you mean and mean what you say.
- Use compliments—recognize others' accomplishments.
- Discourage gossip—silence is the best response.

- Learn and use quid pro quo—do and ask for favors.
- Remember: Appearance matters—attend to grooming and attire.
- Use good manners—be courteous.

Healthcare involves multiple special-interest groups, all competing for their share of a limited pool of resources. The delivery of nursing services occurs at many levels in healthcare organizations. The effectiveness of care delivery is linked to the application of power, politics, and marketing. Nurses belong to a complex organization that is continually confronted with limited resources and is in competition for those resources.

How politically savvy are you? Ask yourself the following questions:

- Do you get credit for your ideas?
- Do you know how to deal with a difficult colleague?
- Do you have a mentor?
- Are you "in the loop"?
- Can you manage and influence others' perceptions of you and your work?
- Are you able to convert enemies to friends?
- Do your ideas get a fair hearing?
- Do you know when and how to present them? (Reardon, 2011)

To take action, first decide what you want to accomplish. Is it realistic? Will you have supporters? Who will be the detractors? The steps in political action are shown in Box 8-3.

Try to find out what other people who are involved—the **stakeholders**—want. Maybe you could piggyback on their ideas. Members of Congress do this all the time by adding amendments to proposed bills in an attempt to satisfy their opponents.

Start telling your supporters about your idea and see if they will join with you in a coalition. This is not necessarily a formal group, but it allows you to know who you can count on in the discussions.

Find out exactly what objections your opponents have. Try to figure out a way to alter your plan accordingly or help your opponents understand how your proposal might help them. Political action is never easy, but the most politically astute people accomplish goals far more often than those who don't even try.

A case study that exemplifies a nurse using organizational politics is shown in Case Study 8-1.

Box 8-3 Steps in Political Action

1. Determine what you want.
2. Learn about the players and what they want.
3. Gather supporters and form coalitions.
4. Be prepared to answer opponents.
5. Explain how what you want can help them.

From Sullivan, E. J. (2013). *Becoming influential: A guide for nurses* (2nd ed.). Upper Saddle River, NJ: Prentice Hall. Reprinted by permission.

CASE STUDY 8-1 | Using Organizational Politics for Personal Advantage

Juanita Pascheco has been nurse manager of medical and surgical ICUs in a large, urban, for-profit hospital for the past 7 years. Two years ago, Juanita completed her master's degree in nursing administration. Her thesis research centered on the acceptance of standardized and computerized documentation methods for critical care units. Juanita is well respected in her current role and is a member of several key committees addressing the need for a replacement health information system (HIS) for the hospital. She reports directly to the director of critical care services.

Although Juanita enjoys her work as nurse manager, she believes she is ready to assume additional responsibilities at the director level. Through her work on the hospital's HIS selection team and as the nursing representative to the physician's technology committee, Juanita identifies the need for a clinical informatics director role. One of Juanita's responsibilities on the HIS selection team is to identify talented staff from clinical areas who could support the HIS implementation. Juanita has also agreed to chair several working committees that will assist in determining required clinical functionality for the HIS.

During her tenure at the hospital, Juanita has cultivated solid working relationships with several key decision makers within the organization. The human resources director, Ken Harding, has worked with Juanita on several large projects over the past 2 years, including implementation of multidisciplinary teams in the ICUs. Juanita schedules a lunch with Ken to discuss growth opportunities in the information technology department, the process for creating new roles, and, in particular, who will determine the need for and approval of new information technology positions. Using this knowledge and her experience on the HIS selection team and the physicians' technology committee, Juanita develops a proposal for the clinical informatics director position.

As the HIS selection team draws closer to selecting a final vendor for the computerized HIS and an implementation timeline is established by the information technology department, Juanita approaches her supervisor, Sherrie Wright, with her proposal. Juanita also provides Sherrie with an overview of the clinical support that will be necessary for successful implementation of the HIS product. Since the critical care units are targeted for the initial phase of implementation, Sherrie is aware that Juanita's high interest in technology and her clinical expertise in the ICU would be invaluable for successful implementation. As a strong manager, Juanita can build acceptance of this change among the nurses, physicians, and other members of the healthcare team.

Sherrie agrees to take Juanita's proposal to the chief nursing officer for formal consideration.

Influencing Public Policies

What happens in the workplace both depends upon and influences what is happening in the larger community, professional organizations, and government. Developing influence in each of these three groups takes time and a long-range plan of action. Although the nurse's first priority should be to establish influence in the workplace, the nurse can gradually increase connections and influence with other groups and, later on, make these other groups a priority.

In order to influence public policies, nurses need to know how to work with the public officials who enact those policies. Box 8-4 lists guidelines for working with public officials.

Box 8-4 How to Work with Public Officials

1. Be respectful.
2. Build relationships.
3. Keep in touch.
4. Arrive informed.
5. Understand the issue.
6. Be a constructive opponent.
7. Be realistic.
8. Be helpful.

From Sullivan, E. J. (2013). *Becoming influential: A guide for nurses* (2nd ed.). Upper Saddle River, NJ: Prentice Hall. Reprinted by permission.

FIRST, BE RESPECTFUL Public officials have many constituents and demands for their support. Build relationships with officials. Do not just contact them when you have a request. Keep in touch at other times.

COMMUNICATING WITH ELECTED OFFICIALS Nurses often wish to contact elected officials to support or oppose legislation. You can call, email, or write to public officials.

Find members of Congress listed as follows:

For the House of Representatives—www.house.gov

For the Senate—www.senate.gov

For individual states' legislators—National Conference of State Legislatures: www.ncsl.org

Call the official's staff and ask to speak to the person who handles the issue that concerns you. Tell the aide that you support or oppose a certain bill and state the reasons why. Name the bill by number.

Email or write directly to the official. Identify the bill in question, state your position on the bill, and explain why you support or oppose it. Keep your comments brief, and address only one issue per correspondence. Handwritten letters get more attention than form letters distributed by organizations.

Use the following format to address members of the U.S. Senate:

The Honorable (full name of senator)
__(Rm.#)__(name of) Senate Office Building
United States Senate
Washington, DC 20510

Dear Senator:

To contact members of the U.S. Congress, use a similar format.

The Honorable (full name)
__(Rm.#)__(name of) House Office Building
United States House of Representatives
Washington, DC 20515

Dear Representative:

Interestingly, a recent report by the Congressional Management Foundation found that social media were more effective than expected in influencing senators and congressional members (Congressional Management Foundation, 2015). Staffers report that as few as 30 comments triggered notice. In addition, such interactions are improving relationships between lawmakers and constituents.

MEETING WITH ELECTED OFFICIALS To meet in person with an elected official, make an appointment, arrive on time, and come prepared. Understand the pros and cons of the issue you are bringing to the person's attention. Be a constructive opponent. Argue for your position and be prepared with additional information and alternative suggestions. Still, be realistic. What you want may not be possible, or it may not be likely at the present time. Always be helpful. Show how your issue benefits the official's constituents and, thus, the representative.

The American Association of Critical-Care Nurses suggests pointers for working with public officials (American Association of Critical-Care Nurses, 2010). In addition, the American Nurses Association provides legislative and government information for nurses (American Nurses Association, 2011).

How Nurses Can Influence the Future

Nurses can have a tremendous impact on healthcare policy. The best impact is often made with a bit of luck and timing—but never without knowledge of the whole system. This includes knowledge of the policy agenda, the policy makers, and the politics that are involved. Once you gain this knowledge, you are ready to move forward with a political base to promote nursing.

To convert your policy ideas into political realities, consider the following power points:

- ***Use persuasion over coercion.*** Persuasion is the ability to share reasons and rationale when making a strong case for your position while maintaining a genuine respect for another's perspective.
- ***Use patience over impatience.*** Despite the inconveniences and failings caused by healthcare restructuring, impatience in the nursing community can be detrimental. Patience, along with a long-term perspective on the healthcare system, is needed.
- ***Be open-minded rather than closed-minded.*** Acquiring accurate information is essential if you want to influence others effectively.
- ***Use compassion over confrontation.*** In times of change, errors and mistakes are easy to pinpoint. It takes genuine care and concern to change course and make corrections.
- ***Use integrity over dishonesty.*** Honest discourse must be matched with kind thoughts and actions. Control, manipulation, and malice must be pushed aside for change to occur.

By using their political skills, nurses can improve patient care in individual institutions, help organizations survive and thrive, and influence public officials.

What You Know Now

- Power is the potential ability to influence others.
- Power can be positional or personal.
- Types of power include reward, coercive, legitimate, expert, referent, information, and connection.
- Image is a source of power.
- Power can be overused, underused, or used inappropriately. To be effective, the power used must be appropriate to the situation.
- Shared visioning is an interactive process in which both leaders and followers commit to the organization's goals.
- Politics is the art of influencing others to achieve a goal.
- Policy is the decision that determines action. Policies result from political action.
- Nurses can use political action to influence policies in the organization and to influence public policies.

Tools for Using Power and Politics

1. Learn the formal lines of authority within your organization.
2. Identify key decision makers and build strong and credible relationships with them.
3. Identify decision makers' priorities and how those affect any new initiatives.
4. Learn the rules for using power and put them into practice.
5. Offer solutions to problems and take advantage of new opportunities.
6. Exhibit a willingness to take on new and challenging tasks that may lead to more responsibility.
7. Pay attention to people who are influential and adopt their strategies if appropriate.
8. Learn strategies for working with public officials.

Questions to Challenge You

1. Consider a person you believe to have power. What are the bases of that person's power?
2. Evaluate how the person you named uses his or her power. Is it positive or negative?
3. Have you observed people using power inappropriately? Describe what they did and what happened as a result.
4. Assess your own power using the seven types of power discussed in the chapter. Name three ways you could increase your power.
5. How politically savvy are you? Did you discover areas to challenge you?
6. Have you been involved in developing policies in your organization or have you worked with public officials? Explain.

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Chapter 9

Thinking Critically, Making Decisions, Solving Problems

Critical Thinking
Critical Thinking in Nursing
Using Critical Thinking
Creativity

Decision Making
Types of Decisions
Decision-making Conditions
The Decision-making Process
Decision-making Techniques
Group Decision Making

Problem Solving
Problem-solving Methods
The Problem-solving Process
Group Problem Solving

Stumbling Blocks
Personality
Rigidity
Preconceived Ideas

Innovation

Learning Outcomes

After completing this chapter, you will be able to:

1. Summarize ways to use the critical-thinking process.
2. Compare and contrast individual and collective decision-making processes in various situations.
3. Develop a plan to improve your problem-solving skills.
4. Evaluate stumbling blocks to making decisions and solving problems.
5. Foster innovation in your work and in the work of others.

Key Terms

adaptive decisions
artificial intelligence
brainstorming
creativity
critical thinking
decision making
descriptive rationality model
experimentation
expert systems
groupthink
innovation
innovative decisions
objective probability
political decision-making model
probability
probability analysis
problem solving
rational decision-making model
routine decisions
satisficing
subjective probability
trial-and-error method

Introduction

Nurse managers are expected to use knowledge from various disciplines to solve problems with patients, staff, and the organization as well as problems in their own personal and professional lives. They must make decisions in dynamic situations, such as these:

- After an employee leaves a position, should the nurse manager refill it, given the tighter economy?
- Is the present policy requiring 12-hour shifts adequate for both patients and nurses?
- Which is the best staffing pattern to prevent turnover and ensure quality patient care?
- What is the best time to have staff meetings and council meetings in order to involve the night shift?

This chapter explains and differentiates critical thinking, decision making, and problem solving, and describes processes and techniques for using each.

Critical Thinking

Critical thinking is the process of examining underlying assumptions, interpreting and evaluating arguments, imagining and exploring alternatives, and developing a reflective criticism for the purpose of reaching a conclusion that can be justified. Critical thinking is not the same as criticism, though it does call for inquiring attitudes, knowledge about evidence and analysis, and skills to combine them.

Critical-thinking skills can be used to resolve problems rationally. Identifying, analyzing, and questioning the evidence and implications of a problem stimulate and illuminate critical thought processes. Critical thinking is also an essential component of decision making. However, compared to problem solving and decision making, which involve seeking a single solution, critical thinking is a higher level cognitive process that includes creativity, problem solving, and decision making (see Figure 9-1).

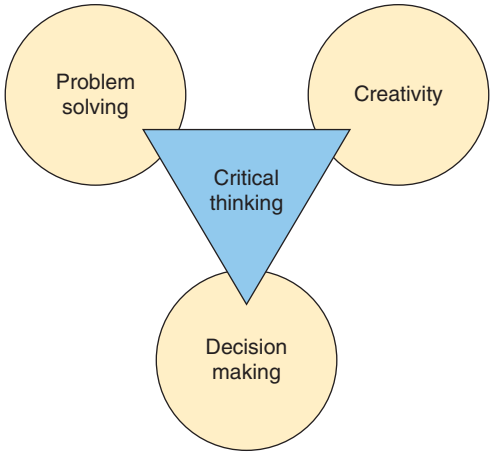

Figure 9-1 Critical-thinking model.

Critical Thinking in Nursing

The need for critical thinking in nursing has long been accepted. Zori, Nosek, and Musil (2010) used the California Critical Thinking Disposition Inventory to measure critical thinking in nurses. The researchers found that the nurses supervised by managers with higher critical-thinking skills perceived their work environment to be more positive than those whose managers scored lower on critical-thinking skills.

Ryan and Tatum (2012) found that RNs' critical-thinking skills correlated with their clinical competence. In a follow-up study, the researchers report that orientation programs customized to new hires' abilities improved their critical-thinking skills, which transferred to their clinical competence (Ryan & Tatum, 2013). Furthermore, Ashcraft (2010) found that critical-thinking classes for new nurses improved patient safety, job satisfaction, and retention.

Using Critical Thinking

The critical-thinking process seems abstract unless it can be related to practical experiences. One way to develop this process is to consider a series of questions when examining a specific problem or making a decision, such as the following:

- ***What are the underlying assumptions?*** Underlying assumptions are unquestioned beliefs that influence an individual's reasoning. They are perceptions that may or may not be grounded in reality.
- ***How is evidence interpreted?*** What is the context? Interpretation of information also can be value laden. Is the evidence presented completely and clearly? Can the facts be substantiated? Are the people presenting the evidence using emotional or biased information? Are there any errors in reasoning?
- ***How are the arguments to be evaluated?*** Is there objective evidence to support the arguments? Have all value preferences been determined? Is there a good chance that the arguments will be accepted? Are there enough people to support decisions? Healthcare organizations were able to change to smoke-free environments once societal values favored nonsmokers, and public policies reflected those values.

Table 9-1 Critical Thinking Through the Nursing Process

The Nursing Process	Critical-Thinking Skills
Assessment	Observing
	Distinguishing relevant from irrelevant data
	Distinguishing important from unimportant data
	Validating data
	Organizing data
	Categorizing data
Diagnosis	Finding patterns and relationships
	Making inferences
	Stating the problem
	Suspending judgment
Planning	Generalizing
	Transferring knowledge from one situation to another
	Hypothesizing
Implementation	Applying knowledge
	Testing hypotheses
Evaluation	Deciding whether hypotheses are correct
	Making criterion-based evaluations

From Wilkinson, J. (1992). *Nursing process in action: A critical thinking approach*. Redwood City, CA: Addison-Wesley Nursing, p. 29.

- ***What are the possible alternative perspectives?*** Using different basic assumptions and paradigms can help the critical thinker develop several different views of an issue. Compare how a nurse manager who assumes that more RNs equal better care will deal with a budget cut with a manager who is committed to adding assistive personnel instead. What evidence supports the alternatives? What solutions do staff members, patients, physicians, and others propose? What would be the ideal alternative?

Critical-thinking skills are used throughout the nursing process (see Table 9-1). Nurses can build on the knowledge base they began acquiring in school to make the critical-thinking process a conscious one in daily activities. Learning to be a critical thinker requires a commitment over time, but the skills can be learned.

Creativity

Creativity is an essential part of the critical-thinking process. **Creativity** is the ability to develop and implement new and better solutions. Creativity demands a certain amount of exposure to outside contacts, receptiveness to new and seemingly strange ideas, a certain amount of freedom, and some permissive management.

Most nurses, however, are employed in bureaucratic settings that do not foster creativity. Control is exercised over staff, and rigid adherence to formal channels of communication jeopardizes innovation. In addition, there is little room for failure, and when failures do occur, they are not well tolerated. When staff are afraid of the consequences of failure, their creativity is inhibited and innovation does not take place.

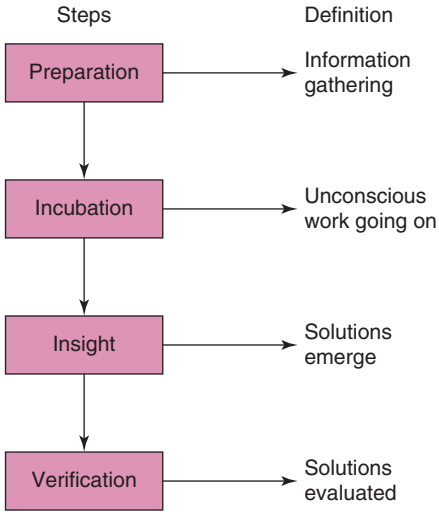

Figure 9-2 The creative process.

Maintaining a certain level of creativity is one way to keep an organization alive. New employees who are not encumbered with details of accepted practices often can make suggestions based on their prior experiences or insights before they get set in their ways or have their innovative ideas "turned off." The advantages offered by new employees should be explored because all staff gain from such use of valuable human resources.

The climate must promote the survival of potentially useful ideas. The nurse manager can foster a climate of support by giving new ideas a fair and adequate hearing, thereby reducing the tendency to discourage the creative process in individuals and within groups. The challenge for nurse managers is to know when, for whom, and to what extent control is appropriate. If creativity does have a priority in the healthcare setting, then the reward system should be geared to, and commensurate with, that priority.

Creativity has four stages: preparation, incubation, insight, and verification. Even people who think they are not naturally creative can learn this process (see Figure 9-2).

1. ***Preparation.*** A carefully designed planning program is essential. First, acquire information necessary to understand the situation. Individuals can do this on their own, or groups can work together.

   The process follows this sequence:

   - Pick a specific task.
   - Gather relevant facts.
   - Challenge every detail.
   - Develop preferred solutions.
   - Implement improvements.

2. ***Incubation.*** After all the information available has been gathered, allow as much time as possible to elapse before deciding on solutions.
3. ***Insight.*** Often solutions emerge after a period of reflection that would not have occurred to anyone without this time lapse.
4. ***Verification.*** Once a solution has been implemented, evaluate it for effectiveness. You may need to restart the process, or go back to another step and create a different solution.

Case Study 9-1 describes how one nurse manager used creativity to solve a problem.

CASE STUDY 9-1 | Creative Problem Solving

Jeffrey was just promoted to manager of an acute care clinic, which recently expanded its hours from 6:00 a.m. until 10:00 p.m. He soon realizes that staff nurses are reluctant to sign up on the schedule and do quality chart audits, an important process used to review clinic operations and patient care. He gathers information about quality improvement, reviews the literature on motivation and incentives, and discusses the issue with other nurse managers (preparation).

Jeffrey continues to manage the clinic, thinking about the information he has gathered but does not consciously make a decision or reject new ideas (incubation). When working on a new problem, self-scheduling for the change in hours, he realizes a connection between the two problems. Many nurses complain that by the time they receive the schedule, the day shifts are filled.

Jeffrey decides to review the chart audits. Nurses who regularly participate in quality improvement projects will receive a perk: They will be allowed, on a rotating basis, first choice at selecting the schedule they want to work (this is the insight stage). He discusses the plan with the staff, and proposes a 2-month trial period to determine whether the solution is effective (verification).

Decision Making

Considering all the practice individuals get in making decisions, it would seem they might become very good at it. However, the number of decisions a person makes does not correspond to the person's skill at making them. The assumption is that decision making comes naturally, like breathing. It does not.

The decision-making process described in this chapter provides nurses with a system for making decisions that is applicable to any decision. It is a useful procedure for making practical choices. A decision not to solve a problem is also a decision.

Although *decision making* and *problem solving* appear similar, they are not synonymous. **Decision making** may or may not involve a problem, but it always involves selecting one of several alternatives, each of which may be appropriate under certain circumstances. **Problem solving**, on the other hand, involves diagnosing a problem and solving it, which may or may not entail deciding on one correct solution. Most of the time, decision making is a subset of problem solving. However, some decisions are not of a problem-solving nature, such as decisions about scheduling, equipment, or in-services.

Types of Decisions

The types of problems nurses and nurse managers encounter and the decisions they must make vary widely and determine the problem-solving or decision-making methods they should use. Relatively well-defined, common problems can usually be solved with **routine decisions**, often using established rules, policies, and procedures. For instance, when a nurse makes a medication error, the manager's actions are guided by policy and the report form. Routine decisions are more often made by first-level managers than by top administrators.

Adaptive decisions are necessary when both problems and alternative solutions are somewhat unusual and only partially understood. Often they are modifications of other well-known problems and solutions. Managers must make **innovative decisions** when problems are unusual and unclear, and when creative, novel solutions are necessary.

Decision-making Conditions

The conditions surrounding decision making can vary and change dramatically. Consider the total system. Whatever solutions are created will succeed only if they are compatible with other parts of the system. Decisions are made under conditions of certainty, risk, or uncertainty.

DECISION MAKING UNDER CERTAINTY When you know the alternatives and the conditions surrounding each alternative, a state of certainty is said to exist. Suppose a nurse manager on a unit with acutely ill patients wants to decrease the number of venipunctures a patient experiences when an IV is started, as well as reduce costs resulting from failed venipunctures. Three alternatives exist:

- Establish an IV team on all shifts to minimize IV attempts and reduce costs.
- Establish a reciprocal relationship with the anesthesia department to start IVs when nurses experience difficulty.
- Set a standard of two insertion attempts per nurse per patient, although this does not substantially lower equipment costs.

The manager knows the alternatives (IV team, anesthesia department, standards) and the conditions associated with each option (reduced costs, assistance with starting IVs, minimum attempts and some cost reduction). A condition of strong certainty is said to exist, and the decision can be made with full knowledge of what the payoff probably will be.

DECISION MAKING UNDER UNCERTAINTY AND RISK Seldom do decision makers know everything there is to know about a subject or situation. If everything was known, the decision would be obvious to everyone.

Most critical decision making in organizations is done under conditions of *uncertainty* and *risk.* The individual or group making the decision does not know all the alternatives, attendant risks, or possible consequences of each option. Uncertainty and risk are inevitable because of the complex and dynamic nature of healthcare organizations. For example, if the weather forecaster predicts a 40% chance of snow, the nurse manager is operating in a situation of risk when trying to decide how to staff the unit for the next 24 hours.

In a risk situation, the availability of each alternative, potential successes, and costs are all associated with probability estimates. **Probability** is the likelihood, expressed as a percentage, that an event will or will not occur. If something is certain to happen, its probability is 100%. If it is certain not to happen, its probability is 0%. If there is a 50—50 chance, its probability is 50%.

Here is another example: Suppose a nurse manager decides to use agency nurses to staff a unit during heavy vacation periods. Two agencies look attractive, and the manager must decide between them. Agency A has had modest growth over the past 10 years and offers the manager a 3-month contract, freezing wages during that time. In addition, the unit will have first choice of available nurses. Agency B is much more dynamic and charges more, but explains that the reason for its high rate of growth is that its nurses are the best and the highest paid in the area. The nurse manager can choose Agency A, which will provide a safe, constant supply of nursing personnel, or B, which promises better care but at a higher cost.

The key element in decision making under conditions of risk is to determine the probabilities of each alternative as accurately as possible. The nurse manager can use a

Table 9-2 Probability Analysis

Probability Analysis	
Agency A	60% Filling shifts
	100% Fixed wages
Agency B	50% Filling shifts
	70% Fixed wage

probability analysis, whereby expected risk is calculated or estimated. Using the probability analysis shown in Table 9-2, it appears as though Agency A offers the best outcome. However, if the second agency had a 90% chance of filling shifts and a 50% chance of fixing costs, a completely different situation would exist.

The nurse manager might decide that the potential for increased costs was a small trade-off for having more highly qualified nurses and the best probability of having the unit fully staffed during vacation periods. **Objective probability** is the likelihood that an event will or will not occur based on facts and reliable information. **Subjective probability** is the likelihood that an event will or will not occur based on a manager's personal judgment and beliefs.

> *Janeen, a nurse manager of a specialized cardiac intensive care unit, faces the task of recruiting scarce and highly skilled nurses to care for coronary artery bypass graft patients. The obvious alternative is to offer a salary and benefits package that rivals that of all other institutions in the area. However, this means Janeen will have costly specialized nursing personnel in her budget who are not easily absorbed by other units in the organization. The probability that coronary artery bypass graft procedures will become obsolete in the future is unknown. In addition, other factors (e.g., increased competition, government regulations regarding reimbursement) may contribute to conditions of uncertainty.*

The Decision-making Process

The **rational decision-making model** is a series of steps that managers take in an effort to make logical, well-grounded rational choices that maximize the achievement of objectives. First, identify all possible outcomes, examine the probability of each alternative, then take the action that yields the highest probability of achieving the most desirable outcome. Not all steps are used in every decision, nor are they always used in the same order. The rational decision-making model is thought of as the ideal, but often cannot be fully used.

Individuals seldom make major decisions at a single point in time, and often are unable to recall when a decision was finally reached. Some major decisions are the result of many small actions or incremental choices the person makes without regarding larger issues. In addition, decision processes are likely to be characterized more by confusion, disorder, and emotionality than by rationality. For these reasons, it is best to develop appropriate technical skills and the capacity to find a good balance between lengthy processes and quick, decisive action.

The **descriptive rationality model**, developed by Simon in 1955 and supported by research in the 1990s (Simon, 1993), emphasizes the limitations of the rationality of the decision maker and the situation. It recognizes three ways in which decision makers depart from the rational decision-making model:

- The decision maker's search for possible objectives or alternative solutions is limited because of time, energy, and money.
- People frequently lack adequate information about problems and cannot control the conditions under which they operate.
- Individuals often use a satisficing strategy.

Satisficing is not a misspelled word; it is a decision-making strategy whereby the individual chooses an alternative that is not ideal but either is good enough (suffices) under existing circumstances to meet minimum standards of acceptance or is the first acceptable alternative. Many problems in nursing are ineffectively solved with satisficing strategies.

> *Elena, a nurse manager in charge of a busy neurosurgical floor with high turnover rates and high patient acuity levels, uses a satisficing alternative when hiring replacement staff. She hires all nurse applicants in order of application until no positions are open. A better approach would be for Elena to replace staff only with nurse applicants who possess the skills and experiences required to care for neurosurgical patients, regardless of the number of applicants or desire for immediate action. Elena also should develop a plan to promote job satisfaction, the lack of which is the real reason for the vacancies.*

Individuals who solve problems using satisficing may lack specific training in problem solving and decision making. They may view their units or areas of responsibility as drastically simplified models of the real world, and be content with this simplification because it allows them to make decisions with relatively simple rules of thumb or from force of habit.

The **political decision-making model** describes the process in terms of the particular interests and objectives of powerful stakeholders, such as hospital boards, medical staffs, corporate officers, and regulatory bodies. Power is the ability to influence or control how problems and objectives are defined, what alternative solutions are considered and selected, what information flows, and, ultimately, what decisions are made (see Chapter 7).

The decision-making process begins when a gap exists between what is actually happening and what should be happening, and it ends with action that will narrow or close this gap. The simplest way to learn decision-making skills is to integrate a model into one's thinking by organizing the components into individual steps. The seven steps of the decision-making process (see Box 9-1) are as applicable to personal problems as they are to nursing management problems. Each step is elaborated by pertinent questions clarifying the statements, and they should be followed in the order in which they are presented.

Decision-making Techniques

Decision-making techniques vary according to the nature of the problem or topic, the decision maker, the context or situation, and the decision-making method or process. For routine decisions, choices that are tried and true can be made for well-defined, known situations or problems. Well-designed policies, rules, and standard operating procedures can produce satisfactory results with a minimum of time. **Artificial intelligence**—including programmed computer systems such as **expert systems** that can store, retrieve, and manipulate data—can diagnose problems and make limited decisions.

For adaptive decisions involving moderately ambiguous problems and modification of known and well-defined alternative solutions, there are a variety of techniques.

Box 9-1 Steps in Decision Making

1.	Identify the purpose.	Why is a decision necessary? What needs to be determined? State the issue in the broadest possible terms.
2.	Set the criteria.	What needs to be achieved, preserved, and avoided by whatever decision is made? The answers to these questions are the standards by which solutions will be evaluated.
3.	Weigh the criteria.	Rank each criterion on a scale of values from 1 (totally unimportant) to 10 (extremely important).
4.	Seek alternatives.	List all possible courses of action. Is one alternative more significant than another? Does one alternative have weaknesses in some areas? Can these be overcome? Can two alternatives or features of many alternatives be combined?
5.	Test alternatives.	First, using the same methodology as in step 3, rank each alternative on a scale of 1 to 10. Second, multiply the weight of each criterion by the rating of each alternative. Third, add the scores and compare the results.
6.	Troubleshoot.	What could go wrong? How can you plan? Can the choice be improved?
7.	Evaluate the action.	Is the solution being implemented? Is it effective? Is it costly?

Many types of decision grids or tables can be used to compare outcomes of alternative solutions. Decisions about units or services can be facilitated, with analyses comparing output, revenue, and costs over time or under different conditions.

Regardless of the decision-making model or strategy chosen, data collection and analysis are essential. In many healthcare organizations, quality teams are using a variety of tools, such as decision grids, flowcharts, or cause-and-effect diagrams to gather, organize, and analyze data about their work. Figure 9-3 illustrates a cause-and-effect

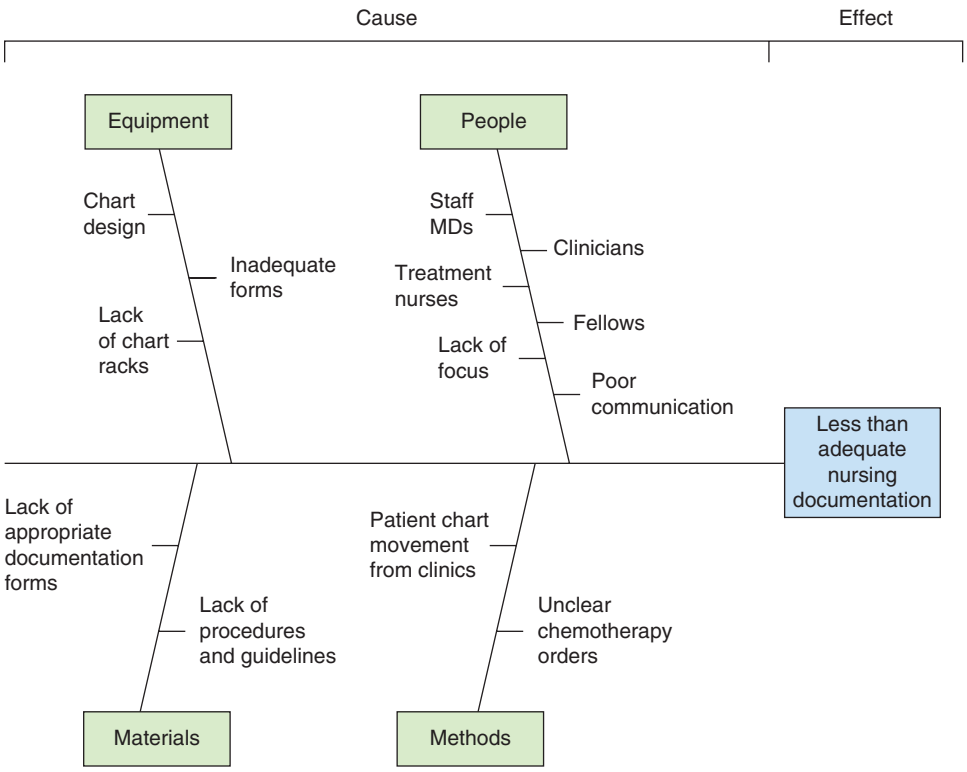

Figure 9-3 Brainstorming session of a nursing quality focus team.

diagram that a team of nurses created to help them improve the documentation process for their ambulatory oncology unit.

Another example of a decision tool is the Dynamic Network Analysis Decision Support (DyNADS) project at the University of Arizona College of Nursing. DyNADS is a decision support tool that improves predictability in today's complex environment. This simulation product enables the manager to predict the consequences of decisions on patient safety and quality outcomes. The tool simulates virtual nursing units, identifies potential errors, and predicts the likely result. Using the tool, the manager can discover if an innovation or a combination of innovations is likely to be successful (Effken, Verrn Logue, & Hsu, 2010).

Group Decision Making

The widespread use of participative management, quality improvement teams, and shared governance in healthcare organizations requires every nurse manager to determine when group, rather than individual, decisions are desirable, and how to use groups effectively. A number of studies have shown that professional people do not function well in a micromanaged environment. As an alternative, group problem solving of substantial issues casts the manager in the role of facilitator and consultant. Compared to individual decision making, groups can provide more input, often produce better decisions, and generate more commitment. One group decision-making technique is brainstorming.

In **brainstorming**, group members meet together and generate many diverse ideas about the nature, cause, definition, or solution to a problem without consideration of their relative value. The focus team whose work is shown in Figure 9-3 used brainstorming.

With brainstorming, a premium is placed on generating lots of ideas as quickly as possible and on coming up with unusual ideas. Most important, members do not critique ideas as they are proposed. Evaluation takes place after all the ideas have been generated. Members are encouraged to improve on each other's ideas. These sessions are enjoyable but are often unsuccessful because members inevitably begin to critique ideas, and as a result, meetings shift to the ordinary interacting group format. Criticisms of this approach are the high cost factor, the time consumed, and the superficiality of many solutions.

Problem Solving

People use problem solving when they perceive a gap between an existing state (what is going on) and a desired state (what should be going on). How one perceives the situation influences how the problem is identified or solved. Therefore, perceptions must be clarified before problem solving can occur.

Problem-solving Methods

A variety of methods can be used to solve problems. People with little management experience tend to use the **trial-and-error method**, applying one solution after another until the problem is solved or appears to be improving. These managers often cite lack of experience, of time, and of resources to search for alternative solutions.

In a step-down unit with an increasing incidence of medication errors, Max, the nurse manager, uses various strategies to decrease errors, such as posting dosage and medication charts in the unit or having the charge nurse check medications. After a few months, by which time none of the methods has worked, it occurs to Max that perhaps making nurses responsible for their actions would be more effective. Max develops a point system for medication errors: When nurses accumulate a certain number of points, they are required to take a medication test; repeated failure of the test may eventually lead to termination. Max's solution is effective, and a low level of medication errors is restored.

As the preceding example shows, a trial-and-error process can be time-consuming and may even be detrimental. Although some learning can occur during the process, the nurse manager risks being perceived as a poor problem solver who has wasted time and money on ineffective solutions.

Experimentation, another type of problem solving, is more rigorous than trial and error. Pilot projects or limited trials are examples of experimentation. Experimentation involves testing a theory (hypothesis) or hunch to enhance knowledge, understanding, or prediction. A project or study is carried out in either a controlled setting (e.g., in a laboratory) or an uncontrolled setting (e.g., in a natural setting such as an outpatient clinic). Data are collected and analyzed and results interpreted to determine whether the solution tried has been effective.

Lin, a nurse manager of a pediatric floor, has received many complaints from mothers of children who think the nurses are short-tempered. Lin has a hunch that 12-hour shifts, which have been recently implemented on her floor, are contributing to the problem; she believes that nurses who must interact frequently with families would perform better on 8-hour shifts. She can test her theory by setting up a small study comparing the two staffing patterns with patient satisfaction.

Experimentation may be creative and effective or uninspired and ineffective, depending on how it is used. As a major method of problem solving, experimentation may be inefficient because of the amount of time and control involved. However, a well-designed experiment can be persuasive in situations in which an idea or activity, such as a new staffing system or care procedure, can be tried in one of two similar groups and results objectively compared.

Still other problem-solving techniques rely on *past experience* and *intuition*. Everyone has various and countless experiences. Individuals build a repertoire of these experiences and base future actions on what they have considered successful solutions in the past. If a particular course of action consistently resulted in positive outcomes, the person will try it again when similar circumstances occur. In some instances, an individual's past experience can determine how much risk he or she will take in present circumstances.

The nature and frequency of the experience also contribute significantly to the effectiveness of this problem-solving method. How much the person has learned from these experiences, positive or negative, can affect the current viewpoint and can result in either subjective, narrow judgments or wise ones. This is especially true in human relations problems. Intuition relies heavily on past experience and trial and error. The extent to which past experience is related to intuition is difficult to determine, but nurses' wisdom, sensitivity, and intuition are known to be valuable in solving problems.

Some problems are self-solving: If permitted to run a natural course, they are solved by those personally involved. This is not to say that a uniform laissez-faire

management style solves all problems. The nurse manager must not ignore managerial responsibilities, but often, difficult situations become more manageable when participants are given time, resources, and support to discover their own solutions.

This typically happens, for example, when a newly graduated nurse joins a unit where most of the staff are associate-degree RNs who resent the new nurse's level of education as well as the nurse's lack of experience. If the nurse manager intervenes, a problem that the staff might have worked out on their own becomes an ongoing source of conflict. The important skill required here is knowing when to act and when not to act.

The Problem-solving Process

Many nursing problems require immediate action. Nurses usually do not have time for the formalized processes of research and analysis specified by the scientific method. Therefore, learning an organized method for problem solving is invaluable. One practical method for problem solving is to adhere to the seven-step process that follows, which is also summarized in Box 9-2.

1. ***Define the problem.*** The definition of a problem should be a descriptive statement of the state of affairs, not a judgment or conclusion. If one begins the statement of a problem with a judgment, the solution may be equally judgmental, and critical descriptive elements could be overlooked.

   Suppose a nurse manager reluctantly implements a self-scheduling process and finds that each time the schedule is posted, evenings and some weekend shifts are not adequately covered. The manager might identify the problem as the immaturity of the staff and their inability to function under participative governance. The causes may be lack of interest in group decision making, minimal concern over providing adequate patient coverage, or, perhaps more correctly, a few nurses' lack of understanding of the process.

   Premature interpretation can alter one's ability to deal with facts objectively. If the nurse manager defines the problem as immaturity and reverts to making out the schedules without further fact-finding, a minor problem could develop into a major upheaval. Instead, the manager might consider other explanations for the apparent behavior that do not entail negative assumptions about the maturity of the staff.

   Accurate assessment of the scope of the problem also determines whether the manager needs to seek a lasting solution or just a stopgap measure. Is this just a situational problem requiring only intervention with a simple explanation, or is it more complex, involving the leadership style of the manager? The manager must define and classify problems in order to take action. To define a problem, ask the following:

   - Do I have the authority to do anything about this myself?
   - Do I have all the information? Do I have enough time?

Box 9-2 Steps in Problem Solving

1. Define the problem.
2. Gather information.
3. Analyze the information.
4. Develop solutions.
5. Make a decision.
6. Implement the decision.
7. Evaluate the solution.

- Who else has important information and can contribute?
- What benefits can be expected? A list of potential benefits provides the basis for comparison and choice of solutions. The list also serves as a means for evaluating the solution.

2. ***Gather information.*** Problem solving begins with collecting facts. This information gathering initiates a search for additional facts that provides clues to the scope and solution of the problem. This step encourages people to report facts accurately. Everyone involved can contribute. Although this may not always provide objective information, it reduces misinformation and allows everyone an opportunity to tell what he or she thinks is wrong with a situation.

   Experience is another source of information—one's own experience as well as the experience of other nurse managers and staff. The people involved usually have ideas about what should be done. Some data will be useless, and some inaccurate, but some will be useful to develop innovative ideas worth pursuing.

3. ***Analyze the information.*** Analyze the information only when all of it has been sorted into some orderly arrangement, as follows:

   - Categorize information in order of reliability.
   - List information from most important to least important.
   - Set information into a time sequence. What happened first? Next? What came before what? What were the concurrent circumstances?
   - Examine information in terms of cause and effect. Is A causing B, or vice versa?
   - Classify information into categories: *human factors,* such as personality, maturity, education, age, relationships among people, and problems outside the organization; *technical factors,* such as nursing skills or the type of unit; *temporal factors,* such as length of service, overtime, type of shift, and double shifts; and *policy factors,* such as organizational procedures or rules applying to the problem, legal issues, and ethical concerns.
   - Consider how long the situation has been going on.

   Because no amount of information is ever complete or comprehensive enough, critical-thinking skills help the manager examine the assumptions, evidence, and potential value conflicts.

4. ***Develop solutions.*** As an individual or a group analyzes information, numerous possible solutions will suggest themselves. Do not consider only simple solutions, because that may stifle creative thinking and cause overconcentration on detail. Developing alternative solutions makes it possible to combine the best parts of several solutions into a superior one. Also, alternatives are valuable in case the first-order solutions prove impossible to implement.

   When exploring a variety of solutions, maintain an uncritical attitude toward the way the problem has been handled in the past. Some problems have had a long-standing history by the time they reach you, and attempts may have been made to resolve them over time. "We tried this before, and it didn't work" is often said and may apply—or more likely, may not apply—in a changed situation. Past experience does not always supply an answer, but it can aid the critical-thinking process and help prepare for future problem solving.

5. ***Make a decision.*** After reviewing the list of potential solutions, select the one that is most applicable, feasible, satisfactory, and has the fewest undesirable consequences. Some solutions have to be put into effect quickly; matters of discipline or compromises in patient safety, for example, need immediate intervention. You

must have legitimate authority to act in an emergency and know the penalties to be imposed for various infractions.

If the problem is a technical one and its solution brings about a change in the method of doing work or using new equipment, expect resistance. Changes that threaten individuals' personal security or status are especially difficult. In those cases, the change process must be initiated before solutions are implemented. If the solution involves change, the manager should fully involve those who will be affected by it, if possible, or at least inform them of the process.

6. ***Implement the decision.*** Implement the decision after selecting the best course of action. If unforeseen new problems emerge after implementation, evaluate these impediments. Be careful, however, not to abandon a workable solution just because a few people object; a minority always will. If the previous steps in the problem-solving process have been followed, the solution has been carefully thought out, and potential problems have been addressed, implementation should move forward.
7. ***Evaluate the solution.*** After the solution has been implemented, review the plan and compare the actual results and benefits to those of the idealized solution. People tend to fall back into old patterns of habit, only giving lip service to change. Is the solution being implemented? If so, are the results better or worse than expected? If they are better, what changes have contributed to its success? How can we ensure that the solution continues to be used and to work? Such a periodic checkup gives you valuable insight and experience to use in other situations and keeps the problem-solving process on course.

See Case Study 9-2 to learn how one nurse manager used critical thinking to solve a problem.

CASE STUDY 9-2 | Critical Thinking and Problem Solving

Latonia Wilson is nurse manager for a busy 20-bed telemetry unit. In addition to providing postsurgical care for cardiac patients, nurses also prepare patients for cardiac catheterization lab procedures. Latonia's staff include eight new graduate nurses, which make up almost half of her nursing staff. The new nurses have attended most of the required nursing orientation for the hospital.

Three times in one month, telemetry unit patients who had orders for heparin drips were administered heparin flush instead. Premixed IV bags for heparin drips as well as heparin flush for indwelling arterial catheters are stocked on the IV solutions cart in the medication room. While no adverse patient outcomes had been reported, procedures have been delayed.

Geena Donati is a graduate nurse on the telemetry unit. Recently, she took a bag of heparin drip from the IV cart and started to attach it to the IV tubing. She noticed that the label stated heparin flush instead of heparin. Upon returning to the med room, she checked the heparin drip bin and found heparin flush bags mixed in with the heparin drip. The pharmacy technician came into the med room and began stocking the IV cart. Geena noticed that the pharmacy technician put extra heparin drip bags in the heparin flush bin. She questioned the pharmacy technician, and he told Geena that since the unit used a lot of heparin solution, he had started bringing extra to decrease his trips to the unit.

Geena met with Latonia later during her shift. She told her manager about the extra heparin bags being mixed into the wrong bins. Latonia asked Geena if she would be interested in working with two other RNs on the unit to develop new procedures to decrease heparin medication errors. Geena and the task force worked with the pharmacy department to change the label color for heparin drip and heparin flush solutions, physically separated the bins on the IV cart onto different shelves, and provided a short educational segment at the monthly staff meeting. Since the new procedures were developed, no further heparin errors have occurred on the telemetry unit.

Group Problem Solving

Traditionally, managers solved most problems in isolation. This practice, however, is outdated. Both the complexity of problems and the staff's desire for meaningful involvement create the impetus for using group approaches to problem solving. Today, consensus-based problem solving, inherent in shared governance, is the norm.

ADVANTAGES OF GROUP PROBLEM SOLVING Groups collectively possess greater knowledge and information than any single member, and may produce more strategies to solve a problem. Under the right circumstances and with appropriate leadership, groups can deal with more complex problems than a single individual, especially if there is no single right or wrong solution. Individuals tend to rely on a small number of familiar strategies; a group is more likely to try several approaches.

Group members may have a greater variety of training and experiences and approach problems from more diverse points of view. Together, a group may generate more complete, accurate, and less biased information than one person. Groups may deal more effectively with problems that cross organizational boundaries or involve change that requires support from other units or departments. Participative problem solving has additional advantages: It increases the likelihood of acceptance and understanding of the decision, and it enhances cooperation in implementation.

DISADVANTAGES OF GROUP PROBLEM SOLVING Group problem solving also has disadvantages: It takes time and resources, and may create conflict. Group problem solving can lead to the emergence of benign tyranny within the group. Members who are less informed or less confident may allow stronger members to control group discussion and problem solving. A disparity in participation can contribute to a power struggle between the nurse manager and a few assertive group members.

Managers might resist using groups to make decisions. They may fear that they will not agree with the decision the group makes or will not be needed if all decisions are made by the group. Neither is the case. Some decisions are rightfully the managers' (e.g., handling the budget), others are staff decisions (e.g., peer review, self-scheduling), and some are shared (e.g., joint hiring decisions).

Group problem solving also can be affected by groupthink. **Groupthink** is a negative phenomenon that occurs in highly cohesive groups that become isolated. Through prolonged close association, group members come to think alike and have similar prejudices and blind spots, such as stereotypical views of outsiders. They exhibit a strong tendency to seek concurrence, which interferes with critical thinking about important decisions. In addition, the leadership of such groups suppresses open, freewheeling discussion and controls what ideas will be discussed and how much dissent will be tolerated. Groupthink seriously impairs critical thinking and can result in erroneous and damaging decisions.

Another drawback of group problem solving is that groups tend to make riskier decisions than individuals. Groups are more likely to support unusual or unpopular positions (e.g., public demonstrations). Groups tend to be less conservative than individual decision makers, and frequently display more courage and support for unusual or creative solutions to problems. Individuals who lack information about alternatives may make a safe choice, but during group discussion, they often acquire additional information and become more comfortable with a less secure alternative.

The group setting allows for the diffusion of responsibility. If something goes wrong, others can be assigned the blame or risk. Leaders may be greater risk takers than individuals, and group members might attach a social value to risk taking because they identify it with leadership.

Stumbling Blocks

The leader's personality traits, inexperience, lack of adaptability, and preconceived ideas may be obstacles to decision making and problem solving.

Personality

The leader's personality can and often does affect how and why certain decisions are made. Managers are often selected because of their expert clinical, not managerial, skills. Inexperienced in management, they may resort to various unproductive actions. On the one hand, a nurse manager who is insecure may base decisions primarily on approval seeking. When a truly difficult situation arises, the manager, rather than face rejection from the staff, makes a decision that will placate people rather than one that will achieve the larger goals of the unit and organization.

On the other hand, a nurse manager who demonstrates an authoritative type of personality might make unreasonable demands on the staff, fail to reward staff for long hours because he or she has a "workaholic" attitude, or give the staff little control over unit decisions. Similarly, an inexperienced manager who is not inclined to act on new ideas or solutions to problems may cause a unit to flounder. Optimism, humor, and a positive approach are crucial to energizing staff and promoting creativity.

Rigidity

Rigidity, an inflexible management style, is another obstacle to problem solving. It may result from ineffective trial-and-error solutions, fear of risk taking, or inherent personality traits. Avoid ineffective trial-and-error problem solving by gathering sufficient information and determining a means for early correction of wrong or inadequate decisions. Also, to minimize risk in problem solving, understand alternative risks and expectations.

The person who uses a rigid style in problem solving easily develops tunnel vision—the tendency to look at new things in old ways and from established frames of reference. It then becomes difficult to see things from another perspective, and problem solving becomes a process whereby one person makes all of the decisions with little information or data from other sources. In today's rapidly changing healthcare setting, rigidity can be a barrier to effective problem solving.

Preconceived Ideas

Effective leaders do not start out with the preconceived idea that one proposed course of action is right and all others wrong. Nor do they assume that only one opinion can be voiced and others will be silent. They start out with a commitment to find out why others disagree. If the staff, other professionals, or patients see a different reality or even a different problem, leaders need to integrate this information into developing additional problem-solving alternatives.

Leading at the Bedside: Applying Critical Thinking

We make many decisions in our lives. Seldom do our decisions result in exactly what we expect; outcomes sometimes surprise us. In some cases, results turn out better than expected—sometimes not so well. You may or may not have used the strategies described in this chapter, but you now have a variety of skills to help you make decisions and solve problems.

You might be inspired to test your creative ability and to try out innovative solutions to problems. Explore your ability to apply critical thinking to your work or your life. Now that you know about stumbling blocks, you'll have an easier time avoiding them. And remember that if you thought you couldn't use the techniques described in this chapter, you would be wrong.

Innovation

Innovation is a strategy to bridge the gap between an existing state and a desired state (Porter-O'Grady & Malloch, 2010). Organized nursing has recognized the importance of innovation to solve healthcare's many problems (Lachman, Glasgow, & Donnelly, 2009). The American Academy of Nursing's campaign "Raise the Voice" highlights "edge runners," those nurses who create innovative solutions for the healthcare system.

The following are several techniques to stimulate innovation:

- Simulations—high-tech mannequins or actors representing standardized patients
- Case studies—participants using critical thinking to analyze actual patient situations
- Problem-based learning—information being added to a case study over time
- Debate—participants examining an issue from more than one viewpoint (Lachman et al., 2009)

One university has even developed a post-master's certificate program in innovation. Using a case-study model, Drexel University's College of Nursing offers an online program in innovation and entrepreneurship designed to foster creative thinking to solve internal and external problems (Lachman et al., 2009).

Critical thinking, creativity, and innovative thinking, along with the appropriate tools and techniques, will enable nurses and their managers to make decisions and solve problems in the least time and with the best outcomes.

What You Know Now

- Critical thinking requires examining underlying assumptions about current evidence, interpreting information, and evaluating the arguments presented to reach a new and exciting conclusion.
- The creative process involves preparation, incubation, insight, and verification, which can be learned by individuals and groups.
- Problem-solving and decision-making processes use critical-thinking skills.

- The decision-making process may employ several models: rational, descriptive rationality, satisficing, and political.
- Decision-making techniques vary according to the problem and the degree of risk and uncertainty in the situation.
- Methods of problem solving include trial and error, intuition, experimentation, past experience, tradition, and recognizing that some problems are self-solving.
- The problem-solving process involves defining the problem, gathering information, analyzing information, developing solutions, making a decision, implementing the decision, and evaluating the solution.
- Group problem solving can be positive, providing more information and knowledge than an individual. It can also be negative if it generates disruptive conflict or groupthink.
- Stumbling blocks to making decisions and solving problems include the leader's personality, rigidity, or preconceived ideas.
- Innovation helps bridge the gap between the existing state and the desired state.

Tools for Making Decisions and Solving Problems

1. Identify problem areas.
2. Ask questions, interpret data, and consider alternatives to make decisions and solve problems.
3. Evaluate the level of certainty, uncertainty, and risk, and consider appropriate alternatives.
4. Identify opportunities to use groups appropriately to make decisions and solve problems.
5. Follow the problem-solving process described in this chapter.
6. Challenge yourself to look for creative and innovation solutions.

Questions to Challenge You

1. Identify someone you believe has critical-thinking skills. What critical thinking attributes does this person possess?
2. Describe a situation during which you made an important decision. What content in the chapter applied to that situation? What was the outcome?
3. Have you been involved in group decision making at school or at work? What techniques were used? Were they effective?
4. A number of ways that problem solving might fail were discussed in this chapter. Name three more.
5. Have you ever proposed a creative or innovative idea at work or school? Describe the idea and explain what happened.

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Chapter 10
Communicating Effectively

Communication
Transactional Model of Communication
Channels of Communication
Nonverbal Messages
Directions of Communication
Effective Listening

Effects of Differences in Communication
Gender Differences in Communication
Generational and Cultural Differences in Communication
Differences in Organizational Culture

The Role of Communication in Leadership
Employees
Administrators
Coworkers
Medical Staff
Other Healthcare Personnel
Patients and Families

Collaborative Communication

Enhancing Your Communication Skills

Learning Outcomes

After completing this chapter, you will be able to:

1. Identify the factors that influence communication.
2. Describe how difference in gender, generation, culture, and organization can affect communication.
3. Explain how communication content and medium selection vary according to the situation (context), goals, and relationship of those involved.
4. Explain what principles must be followed for collaborative communication to take place.
5. Develop a plan to improve your communication skills.

Key Terms

communication
channels of communication
diagonal communication
downward communication
lateral communication
negative inquiry
synchronous and asynchronous channels
upward communication

Introduction

Communication is a complex, ongoing, dynamic process in which the participants simultaneously create shared meaning in an interaction. It is a process in which individuals employ symbols (both verbal and nonverbal) to establish and interpret meaning within their environment (West & Turner, 2014). As you will see by the end of this chapter, communication is *simple*, but it is not *easy*. However, careful consideration of factors influencing the communication process when you design messages in any encounter will increase the likelihood that you will communicate effectively (see Leading at the Bedside: Communicating Effectively).

Communication

Effective communication is more challenging than it may appear on the surface because in any one situation we are trying to achieve at least three goals simultaneously: instrumental, relational, and identity (Clark & Delia, 1979). An instrumental goal is what we want to have happen or the focus of the interaction (e.g., I want Chris to get to work on time). Second, in any particular interaction we are trying to build or maintain a relationship (e.g., I want to build or maintain goodwill with Chris). Last, we want to enhance our own identity and protect the identity, or face, of the other person (e.g., I want to be perceived as a competent manager, and I want Chris to feel that she is a valued employee). The importance of each goal in relation to the other goals will vary with the situation and people involved, but all three goals always are involved in any one interaction. Instrumental goals would be relatively easy to achieve through coercion, if an instrumental goal were our singular goal. However, if we also want to achieve the other two goals at the same time, then communication becomes much more challenging.

Leading at the Bedside: Communicating Effectively

You might think you don't have anything to learn about communication. You've been communicating all your life. But do you know when it's best to contact someone in person? By phone? Is voice mail appropriate? When is texting the right way? Social media post? Email? Or is a formal letter required? Deciphering communication makes it possible for you to choose the best method to use in a variety of different situations and, thus, to make your communications more effective.

You will learn that one size does not fit all people or all situations. You will learn that communication is not static; it is always evolving. Finally, you will learn how to adapt your communication to circumstances as they develop, being ever mindful of your role, your goals, and your purpose.

All set? Let's talk!

Transactional Model of Communication

The basic components of any communicative process are illustrated in the transactional communication model (see Figure 10-1). All participants are influenced by past experiences, the present situation, the contexts in which the interaction is occurring, each person's goals in the current encounter, the channel selected, noise, feedback, and each person's attitudes toward self, the topic, and each other. While it is difficult to demonstrate in a two-dimensional model, it is important to keep in mind that the communication process is dynamic (duPre, 2014), irreversible (Russo, 1995), and contextual (West and Turner, 2014).

The communication process is dynamic in the sense that it is ever moving forward. The sharing and creating of meaning is a process of continually refining what we say and listening attentively, all the while thinking carefully about with whom we are talking or for whom we are writing, as well as the situation we are in, our goals, and the background of our audience (receiver).

The communication process is also irreversible. How many times have we wished we could take back what we said or recapture the email or text we just sent? It is an ongoing process of framing and reframing what we say or write to try to share with our audience what we mean.

Last, communication is contextual. Every interaction in which we participate is enmeshed in multiple contexts and environments that help shape or influence the meanings we create with others. A conversation we have with a colleague at work is framed differently from a conversation we have with the same colleague in a social setting. Our work setting is enmeshed in our unit or agency, our institution, our healthcare system, and our various cultures. All of these contexts must be carefully considered as we design messages of any kind.

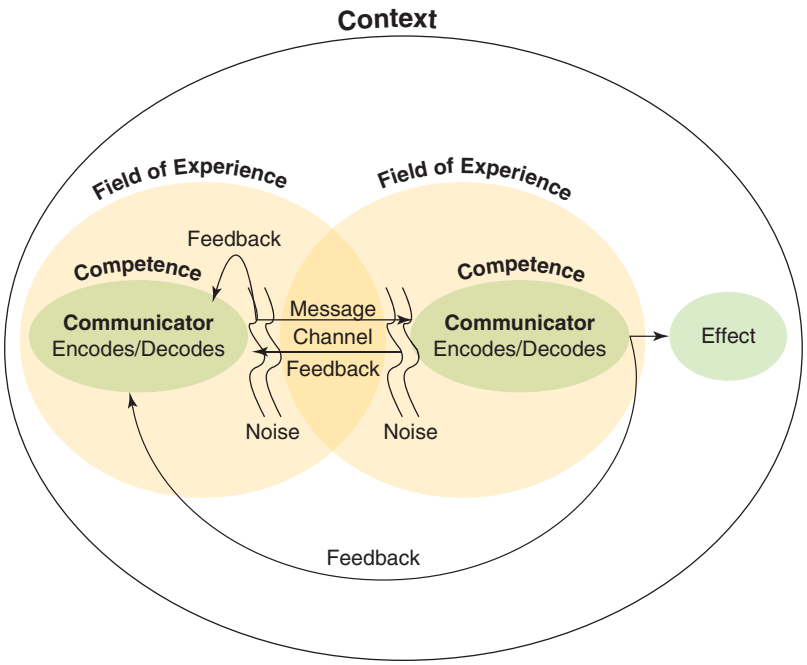

Figure 10-1 Transactional Model of Communication

Channels of Communication

Messages may be sent and received through channels, or pathways. **Channels of communication** may be described on a continuum with **synchronous and asynchronous channels** as endpoints (Kalman & Rafaeli, 2007). In other words, the more ability that a channel has to offer rapid feedback, multiple cues, natural language, and personal focus, the more synchronous and rich the medium is (Daft, Lengel, & Trevino, 1987; D'Urso & Rains, 2008). In this category, think of face-to-face (one-to-one, dyads, or groups) and to some extent telephone, voicemail, and video, such as FaceTime or Skype. Both communicators have more access to message information and are more likely to share meaning more easily when more cues are present.

When a medium offers slower feedback, fewer cues, less naturally occurring language, and less personal focus, the more asynchronous the medium is. Examples of asynchronous media include email, postal mail, fax, posts on a social media website, or discussion boards. When fewer cues are present in a channel, messages are more difficult to understand.

A combination of the goal of the message, the context, and the audience or people involved influence the best channel to use (Sheer & Chen, 2004). In general, the more important or delicate the issue, the more information you want available in your channel to all parties in the conversation, so the more synchronous the medium should be. Any difficult issue should be communicated face-to-face, such as terminating an individual's employment or conducting a performance review. Conflict or confrontation also is usually best handled in person so that the individual's response, especially nonverbal signals (to be discussed later), can be seen and addressed appropriately.

What channel to use depends on the number of cues or information required based on the person, your relationship, your goals, and the message. Channels with more to less information, or cues, are ranked here from more synchronous to less synchronous:

- In person
- By phone
- Voice mail
- Text
- Email
- Postal mail
- Posting on social media websites, including blogs

Meeting someone face-to-face offers the most opportunities for both parties to see and hear cues or information in messages. Individuals can see each other's face and body movements and can hear words simultaneously. The telephone is slightly less intimate than in-person communication. Tone of voice, for instance, can be conveyed, and phone conversations can be two-way. Voice mail is the next level of communication. Voice mail is useful to convey information that is not necessarily sensitive and may or may not require a reply.

Email is useful for information similar to that conveyed by voice mail and, like some voice mail systems, can be broadcast to large groups at once. Announcing the dates and times for a blood drive is a good example of a broadcast message.

Conveying complicated information that may require thought before the receiver replies is another value of using email. However, it is vital to remember that an email message is essentially a public message. It easily can be forwarded to unintended audiences. It is wise to consider email as postcards when deciding what to write in an email. Texting is similar to email, although briefer, often with a quicker response time. Posts on social media sites are the least personal communication.

The level of formality of the communication also affects the channel used. Applying for a position requires a written format, even if a letter is emailed or uploaded to a website rather than mailed. The relationship between the sender and receiver also affects the channel choice. If a staff nurse, for example, wants to nominate a coworker for an award given by the hospital board of directors, a written letter or email often is required. Memos are less formal than letters and can be emailed, faxed, or mailed. Social media postings are public and impersonal. Email and texts between colleagues who have worked together for a long time may be shorter than other situations since the parties know each other and their past experiences well.

Nonverbal Messages

Oral messages are accompanied by a number of nonverbal messages. These behaviors include head or facial agreement or disagreement; eye contact; tone, volume, and inflection of the voice; gestures of the shoulders, arms, hands, or fingers; body posture and position; dress and appearance; timing; and environment.

Nonverbal communication may be more powerful than the words one speaks and can influence the meaning of the spoken words. When a verbal message is incongruent with the nonverbal message, the recipient has difficulty interpreting the intended meaning. For example, a manager who states "Come talk to me anytime" but keeps typing at the keyboard while you talk, sends a conflicting message to the staff. A person may receive conflicting messages from differing sources. For example, the risk manager may encourage a nurse to report medication errors, but the nurse manager follows up with discipline over the error. The nurse is caught between conflicting messages from the two managers.

The following are other common causes of unclear messages:

- Using inadequate reasoning
- Using strong, judgmental words
- Speaking too quickly or too slowly
- Using unfamiliar words
- Spending too much time on details

Messages become less clear when the recipient is busy or distracted, bases understanding on previous unsatisfactory experience with the sender, or has a biased perception of the meaning of the message or the messenger. Email is particularly fraught with opportunities for misunderstanding. From the greeting (e.g., dear, hi, hello, or no salutation) to the sign-off (e.g., warm regards, best wishes, best, or no sign-off), the sender conveys more than the choice of words. A speedy reply is expected and encourages a response, sometimes without adequate thought. Finally, the possibility of sending the message to the wrong person, especially the dreaded "reply to all," is another chance for your message to be misinterpreted. Texting shares many of the same dangers as email and has the added pressure for a faster response.

Directions of Communication

Formal or informal communication in an organization may be downward, upward, lateral, or diagonal. **Downward communication** (manager to staff) is often directive. The staff is told what needs to be done or given information to facilitate the job to be done. **Upward communication** occurs from staff to management or from lower management to middle or upper management. Upward communication often involves reporting pertinent information to facilitate problem solving and decision making. **Lateral communication** occurs between individuals or departments at the same hierarchical level (e.g., nurse managers, department heads). **Diagonal communication** involves individuals or departments at different hierarchical levels (e.g., staff nurse to chief of the medical staff). To a greater or lesser degree, communication in all of these directions involves information sharing, discussion, and negotiation.

An informal channel commonly seen in organizations is the grapevine (e.g., conversations among members of an organization; these conversations may include rumors and gossip). Grapevine communication is usually rapid, haphazard, and prone to changes in interpretations. It can also be useful. Sometimes the only way to learn about a pending change is through the grapevine. One problem with grapevine communication, however, is that no one is accountable for any misinformation that is relayed. Keep in mind, too, that information gathered this way is often a slightly altered version of the original message, changing as the message passes from person to person.

Effective Listening

Most nurses believe they are good listeners. Observing and listening to patients are skills nurses learn early in their careers and use every day. Being a good listener, however, involves more than just hearing words and watching body language (Sullivan, 2013). Maintaining eye contact as a cue to effective listening is misleading; it may or may not signal that a person is listening, although it helps. Barriers to effective listening include preconceived beliefs, lack of self-confidence, flagging energy, defensiveness, and habit (Donaldson, 2007).

PRECONCEIVED BELIEFS The longer your relationship with someone lasts, the more apt you are to think you know what the person says or means and, thus, the more likely you are not to listen. This holds true in personal as well as professional relationships and also applies to groups of people (known as stereotyping). Not expecting others to have anything worthwhile to say also is an example of preconceptions about them.

LACK OF SELF-CONFIDENCE Listening is difficult if you are nervous, and low self-confidence frequently is the cause. People tend to talk too much or think about what they are planning to say next instead of paying attention to the person speaking. Often their minds are racing, and they may not be listening even when they themselves are talking.

FLAGGING ENERGY Listening takes energy and sometimes we simply do not have enough energy to listen carefully. Hearing too many people speaking at once, having too much to do, being worried, or being too tired can all interfere with our ability to listen.

DEFENSIVENESS Survival required that we learned to hear danger approaching, but today humans have translated defense mechanisms into a way to avoid hearing

bad news. Then, we think, we do not have to deal with it. The opposite is true, however. Only when we can hear and consider information can we handle it.

HABIT Over time, many people develop the habit of thinking ahead during conversations. Thinking ahead is valuable in most aspects of life, but it can be deadly when you need to be listening. Like all behaviors that have become habits, changing this one is not easy. Reminding yourself to refocus on the speaker can help.

Effects of Differences in Communication

Although the communication process may appear to be the same regardless of who is involved, that is not the case. The individual's gender, age, and culture all affect the effectiveness of the communication. Furthermore, the culture of the organization provides context for the communication and affects how messages are sent and received.

Gender Differences in Communication

Men and women communicate somewhat differently (Feldhahn, 2009; Tannen, 2001). They have become socialized through communication patterns that reflect their societal roles. Men tend to talk more, longer, and faster, whereas women tend to be more descriptive, attentive, and perceptive. Women tend to use tag questions (e.g., "I can take off this weekend, can't I?") and tend to self-disclose more than men. Women tend to ask more questions and solicit more input than their male counterparts. Table 10-1 lists differences in the ways that men and women communicate.

Helgeson and Johnson (2010) suggest ways that women can improve their communication at work. Neither men nor women should raise their voices no matter what the provocation. Nor should one omit important details or assume that everyone knows what you mean. Encouraging questions or objections will help keep the dialogue moving forward. Finish what you are saying before you leave a conversation.

Using gender-neutral language in communication helps bridge the gap between the way men and women communicate. Men and women can improve their ability to communicate with each other by following the recommendations for gender-neutral communication found in Table 10-2.

Table 10-1 Gender Differences in Communication

Men tend to . . .	Women tend to . . .
Interrupt more frequently	Wait to be noticed
Talk more, longer, louder, and faster	Use qualifiers (prefacing and tagging)
Disagree more	Use questions in place of statements
Focus on the issue more than the person	Relate personal experiences
Boast about accomplishments	Promote consensus
Use banter to avoid a one-down position	Withdraw from conflict

From Sullivan, E. J. (2013). *Becoming influential: A guide for nurses*. (2nd ed.). Upper Saddle River, NJ: Pearson, p. 57. Reprinted by permission.

Table 10-2 Recommendations for Gender-Neutral Communication

Men may need to . . .	Women may need to . . .
Listen to objections and suggestions	State your message clearly and concisely
Listen without feeling responsible	Solve problems without personalizing them
Suspend judgment until information is in	Say what you want without hinting
Explain your reasons	Eliminate unsure words ("sort of") and nonwords ("truly")
Not yell	Not cry

From Sullivan, E. J. (2013). *Becoming influential: A guide for nurses*, 2nd ed. Upper Saddle River, NJ: Pearson, p. 58. Reprinted by permission.

Generational and Cultural Differences in Communication

Generational differences affect communication styles, patterns, and expectations. People who describe themselves as traditionals tend to be more formal, following the chain of command without question. People who identify as baby boomers question more. They enjoy the process of group problem solving and decision making. Independent generation Xers are just the opposite and want decisions made without extensive discussion. People who identify as millennials (also sometimes called generation Y) often expect more immediate feedback to their messages. Email, text, or voice mail is often a good way to connect with them, depending on the situation and your goals. Mutual respect and understanding of the unique differences between and among individuals in these groups will help to minimize conflict and maximize satisfaction for both managers and staff (Hahn, 2009).

Cultural attitudes, beliefs, and behaviors also affect communication (Robertson-Malt, Herrin-Griffith, & Davies, 2010). Such elements as body movement, gestures, tone, and spatial orientation are culturally defined. A great deal of misunderstanding results from a lack of understanding of each other's cultural expectations. For example, people of Asian descent often take great care in exchanges with supervisors so there is no conflict or "loss of face" for either person.

Understanding the cultural heritage of employees and learning to interpret cultural messages are essential to communicating effectively with staff from diverse backgrounds. Personal and professional cultural competency training is recommended. This includes reading the literature and history of the culture; participating in open, honest, respectful communication; and exploring the meaning of behavior. It is important to recognize, however, that subcultures exist within all cultures; therefore, what applies to one individual will not be true for everyone else in that culture.

Differences in Organizational Culture

As discussed in Chapter 2, the customs, norms, and expectations within an organization are powerful forces that shape behavior. Focusing on relevant issues regarding the organizational culture can identify problems in communication. Poor communication is a frequent source of job dissatisfaction as well as a powerful determinant of an organization's effectiveness. Just as violation of other norms within the organization results in repercussions, so does violation of communication rules.

To discover what rules affect communication in your organization, ask yourself the following:

- Who has access to what information? Is information withheld? Is it shared widely?
- What channels of communication are used for which messages? Are they used appropriately?
- How clear are the messages? Do the messages reveal the senders to be more or less transparent?
- Does everyone receive the same information? If not, why not?
- Do you receive too much information? Not enough?
- How effective is the message?

The Role of Communication in Leadership

Although communication is inherent in the manager's role, the manager's ability to effectively communicate often determines his or her success as a leader. Leaders often are viewed as informative when they engage in frank, open, two-way communication and when their nonverbal communication reinforces the verbal messages. Communication is enhanced when the manager listens carefully and is sensitive to others' backgrounds and needs. The major underlying factor, however, is an ongoing relationship between the manager and employees.

Successful leaders are able to persuade others, solicit input from them, and enlist their support. One of the most effective means of engaging others is the leader's personal characteristics. Competence, emotional control, assertiveness, consideration, and respect promote perceptions of trustworthiness and credibility. A participative leader is seen as a careful listener who is open, frank, trustworthy, informative, and encourages and acts upon others' ideas whenever possible.

Employees

Depending on the organization's policies, the nurse manager's responsibilities may include selecting, interviewing, evaluating, counseling, and disciplining employees; handling their complaints; and settling conflicts. The principles of effective communication are especially pertinent in these activities because effective communication is the adhesive that builds and maintains an effective work group.

Giving direction is not, in itself, communication. If the manager receives an appropriate response from the subordinate, however, understanding or shared meaning likely has occurred. To give directions and achieve the desired results, develop a message strategy. The techniques that follow can help improve effective responses from others.

- ***Know the context of the instruction.*** Be certain you know exactly what you want done, by whom, within what time frame, and what steps should be followed to do it. Be clear in your own mind what information a person needs to carry out your instruction, what the outcome will be if the instruction is carried out, and how that outcome can or will be evaluated. When you have thought through these questions, you are ready to give the proper instruction.

- ***Get positive attention.*** Avoid factors that interfere with effective listening. Informing the person that the instructions will be given is one simple way to try to get positive attention. Highlighting the background, giving a justification, or indicating the importance of the instructions also may be appropriate.
- ***Give clear, concise instructions.*** Use an inoffensive and nondefensive style and tone of voice. Be precise, and give all the information receivers need to carry out your expectations. Follow a step-by-step procedure if several actions are needed.
- ***Verify through feedback.*** Make sure the receiver has understood your specific request for action. Allow a short time for the listener to absorb the information and ask questions. Ask for a repeat of the instructions.
- ***Provide follow-up messages.*** Understanding does not guarantee performance. Follow up to discover if your instructions were clear and if the person has any questions.

The nurse manager is responsible both for the quality of the work life of individual employees, and for the quality of patient care in the entire unit. To carry out this job, acknowledge the needs of individual employees, especially if the needs of one conflict with needs of the unit, speak directly with those involved, and state clearly and accurately the rationale for the decisions made.

Administrators

The manager's interaction with administration higher in the organizational chart is comparable to the interaction between the manager and an employee, except that the manager reports to the administrator. Higher administration is responsible for the consequences of decisions made for a larger area, such as all of nursing service or the entire organization. The principles used in communicating with subordinates are equally appropriate here. Managers should be organized and prepared to state their needs clearly, explain the rationale for requests, suggest benefits for the larger organization, and use appropriate channels. Listen objectively to your supervisor's response and be willing to consider reasons for possible conflict with the needs of other areas.

Working effectively with an administrator is important because this person directly influences personal success in a career and within the organization. Managing a supervisor, or managing upward, is a crucial skill for nurses. To manage upward, remember that the relationship requires participation from both parties. Managing upward is successful when power and influence move in both directions. Rules for managing your supervisor are found in Box 10-1.

Box 10-1 Rules for Managing Your Boss

- Never let your supervisor be surprised; keep her or him informed.
- Always tell the truth.
- Find ways to compensate for your supervisor's weaknesses. Fill in weak areas tactfully. Volunteer to do something the supervisor dislikes doing.
- Be your own publicist. Don't brag, but keep your supervisor informed of what you achieve.
- Keep aware of your supervisor's achievements and acknowledge them.
- If your supervisor asks you to do something, do it well and ahead of the deadline if possible. If appropriate, add some of your own suggestions.
- Establish a positive relationship with the supervisor's assistant.

One aspect of managing upward is understanding the supervisor's position from her or his frame of reference. This will make it easier to propose solutions and ideas that the supervisor will accept. Understand that a supervisor is a person with much responsibility and pressure. Learn about the supervisor from a personal perspective: What pressures, both personal and professional, does the supervisor face? How does the supervisor respond to stress? What previous experiences are liable to affect today's issues? This assessment will allow you to identify ways to help your supervisor with his or her job and for your supervisor to help you with yours.

INFLUENCING YOUR SUPERVISOR Nurses need to approach their supervisor to exert their influence on a variety of issues and problems. Support for the purchase of capital equipment, for changes in staffing, or for a new policy or procedure all require communicating with a supervisor. Your rationale, choice of form or format, and possible objections all are important factors to consider as you prepare to make such a request. Timing is critical; a good opportunity is when the supervisor has time and appears receptive. Also, consider the impact of your ideas on other events occurring at that time on your unit and/or organization-wide.

Should ideas be presented in spoken or written form? Usually some combination is used. Even if you have a brief meeting about a relatively small request, it is a good idea to follow up with an email, detailing your ideas and the plans to which you both agreed. Sometimes the procedure works in reverse. If you provide the supervisor with a written proposal prior to a meeting, both of you will be familiar with the idea at the start. In the latter case, careful preparation of the written material is essential.

What can be done if, in spite of careful preparation, your supervisor says no? First, make sure you have understood the objections and associated feelings. **Negative inquiry** (e.g., "I don't understand") is a helpful technique to use. Do not interrupt or become defensive or distraught; remain diplomatic.

The next step is confrontation. Keep your voice low and measured; use "I" language; and avoid absolutes, why questions, put-downs, inflammatory statements, and threatening gestures. Finally, if you feel you have lost and compromise is unlikely, table the issue by saying "Could we continue discussing this at another time?" Then, think through your supervisor's reasoning and evaluate it. Afterward, ask yourself "What new information did I get from the supervisor?" "What are ways I can renegotiate?" "What do I need to know or do to overcome objections?" Once you can answer these questions, approach your supervisor again with the new information. This behavior shows that the proposal is a high priority, and the new information may cause him or her to reevaluate.

Managers often succeed in influencing supervisors through persistence and repetition, especially if supporting data and documentation are supplied. If the issue is important enough, you may want to take it to a higher authority. If so, tell your supervisor you would like an administrator at a higher level to hear the proposal. Keep an open mind, listen, and try to meet objections with suggestions of how to solve problems. Be prepared to compromise, which is better than no movement at all, or to be turned down.

TAKING A PROBLEM TO YOUR SUPERVISOR No one wants to hear about a problem, and your boss is no different. Nonetheless, work involves problems, and the manager's job is to solve them. Go to your supervisor with a goal to problem solve together. Have some ideas about solving the problems in hand if you can, but do not be so

wedded to them that you are unable to listen to your supervisor's ideas. Keep an open mind. Use the following steps to take a problem to your supervisor:

- Find an appropriate time to discuss a problem, scheduling an appointment if necessary.
- State the problem succinctly, and explain why it is interfering with work.
- Listen to your supervisor's response, and provide more information if needed.
- If you agree on a solution, offer to do your part to solve it. If you cannot discover an agreeable solution, schedule a follow-up meeting or decide to gather more information.
- Schedule a follow-up appointment, if appropriate.

By solving the problem together and, if necessary, by taking active steps together, you and your supervisor are more likely to accept the decision and be committed to it. Setting a specific follow-up date can prevent a solution from being delayed or forgotten.

IF ALL ELSE FAILS Sometimes no matter what you do, working with your supervisor seems nearly impossible. Some managers foster a negative work environment, and employees become dissatisfied, angry, and depressed. High absenteeism and turnover result. As a manager, you are charged with supporting your supervisor. If working with that person is too difficult for you to manage your work satisfactorily, you may have to transfer elsewhere or leave.

Coworkers

Interactions with coworkers are inevitable. Relationships can vary from comfortable and easy to challenging and complex. Coworkers often share similar concerns. Camaraderie may be present; coworkers can exchange ideas and address problems creatively. They can provide social support in difficult situations.

Conversely, there may also be competition or conflicts (e.g., battles over territory, personality clashes, differences of opinion) affected by history, the organization's norms, or generational or cultural differences. Even during conflicts, coworkers should interact on a professional level.

Medical Staff

Communication with the medical staff may be difficult for the nurse manager because the relationship of physicians and nurses historically has been that of superior and subordinate. Complicating physician–nurse relationships is the employee status of the medical staff. They may not be employees of the organization but still have considerable power because of their ability to attract patients to the organization. Finally, the medical staff is in itself diverse, consisting of physicians who are organizational employees, residents, physicians in private practice, and consulting physicians, all with their own cultural, gender, and generational backgrounds.

Other Healthcare Personnel

The nurse manager has the overwhelming task of coordinating the activities of a number of personnel with varied levels and types of preparation and different kinds of tasks. The patient may receive regular care from a registered nurse, unlicensed

assistive personnel, a respiratory therapist, a physical therapist, and a dietician, among others. The nurse manager may supervise all of them. Regardless, the manager needs considerable skill to communicate effectively with diverse personnel, recognize their commonalities, and deal with their differences.

Patients and Families

Nurse managers deal with many difficult issues, such as complaints about delivery of care, a staff member, or violations of policy. When dealing with patient or family complaints (e.g., about a staff member or violations of policy), keep the following principles in mind:

- ***The patient and family are the principal customers of the organization.*** Treat patients and families with respect; keep communication open and honest. Dissatisfied customers fail to continue to use a service and inform their friends and families about their negative experiences. Handle complaints or concerns tactfully and expeditiously. Many times lawsuits can be avoided if the patient or family feels that someone has taken the time to listen to their complaints.
- ***Most individuals are unfamiliar with medical jargon.*** Use words that are appropriate to the recipient's level of understanding. However, take care not to be condescending or intimidating. It is just as important to assess the person's knowledge base and level of understanding as it is to know his or her vital signs or liver status.
- ***Maintain privacy and identify a neutral location for dealing with difficult interactions.***
- ***Make special efforts to find interpreters if a patient or family does not speak English.*** Have readily available a list of individuals who are able to communicate in a variety of languages, including sign language and Braille. Another resource is AT&T's language line service, which provides interpreters for seven languages 24 hours a day.
- ***Recognize cultural differences in communicating with patients and their families.*** People in some cultures do not ask questions for fear of imposing on others (Huber, 2009). Some cultures prefer interpreters from their own culture; others do not. Cultural education for the staff can help them identify some of these differences and teach them appropriate, culturally sensitive responses (Raingruber et al., 2010).

Collaborative Communication

Collaboration is central to patient safety, according to a study by Vitalsmarts (Maxfield, Grenny, Lavandero, & Groah, 2005). The researchers found seven areas where healthcare workers found it difficult to speak up, including seeing colleagues make mistakes, perform incompetently, disrespect others, break rules, fail to support colleagues, exhibit poor teamwork, or micromanage inappropriately.

Propp and colleagues (2010) found that two processes were critical to ensuring collaboration with physicians and other members of the healthcare team: ensuring quality decisions and promoting team synergy. By developing a collaborative practice model, nurses can build their credibility with physicians and enhance the workplace environment.

Another study found communication and role understanding crucial to collaborative practice (Suter et al., 2009). Appreciation of one another's roles was key to improving communication and positive patient outcomes. Focusing educational objectives on communication and understanding others' roles, rather than more diffuse skills, such as respect, is more likely to lead to better practices, the researchers assert.

To support greater collaboration between nurses and physicians and to improve the product of nursing service—patient care—keep these principles in mind:

- Respect physicians as persons, and expect them to respect you.
- Consider yourself and your staff equal partners with physicians in healthcare.
- Build your staff's clinical competence and credibility. Ensure that your staff has the clinical preparation necessary to meet required standards of care.
- Actively listen and respond to physician complaints as customer complaints. Create a problem-solving structure. Stop blaming physicians exclusively for communication problems.
- Consider implementing Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS), an evidence-based series of team-building phrases available at www.ahrq.gov that help promote collaborative interactions among healthcare professionals.
- Use every opportunity to increase your staff's contact with physicians and to include your staff in meetings that include physicians. Remember that limited interactions contribute to poor communication.
- Establish a collaborative practice committee on your unit with membership composed equally of nurses and physicians. Identify problems, develop mutually satisfactory solutions, and learn more about each other. Emphasize similarities and the need for quality care. Begin with those physicians who have a positive attitude toward collaboration.
- Serve as a role model to your staff in nurse–physician communication.
- Support your staff by your words and by your actions when participating in collaborative efforts.

Case Study 10-1 shows how one nurse manager handled a problem with a physician. Table 10-3 offers strategies for responding to power plays or intimidation.

Enhancing Your Communication Skills

Communication skills can be developed. To improve your communication skills, take the following steps.

1. ***Consider your relationship to the receiver.*** This could be a boss, employee, or patient.
2. ***Craft your message, including your goal and how to answer responses.*** Be clear about your goal. Think about how the other person might interpret your message and what he or she is liable to say in return. Consider how you might respond.
3. ***Decide on the medium, based on your relationship, the content, and the setting.*** Is the message best conveyed in person, by phone, email, or text? Should you leave a message if the person is not available? Note the number of cues available through a particular channel for guidance. Generally, the more likely a message might be

CASE STUDY 10-1 | Communication

Josie Randolph is nurse manager of a perioperative unit, which includes responsibility for the preoperative testing unit, 18 OR suites, pre-op holding, and sterile processing. The OR department supports the hospital's Level I trauma service as well as all other surgical services.

Dr. Jonas Welborne is a plastic surgeon with a history of aggressive behavior. He has several cases on today's OR schedule. While he is in his first surgery, a trauma case is brought to the OR. Susan Richardson, the OR charge nurse, decides to bump Dr. Welborne's second case out of OR #3 in order to make room for the trauma case. When Dr. Welborne has finished his first case, he is informed of the delay in his second case. Dr. Welborne storms into the OR scheduling office and begins yelling at Susan. The situation quickly escalates to the point where Dr. Welborne uses obscenities and throws several charts on the floor. Loretta Donnelly, an OR tech, runs to Josie's office and asks her to come immediately to the OR scheduling office.

Susan and Dr. Welborne continue to yell at one another, in full view of patients in the pre-op area. Josie immediately steps between Dr. Welborne and Susan and firmly asks both of them to lower their voices. She instructs Susan to wait in the staff lounge while she speaks with Dr. Welborne. Josie asks Dr. Welborne to step into her office so they can calmly discuss the situation. Dr. Welborne is still visibly agitated but agrees to discuss the problem.

After hearing his side of the story, Josie apologizes for the inconvenience but reminds him of the OR policies. Emergent cases take precedence over elective cases, and no other elective cases were on the schedule at that time. She asks Dr. Welborne if there are alternatives to scheduling his cases that would minimize delays or bumps. As they talk, Dr. Welborne becomes calmer.

Josie informs Dr. Welborne that his earlier behavior is unacceptable. Within a few minutes, he apologizes to Josie and asks to speak with Susan. He also apologizes to Susan. Josie and Susan discuss the incident and ways Susan can help diffuse similar situations in the future. As with Dr. Welborne, Josie indicates that Susan's behavior was unprofessional and, as the OR charge nurse, she is always expected to act as a nursing professional and role model.

Table 10-3 Assertive Communication Strategies

If you are confronted with power plays or intimidation, what is the best way to respond? Intimidation can be counteracted by increasing self-confidence and personal feelings of power. Four strategies that generate feelings of personal power are outlined below.

Word choices	Use the other person's name frequently. Use strong statements. Avoid discounters, such as "I'm sorry, but . . ." Avoid clichés, such as "hit the nail on the head," "goes without saying," "easier said than done." Avoid fillers (such as "ah," "uh," and "um").
Through delivery	Be enthusiastic. Speak clearly and forcefully. Make one point at a time. Do not tolerate interruptions.
By listening	Listen for facts. Pay attention to emotions. Listen for what is not being said (e.g., body language, mixed messages, hidden messages).
Through body posture and body language	Sit next to your antagonist; turn 30 degrees toward the person when you address him or her. Lean forward. Expand your personal space. Use gestures. Stand when you talk. Smile when you are pleased, not in order to please. Maintain eye contact, but do not stare.

interpreted in a variety of ways (increased equivocality), then the more important it is to select a channel with many cues (as synchronous a channel as possible).

4. ***Check your timing.*** Timing plays a critical role in successful communication. Catch your boss in the midst of planning for a budget shortfall and you are less apt to get a receptive hearing.
5. ***Deliver your message.*** Be prepared when you deliver your message. The best-crafted message, delivered by the appropriate medium can misfire by a sender who fails to listen carefully, avoids responding out of fear of consequences, or undermines the message with qualifiers such as "I don't know if you're interested."
6. ***Attend to verbal or written responses.***
7. ***Reply appropriately.***
8. ***Conclude when both parties' messages have been understood.***
9. ***Evaluate the communication process.***

(For more information on communicating effectively, see Sullivan, E. J. [2013]. *Becoming influential: A guide for nurses* [2nd ed.]. Upper Saddle River, NJ: Pearson.)

What You Know Now

- Communication is a complex, ongoing, dynamic process.
- How to deliver a message depends on the goal, the context, the content, and the relationship.
- Messages can be misconstrued.
- Gender, generation, cultural background, and the organizational culture influence communication and its outcomes.
- Expert communication skills are essential for a leader to be successful.
- Communication strategies vary according to the situation and the roles of people involved.
- Collaborative communication is challenging, and specific skills can help.
- Nurses can enhance their communication skills with effort and practice.

Tools for Communicating Effectively

1. Identify and use the appropriate channel (in person, phone, voice mail, text, email, letter) for your messages.
2. Evaluate your communication skills in various situations. Seek out ways to improve.
3. Practice using the skills described in specific situations, such as with your coworkers, with the medical staff, and with patients and their families.
4. Become sensitive to others' responses, both verbal and nonverbal, and craft your messages appropriately.
5. Gather feedback and continue to assess the effectiveness of your communications.
6. Strive to improve your communication skills.

Questions to Challenge You

1. Consider a recent interaction you witnessed:
   - What appeared to be the situation and the contexts that framed what was going on?
   - Did the sender express the message clearly?
   - Did the sender use the appropriate medium?
   - Listen and respond to questions and comments?
   - How did the receiver respond?
   - What was the outcome?
2. Now think about a recent interaction where you were the sender using the above questions. If you could replay the interaction, what would you do differently?
3. How well does communication function in your workplace, school, or clinical site?
4. To improve your communication, practice the skills described in the chapter by role playing or recording yourself (Sullivan, 2013).

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Chapter 11
Delegating Successfully

Delegation

Benefits of Delegation
Benefits to the Nurse
Benefits to the Delegate
Benefits to the Manager
Benefits to the Organization

The Five Rights of Delegation

The Delegation Process
Steps in the Delegation Process
Key Behaviors for Successful Delegation
Accepting Delegation

Ineffective Delegation
Organizational Culture
Lack of Resources
An Insecure Delegator
An Unwilling Delegate
Underdelegation
Reverse Delegation
Overdelegation

Learning Outcomes

After completing this chapter, you will be able to:

1. Explain delegation and distinguish between responsibility, accountability, and authority.
2. Describe how effective delegation benefits the delegator, the delegate, the unit, and the organization.
3. Explain how following the five rights of delegation can reduce nurses' fears about delegation.
4. Evaluate the delegation process, including the steps in delegation, key behaviors for successful delegation, and the implications of accepting delegation.
5. Assess the factors that contribute to ineffective delegation.

Key Terms

accountability
assignment
authority
delegation
overdelegation
responsibility
reverse delegation
underdelegation

Introduction

It is easy to say delegate, but delegation is a difficult leadership skill for nurses to learn. Most would rather do all their patients' nursing care themselves than assign others to do it (Case, 2015). A leader who models delegation promotes collaboration between nurses and support personnel (Orr, 2010). Never before, however, has delegation been for nurses and nurse managers as critical a skill to perfect as it is today, with the emphasis on doing more with less.

Delegation

Delegation is the process by which responsibility and authority for performing a task (function, activity, or decision) are transferred to another individual who accepts that authority and responsibility. Although the delegator remains accountable for the task, the delegate is also accountable to the delegator for the responsibilities assumed. Delegation can help others to develop or enhance their skills, promote teamwork, and improve productivity (Weydt, 2010).

An American Nurses Association (ANA) publication (2012) delineates the principles for delegation, as shown in Box 11-1. Based on the scope and standards of nursing practice, these principles make clear that the ultimate responsibility for the patient's care rests with the RN. In addition, the organization is responsible for providing necessary resources and competency information and to develop organizational policies with the involvement of RNs.

Responsibility, accountability, and authority are concepts related to delegation. Although *responsibility* and *accountability* are often used synonymously, the two words represent different concepts that go hand in hand. **Responsibility** denotes an obligation to accomplish a task, whereas **accountability** is accepting ownership for the results or lack thereof. Responsibility can be transferred, but accountability is shared.

You can delegate only those tasks for which you are responsible. If you have no direct responsibility for the task, then you cannot delegate that task. For instance, if a manager is responsible for filling openings in the staffing schedule, the manager can delegate this responsibility to another individual. However, if staffing is the responsibility of a central coordinator, the manager can make suggestions or otherwise assist the staffing coordinator but cannot delegate the task.

Likewise, if an orderly who is responsible for setting up traction is detained and a nurse asks a physical therapist on the unit to assist with traction, this is not

Box 11-1 Principles for Delegation

The following principles provide guidance and inform the registered nurse's decision making about delegation:

- The nursing profession determines the scope and standards of nursing practice.
- The RN takes responsibility and accountability for the provision of nursing practice.
- The RN directs care and determines the appropriate utilization of resources when providing care.
- The RN may delegate tasks or elements of care but does not delegate the nursing process itself.
- The RN considers facility/agency policies and procedures and the knowledge and skills, training, diversity awareness, and experience of any individual to whom the RN may delegate elements of care.
- The decision to delegate is based upon the RN's judgment concerning the care complexity of the patient, the availability and competence of the individual accepting the delegation, and the type and intensity of supervision required.
- The RN acknowledges that delegation involves the relational concept of mutual respect.
- Nurse leaders are accountable for establishing systems to assess, monitor, verify, and communicate ongoing competence requirements in areas related to delegation.
- The organization/agency is accountable to provide sufficient resources to enable appropriate delegation.
- The organization/agency is accountable for ensuring that the RN has access to documented competency information for staff to whom the RN is delegating tasks.
- Organizational/agency policies on delegation are developed with the active participation of registered nurses.

Source: American Nurses Association. (2012). *ANA's principles for practice*. Retrieved August 20, 2015 from http://www.nursingworld.org/MainMenuCategories/ThePracticeofProfessionalNursing/NursingStandards/ANAPrinciples/PrinciplesofDelegation.pdf

delegation because setting up traction is not the responsibility of the nurse. However, if the orderly (the person responsible for the task) had asked the physical therapist to help, this could be an act of delegation if the other principles of delegation are met.

Along with responsibility, you must transfer authority. **Authority** is the right to act. Therefore, by transferring authority, the delegator is empowering the delegate to accomplish the task. Too often this principle of delegation is neglected. Nurses retain authority, crippling the delegate's abilities to accomplish the task, setting the individual up for failure, and minimizing efficiency and productivity.

Delegation is often confused with work **assignment**. Delegation involves transfer of responsibility and authority. In assignment no transfer of authority occurs. Instead, assignments are a bureaucratic function that reflects job descriptions and patient or organizational needs. Effective delegation benefits the delegator, the delegate, the manager, and the organization.

Benefits of Delegation

The nurse, the delegate, the manager, and the organization all benefit from delegation. Nurses save time when work is delegated appropriately to others. The delegate has the opportunity to learn new skills. When delegation is used correctly, the manager can better utilize time and resources. Delegation improves the functioning of the organization as a whole.

Benefits to the Nurse

Nurses benefit from delegation. If the nurse is able to delegate some tasks to unlicensed assistive personnel (UAP), more time can be devoted to those tasks that cannot be delegated, especially complex patient care. Thus, patient care is enhanced, the nurse's job satisfaction increases, and retention is improved.

> *Nancy, RN, has three central-line dressing changes to complete as well as two patients to transfer to another unit before the end of shift in 1 hour. Nancy delegates the transfer duties to Shelley, LPN, and completes the central-line dressing changes.*

Benefits to the Delegate

The delegate also benefits from delegation. The delegate gains new skills and abilities that can facilitate upward mobility. In addition, delegation can bring trust and support, and thereby build self-esteem and confidence. Subsequently, job satisfaction and motivation are enhanced as individuals feel stimulated by new challenges. Morale improves, and a sense of pride and belonging develops as well as greater awareness of responsibility. Individuals feel more appreciated and learn to appreciate the roles and responsibilities of others, increasing cooperation and enhancing teamwork.

Benefits to the Manager

Delegation yields benefits for the manager as well. If staff use UAPs appropriately, the manager will have a better functioning unit. Also the manager may be able to delegate some tasks to staff members and devote more time to management tasks that cannot be delegated. With more time available, the manager can develop new skills and abilities, facilitating the opportunity for career advancement.

Benefits to the Organization

As teamwork improves, the organization benefits by achieving its goals more efficiently. Overtime and absences decrease. Subsequently, productivity increases, and the organization's financial position may improve. As delegation increases efficiency, the quality of care improves. As quality improves, patient satisfaction increases.

The Five Rights of Delegation

Fear of liability often keeps nurses from delegating. State nurse practice acts determine the legal parameters for practice, professional associations set practice standards, and organizational policy and job descriptions define delegation appropriate to the specific work setting. In addition, each state board of nursing has its own rules regarding delegation.

Guidelines from the ANA and the National Council of State Boards of Nursing (NCSBN) can also help. Their Joint Statement on Delegation (American Nurses Association [ANA] and the National Council of State Boards of Nursing [NCSBN], 2012) identified the five rights of delegation shown in Box 11-2.

Box 11-2 The Five Rights of Delegation

- Right task
- Right circumstances
- Right person
- Right direction and communication
- Right supervision

Source: American Nurses Association (ANA) and the National Council of State Boards of Nursing (NCSBN). (2015). *Joint Statement on Delegation.* Retrieved http://www.ncsbn.org/1625.htm

- The *right task* specifies what can be safely delegated to a specific patient. These are commonly assigned tasks. Tasks that require nursing assessment or judgment should not be delegated.
- The *right circumstances* include an appropriate setting and available resources. Evaluate the patient's needs and the skills of personnel who could be assigned to meet those specific needs.
- The *right person* refers to both the delegator and the delegate. The delegator must have the authority and responsibility for the patient's care and for the task to be assigned. The delegate must be capable of performing the task and be available to assist. Give the right task to the right person for the right patient.
- The *right direction and communication* require the delegator to give clear, concise description of the task as well as to describe the objectives, limits, and expectations as a result. The delegate should be able to recognize that the patient is responding as expected.
- The *right supervision* includes monitoring the delegate, evaluating the person's performance, giving feedback as required, and intervening if necessary. The delegator remains responsible for the patient's care regardless of who delivers it (Knox, 2013).

The Joint Statement on Delegation decision tree can help guide nurses' decisions about delegation (see Figure 11-1).

The Delegation Process

The delegation process begins with a series of steps that include defining the task, deciding on the delegate, describing the task to the delegate, securing the delegate's agreement, monitoring the delegate's performance, and providing feedback to the individual (see Box 11-3). Following key behaviors will assist nurses to delegate effectively.

Box 11-3 The Delegation Process

1. Define the task.
2. Decide on the delegate.
3. Determine the task.
4. Reach agreement.
5. Monitor performance and provide feedback.

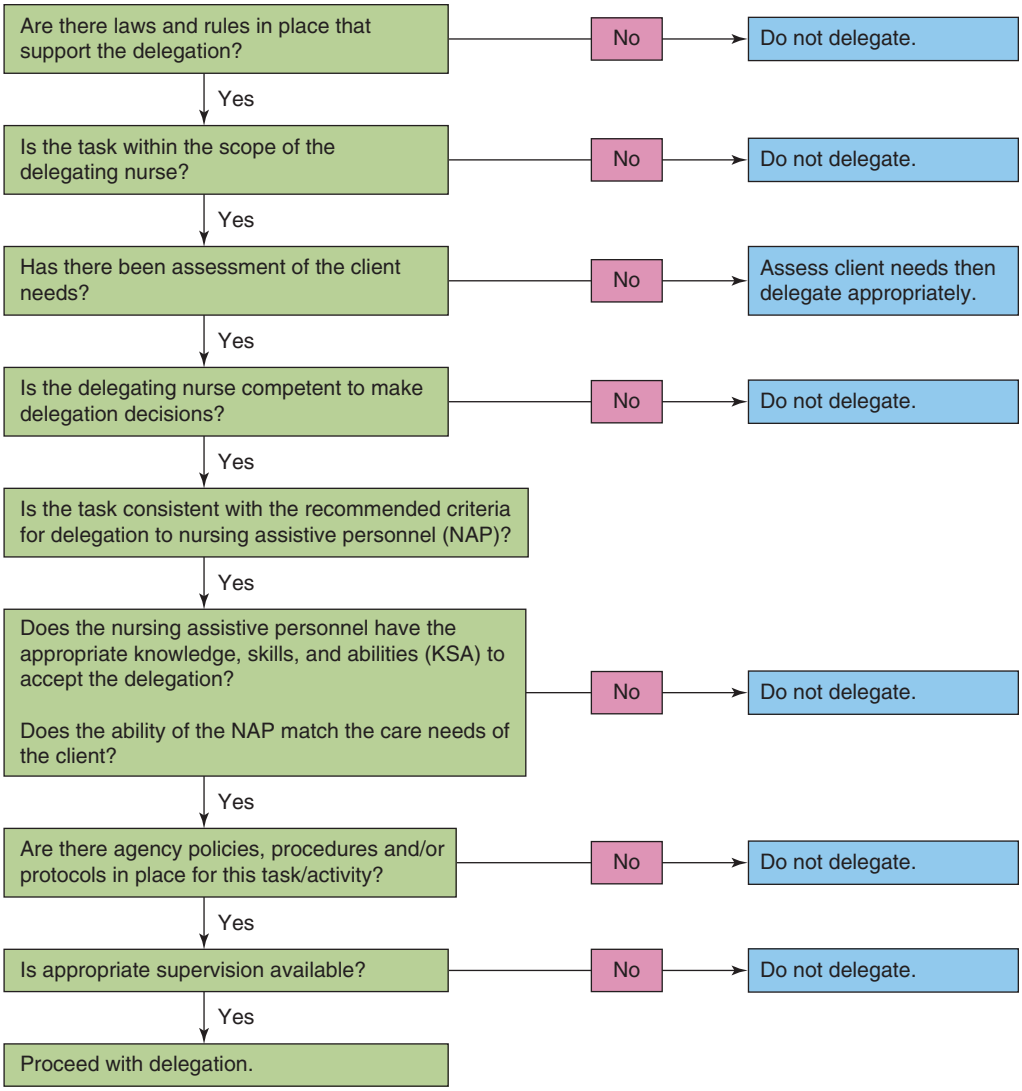

Figure 11-1 Decision tree for delegation to nursing assistive personnel

Source: Adapted from National Council of State Boards of Nursing. (2006). Joint statement on delegation. Retrieved December 2007 from www.ncsbn.org/Joint_statement.pdf

Steps in the Delegation Process

1. ***Define the task.*** Delegate only an aspect of your own work for which you have responsibility and authority, including the following:
   - Routine tasks
   - Tasks for which you do not have time
   - Tasks that have moved down in priority

   Define the aspects of the task. Ask yourself these questions:
   - Does the task involve technical skills or cognitive abilities?
   - Are specific qualifications necessary?
   - Is performance restricted by practice acts, standards, or job descriptions?
   - How complex is the task?

- Is training or education required?
- Are the steps well defined, or are creativity and problem solving required?
- Would a change in circumstances affect who could perform the task?

While you are trying to define the complexity of the task and its components, it is important not to fall into the trap of thinking no one else is capable of performing it. Often others can be prepared to perform a task through education and training. The time taken to prepare others can be recouped many times over. Also, know well the task to be delegated.

An alternative would be to subdivide the task into component parts and delegate the components congruent with the available delegate's capabilities. For example, developing a budget is a managerial responsibility that cannot be delegated, but someone else could explore the types of tympanic thermometers on the market, their costs, advantages, and so on. A committee of staff nurses could evaluate the options and make a recommendation that you could include in the budget justification.

But how do you know what should not be delegated?

Before a task is delegated, determine what areas of authority and what resources you control to achieve the expected results. A unit manager who is responsible for maintaining adequate supplies needs budget authority. The authority to spend money on supplies, however, may be limited to a specific amount for specific supplies or may be allocated to supplies in general.

Certain tasks should never be delegated. For example, discipline should not be delegated, nor should a highly technical task. In addition, any situation that involves confidentiality or controversy should not be delegated to others.

2. ***Decide on the delegate.*** Match the task to the individual. Analyze individuals' skill levels and abilities to evaluate their capability to perform the various tasks; also, determine characteristics that might prevent them from accepting responsibility for the task. Conversely, experience and individual characteristics, such as initiative, intelligence, and enthusiasm, can expand the individual's capabilities. A rule of thumb is to delegate to the lowest person in the hierarchy who has the requisite capabilities and who is allowed to do the task legally and by organizational policy.

   Next, determine availability. For example, Su Ling might be the best candidate, but she leaves for vacation tomorrow and will not be back before the project is due. Then ask who would be willing to assume responsibility. Delegation is an agreement that is entered into voluntarily.

3. ***Determine the task.*** The next step in delegation is to clearly define your expectations for the delegate. Also, plan when to meet. Attempting to delegate in the middle of a crisis is not delegation—that is directing. Provide for enough time to describe the task and your expectations and to entertain questions. It is best to meet in an environment as devoid of distractions as possible.

   - Describe the task using "I" statements, such as "I would like . . .", and appropriate nonverbal behaviors—open body language, face-to-face positioning, and eye contact. The delegate needs to know what is expected, when the task should be completed, and where and how, if that is appropriate. The more experienced delegates may be able to define for themselves the where and how. Decide whether written reports are necessary or if brief oral reports are sufficient. If written reports are required, indicate whether tables, charts, or other graphics

are necessary. Be specific about reporting times. Identify critical events or milestones that might be reached and brought to your attention. For patient care tasks, determine who has responsibility and authority to chart certain tasks. For example, UAPs can enter vital signs, but if they observe changes in patient status, the RN must investigate and chart the assessment.

- Discuss the importance to the organization, you, the patient, and the delegate. Provide the delegate with an incentive for accepting both the responsibility and the authority to do the task.
- Explain the expected outcome and the timeline for completion. Establish how closely the assignment will be supervised. Monitoring is important because you remain accountable for the task, but controls should never limit an individual's opportunity to grow.
- Identify any constraints for completing the task or any conditions that could change. For example, you may ask an assistant to feed a patient for you as long as the patient is coherent and awake, but you might decide to feed the patient if he becomes confused.
- Validate understanding of the task and your expectations by eliciting questions and providing feedback.

4. ***Reach agreement.*** Once you have outlined your expectations, you must be sure that the delegate agrees to accept responsibility and authority for the task. You need to be prepared to equip the delegate to complete the task successfully. This might mean providing additional information or resources or informing others about the arrangement as needed to empower the delegate. Before meeting with the individual, anticipate areas of negotiation, and identify what you are prepared and able to provide.
5. ***Monitor performance and provide feedback.*** Monitoring performance provides a mechanism for feedback and control, which ensures that the delegated tasks are carried out as agreed. Give careful thought to monitoring efforts when objectives are established. When defining the task and expectations, clearly establish the where, when, and how. Remain accessible. Support builds confidence and reassures the delegate of your interest in the delegate and negates any concerns about dumping undesirable tasks.

   Monitoring the delegate too closely, however, conveys distrust. Analyze performance with respect to the established goal. If problem areas are identified, privately investigate and explain the problem, provide an opportunity for feedback, and inform the individual how to correct the mistake in the future. Provide additional support as needed. Also, be sure to give the praise and recognition due, and do not be afraid to do so publicly.

Key Behaviors for Successful Delegation

Following specific guidelines helps the delegation be successful. Success is achieved when the delegate completes the assigned tasks to the satisfaction of the delegator. These key behaviors require the delegator to focus on the delegate's experience and skills and to give the individual specific, concrete instructions (see Box 11-4).

Box 11-4 Key Behaviors in Delegating Tasks

- Describe the task using "I" statements.
- Discuss the importance to the organization.
- Explain the expected outcome and timeline for completion.
- Identify any constraints for completing the task.
- Validate understanding of the task and your expectations.

Accepting Delegation

Accepting delegation means that you accept full responsibility for the outcome and its benefits or liabilities. Just as the delegator has the option to delegate parts of a task, you also have the option to negotiate for those aspects of a task you feel you can accomplish. Recognize, however, that this may be an opportunity for growth. You may decide to capitalize on it, obtaining new skills or resources in the process.

When you accept delegation, you must understand what is being asked of you. First, acknowledge the delegator's confidence in you, but realistically examine whether you have the skills and abilities for the task and the time to do it. If you do not have the skills, you must inform the delegator. However, it does not mean you cannot accept the responsibility. See whether the person is willing to train or otherwise equip you to accomplish the task. If not, then you need to refuse the offer.

Once you agree on the role and responsibilities you are to assume, make sure you are clear on the time frame, feedback mechanisms, and other expectations. Don't assume anything. As a minimum, repeat to the delegator what you heard said; better yet, outline the task in writing.

Throughout the project, keep the delegator informed. Report any concerns you have as they come up. Foremost, complete the task as agreed. Successful completion can open more doors in the future.

If you are not qualified or do not have the time, do not be afraid to say no. Thank the delegator for the offer and clearly explain why you must decline at this time. Express your interest in working together in the future.

See how a school nurse handled delegation in Case Study 11-1.

CASE STUDY 11-1 | Delegation

Lisa Ford is a school nurse for a suburban school district. She has responsibility for three school buildings, including a middle school, a high school, and a vocational rehabilitation workshop for mentally and physically handicapped secondary students. Her management responsibilities include providing health services for 1,000 students, 60 faculty members, and 25 staff members, as well as supervising two unlicensed school health aides and three special education health aides. The logistics of managing multiple school sites results in the delegation of many daily health room tasks, including medication administration, to the school-based health aides.

Nancy Andrews is an unlicensed health aide at the middle school. This is her first year as a health aide and she has a limited background in healthcare. The nurse practice act in the state allows for the delegation of medication administration in the school setting. Lisa is responsible for training Nancy to safely administer medication to students, documenting the training, evaluating Nancy's performance, and providing ongoing supervision. Part of Nancy's training will also include a discussion of those medication-related decisions that must be made by a registered nurse.

Ineffective Delegation

Ineffective delegation results in missed or omitted routine care, such as feeding, turning, ambulating, and toileting (Gravlin & Bittner, 2010). Poor communication and interpersonal relationships between nurses and UAPs have been found to result in ineffective delegation (Bittner, Gravlin, Hansten, & Kalisch, 2011).

The RN/UAP unit is a microsystem in healthcare. When that unit is dysfunctional or functioning at less than optimal performance, the quality of care suffers. One reason for problems with delegation is the assignment of a single UAP to more than one RN. The UAP's workload may be more than one person can handle, but each nurse may be unaware of the assistant's overload.

Another reason for ineffective delegation is that nurses define delegation differently (Bittner et al., 2011). Some nurses define delegation as explicit instructions to carry out a specific task. Others think that delegation is both specific and implicit in expected tasks, such as ambulating or toileting. Potential barriers to effective delegation include organizational factors or the delegator's or delegate's beliefs or inexperience.

Organizational Culture

The culture within the organization may restrict delegation. Hierarchies, management styles, and norms may all preclude delegation. Rigid chains of command and autocratic leadership styles do not facilitate delegation and rarely provide good role models. The norm is to do the work oneself because others are not capable or skilled. An atmosphere of distrust prevails as well as a poor tolerance for mistakes. Norms such as inadequate crisis management or poorly defined job descriptions or chains of command also impede successful delegation.

Lack of Resources

Another difficulty frequently encountered is a lack of resources. For example, there may be no one to whom you can delegate. Consider the sole registered nurse in a skilled nursing facility. If practice acts define a task as one that only a registered nurse can perform, there is no one else to whom that nurse can delegate that task.

Financial constraints also can interfere with delegation. For instance, someone from your department must attend the annual conference in your nursing specialty area. However, the organization will only pay the manager's travel and conference expenses, which precludes anyone else from attending.

Educational resources may be another limiting factor. Perhaps others could learn how to do a task if they could practice with the equipment, but the equipment or a trainer is not available.

Time can also be a limiting factor. For example, it is Friday, and the schedule should be posted on Monday. No one on your staff has experience developing schedules, and you need to go out of town for a family emergency, so there is no one else to prepare the schedule.

An Insecure Delegator

The majority of the barriers to delegation arise from the delegator. Reasons people give for failing to delegate include the following:

"I can do it better."
"I can do it faster."
"I'd rather do it myself."
"I don't have time to delegate."

Often underlying these statements are erroneous beliefs, fears, and inexperience in delegation. Certainly, the experienced person can do the task better and faster. Indeed, delegation takes time, but failing to delegate is a time waster. Time invested in developing staff today is later repaid many times over.

The following are common fears:

- ***Fear of competition or criticism.*** What if someone else can do the job better or faster than I? Will I lose my job? Be demoted? What will others think? Will I lose respect and control? This fear is unfounded if the delegator has selected the right task and matched it with the right individual. In fact, the delegate's success in the task provides evidence of the delegator's leadership and decision-making abilities.
- ***Fear of liability.*** Some individuals are not risk takers and shy away from delegation for this reason. Yes, risks are associated with delegation, but the delegator can minimize these risks by following the steps of delegation. A related concern is a fear of being blamed for the delegate's mistakes. If the delegator selected the task and the delegate appropriately, then the responsibility for any mistakes made are solely those of the delegate; it is not necessary to be afraid of repercussions or to take on guilt for another's mistakes.

  Review the five rights of delegation and the decision tree from the Joint Statement for Delegation from ANA and NCSBN (2012) as well as the state's nurse practice act and the organization's policies. RNs often fear blame from management if something goes wrong when a task has been delegated to an LPN or UAP, but those fears can be relieved if state law, organizational policies, and job descriptions are followed.
- ***Fear of loss of control.*** Will I be kept informed? Will the job be done right? How can I be sure? The more insecure and inexperienced in delegation one is, the more fear is an issue. This is also a predominant concern in individuals who tend toward autocratic styles of leadership and perfectionism. The key to retaining control is to clearly identify the task and expectations and then to monitor progress and provide feedback.

Leading at the Bedside: Delegation

When you first become an RN, delegation may seem foreign to you. Yes, you learned the concepts and you've accepted delegation even as a student. But to delegate to others—UAPs, other staff—you'd rather do it yourself. You have no choice, however. If you are to be productive, provide good care to your patients, and advance in your career, you must learn to delegate.

Fortunately, you have this chapter's specific guidelines, your experiences, and your observations of others to help you. Note your experience as a delegate. Did your delegator follow these guidelines? If not, how could you do it better? Pay attention to how others delegate and accept delegation. Always ask yourself if you could do better.

Follow this advice and you'll soon be as proficient at delegating as you are as a clinician.

- ***Fear of overburdening others.*** "They already have so much to do; how can I suggest more?" Such a statement belittles the decisional capabilities of others. Everyone has work to do. Recall that delegation is a voluntary, contractual agreement; acceptance of a delegated task indicates the availability and willingness of the delegate to perform the task. Often, the delegate welcomes the diversion and stimulation, and what the delegator perceives as a burden is actually a blessing. The onus is on the delegator to select the right person for the right reason.
- ***Fear of decreased personal job satisfaction.*** Because the tasks recommended to delegate are those that are familiar and routine, the delegator's job satisfaction should actually increase with the opportunity to explore new challenges and obtain other skills and abilities.

An Unwilling Delegate

Inexperience and fear of failure can motivate a potential delegate to refuse to accept a delegated task. Much reassurance and support are needed. In addition, the delegate should be equipped to handle the task. If proper selection criteria are used and the steps of delegation followed, then the delegate should not fail. The delegator can boost the delegate's lack of confidence by building on simple tasks. The delegate needs to be reminded that everyone was inexperienced at one time. Another common concern is how mistakes will be handled. When describing the task, the delegator should provide clear guidelines for handling problems—guidelines that adhere to organizational policies.

Another barrier is the individual who avoids responsibility or is overdependent on others. Success breeds success; therefore, it is important to use an enticing incentive to engage the individual in a simple task that guarantees success.

When the steps of delegation are not followed or barriers remain unresolved, delegation is often ineffective. Inefficient delegation can result from unnecessary duplication, underdelegation, reverse delegation, and overdelegation.

Underdelegation

Underdelegation occurs when any of the following happens:

- The delegator fails to transfer full authority to the delegate.
- The delegator takes back responsibility for aspects of the task.
- The delegator fails to equip and direct the delegate.

As a result, the delegate is unable to complete the task, and the delegator must resume responsibility for its completion.

Sharon, RN, is a school nurse with three separate buildings under her direction. UAPs, called health clerks, operate in the school health office when Sharon is at another building. Joye, a first-year health clerk, has had minimal medication administration instruction and experience. During the first week of school, Joye tries to "speed up" the medication administration process and sets out all of the noon medications in individual, unlabeled cups for the students. The cups are rearranged by students trying to find their meds, and Joye cannot identify what meds belong to which students. Sharon is called back to the school to administer the correct medications, students are late to class, and Joye is frustrated that she couldn't handle the task.

It may be that the RN fears liability or lacks confidence or experience in delegating and decides to do all the tasks rather than delegate to an assistant (Mitty et al., 2010). Conversely, the assistant may not be prepared for the tasks or may not believe the task is within the assistant's scope of practice. In addition, the assistant may not be able to complete all the tasks, especially if the person is assigned to several nurses.

Reverse Delegation

In **reverse delegation**, someone with a lower rank delegates to someone with more authority.

Thomas is a nurse practitioner for the burn unit. He recently arrived on the unit to find several patients whose dressing changes had not been completed due to a code earlier that morning. Dawn, LPN, asks Thomas to help the staff complete dressing changes before physician rounds begin.

Overdelegation

Overdelegation occurs when the delegator loses control over a situation by providing the delegate with too much authority or too much responsibility. This places the delegator in a risky position, increasing the potential for liability. In this instance, the nurse assumes that any task that does not involve nursing assessment or judgment should be assigned to assistive personnel.

Ellen, GN, is in her sixth week of orientation in the trauma ICU. Her mentor, Dolores, RN, notes that Mr. Anderson is scheduled for an MRI off the unit. Dolores delegates the task of escorting Mr. Anderson to the MRI unit to Ellen, who is not ACLS certified. During the MRI, Mr. Anderson is accidentally extubated and suffers respiratory and cardiac arrest. A code is called in the MRI suite, and ER nurses must respond since an ACLS-certified nurse is not with the patient.

Not delegating appropriately negatively affects other staff on the unit as well, as the next two examples illustrate.

Sally, RN, always says she "likes to do everything herself" for her patients. She does not like to ask aides for assistance. Her patients are usually happy, but Sally is extremely busy all day and does not ever have time to help a peer RN when asked or answer call lights to help the team. Sally's peers get frustrated because her lack of delegating appropriate tasks to her nurse's aide partner makes the aide feel not valued, Sally feels too busy in her job, and her peers feel like they get no help from Sally when needed.

Bridgett, RN, feels that she has spent her time doing aide work while she was in nursing school. Now that she has taken NCLEX boards and is working as a nurse, she will not help patients to the bathroom, or empty a bedpan, or change bed linens. She will call an aide to do these tasks even if she is in the room and has time to do the tasks herself. Bridgett's inappropriate delegation causes aides to be angry, peer RNs to be frustrated because the aides do not have time to help them because they are always doing Bridgett's work, and results in inconsistency in the practice between Bridgett and other nurses, which Bridget's patients' notice.

Delegation is a skill that can be learned. Like other skills, successfully delegating requires practice. Sometimes it seems it might be easier to do it yourself—but it is not.

Once you learn how to delegate, you will extend your ability to accomplish more by using others' help.

By delegating appropriately, managers can role model this behavior and teach their staff to do likewise. It is the best use of their time.

No one in healthcare today can afford not to delegate.

What You Know Now

- Delegation is a contractual agreement in which authority and responsibility for a task are transferred by the person accountable for the task to another individual.
- Delegation benefits the delegator, delegate, manager, unit, and organization.
- The five rights of delegation are right task, right circumstances, right person, right direction, and right supervision.
- Delegation involves skill in identifying and determining the task and level of responsibility, deciding who has the requisite skills and abilities, describing expectations clearly, reaching mutual agreement, and monitoring performance and providing feedback.
- Delegable tasks are personal, routine tasks that the delegator can perform well; that do not involve discipline, highly technical tasks, or confidential information; and that are not controversial.
- To accept delegation, the delegator and delegate must agree on roles and responsibilities, the time frame for completion, feedback mechanisms, and expectations.
- Ineffective delegation can occur with organizational constraints or the lack of experience or beliefs of the delegate or delegator.
- Managers can role model appropriate delegation.
- Delegation is essential in healthcare today.

Tools for Delegating Successfully

1. Delegate only tasks for which you have responsibility.
2. Transfer authority when you delegate responsibility.
3. Be sure you follow state regulations, job descriptions, and organizational policies when delegating.
4. Follow the delegation process and key behaviors for delegating described in this chapter.
5. Accept delegation when you are clear about the task, time frame, reporting, and other expectations.
6. Review the five rights of delegation and the NCSBN's decision tree to delegate appropriately.

Questions to Challenge You

1. Review your state's nurse practice act. How is delegation defined? What tasks can and cannot be delegated? How is supervision defined? Are there any other guidelines for supervision? Are responsibilities regarding advanced practice delineated? How does the scope of practice differ

between registered and licensed practical/vocational nurses? What is the scope of practice of other healthcare providers?

2. What are your organization's policies on delegation?
3. Describe a situation when you delegated a task to someone else. Did you follow the steps of delegation explained in this chapter? Was the outcome positive? If not, what went wrong?
4. Describe a situation when someone else delegated a task to you. Did your delegator explain what to do? Did you receive too much information? Not enough? Was supervision appropriate to the task and to your abilities? What was the outcome?

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Chapter 12

Building and Managing Teams

Groups and Teams
Group Interaction
Group Leadership

Group and Team Processes: Homans Framework
Norms
Roles

Building Teams
Assessment
Team-building Activities

Managing Teams
Task
Group Size and Composition
Productivity and Cohesiveness
Development and Growth
Shared Governance

The Nurse Manager as Team Leader
Communication
Evaluating Team Performance

Leading Committees and Task Forces
Guidelines for Conducting Meetings
Managing Task Forces
Patient Care Conferences

Learning Outcomes

After completing this chapter, you will be able to:

1. Describe how groups and teams function.
2. Explain the norms and roles in groups and teams.
3. Describe various methods of team building.
4. Discuss factors that influence team management.
5. Explain why the nurse manager's leadership skills are essential to team performance.
6. Discuss how to lead groups, task forces, and patient care conferences.

Key Terms

additive task
adjourning
cohesiveness
committees
conjunctive task
disjunctive task
divisible task
formal committees
formal groups
forming
group
hidden agendas
informal committees
informal groups
norming
norms
ordinary interacting groups
performing
pooled interdependence
productivity
real (command) groups
reciprocal interdependence
re-forming
role
sequential interdependence
status
status incongruence
storming
task forces
task group
teams
team building

Introduction

Most often, nursing occurs in a team environment. Work groups that share common objectives function in a harmonious, coordinated, purposeful manner as teams. The staff nurse is constantly involved in teamwork. The nurse/aide/unit secretary team works together every day on a nursing unit or in a clinic setting. With shared governance more often the norm and interprofessional team work common, the nurse may participate or lead a team broader in scope than one unit. For example, a nurse might lead the acute care practice council or be on a team to implement supplies at the bedside.

Teamwork is essential in healthcare's demanding environment. Kalisch and Lee (2010) found that poor teamwork contributed to both the quality of care provided and, often, in missed care.

High-performance teams require expert leadership skills. In a healthcare delivery system integrated across settings, a team environment becomes increasingly essential. Nurse managers must skillfully orchestrate the activity and interactions of interprofessional teams as well as conventional nursing work groups. Understanding the nature of groups and how groups are transformed into teams is essential for the nurse to be effective.

Groups and Teams

A **group** is an aggregate of individuals who interact and mutually influence each other. Both formal and informal groups exist in organizations. **Formal groups** are clusters of individuals designated temporarily or permanently by an organization to perform specified organizational tasks. Formal groups may be structured laterally, vertically, or diagonally. Task groups, teams, task forces, and committees may be structured in all of these ways, whereas command groups generally are structured vertically.

Group members may include the following:

- Individuals from a single work group (e.g., nurses on one unit) or individuals at similar job levels from more than one work group (e.g., all professional staff)
- Individuals from different job levels (e.g., nurses and UAPs)
- Individuals from different work groups and different job levels in the organization (e.g., committee to review staff orientation classes)

Groups may be permanent or temporary. Command groups, teams, and committees usually are permanent, whereas task groups and task forces are often temporary.

Informal groups evolve naturally from social interactions. Groups are informal in the sense that they are not defined by an organizational structure. Examples of informal groups include individuals who regularly eat lunch together or who convene spontaneously to discuss a clinical dilemma.

Real (command) groups accomplish tasks in organizations and are recognized as a legitimate organizational entity. Its members are interdependent, share a set of norms, generally differentiate roles and duties among themselves, are organized to achieve ongoing organizational goals, and are collectively held responsible for measurable outcomes. The group's manager has line authority in relation to group members individually and collectively. The group's assignments are usually routine and designed to fulfill the specific mission of the agency or organization. The regularly assigned staff who work together under the direction of a single manager constitute a command group.

A **task group** is composed of several persons who work together, with or without a designated leader, and are charged with accomplishing specific, time-limited assignments. A group of nurses selected by their colleagues to plan an orientation program for new staff constitutes a task group. Usually, several task groups exist within a service area and may include representatives from several disciplines (e.g., nurse, physician, dietitian, social worker).

Other special groups include committees or task forces formed to deal with specific issues involving several service areas. A committee responsible for monitoring and improving patient safety or a task force assigned to develop procedures to adhere to patient privacy regulations is an example of a special work group.

Healthcare organizations depend on numerous committees, which nurses participate in and often lead (see Leading at the Bedside: Workplace Teams and Groups.) Some of these committees are mandated by accrediting and regulatory bodies, such as committees for education, standards, disaster, and patient care evaluation. Others are established to meet a specific need (e.g., to formulate a new policy on substance abuse).

Leading at the Bedside: Workplace Teams and Groups

Teams and groups are not new to you. You may have been on an athletic team, a debate team, or participated in religious or community groups. Workplace teams and groups, however, carry the responsibility of providing care to patients, supporting colleagues, and furthering the goals of the organization. These purposes—high-minded though they are—need not intimidate you. As you find yourself a member of a team or assigned to a committee, refer to this chapter for suggestions on how to fulfill your role as a member or a leader.

What is the most exciting aspect of working with teams and groups? You have the opportunity to learn from others! Pay attention to how each individual participates in the group. Use what you learn to improve your own ability as a participant in groups.

Teams are real groups in which individuals must work cooperatively with each other in order to achieve some overarching goal. Teams have command or line authority to perform tasks, and membership is based on the specific skills required to accomplish the tasks. Similar to the groups previously described, teams may include individuals from a single work group or individuals at similar job levels from more than one work group; individuals from different job levels, or individuals from different work groups and different job levels in the organization. They may have a short life span or exist indefinitely.

Metropolitan Hospital has established a clinical ladder system for nursing staff. Each quarter, members of the clinical excellence committee meet to review applications from staff nurses who are seeking promotion to the next clinical ladder level. The committee is made up of staff nurses and nurse managers from each service line. Each applicant is responsible for completing a comprehensive application. The committee members evaluate each application and make recommendations to the vice president for patient care on those nurses who should be considered for promotion.

A work group becomes a team when the individuals must apply group process skills to achieve specific results. They must exchange ideas, coordinate work activities, and develop an understanding of other team members' roles in order to perform effectively. Members appreciate the talents and contributions of each individual on the team and find ways to capitalize on them. Most work teams have a leader who maintains the integrity of the team's function and guides the team's activities, performance, and development. Teams may be self-directed—that is, led jointly by group members who decide together about work objectives and activities on an ongoing basis.

In a given service area, the entire staff might not function as a team, but a subgroup may. For example, case managers for the inpatient and ambulatory cystic fibrosis population in a children's medical center might be called a team. Individual members of an interdisciplinary team, such as this one, may report formally to different managers, but in delivering care to the cystic fibrosis population there is no designated individual in charge. In meetings, the team members discuss patients' problems and jointly decide on plans of action.

Many different types of groups and teams are used throughout organizations. Examples are ad hoc task groups, quality improvement teams, quality circles, self-directed work teams, shared governance councils, and focus groups.

Nurse managers at a large university hospital are responsible for educating their staff about patient satisfaction. Patient satisfaction surveys are sent to randomly selected patients. Results are compiled, and each department receives a detailed report of the results. Staff members review the data at monthly staff meetings, using both positive and negative comments to guide their patient care activities. As needed, department standards and protocols are updated to reflect improved processes.

Most groups are considered **ordinary interacting groups**. These groups usually have a designated formal leader, but they may be leaderless. Work teams, task groups, and committees are examples of ordinary interacting groups. Discussions usually begin with a statement of the problem by the group leader followed by an open, unstructured conversation. Normally, the final decision is made by consensus (without formal voting; members indicate concurrence with a group agreement that members can live with and support publicly). The decision may also be made by the leader

or someone in authority, majority vote, an average of members' opinions, minority control, or an expert member. Interacting groups enhance the cohesiveness and *esprit de corps* among group members. Participants are able to build strong social ties and will be committed to the solution decided on by the group.

> *Infection control nurses have been tracking occurrences of MRSA infections among patients in their hospital system. In addition to implementing patient care protocols as recommended by federal and state infectious disease agencies, the nurses track compliance in high-risk units and tailor education programs to meet the needs of nursing and assistive staffs.*

Group Interaction

Ordinary interacting groups may be dominated by one or a few members. If the group is highly cohesive, its decision-making ability may be affected by groupthink (Shirey, 2012). Groupthink results in pressure for every member to conform, usually to the leader's beliefs, even to violating personal norms.

Sometimes groups spend excessive time dealing with socioemotional relationships, thereby reducing the time spent on the problem and slowing consensus. Ordinary groups may reach compromise decisions that may not really satisfy any of the participants. Because of these problems, the functioning of ordinary groups is dependent on the leader's skills.

Group Leadership

Each type of group presents unique opportunities and challenges. An important role of the nurse manager is to link service areas with groups at higher levels in the organization. This link facilitates problem solving, coordination, and communication throughout the organization. Leadership roles in work groups are important and may also be either formal or informal. For example, the nurse manager formally leads the unit or service area staff but may also informally lead a support group of nurse managers.

The leader's influence on group processes, formal or informal, and the ability of the group to work together as a team often determine whether the group accomplishes its goals. Nurse managers may effectively manage work groups and turn them into teams by understanding principles of group processes and applying them to group decision making, team building, and leading committees and task forces.

Group and Team Processes: Homans Framework

The modified version of Homans's (1950, 1961) social system conceptual scheme, presented in Figure 12-1, provides a framework for understanding group inputs, processes, and outcomes. The schematic depicts the effects of organizational and individual background factors on group leadership, including dynamics (tasks, activities, interactions, attitudes) and processes (forming, storming, norming, performing, adjourning). Elements of the required group system and processes influence each other and the emergent group system and social structure.

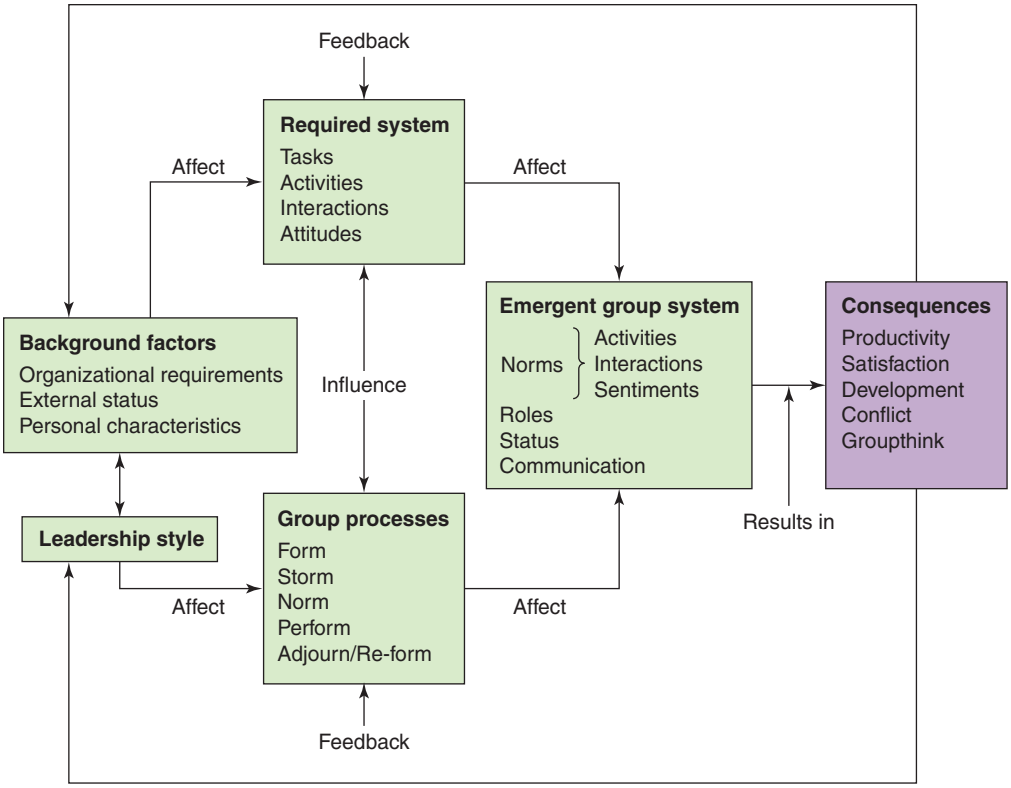

Figure 12-1 Conceptual scheme of a basic social system.

Source: Adapted from Homans, G. (1950). *The human group*. New York: Harcourt Brace Jovanovich; and Homans, G. (1961). *Social behavior: Its elementary forms*. New York: Harcourt Brace. By permission of Transaction Publishers

This system determines the productivity of the group as well as members' quality of work life, such as job satisfaction, development, growth, and similarity in thinking. The framework distinguishes required factors that are imposed by the external system from factors that emerge from the internal dynamics of the group.

According to Homans's framework, the three essential elements of a group system are activities, interactions, and attitudes. Activities are the observable behaviors of group members. Interactions are the verbal or nonverbal exchanges of words or objects among two or more group members. Attitudes are the perceptions, feelings, and values held by individual group members, which may be both positive and negative. To understand and guide group functioning, a manager should analyze the activities, interactions, and attitudes of work group members.

Homans's framework indicates that background factors, the manager's leadership style, and the organizational system influence the normal development of the group. Groups, whether formal or informal, typically develop in these phases: form, storm, norm, perform, and adjourn or re-form. In the initial stage, **forming**, individuals assemble into a well-defined cluster. Group members are cautious in approaching each other as they come together as a group and begin to understand requirements of group membership. At this stage, the members often depend on a leader to define purpose, tasks, and roles.

As the group begins to develop, **storming** occurs. Members wrestle with roles and relationships. Conflict, dissatisfaction, and competition arise on important issues related to procedures and behavior. During this stage, members often compete for power and

status, and informal leadership emerges. During the storming stage, the leader helps the group to acknowledge the conflict and to resolve it in a win–win manner.

In the third stage, **norming**, the group defines its goals and rules of behavior. The group determines what are or are not acceptable behaviors and attitudes. The group structure, roles, and relationships become clearer. Cohesiveness develops. The leader explains standards of performance and behavior, defines the group's structure, and facilitates relationship building.

In the fourth stage, **performing**, members agree on basic purposes and activities and carry out the work. The group's energy becomes task oriented. Cooperation improves, and emotional issues subside. Members communicate effectively and interact in a relaxed atmosphere of sharing. The leader provides feedback on the quality and quantity of work, praises achievement, critiques poor work and takes steps to improve it, and reinforces interpersonal relationships within the group.

The fifth stage is either **adjourning** (the group dissolves after achieving its objectives) or **re-forming**, when some major change takes place in the environment or in the composition or goals of the group that requires the group to refocus its activities and recycle through the four stages. When a group adjourns, the leader must prepare group members for dissolution and facilitate closure through celebration of success and leave-taking. If the group is to refocus its activities, the leader will explain the new direction and provide guidance in the process of re-forming.

Norms

Norms are the informal rules of behavior shared and enforced by group members, and they emerge whenever humans interact. Groups develop norms that members believe must be adhered to for fruitful, stable group functioning. Nursing groups often establish norms related to how members deal with absences that affect the workload of colleagues. Norms may include not calling in sick on weekends, readily accommodating requests for trading shifts, and returning from breaks in a timely manner. In a team environment, norms are usually linked to each team member's expected contribution to the performance and products of the team's efforts.

Group norms are likely to be enforced if they serve to facilitate group survival, ensure predictability of behavior, help avoid embarrassing interpersonal problems, express the central values of the group, and clarify the group's distinctive identity. If an individual agrees to take on a specific assignment on the team's behalf and fails to complete the assignment on time, a group norm has been violated.

Groups go through several stages in enforcing norms with deviant members. First, members use rational argument or present reasons to the deviant individual for adhering to the norms. Second, if rational argument is not effective, members may use persuasive or manipulative techniques, reminding the deviant of the value of the group. The third stage is attack. Attacks may be verbal or even physical and sometimes include sabotaging the deviant's work. The final stage is ignoring the deviant.

It becomes increasingly difficult for a deviant to acquiesce to the group as these strategies escalate. Agreeing to rational argument is easy, but agreeing after an attack is difficult. When the final stage (ignoring) is reached, acquiescence may be impossible because group members refuse to acknowledge the deviant's surrender. A nurse manager has a responsibility to help groups deal with members who violate group norms related to performance, including counseling the employee and preventing destructive conflict.

Roles

Norms apply to all group members, whereas roles are specific to positions in the group. A **role** is a set of expected behaviors that fit together into a unified whole and are characteristic of persons in a given context. Roles commonly seen in groups can be classified as either task roles or socioemotional (nurturing) roles. Often, individuals fill several roles.

Individuals performing task roles attempt to keep the group focused on its goals. Task roles include the following:

- ***Initiator–contributor:*** redefines problems and offers solutions, clarifies objectives, suggests agenda items, and maintains time limits
- ***Information seeker:*** pursues descriptive bases for the group's work
- ***Information giver:*** expands information given by sharing experiences and making inferences
- ***Opinion seeker:*** explores viewpoints that clarify or reflect the values of other members' suggestions
- ***Opinion giver:*** conveys to group members what their pertinent values should be
- ***Elaborator:*** predicts outcomes and provides illustrations or expands suggestions, clarifying how they could work
- ***Coordinator:*** links ideas or suggestions offered by others
- ***Orienter:*** summarizes the group's discussions and actions
- ***Evaluator-critic:*** appraises the quantity and quality of the group's accomplishments against set standards
- ***Energizer:*** motivates group to accomplish, qualitatively and quantitatively, the group's goals
- ***Procedural technician:*** supports group activity by arranging the environment (e.g., scheduling meeting room) and providing necessary tools (e.g., ordering visual equipment)
- ***Recorder:*** documents the group's actions and achievements

Nurturing roles facilitate the growth and maintenance of the group. Individuals assuming these roles are concerned with group functioning and interpersonal needs. Nurturing roles include the following:

- ***Encourager:*** compliments members for their opinions and contributions to the group
- ***Harmonizer:*** relieves tension and conflict
- ***Compromiser:*** suppresses own position to maintain group harmony
- ***Gatekeeper:*** encourages all group members to communicate and participate
- ***Group observer:*** takes note of group processes and dynamics and informs group of them
- ***Follower:*** passively attends meetings, listens to discussions, and accepts group's decisions

Status is the social ranking of individuals relative to others in a group based on the position they occupy. Status comes from factors the group values, such as achievement, personal characteristics, the ability to control rewards, or the ability to control

information. Status is usually enjoyed by members who most conform to group norms. Higher-status members often exercise more influence than others in group decisions.

Status incongruence occurs when factors associated with group status are not congruent, such as when a younger, less experienced person becomes the group leader. Status incongruence can have a disruptive impact on a group. For example, isolates are members who have high external status and different backgrounds from regular group members. They usually work at acceptable levels but are isolated from the group because they do not fit the group member profile. Sometimes status incongruence occurs because the individual does not need the group's approval and makes no effort to obtain it.

The most important role in a group is the leadership role. Leaders are appointed for most formal groups, such as command groups, teams, committees, or task forces. Leaders in informal groups tend to emerge over time and in relation to the task to be performed. Some of the factors contributing to the emergence of leadership in small groups include the ability to accomplish the group's goals, sociability, good communication skills, self-confidence, and a desire for recognition.

Building Teams

Team building focuses on both task and relationship aspects of a group's functioning and is intended to increase efficiency and productivity. The group's work and problem-solving procedures, member–member relations, and leadership are analyzed, and exercises are prescribed to help members modify their patterns of interaction or processes of decision making.

Assessment

The most important initial activities in team building are data gathering and diagnosis. Questions must be asked about the group's context (organizational structure, climate, culture, mission, and goals); the characteristics of the group's work, including group members' roles, styles, procedures, job complexity; and the team, its problem-solving style, interpersonal relationships, and relations with other groups.

The following questions may be asked:

1. To what extent do the team's members understand and accept the goals of the organization?
2. What, if any, hidden agendas interfere with the group's performance? (**Hidden agendas** are members' individual unspoken objectives that interfere with commitment or enthusiasm.)
3. How effective is the group's leadership?
4. To what extent do group members understand and accept their roles?
5. How does the group make decisions?
6. How does the group handle conflict? Are conflicts dealt with through avoidance, forcing, accommodating, compromising, competing, or collaborating?
7. What personal feelings do members have about each other?
8. To what extent do members trust and respect each other?
9. What is the relationship between the team and other units in the organization?

Only after assessing and diagnosing problems can the leader take actions to improve team functioning (Hill, 2010).

Team-building Activities

Team-building activities, originally designed to improve interpersonal workplace relationships, have expanded to include meeting goals and accomplishing tasks. Wilhelmsson, Ponzer, Dahlgren, Timpka, and Faresjö (2011) found that female students in medicine and nursing were more open-minded about cooperating with other health professions than were male medical or nursing students. This is positive news for those involved in team building with women, less so with male participants.

Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS) is a program developed by the Department of Defense and the Agency for Healthcare Research and Quality (AHRQ) to integrate teamwork into practice (Agency for Healthcare Research and Quality, 2015). TeamSTEPPS involves three phases:

1. Assessing the need
2. Training on-site
3. Implementing and sustaining training

TeamSTEPPS has been tested in nursing settings. One study found that teamwork training improved RNs' perceptions of leadership (Castner, Foltz-Ramos, Schwartz, & Ceravolo, 2012). Vertino (2014) found that such training improved nurses' attitudes toward teamwork.

Thoughtful team-building strategies allow group members to acknowledge the developmental process and respond to it in constructive ways. Team-building activities may also be used to facilitate the normal stages of group development (forming, storming, norming, performing, and adjourning or re-forming), an important process in managing teams.

In traditional work groups experiencing problems, team-building strategies may help improve performance. Numerous techniques and commercial resources are available.

A nurse manager may decide to assume personal responsibility for team building when the team is basically functional and simply needs some fine-tuning to deal more effectively with minor interpersonal issues or changing circumstances.

Managing Teams

Managing teams differs from team building and depends on the task, group size and composition, productivity and cohesiveness, the group's development and growth, and the extent of shared governance in the organization.

Task

The size of the group can influence its effectiveness, depending on the type of task: additive, disjunctive, divisible, or conjunctive (Steiner, 1972, 1976). The more people who work on an **additive task** (group performance depends on the sum of individual performance), the more inputs are available to produce a favorable result. For example, the game tug-of-war involves the combined effort of the team.

For a **disjunctive task** (the group succeeds if one member succeeds), the greater the number of people, the higher the probability that one group member will solve the problem. Consider the Olympics. The more athletes on one team, the greater the opportunity for a gold medal. Regardless of the event, a medalist from the team brings recognition to the nation, and every citizen is able to share the honor.

With a **divisible task** (tasks that can break down into subtasks with division of labor), more people provide a greater opportunity for specialization and interdependence in performing the tasks. For instance, the construction of a car is a complex task. From design of the car to insertion of the last bolt, each individual involved has a specialized task.

With a **conjunctive task** (the group succeeds only if all members succeed), more people increase the likelihood that one person can slow up the group's performance (e.g., a jury trial).

On many tasks, interdependence is important. There are three kinds:

- **Pooled interdependence**, in which each individual contributes but no one contribution is dependent on any other (e.g., a committee discussion)
- **Sequential interdependence**, in which group members must coordinate their activities with others in some designated order (e.g., an assembly line)
- **Reciprocal interdependence**, in which members must coordinate their activities with every other individual in the group (e.g., team nursing)

Group Size and Composition

Groups with five to ten members tend to be optimal for most complex organizational tasks, which require diversity in knowledge, skills, and attitudes and allow full participation. In larger groups, members tend to contribute less of their individual potential while the leader is called on to take more corrective action, do more role clarification, manage more disruption, and make recognition more explicit. Groups tend to perform better with competent individuals as members. However, coordination of effort and proper utilization of abilities and task strategies must occur as well. Homogeneous groups tend to function more harmoniously, whereas heterogeneous groups may experience considerable conflict.

Today's healthcare settings employ multigenerational cohorts of nurses (Douglas, Howell, Nelson, Pilkington, & Salinas, 2015). Traditionals, baby boomers, generation Xers, and millennials comprise healthcare's workforce. Differences among expectations of each cohort must be incorporated into team management (Keepnews, Brewer, Kovner, & Shin, 2010).

Productivity and Cohesiveness

Productivity represents how well the work group or team uses the resources available to achieve its goals and produce its services. If patient care is satisfactorily completed at the end of each shift in relation to the levels of staffing, supplies, equipment, and support services used, the group has been productive. Productivity is influenced by work-group dynamics, especially a group's cohesiveness and collaboration.

Cohesiveness is the degree to which the members are attracted to the group and how much they are willing to contribute. Cohesiveness is also related to homogeneity of interests, values, attitudes, and background factors. Strong group cohesiveness leads to a feeling of "we" as more important than "I" and ensures a higher degree of cooperation and interpersonal support among group members.

Group norms may support or subvert organizational objectives, depending on the level of group cohesiveness. High group cohesiveness may foster high or low individual performance, depending on the prevailing group norms for performance. When cohesiveness is low, productivity may vary significantly. Although groups, in general, tend toward lower productivity, nursing education and practice have especially high standards of performance that help to counter this tendency.

Groups are more likely to become cohesive when members are characterized by the following:

- Share similar values and beliefs
- Are motivated by the same goals and tasks
- Interact to achieve their goals and tasks
- Work in proximity to each other (e.g., on the same unit and on the same shift)
- Have specific needs that can be satisfied by involvement in the group

Group cohesiveness is also influenced by the formal reward system. Groups tend to be more cohesive when group members receive comparable treatment and pay and perform similar tasks that require interaction among the members. Similarities in values, education, social class, gender, age, and ethnicity that lead to similar attitudes strengthen group cohesiveness.

Cohesiveness can produce intense social pressure. Highly cohesive groups can demand and enforce adherence to norms regardless of their practicality or effectiveness. In this circumstance, the nurse manager may have a difficult time influencing individual nurses, especially if the group norms deviate from the manager's values or expectations. For example, operating room nurses may be used to arriving at the time their shift starts and then changing into scrubs. The nurse manager, in contrast, may expect the staff to be changed and ready for work by the time the shift starts. In addition, group dynamics can affect absenteeism and turnover. Groups with high levels of cohesiveness exhibit lower turnover and absenteeism than groups with low levels of cohesiveness.

For most individuals, the work group provides one of the most important social contacts in life; the experience of working on an effective work team contributes significantly to one's professional confidence and to the quality of work life and job satisfaction. The work group often provides the primary motivation for returning to the job day after day, even when employees are dissatisfied with the employing organization or other working conditions.

Work groups not only perform tasks but also provide the context in which novices learn basic skills and become socialized and experts engage in clinical mentorship, standard setting, quality improvement, and innovation. Work-group relations influence the satisfaction of staff with their jobs, the overall quality of work life, and the quality of the environment for patient care. Managers play key roles in guiding the tasks of work groups and ensuring efficient and effective performance; managers also encourage relationships among members of work teams to promote coordination and cooperation.

Development and Growth

Groups can provide learning opportunities by increasing individual skills or abilities. The group may facilitate socialization of new employees into the organization by "showing them the ropes." The nurse manager must establish an atmosphere that encourages learning new skills and knowledge, creating a group-oriented learning environment by continuously encouraging group members to improve their technical and interpersonal skills and knowledge through training and development. Group cohesiveness and effectiveness improve as staff members take responsibility for teaching each other and jointly seeking new information or techniques.

Shared Governance

Shared decision making is a hallmark of shared governance. That is, both managers and staff members participate in making decisions. Such participation can improve collaboration, staff retention, job satisfaction, productivity, and patient outcomes. Measuring the distribution of control, influence, power, and authority, Hess (2011) found that managers perceived staff to have more power in making decisions than staff perceived that they did. Workload issues offered opportunities for shared decision making in another study (MacPhee, Wardrop, & Campbell, 2010). As a requirement for Magnet certification, shared governance increases staff involvement in the organization's functioning and future planning and, at the same time, increases staff allegiance to the organization.

The Nurse Manager as Team Leader

Because staff nurses work in close proximity and frequently depend on each other to perform their work, the nurse manager's leadership is vital. A positive climate is one in which there is mutual high regard and in which group members may safely discuss work-related concerns, critique and offer suggestions about clinical practice, and comfortably experiment with new behaviors. Maintaining a positive work group climate and building a team make up a complex and demanding leadership task.

Communication

Communication is a central component of the nurse manager's leadership. The Joint Commission, the organization that accredits hospitals, found that poor interprofessional communication was the cause of nearly 70% of unexpected events causing death or serious injury (Joint Commission, 2015).

Effective nurse managers can facilitate communication in groups by maintaining an atmosphere in which group members feel free to discuss concerns, make suggestions, critique ideas, and show respect and trust. An important leadership function related to communication is gatekeeping—that is, keeping communication channels open, refocusing attention on critical issues, identifying and processing conflict, fostering self-esteem, checking for understanding, actively seeking the participation of all group members, and suggesting procedures for discussing group problems.

The manager's communication style also affects group cohesiveness. If the manager maintains a high degree of information power and controls not only what information is received but also who receives it, group performance may suffer. By

interrupting, changing the subject, monopolizing the conversation, or ignoring the feedback, problems escalate, and the leader remains uninformed; individuals in the group and the group's ability to function both suffer.

If, on the other hand, the manager shares information freely and encourages a high degree of mutual communication and participative problem solving, performance and job satisfaction improve. In participative groups, each individual has the opportunity, and is encouraged, to seek and share information and to communicate frequently with anyone and everyone in the group. Managers and staff alike check with each other to ensure that information is clear, offer suggestions, and provide feedback.

Evaluating Team Performance

The manager may be accustomed to evaluating individual performance, but evaluating how well a team performs requires different assessments. Patient outcomes and team functioning are the criteria by which teams can be evaluated. Outcome data—such as clinical pathway information, variances in critical paths, complication rates, falls, and medication errors—can help evaluate team performance.

Group functioning can be assessed by the level of work-group cohesion, involvement in the job, and willingness to help each other. Conversely, aggression, competition, hostility, aloofness, shaming, or blaming are characteristics of poorly functioning groups. Stability of members is an additional measure of group functioning.

Influencing team processes toward the attainment of organizational objectives is the direct responsibility of the nurse manager. By publicizing team accomplishments, creating opportunities for team members to demonstrate new skills, and supporting social activities, the manager can increase the perceived value of group membership. Members of groups who have a history of success are attracted to each other more than those who have not been successful. Case Study 12-1 shows how one nurse manager handled introduction of multidisciplinary staff into an existing staff team.

CASE STUDY 12-1 | Introducing Multidisciplinary Teams

Bruce Shapiro was promoted 6 months ago to nurse manager for the stroke rehabilitation unit of a nationally owned rehabilitation hospital chain. Patient care delivery systems have been under intensive review at the corporate level, and major changes in staffing are underway. Previously, physical and occupational therapists were staffed out of a separate department and reported to the director of physical therapy. Now, all therapists will be unit based and report to the nurse manager. Documentation will now be team centered instead of being split among nursing, therapists, and other care providers.

Janice Pacheco has been a physical therapist for 25 years and has been at the rehab hospital for the past 6 years. She worked as a shift leader for physical therapy until the new unit-based staffing was implemented. Janice has been assigned to the stroke rehab unit and will report to Bruce. She feels uncomfortable in her new role and is concerned about how she will fit in with the established nursing staff. Janice is also concerned that, with the new documentation system, the physical therapy patient evaluations will not be included in determining patient goals.

Bruce is eager for Janice to join the staff of the stroke rehabilitation unit. He schedules individual meetings with Janice and the three other therapists who will be assigned to his unit. Bruce outlines the roles and expectations of staff on the unit and listens attentively to their questions and concerns. He also reviews the physical and occupational therapy job descriptions and reviews their respective documentation standards. At the monthly staff meeting, Bruce discusses the roles and responsibilities of the therapists with the nursing staff. A mentor is assigned to meet daily with each therapist for their first 2 weeks on the unit.

Leading Committees and Task Forces

Committees are generally permanent and deal with recurring problems. Membership on committees is usually determined by organizational position and role. **Formal committees** are part of the organization and have authority as well as a specific role. **Informal committees** are primarily for discussion and have no delegated authority. **Task forces** are ad hoc committees appointed for a specific purpose and a limited time. Task forces work on problems or projects that cannot be readily handled by the organization through its normal activities and structures. Task forces often deal with problems crossing departmental boundaries. They tend to generate recommendations and then disband.

Nurses are often selected for leadership roles on committees and task forces. In these leadership roles, and as unit managers and team leaders, they conduct numerous meetings. The following section provides guidance for leading and conducting meetings.

Guidelines for Conducting Meetings

Although meetings are vital to the conduct of organizational work, they should be held principally for problem solving, decision making, and enhancing working relationships. Other uses of meetings, such as socializing, giving or clarifying information, or soliciting suggestions must be thoroughly justified. Information that can be shared via other means, such as email, should be used if possible. Meetings should be conducted efficiently and should result in relevant and meaningful outcomes. Meetings should not result in damaged interpersonal relations, frustration, or inconclusiveness.

PREPARATION The first key to a successful meeting is thorough preparation. Preparation includes clearly defining the purpose of the meeting. The leader should prepare an agenda, determine who should attend, make assignments, distribute relevant material, arrange for recording of minutes, and select an appropriate time and place for the meeting. The agenda should be distributed well ahead of time—7 to 10 days prior to the meeting—and it should include what topics will be covered, who will be responsible for each topic, what prework should be done, what outcomes are expected in relation to each topic, and how much time will be allotted for each topic.

Sometimes a "meeting before the meeting" is advisable (Sullivan, 2013). This is especially important if you are going into a meeting where you expect dissension. It may involve simply chatting with a few key people to identify any problems or issues they expect, or you may need to actually sit down with a key decision maker who has veto power. Asking people you expect might have opposing points of view their opinion might be helpful as well.

PARTICIPATION In general, the meeting should include the fewest number of stakeholders who can actively and effectively participate in decision making, who have the skills and knowledge necessary to deal with the agenda, and who can adequately represent the interests of those who will be affected by decisions made. Too few or too many participants may limit the effectiveness of a committee or task force.

PLACE AND TIME Meetings should be held where interruptions can be controlled and when there is a natural time limit to the meeting, such as late in the morning or afternoon. Meetings should be limited to 50 to 90 minutes, except when members are dealing with complex, detailed issues in a one-time session. Meetings that exceed 90 minutes should be planned to include breaks at least every hour. Meetings should start and finish on

time. Starting late positively reinforces latecomers, while penalizing those who arrive on time or early. If sanctions for late arrival are indicated, they should be applied respectfully and objectively. If it is the leader who is late, the cost of starting meetings late should be reiterated, and an appropriate designee should begin the meeting on time.

MEMBER BEHAVIORS The behavior of each member may be positive, negative, or neutral in relation to the group's goals. Members may contribute very little, or they may use the group to meet personal needs. Some members may assume most of the responsibility for the group action, thereby enabling less participative members to avoid contributing.

Group members should adhere to the following:

- Be prepared for the meeting, having read pertinent materials ahead of time.
- Ask for clarification as needed.
- Offer suggestions and ideas as appropriate.
- Encourage others to contribute their ideas and opinions.
- Offer constructive criticism as appropriate.
- Help the discussion stay on track.
- Assist with implementation as agreed.

These behaviors facilitate group performance. All attendees should be familiar with behaviors that they may employ to facilitate well-managed meetings. All meeting participants must be helped to understand that they share responsibility for successful meetings.

A leader can increase meeting effectiveness greatly by doing the following:

- Not permitting one individual to dominate the discussion
- Separating idea generation from evaluation
- Encouraging members to refine and develop the ideas of others (a key to the success of brainstorming)
- Recording problems, ideas, and solutions on a white board or flip chart
- Checking for understanding
- Summarizing information and the group's progress periodically
- Encouraging further discussion
- Bringing disagreements out into the open and facilitating their reconciliation

The leader is also responsible for drawing out members' hidden agendas (personal goals or needs). Revealing hidden agendas ensures that these agendas either contribute positively to group performance or are neutralized. Guidelines for leading group meetings are provided in Box 12-1.

Managing Task Forces

There are a few critical differences between task forces and formal committees. For example, members of a task force have less time to build relationships with one another, and, because task forces are temporary, there may be no desire for long-term positive relationships. Formation of a task force may suggest that the organization's usual problem-solving mechanisms have failed. This perception may lead to tensions among task force members and between the task force and other units in the

Box 12-1 Guidelines for Leading Group Meetings

- Begin and end on time.
- Create a warm, accepting, and nonthreatening climate.
- Arrange seating to minimize differences in power, maximize involvement, and allow visualization of all meeting activities. (A U-shape is optimal.)
- Use interesting and varied visuals and other aids.
- Clarify all terms and concepts. Avoid jargon.
- Foster cooperation in the group.
- Establish goals and key objectives.
- Keep the group focused.
- Focus the discussion on one topic at a time.
- Facilitate thoughtful problem solving.
- Allocate time for all problem-solving steps.
- Promote involvement.
- Facilitate integration of material and ideas.
- Encourage exploration of implications of ideas.
- Facilitate evaluation of the quality of the discussion.
- Elicit the expression of dissenting opinions.
- Summarize discussion.
- Finalize the plan of action for implementing decisions.
- Arrange for follow-up.

organization. The various members of a task force usually come from different parts of the organization and, therefore, have different values, goals, and viewpoints. The leader will need to take specific action to efficiently familiarize task force members with each other and create bonds in relation to the task.

PREPARING FOR THE FIRST MEETING Prior to the task force's first meeting, the leader must clarify the objectives in specific measurable outcomes, determine its membership, set a task completion date, plan how often and to whom the task force should report while working on the project, and ascertain the group's scope of authority, including its budget, availability of relevant information, and decision-making power. The task force leader should communicate directly and regularly with the administrator or governing body that commissioned the task force's work so that ongoing clarification of its charge and progress can be tracked and adjusted.

Task force members should be selected on the basis of their knowledge, skills, personal concern for the task, time availability, and organizational credibility. They should also be selected on the basis of their interpersonal skills. Those who relish group activities and can facilitate the group's efforts are especially good members. The group leader should also plan to include one or two individuals who potentially may oppose task force recommendations in order to solicit their input, involve them in the decision-making process, and win their support. By holding personal conversations with task force members before the first meeting, the group leader can explore individual expectations, concerns, and potential contributions. That also provides the leader with an opportunity to identify potential needs and conflicts and to build confidence and trust.

CONDUCTING THE FIRST MEETING The goal of the first meeting is to come to a common understanding of the group's task and to define the group's working procedures and relationships. Task forces must rely on the general norms of the organization to function. The task force leader should legitimize the representative nature of participation on the task force and encourage members to discuss the task force's process with the other members of the organization.

During the first meeting, a standard of total participation should be well established. The leader should remain as neutral as possible and should prevent premature decision making. Working procedures and relationships among the various members, the subgroups, and the rest of the organization must be established. The frequency and nature of full task force meetings and the number of subgroups must be determined.

Ground rules for communicating must be established, along with norms for decision making and conflict resolution.

MANAGING SUBSEQUENT MEETINGS AND SUBGROUPS In running a task force, especially when several subgroups are formed, the leader should hold full task force meetings often enough to keep all members informed of the group's progress. Unless a task force is small, subgroups are essential. The leader must not be aligned too closely with one position or subgroup. A work plan should be developed that includes realistic interim project deadlines. The task force and subgroups should be held to these deadlines. The leader plays a key role in coaching subgroups and the task force to meet its deadlines.

The leader must also be sensitive to the conflicting loyalties sometimes created by belonging to a task force. One of the leader's most important roles is to communicate information to task force members as well as the rest of the organization in a timely and regular fashion. The leader should solicit feedback from other key organizational representatives during the course of the task force's work.

COMPLETING THE TASK FORCE'S REPORT In bringing a project to completion, the task force should prepare a written report for the commissioning administrators that summarizes the findings and recommendations. Drafts of this report should be shared with the full task force prior to presentation. To identify any overlooked or sensitive information and reduce defensive reactions, it is especially important that the task force leader personally brief key administrators prior to presenting the report. This gives administrators a chance to read and respond to the report before making recommendations. The leader should consider involving a few task force members in the administrative presentation.

Patient Care Conferences

Patient-related conferences are held to address the needs of individual patients or patient populations. The purpose of the conference determines the composition of the group. Patient-focused meetings are usually interprofessional and used for case management to discuss specific patient care problems. For example, an interprofessional team may form to discuss the failure of a rehabilitation regimen for a home care patient and to develop new plans for intervention.

Often nurses are also involved in activities associated with improving the quality of care for various patient groups and their families. For example, a nurse manager might organize meetings with primary care physicians and other managers to discuss how to improve discharge planning, to explore strategies to reduce the length of inpatient stays, or to improve coordination with outpatient clinics.

The team leader of a patient care conference often may not be a manager with line responsibility to supervise, evaluate, or hire employees. Frequently in patient rounds, the nurse is the person who can lead the conversation because the nurse has spent the most amount of time with the patient. The team leader is, however, a coach, teacher, and facilitator. Thus, the team leader needs to have excellent leadership skills. The task of a team leader varies according to the task and the skill level of the team members.

Nurses may be members of teams as well as leaders. Understanding how groups and teams function (or do not) is essential to contribute to the organization, to be successful in your position, and to garner satisfaction from your work.

What You Know Now

- A group is an aggregate of individuals who interact and mutually influence each other.
- Groups may be classified as real or task, formal or informal, permanent or temporary.
- A team is a group of individuals with complementary skills, a common purpose and performance goals, and a set of methods for which they hold themselves accountable.
- Assessment of problems should precede team-building activities.
- Team building includes a focus on meeting goals and accomplishing tasks as well as improving interpersonal relationships.
- Team-building activities are more likely to be successful if skills are reinforced on the job.
- The specifics of how to manage a team depend on the task, group size and composition, productivity and cohesiveness, development and growth, and the extent of shared governance in the organization.
- The nurse manager's communication skills affect the team's productivity and performance.
- Managing meetings involves preparing thoroughly, facilitating participation, and completing the group's work.

Tools for Building and Managing Teams

1. Notice how groups around you function. Use the best ideas with your own groups.
2. Watch effective leaders. Identify skills you could incorporate into your own leadership repertoire.
3. Recognize that you can develop good team leadership skills. Practice those discussed in this chapter.
4. At the next opportunity, be prepared to follow the directions for leading meetings.
5. Make a development plan to enhance your leadership skills.

Questions to Challenge You

1. Identify the groups that include you in your work or school. How are they different? Similar? Explain.
2. Describe an example of effective group leadership and an example of poor leadership.
3. Evaluate your own leadership performance. How could you improve?
4. Have you been involved in team building at work or school? Was it effective? Explain.
5. What roles do you usually play in a group meeting (or class)? What role would you like to play? Describe it.

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Chapter 13
Handling Conflict

Conflict
Interprofessional Conflict

Conflict Process Model
Antecedent Conditions
Perceived and Felt Conflict
Conflict Behaviors
Conflict Resolved or Suppressed Outcomes

Managing Conflict
Conflict Responses
Alternative Dispute Strategies

Learning Outcomes

After completing this chapter, you will be able to:

1. Explain how the various types of conflict can be positive or negative.
2. Describe the conflict process.
3. Describe approaches that can be used to manage conflict.

Key Terms

accommodating
avoiding
collaboration
competing
compromise
conflict
confrontation
consensus
felt conflict
forcing
mediation
negotiation
perceived conflict
resistance
resolution
smoothing
suppression
withdrawal

Introduction

Conflict is a natural, inevitable condition in organizations, and a manager's communication frequently centers on conflict. It is often a prerequisite to change in people and organizations. Effectively participating in conflict situations, as well as coaching others in conflict situations, requires an understanding of conflict processes, your personal conflict style, and approaches to participating in conflict.

Conflict

Conflict is defined as the consequence of real or perceived differences in mutually exclusive goals, values, ideas, attitudes, beliefs, feelings, or actions (a) within one individual (*intrapersonal conflict*), (b) between two or more individuals (*interpersonal conflict*), (c) within one group (*intragroup conflict*), or (d) between two or more groups (*intergroup conflict*). As a communication process, conflict is a dynamic process, rather than a state. From this perspective, conflict is expressed "through communication (verbal and nonverbal messages); likewise, the means to manage and address conflict is through communication" (Oetzel & Ting-Toomey, 2013, p. viii). The outcomes of conflict processes can be positive or negative, healthy or dysfunctional.

A certain amount of conflict is beneficial to an organization. It can provide heightened sensitivity to an issue, further piquing the interest and curiosity of others. Conflict can also increase creativity by acting as a stimulus for developing new ideas or identifying methods for solving problems. Disagreements can help all parties become more aware of the trade-offs, especially costs versus benefits, of a particular service, process or technique.

Conflict also helps people recognize legitimate differences within the organization or profession and may serve as a powerful motivator to improve performance, effectiveness, and satisfaction. For example, during intergroup conflict, individual groups become more cohesive and task oriented while communication between groups diminishes.

Interprofessional Conflict

Working in high-stress jobs, nurses often have conflicts with other healthcare professionals, administrators, or coworkers. Conflict in the interprofessional team often occurs when coworkers feel their time is not respected. To do multidisciplinary rounds, the doctor might want to meet at 1:00 p.m., the nurse at 1:30 p.m., and the social worker at 10:00 a.m. Finding a time that fits the work flow of each job is important so that no one feels undervalued or disrespected and consequently is better able to achieve his or her goals for working with patients.

Leading at the Bedside: Dealing with Conflict

Conflict is inevitable. Conflict can take place at work, at home, anywhere that you interact with one other person. Sometimes conflict is helpful; you learn facts you didn't know, resolve differences between you, or find unique solutions to common problems. More often, you will face conflict involving difficult people and problem situations. In those cases, learning to deal with disruptive conflict will help you navigate the minefield of relationships and circumstances at work and elsewhere. Heed the lessons in this chapter. Practice the skills presented. You and your career will benefit.

Conflicts between physicians and nurses dominate the problems reported by both professions (Leever, Hulst, Berendsen, Boendemaker, & Roodenburg, 2010). For example, the physician may want to send the patient home today, the nurse knows the patient is struggling to understand ordered medications, and the physical therapist tells the nurse that the patient needs another day of practicing exercises before safely being discharged.

One approach a nurse manager can use to teach staff how to handle interprofessional conversations is to advocate from the perspective of the patient, rather than that of the nurse or other healthcare provider. The DESC script from the Agency for Healthcare Research and Quality may be helpful (Agency for Healthcare Research and Quality, 2015):

- D: Describe the specific situation or behavior; provide concrete data.
- E: Express how the situation makes you feel (e.g., uncomfortable), and what your concerns are.
- S: Suggest other alternatives and seek agreement.
- C: Consequences should be stated in terms of impact on established goals; strive for consensus.

This series of actions helps the participants to stay focused on understanding and resolving the problem, rather than focusing on the people involved (Runde & Flanagan, 2013).

Conflict Process Model

Several authors have proposed models for examining conflict (e.g., Filley, 1975; Pondy, 1967). Thomas and Kilmann (1974) developed the now-classic Thomas-Kilmann Conflict Mode Instrument, a tool for self-assessing one's preferred approach to conflict resolution. All follow a generalized format for examining the life span of a conflict. These models provide a framework that helps explain how and why conflict occurs.

A conflict and its resolution develop according to a process that may be characterized as a life span (see Figure 13-1). This process begins with certain preexisting conditions (antecedent conditions). The parties are influenced by their feelings or perceptions about the situation (perceived or felt conflict), which initiates behavior, and conflict is revealed in the messages used by all involved parties. The conflict is either resolved or suppressed, and its outcome results in new or reinforced attitudes and feelings among the parties.

Antecedent Conditions

Antecedent conditions propel a situation toward conflict; they may or may not be the cause. In nursing, antecedent conditions include incompatible goals, differences in values and beliefs, task interdependencies (especially asymmetric dependencies, in which one party is dependent on the other but not vice versa), unclear or ambiguous roles, competition for scarce resources, differentiation or distancing mechanisms, and unifying mechanisms.

INCOMPATIBLE GOALS The most important antecedent condition to conflict is incompatible goals. As discussed in Chapter 2, goals are desired results toward which behavior is directed. Even though the common goal in healthcare organizations is to give quality

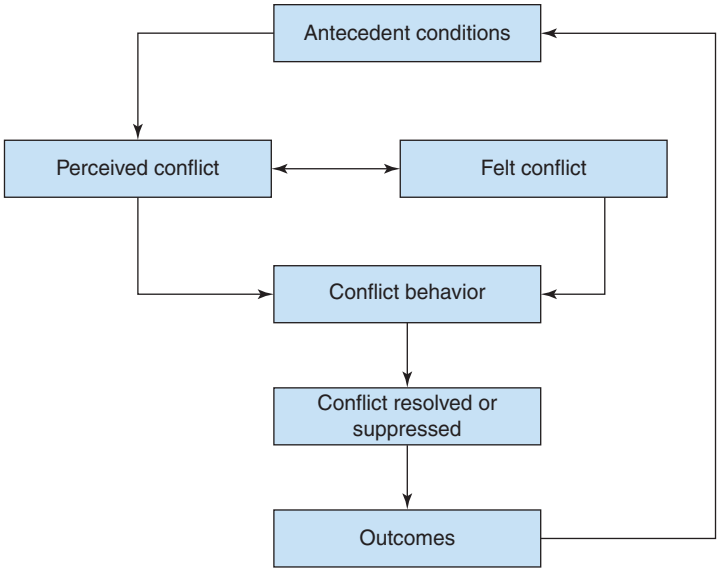

Figure 13-1 The conflict process.

patient care in a cost-effective manner, conflict in achieving these goals is inevitable because individuals often view this from different perspectives. The dichotomy between healthcare providers and third-party payers is an example. Healthcare providers want to maximize the quality of care, whereas payers are concerned with minimizing costs.

A healthcare organization may have specific goals to achieve the best possible care for patients and control costs to stay within budget and, at the same time, to provide intrinsically satisfying jobs for its employees. These multiple goals will frequently conflict with each other, so they will have to be prioritized. Priority setting can be one of the most difficult but important activities a healthcare manager must implement. Goals are important because they become the basis for allocating resources and thus become an important source (antecedent) of conflict in the organization.

Similarly, individuals themselves have multiple goals, and those goals may also conflict. Individuals allocate scarce resources, such as their time, on the basis of priority and, therefore, might achieve one goal at the expense of others. The inability to attain multiple (and in some cases mutually incompatible) goals—whether those goals are personal or organizational—can cause conflict.

ROLE CONFLICTS Roles are defined as other people's expectations regarding behavior and attitudes. Roles become unclear when one or more parties have related responsibilities that are ambiguous or overlapping. A manager might experience conflict between his or her responsibilities as an administrator and responsibilities as a staff member. Similarly, unclear or overlapping job descriptions or assignments among healthcare professionals may lead to conflict. For example, there could be conflict over such mundane issues as who has responsibility to deliver a patient to the radiology department: the nurse or the transport staff?

Task interdependence is another potential source of conflict. Nursing and housekeeping, for example, are interdependent. Housekeeping cannot completely clean a room until nursing has discharged the patient. Other examples of interdependence are the relationships among shifts and those between physicians and nurses. Interdependent relationships have the potential to initiate conflict.

STRUCTURAL CONFLICT One conflict commonly seen in the healthcare environment is structural conflict. Structured relationships (manager to staff, peer to peer) may generate conflict because of ineffective communication, competition for resources, opposing interests, or a lack of shared perceptions or attitudes. A structural conflict might occur when a nurse manager responds to a patient complaint about a staff nurse by following up with corrective counseling or coaching. The staff nurse might dispute the complaint and become defensive. In this situation, one strategy that the manager could impose is positional power. Positional power involves using the authority inherent in a certain position—for example, the nurse administrator has greater positional power than a nurse manager.

COMPETITION FOR RESOURCES Competition for scarce resources can be internal (among different units in the organization) or external (among different organizations). Internally, competition for resources may involve assigning staff from one unit to another or purchasing high-technology equipment when another unit is desperate for staff.

Externally, healthcare organizations compete for finite external resources (e.g., designation as an accountable care organization for Medicare). Organizations are using a variety of means, such as striving for documented high-quality care, developing new services, and advertising to try to capture the market in healthcare.

VALUES AND BELIEFS Differences in values and beliefs frequently contribute to conflict in healthcare organizations. An individual's values and beliefs result from the individual's socialization experience. Conflicts between physicians and nurses, between nurses and administrators, between nurses with associate degrees and those with baccalaureate degrees, or between nurses and their patients often occur because of differences in values, beliefs, and experiences.

Distancing mechanisms or differentiation serve to divide a group's members into small, distinct groups, thus increasing the chance for conflict. This tends to lead to a "we–they" distinction. One frequently seen example is distancing between physicians and nurses. Opposition between intensive care nurses and nurses on medical floors, night versus day shifts, and unlicensed versus licensed personnel are also examples. Differentiation among subunits also occurs and may arise due to differences in structure. The administrative unit may have a highly bureaucratic structure, the nursing unit may have a shared governance structure, and the staff physicians may have a contracting unit structure. Nonstaff physicians might be relatively independent of the healthcare organization. These differences in structure might result in different reporting mechanisms, different priorities, and different goals, all of which increase the likelihood of conflict.

Unifying mechanisms also may contribute to the development of a conflict. Unifying mechanisms occur when greater intimacy develops or when unity is sought. All nurses might be expected to reach **consensus** over an issue, but they might experience internal conflict if they are forced to accept a group position when individually they may not be wholly committed to the decision. A nurse manager's friendship with a staff member may also lead to this type of conflict.

Perceived and Felt Conflict

Perceived and felt conflict account for the conflict that may occur when the parties involved view situations or issues from differing perspectives, when they misunderstand

each other's position, or when positions are based on limited knowledge. **Perceived conflict** occurs when each party's perception of the other's position is different from what it actually is. **Felt conflict** describes the negative feelings that exist between two or more parties. It is often characterized by mistrust, hostility, and/or fear.

To understand how perceived and felt conflicts develop, consider two situations. A nurse manager and a surgeon have worked together for years. They have mutual respect for each other's abilities and skills, and they communicate frequently. When their subordinates clash, they are left with conflicting accounts of an event in which the only agreed-upon fact is that a patient received less-than-appropriate care. Now consider the same scenario if the nurse and doctor have never dealt with each other, or if one feels that the other will not approach the problem constructively.

In the first situation—perceived conflict—the positive regard the nurse and surgeon have for each other's abilities and their history of a positive relationship enable them to believe they can constructively solve the conflict. The nurse does not feel that the physician will try to dominate, and the physician respects the nurse manager's leadership ability. With these preexisting attitudes, the physician and nurse can remain neutral while helping their subordinates solve the conflict.

If the nurse and physician experience felt conflict, as they do in the second situation, they might approach the situation differently. Each might assume the other will defend her or his subordinates at all costs; then communication likely will be inhibited. The conflict will likely be resolved by domination of the stronger party, either in personality or position. One wins, the other loses, often resulting in the conflict behaviors discussed in the next section.

Conflict Behaviors

Conflict behavior results from the parties' perceived or felt conflict. Behaviors may be overt or covert. Overt behavior may take the form of aggression, competition, debate, or problem solving. Covert behavior may be expressed by a variety of indirect tactics, such as scapegoating, avoidance, or apathy.

Conflict Resolved or Suppressed

When conflict behaviors occur, the conflict is resolved or suppressed. Resolution occurs when a mutually agreed-upon solution is arrived at and both parties commit themselves to carrying out the agreement. Suppression occurs when one person or group defeats the other. Only the dominant side is committed to the agreement, and the loser may or may not carry out the agreement.

Outcomes

The outcome of a conflict affects how the parties will address conflict in the future. The optimal approach is to manage the issues in a way that will lead to a solution wherein both parties see themselves as having achieved their goals while solving the problem. This leaves a positive aftermath that will affect future relations and positively influence feelings and attitudes. In the example of conflict between the nurse manager and the physician, consider the difference in the aftermath and how future issues would be approached if both parties felt positive about the outcome, as compared to future interactions if one or both parties felt they had lost.

Managing Conflict

Managing conflict is an important part of the nurse manager's job. Managers are often involved in conflict management on several different structural levels. Managers may be participants in the conflict as individuals, administrators, or representatives of a unit—and sometimes on multiple levels simultaneously. They must often confront staff, individually or collectively, when a problem develops but also serve as mediators or judges to conflicting parties. Conflicts can occur within the unit, between parties from different units, or between internal and external parties (e.g., a university nursing instructor may have a conflict with staff on a particular unit).

Everyone involved in conflict negotiations must be realistic regarding the outcome. Often inexperienced negotiators expect unrealistic outcomes. When two or more parties hold what appear to be mutually exclusive ideas, attitudes, feelings, or goals, it is extremely difficult, without the commitment and willingness of all concerned, to arrive at an agreeable solution that meets the needs of both (e.g., battles between Democrats and Republicans in Congress).

Conflict management begins with a decision regarding whether and when to intervene. Failure to intervene can allow the conflict to get out of hand, whereas early intervention may be detrimental to those involved, causing them to lose confidence in themselves and reduce risk-taking behavior in the future.

Some conflicts are so minor, particularly if between two people, that they do not require intervention and would be better handled only by the two people involved. Allowing them to resolve their conflict might provide a developmental experience and improve their abilities to resolve conflict in the future.

Increased intensity can motivate participants to seek **resolution**, so sometimes it is best to postpone intervention purposely to allow the conflict to escalate. You could escalate the conflict even further by exposing participants to each other more frequently without the presence of others and without an easy means of escape. Participants are then forced to face the conflict between them.

Giving participants a shared task or shared goals not directly related to the conflict may help them understand each other better and increase their chances of resolving their conflicts by themselves. Using such a method is useful only if the conflict is not of high intensity, if the participants are not highly anxious about it, and if the manager believes that the conflict will not decrease the efficiency of the unit in the meantime. When the conflict might result in considerable harm, however, the nurse manager must intervene.

If you decide to intervene in a conflict between two or more parties, you can apply mediation techniques, deciding when, where, and how the intervention should take place. Routine problems can be handled in either party's office, but serious confrontations should take place in a neutral location unless the parties involved are of unequal power. In this case, the setting should favor the disadvantaged participant, thereby equalizing their power.

The location for an intervention should have no distractions and be available for an adequate length of time. Because conflict management takes time, the manager must be prepared to allow sufficient time for all parties to explain their points of view and arrive at a mutually agreeable solution. A quick solution that inexperienced managers often resort to is to impose positional power and make a premature decision. This results in a win–lose outcome, which leads to feelings of elation and eventual complacency for the winners and loss of morale for the losers.

Runde and Flanagan (2013) describe a useful model for influencing conflict processes developed in conjunction with the Center for Creative Leadership. Grounded in work by Capobianco, Davis, and Kraus in 2001 (as cited in Runde and Flanagan, 2013), this model illustrates messages that are constructive or destructive. Constructive messages are behaviors that keep conflict to a minimum, such as focusing on the task and problem solving. Destructive messages are behaviors that escalate or prolong the conflict, such as focusing on the personalities involved (Runde & Flanagan).

Constructive responses to conflict include perspective taking, creating solutions, expressing emotions, reaching out, thinking reflectively, delaying response, and adapting. Destructive responses to conflict include winning at all costs, displaying anger, demeaning others, retaliating, avoiding, yielding, hiding emotions, and criticizing oneself (Runde & Flanagan, 2013). These responses are reflected in the basic guidelines found in Box 13-1 for helping two or more parties navigate conflict processes.

These guidelines are provided with a caveat. As Runde and Flanagan (2013) stated, "Every conflict is different. That is why conflict competent leaders cannot, and do not, follow a script. Their effectiveness derives from an array of behaviors, techniques, analysis, timing, and attitudes" (p. 217). Conflict management is a difficult process, consuming both time and energy from all parties. However, constructive conflict processes often result in positive outcomes that not only resolve the immediate conflict but also help enhance trust among the parties for future interactions.

These strategies require particular effort from the nurse manager as mediator. In addition to carefully monitoring the situation according to the preceding guidelines and participating as needed, conflict-competent nurse managers are also emotionally

Box 13-1 Guidelines for Navigating Conflict

1. Protect each party's self-respect. Focus on the conflict of issues, not personalities.
2. Avoid putting blame or responsibility for the problem on the participants. The participants are responsible for developing a solution to the problem.
3. Allow open and complete discussion of the problem from each participant.
4. Maintain equity in the frequency and duration of each party's presentation. A person of higher status tends to speak more frequently and longer than a person of lower status. If this occurs, you as the nurse manager should intervene and ask the person of lower status for a response and opinion.
5. Encourage full expression of positive and negative feelings in an accepting atmosphere. The novice mediator tends to discourage expressions of disagreement, so it is helpful to remember that expressions of disagreement play an important role in finding solutions.
6. Make sure both parties listen actively to each other's words. One way to do this is to ask one person to summarize the other person's comments before stating her or his own.
7. Identify key themes in the discussion and restate them at frequent intervals.
8. Encourage the parties to provide frequent feedback to each other's comments; each must truly understand the other's position.
9. Help the participants develop alternative solutions, select a mutually agreeable one, and develop a plan to carry it out. All parties must agree to the solution for successful resolution to occur.
10. At an agreed-upon interval, follow up on the progress of the plan.
11. Give positive feedback to participants regarding their cooperation in solving the conflict.

Source: Runde, C., & Flanagan, T. (2013). *Becoming a conflict competent leader: How you and your organization can manage conflict effectively* (2nd ed.). San Francisco, CA: John Wiley & Sons, Inc.

intelligent (Goleman, 2006). They monitor when their own emotions are rising, use constructive behaviors to slow responses when emotions are running high, and later work to determine what is really behind people's actions (Runde & Flanagan, 2013). This takes energy, self-awareness, self-development, and practice, but the results are well worth the investment.

Conflict Responses

Patterns of conflict responses have been studied for more than 50 years. There is a wide variety of conflict responses or conflict styles (e.g., Filley, 1975; Thomas & Kilmann, 1974). These are briefly mentioned here so that you are aware of the language used to describe these patterns.

Confronting often is considered the most effective means for resolving conflicts in a time-constrained situation. This is a problem-oriented technique in which the conflict is brought out into the open and attempts are made to resolve it through knowledge and reason. The goal of this technique is to achieve win–win solutions. Facts should be used to identify the problem. The desired outcome should be explicit—for example, "This is the third time this week that you have not been here for report. According to hospital policy, you are expected to be changed, scrubbed, and ready for report in the lounge at 7:00 a.m."

Confrontation is most effective when delivered in private as soon as possible after the incident occurs (Sullivan, 2013). Employee respect and manager credibility are two important considerations when a situation warrants confrontation. A more immediate confrontation also helps both the employee and manager sort out pertinent facts. In an emotionally charged situation, however, it may be best for the parties to wait. Regardless of timing, the message is usually more effective if the manager listens and is empathetic.

Negotiating involves give-and-take on various issues among the parties. Its purpose is to achieve agreement even though total agreement will never be reached. Therefore, the best solution from the perspective of either party or the organization may not be achieved. Negotiation often becomes a structured, formal procedure, as in collective bargaining. However, negotiation skills are important in arriving at an agreeable solution between any two parties. Staff members learn to negotiate schedules, advanced practice nurses negotiate with third-party payers for reimbursement, insurance companies negotiate with vendors and hospitals for discounts, and clinic managers negotiate employment contracts with physicians. Although adept communication skills are the tools needed for negotiation, their usefulness revolves around issues of conflict. Without differences in opinion, there would be no need for negotiation.

Collaborating implies mutual attention to the problem, in which the talents of all parties are used. In collaboration, the focus is on solving the problem, not defeating the opponent. The goal is to work to create a solution that addresses both parties' concerns. Collaboration is useful in situations in which the goals of both parties are too important to be compromised.

Compromising is used to divide the rewards between both parties. Neither gets what she or he wants. Compromise can serve as a backup to resolve conflict when collaboration is ineffective. It is sometimes the only choice when opponents of equal power are in conflict over two or more mutually exclusive goals. Compromising is also expedient when a solution is needed rapidly.

Competing is an all-out effort to win, regardless of the cost. Competing may be needed in situations involving unpopular or critical decisions. Competing is also used in situations in which time does not allow for more cooperative techniques.

Accommodating is an unassertive, cooperative tactic used when individuals neglect their own concerns in favor of others' concerns. Accommodating frequently is used to preserve harmony when one person has a vested interest in an issue that is unimportant to the other party.

In situations where conflict is discouraged, **suppressing** is often used. Suppression could even include the elimination of one of the conflicting parties through transfer or termination. Other, less effective techniques for managing conflict include withdrawing, smoothing, and forcing, although each mode of response is useful in given situations.

In **avoiding**, the participants never acknowledge that a conflict exists. Avoidance is the conflict resolution technique often used in highly cohesive groups. The group avoids disagreement because its members do not want to do anything that may interfere with the good feelings they have for each other.

Withdrawing from the conflict means that one party removes itself, thereby making it impossible to resolve the situation. The issue remains unresolved, and feelings about the issue may resurface inappropriately. If the conflict escalates into a dangerous situation, avoidance and withdrawing are appropriate strategies.

Smoothing is accomplished by complimenting one's opponent, downplaying differences, and focusing on minor areas of agreement, as though little disagreement existed. Smoothing may be appropriate in dealing with minor problems, but it produces the same results as withdrawing in response to major problems.

Forcing is a method that yields an immediate end to the conflict but leaves the cause of the conflict unresolved. A superior can resort to issuing orders, but the subordinate will lack commitment to the demanded action. Forcing may be appropriate in life-or-death situations but is otherwise inappropriate.

Resisting can be positive or negative. It may mean a resistance to change or disobedience, or it may be an effective approach to handling power differences, especially verbal abuse.

All of these responses are commonly discussed approaches to working through conflict situations. Discovering your own preferences for engaging in conflict conversations is an important first step in interacting with others, particularly in conflict situations. Resources for low-cost self-assessment instruments are provided at the end of this chapter.

Being aware of your own style preferences for resolving conflict is the first step toward working through a conflict conversation. It contributes to reflexivity, a level of self-awareness, particularly awareness of the possible ways of understanding a conflict and your own role in a conflict (Littlejohn & Dominici, 2007).

Working with the Littlejohn and Dominici (2007) model to tie together these concepts, consider how a reflexive nurse manager might approach a conflict:

- Think of the conflict not as an obstacle, but as an opportunity for problem-solving.
- Reframe the issue from emotional reaction to substantive issues.
- Turn the situation into an opportunity for building respect.
- Present or generate a variety of options for resolution.
- Shift attention from positions to interests and then to mutual interests (such as patient-centered, high-quality, safe care).

While these steps may seem straightforward, they can constitute an engaging, time-consuming process. However, the outcomes are potentially transformative for future interactions.

Alternative Dispute Strategies

Conflicts that have the potential to lead to legal action are often negotiated using alternative dispute resolution (ADR) (Sander, 2009). **Mediation** is a form of ADR that involves a third-party mediator to help settle disputes. Mediation agreements can satisfy all parties, cost less and take less time than legal remedies, and lead to improved interprofessional relationships (Gardner, 2010). Mediation has been used successfully in settling disputes in long-term care facilities (Rosenblatt, 2008).

ADR efforts have resulted in the creation of the International Institute of Conflict Prevention and Resolution, expanded state and federal legislation encouraging mediation, a dispute resolution division in the American Bar Association, and development of ADR courses in law schools. The use of ADR in public policy promises to increase in the coming years (Susskind, 2009).

See how one nurse manager handled a conflict between two members of her staff in Case Study 13-1.

Managing conflict is an essential skill for the manager and, indeed, all nurses. Avoiding unnecessary conflict or allowing conflict to fester and remain unresolved undermines the manager's effectiveness, can result in dissatisfied staff and turnover, and potentially harms patients. Resolving conflict, on the other hand, can lead to better

CASE STUDY 13-1 | Conflict Management

Mai Tran is the nurse manager of a 20-bed medical–surgical unit in a large university hospital. Her nursing staff is diverse in experience and educational background. Working in a teaching hospital, Mai believes that nurses should be open to new methods and work processes, with an emphasis on evidence-based practice.

Ken Robertson, RN, has worked for 2 years on the unit and is in his final semester of a master's program focusing on geriatric care. Eileen Holcomb, RN, has worked on the same unit for the past 28 years and is a graduate of the hospital's former diploma program. Ken recently completed a clinical rotation in dermatology and has worked with the skin care team at the hospital to develop new protocols for preventing skin breakdown. During a recent staff meeting, Ken presents the new protocols to the staff. During the presentation Eileen comments that simply getting patients out of bed and making sure they have adequate nutrition is easier and less time-consuming than the new protocol. "All these new protocols are just a way to justify all those credentials behind a name," Eileen says, gathering a chorus of chuckles from some of the older nurses on the staff. Ken frowns at Eileen and responds, "As nurses become educated, we need to reflect a professional practice." Mai notices that several staff members are uncomfortable as the meeting ends.

Ken and Eileen continue to exchange sarcastic comments and glares over the next two shifts they work together. The obvious disagreement is affecting their coworkers, and gossiping is decreasing productivity on the unit. Mai schedules individual meetings with Ken and Eileen to discuss their perspectives. After reviewing the situation and determining that the issue is simply one of personality conflict, Mai brings Ken and Eileen together for a meeting in her office. Mai reviews the facts of the situation with them and shares her opinion that both have acted inappropriately. She states that their actions have affected not only their work but also that of the unit as a whole. She informs Ken and Eileen that they must act in a professional and respectful manner with each other or disciplinary action will be taken. She then works to facilitate a conversation during which both parties can express their concerns, with the goal of finding common ground.

outcomes, both with immediate and future situations, and encourages the manager to resolve conflict in the future.

More strategies for handling conflict can be found in Chapter 10, "Dealing with Difficult People and Situations," in *Becoming Influential: A Guide for Nurses* (Sullivan, 2013).

What You Know Now

- Conflict is a dynamic communication process and the consequence of real or perceived differences between individuals or groups.
- Conflict can be positive and the first step in initiating change, or it may be negative and disruptive.
- Antecedent conditions that cause conflict include incompatible goals, role conflicts, structural conflict, competition for scarce resources, and differences in values and beliefs.
- A number of strategies exist to handle conflict; choosing the best one to use is based on the situation and the people involved.
- Learning to manage conflict is a key to success for all nurses and managers.

Tools for Handling Conflict

1. Evaluate conflict situations to decide if and when to intervene.
2. Understand the antecedent conditions for the conflict and the positions of those involved.
3. Enlist others to help solve conflicts when appropriate.
4. Be aware of your preference for a conflict management strategy, then consider a style appropriate to the situation and the other people involved.
5. Practice the conflict management strategies discussed in the chapter and evaluate the outcomes.

Questions to Challenge You

1. How are conflicts handled at work or school? Do leaders need to be good conflict managers? Give an example to explain your answer.
2. Briefly describe a conflict in which you were involved. How did you handle yourself? How did the others involved handle it? Did it turn out well? Explain.
3. What have you found to be the most difficult part of handling conflicts? What strategies from this chapter are you planning to try when you encounter your next conflict?

Resources

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Chapter 14
Managing Time

Time-wasters

Setting Goals

Determining Priorities

Daily Planning and Scheduling

Grouping Activities and Minimizing Routine Work

Personal Organization and Self-discipline

Controlling Interruptions

Phone Calls, Voice Mail, Email, and Text Messages

Email

In-person Interruptions

Paperwork

Controlling Time in Meetings

Respecting Time

Learning Outcomes

After completing this chapter, you will be able to:

1. Critique time-wasters.
2. Examine goals and determine priorities.
3. Develop ways to control interruptions.
4. Incorporate time management strategies into meeting activities.
5. Summarize methods to respect time for yourself and others.

Key Terms

goal setting
interruption log
time logs
time-waster
to-do list

Introduction

Time management is a misnomer. No one manages time: What is managed is how time is used. In today's downsized healthcare organization, the pressure to do more in less time has increased. Job enlargement occurs when a flatter organizational structure causes positions to be combined and results in managers having more employees to supervise, a situation common today.

The managerial skills needed today are different from those in the past. The flatter organizational structures result in more responsibilities shared throughout the organization and a greater use of electronic communications. Technology has changed how managers and staff interact. Geographic location is less important than it was before the widespread utilization of the internet, as is time away from work. Being always connected can be both a time-saver and a time-stealer. Nonetheless, instant communication is here to stay.

Teams often do what managers formerly dictated, with the best decisions coming out of the team's cooperative efforts. Time management is equally important in teamwork as it is for individuals. Teams must plan and organize their work to meet deadlines. Efficiency is paramount.

Time can be used proactively or reactively. If you focus your energy on people and events over which you have some direct or indirect control, you are using a proactive approach. If, on the other hand, you spend most of your time on what concerns you most about other people and events, your efforts are less apt to be effective. For example, you can set and follow your goals and priorities, or you can spend your time worrying, blaming, or making excuses about what you do not accomplish.

Time-wasters

Why do we waste time? It is one of our most valuable resources, and yet everyone admits to wasting it. Box 14-1 answers this question by showing some of the constraints on an individual's ability to manage time effectively. These patterns of behavior must be understood and dealt with to be effective in managing time.

Box 14-1 Why We Fail to Manage Time Effectively

- We do what we like to do before we do what we do not like to do.
- We do things we know how to do faster than things we do not know how to do.
- We do things that are easiest before things that are difficult.
- We do things that require a little time before things that require a lot of time.
- We do things for which resources are available.
- We do things that are scheduled (e.g., meetings) before unscheduled things.
- We sometimes do things that are planned before things that are unplanned.
- We respond to demands from others before demands from ourselves.
- We do things that are urgent before things that are important.
- We readily respond to crises and emergencies.
- We do interesting things before uninteresting things.
- We do things that advance our personal objectives or that are politically expedient.
- We wait until a deadline approaches before we really get moving.
- We do things that provide the most immediate closure.
- We respond on the basis of who wants it.
- We respond on the basis of the consequences of our doing or not doing something.
- We tackle small jobs before large jobs.
- We work on things in the order of their arrival.
- We work on the basis of the squeaky-wheel principle ("The squeaky wheel gets the grease").
- We work on the basis of consequences to the group.

In addition to these patterns of behavior, certain time-wasters prevent us from effectively managing time. A **time-waster** is something that prevents a person from accomplishing the job or achieving the goal. Common time-wasters include the following:

- Interruptions, in person or by phone calls, text messages, and email alerts
- Meetings, both scheduled and unscheduled
- Lack of clear-cut goals, objectives, and priorities
- Lack of daily and/or weekly plans
- Lack of personal organization and self-discipline
- Lack of knowledge about how one spends one's time
- Failure to delegate
- Working on routine tasks
- Ineffective communication
- Waiting for others and thus not using transition time effectively
- Inability to say no

The first step in time management is to analyze how time is being used. The second is to determine whether time use is appropriate to your role. You may find much of your time is taken up doing busywork rather than activities that contribute to a particular outcome. Job redesign places emphasis on ensuring that time is spent wisely, and that the right individual is correctly assigned the responsibility for tasks.

Time logs are written or digital records of what you do every minute of the day and are useful in analyzing your time. See an example of a nurse manager's time log in Table 14-1. Start by selecting a typical week and keeping a log of activities in 15- to 60-minute increments. You can use your smartphone's calendar, a planner, or a separate log. Keep it simple. List columns for the time period and the activity. Review your log for what activities are essential and what can be delegated or eliminated.

Table 14-1 Nurse Manager's Time Analysis Log

Time	Activity	Purpose	Value
7:00–7:30	Review emails received overnight; list work to accomplish during shift	To respond to people who have emailed and to plan what work must be done	Sets the plan for the day so as much work as possible can be accomplished
7:30–8:30	Be available for any night shift staff who need to talk with manager before leaving	Manager is accountable to all staff that work on unit. During this time, manager can have face-to-face interaction with night shift staff and follow up on any issues that present	Provides time for night shift staff to see and talk to manager and develop relationships and strong lines of communication
8:30–10:00	Budget planning meeting	Meet with VP of patient care and other managers to work on planning next fiscal year budget	Manager has input into the budget that he/she will work to meet during next fiscal year

Setting Goals

Nurses are accustomed to setting both long- and short-range goals, although typically such goals are stated in terms of what patients will accomplish rather than what the nurse will achieve. A critical component of time management is establishing one's own goals and time frames.

Goals are specific statements of outcomes that are to be achieved. They provide direction and vision for actions as well as a timeline for activities to be accomplished. Defining goals and time frames helps reduce stress by preventing the panic people often feel when confronted with multiple demands. Although time frames may not be as short as the nurse manager would like (the tendency is to expect completion yesterday), necessary actions have been identified and time frames can be adjusted as a task unfolds.

Individual or organizational goals encourage thinking about the future and what might happen, what one wants to happen, and what is likely to happen (Sullivan, 2013). **Goal setting** helps relate current behavior, activities, or operations to the long-range goals of an organization or individual. Without this future orientation, activities may not lead to the outcomes that will help achieve the goals and meet the ideals of the individual or organization. The focus should be to develop measurable, realistic, and achievable goals.

It is useful to think of individual or personal goals in categories, such as the following:

- Department or unit
- Interpersonal (at work)
- Professional
- Financial
- Family and friends (outside of work)
- Vacation and travel
- Physical
- Lifestyle
- Community
- Spiritual

This partial listing is a guide to stimulate thinking about goals. Think about long-term goals, lifetime goals, and short-term goals. These should be divided into job-related goals and personal goals. Job-related goals may revolve around the clinic, unit, or department, whereas personal goals may include family life and community involvement.

Short-term goals should be set for the next 6 to 12 months, but they should be related to long-term goals. To manage time effectively, answer five major questions about these goals:

1. What specific objectives are to be achieved?
2. What specific activities are necessary to achieve these objectives?
3. How much time is required for each activity?
4. Which activities can be planned and scheduled for concurrent action, and which must be planned and scheduled sequentially?
5. Which activities can be delegated to others?

Delegating tasks to others can be an efficient time-management tool. Delegation is the process by which responsibility and authority are transferred to another individual. It involves assigning tasks, determining expected results, and granting authority to the individual expected to accomplish these tasks. Delegation is perhaps the most difficult leadership skill for a nurse or a manager to acquire (Murray, 2010). Today, when more assistive personnel are being used to carry out the nurse's work and when the manager's span of control has expanded, appropriate delegation skills are essential for both nurses and nurse managers to be successful.

Determining Priorities

To establish priorities, take into consideration both short- and long-term goals. Categorize them according to the following:

- What you must do
- What you should do if possible
- What you could do if you have time to spare (Jones & Loftus, 2009)

Next, determine the importance and urgency of each activity as shown in Table 14-2. Activities can be identified according to the following:

- Urgent and important
- Important but not urgent
- Urgent but not important
- Busywork
- Wasted time

Activities that are both urgent and important must be completed. Activities that are important but not urgent may make the difference between career progression and maintaining the status quo. Urgent but not important activities must be completed immediately but are not considered important or significant. Busywork and wasted time are self-explanatory.

In addition, others' emergencies or crises can intrude on your priorities. Again, determine if these are truly urgent and important or if the person is overreacting to an immediate situation.

Table 14-2 Importance–Urgency Chart

Category of Time Use	Examples
Important and urgent	Replacing two call-offs and ensuring sufficient staffing for the upcoming shift
Important, not urgent	Drafting an educational program for nurses on the changes in Medicare reimbursement
Urgent, not important	Completing and submitting the "Beds Available List" for a disaster drill
Busywork	Compiling new charts for future patient admissions
Wasted time	Sitting by the phone waiting for return calls

Daily Planning and Scheduling

Once goals and priorities have been established, you can concentrate on scheduling activities. Prepare a **to-do list** of the tasks to be completed each day, either after work hours the previous day or early before work on the same day. The list is typically planned by workday or workweek. If you have a combination of many responsibilities, a weekly to-do list may be more effective. Flexibility must be a major consideration in this plan; some time should remain uncommitted to allow you to deal with emergencies and crises that are sure to happen. The focus is not on activities and events but, rather, on the outcomes that can be achieved in the time available.

A system to keep track of regularly scheduled meetings (e.g., staff meetings), regular events (e.g., annual or quarterly report due dates), and appointments is also necessary. This system should be used when establishing the to-do list; it should include both a calendar and files.

The calendar might include information on the purpose of the meeting, who will be attending, and the time and place. Several commercial planning systems are available, including software for computers, tablets, and smartphones. Any such system includes a daily, weekly, or monthly calendar; a to-do section; a memo or note section; and an address book with phone numbers. Separate files for projects, committees, or reports should be kept arranged by date.

Grouping Activities and Minimizing Routine Work

Work items that are similar in nature and require similar environmental surroundings and resources should be grouped within divisions of the work shift. Set aside blocks of uninterrupted time for the really important tasks, such as preparing the budget.

Group routine tasks, especially those that are not important or urgent, during your least productive time. For example, list what you can do in 5 minutes, such as scan your email, check text messages, confirm a meeting, or set up an appointment, or in 10 minutes, such as return a phone call, scan a website, or compose an email. This helps you spend the small allotments of time productively.

Much time spent in transition or waiting can be turned into productive use. Commuting time can be used for self-development or planning work activities. We all have to wait sometimes: waiting for a meeting to start or to talk to someone are just two examples. Keep up with texts, voice mails, and emails on your phone, or use the time to read blogs or scan websites. View waiting or transition time as an opportunity, especially to think.

If you are having difficulty completing important tasks and are highly stressed, especially as the day winds down, doing routine tasks for a while often helps reduce stress. Pick a task that can be successfully completed, then save it for the end of the day. Reaching closure on even a routine task at the end of the day can reduce your sense of overload and stress.

Implementing the daily plan and daily follow-up is essential to managing your time. You should also repeat your time analysis at least semiannually to see how well you are managing your time, whether the job or the environment has changed, and if changes in planning activities are required. This can help prevent reverting to poor time-management habits.

Leading at the Bedside: Managing Time

As a staff nurse, you may have little, if any, free or uncommitted time. No planning is required because every minute is taken. However, you may have more discretionary time than you think.

Ask yourself the following:

- Do you chart as you complete a task? Or do you wait until end of shift and end up staying beyond your shift to do so?
- Do you make or take personal calls during your shift?
- Do you search online during work time?
- What about text messages? Or emails?
- Do you gather the necessary supplies before beginning a task?
- Finally, are you able to delegate to others appropriately?

Follow up your answers with changes as you see fit, and you're likely to find some minutes or more that will help you manage your time (Murray, 2010).

Personal Organization and Self-discipline

Some other time-wasters are lack of personal organization and self-discipline, including the inability to say no, having to wait for others, multitasking, and excessive or ineffective paperwork. Effective personal organization results from clearly defined priorities based on well-defined, measurable, and achievable objectives. Priorities and objectives are often related to those of many professionals as well as to objectives of patients and their families.

How time is used is often a matter of resolving conflicts among competing needs. It is easy to become overloaded with responsibilities and with more tasks to do than can be accomplished in the time available. This is typical. There is never enough time for all the activities, situations, and events in which one might like to become involved.

To be effective, nurses and nurse managers must be personally well organized and possess self-discipline. Trying to do several tasks at once is known as multitasking and, while such production sounds good if possible, the reality is that such behavior usually results in none of the tasks completed appropriately. It is better to concentrate on one task at a time, then move on to the next one.

Self-discipline also includes being able to say no. Taking on too much work can lead to overload and stress. Being realistic about the amount of work to which you commit is an indication of effective time management. If a superior is overloading you, make sure that person understands the consequences of additional assignments. Be assertive in communicating your own needs to others.

One manager who felt overwhelmed by all of her responsibilities used the strategies shown in Case Study 14-1 to help her solve her problems.

Controlling Interruptions

An interruption occurs any time you must stop in the middle of one activity to give attention to something else. Interruptions can be an essential part of your job, or they can be a time-waster. An interruption that is more important and urgent than the activity in which you are involved is a positive interruption: It deserves immediate attention. An emergency or crisis, for instance, may cause you to interrupt daily rounds.

Some interruptions interfere with achieving the job and are less important and urgent than current activities. Because the manager's role has expanded to a broader span of responsibility, more decision making is placed on teams and staff. When a

CASE STUDY 14-1 | Time Management

For the past 6 years, Jane Schumann has been the manager of staff development for three hospitals in a Catholic healthcare system. After the healthcare system suffered record operating losses last fiscal year, many middle management positions were eliminated. Jane was retained but had several additional departments assigned to her. Now Jane is responsible for staff development, utilization review staff, in-house float pool, night nursing supervisors, agency staffing, coordination of student nurse clinical rotations, and training of all nursing staff for the new hospital information system at four different hospitals.

Jane has been overwhelmed with her new responsibilities. Wanting to establish trust and learn more about her staff, Jane has adopted an open-door policy, resulting in many drop-in visits each day. She has been working much longer hours and most weekends. She has frequently had to fill in for night supervisors, stretching her workday to 18 hours. Her desk is stacked with paperwork, and her voice mailbox is full of messages to be returned. On average, she returns 40 of the 60 emails received each day.

When Jane comes across information about a time-management seminar, she quickly signs up. At the seminar, Jane learns a number of strategies that she can use.

Back at work, she makes a plan. First, she makes a list of priorities for each of her departments and a time frame for completing each project. Then she completes daily plans for the next two weeks as well as a three-month plan for the upcoming quarter. Jane also determines who among her new staff members can assume additional responsibilities and notes which tasks can be delegated. She sorts through paperwork and establishes a filing system for each department. Jane decides that she will train her administrative assistant to file routine paperwork and route other paperwork to Jane or delegated personnel. Jane also decides that at each departmental meeting, she will establish specific times that she will be available for drop-in visitors. She schedules a meeting with the senior nursing executive to discuss the staffing implications for training nurses at the four hospitals to use the new hospital information system. Finally, she takes advantage of an upcoming four-day weekend to catch up on some well-deserved rest.

manager is interrupted to solve problems within the staff nurse's scope of accountability, the manager should not become responsible for solving the problem. Gently but firmly directing the individual to search for solutions will begin to break old patterns of behavior and help develop individual responsibility. Although it is time-consuming in the beginning, this practice eventually reduces the number of unnecessary interruptions.

Keeping an **interruption log** on an occasional basis may help. The log should show who interrupted, the nature of the interruption, when it occurred, how long it lasted, what topics were discussed, the importance of the topics, and time-saving actions to be taken. An example of a nurse manager's interruption log is shown in Table 14-3.

Analysis of these data may identify patterns for you to plan ways to reduce the frequency and duration of interruptions. They may also indicate that certain staff members are the most frequent interrupters and require individual attention to develop problem-solving skills.

Phone Calls, Voice Mail, Email, and Text Messages

Phone calls, voice mail, email, and text messages are a major source of interruption. A ringing phone or beep from an incoming text is highly compelling; few people can allow it to go unanswered. All of us receive numerous phone calls and texts, and some of them are time-wasters. Handling them effectively is a must.

PHONE CALL STRATEGIES Employing a few simple methods to manage phone calls can increase efficiency and decrease time wasted:

- ***Minimize socializing and small talk.*** If you answer the phone with "Hello, what can I do for you?" rather than "Hello, how are you?" the caller is encouraged to

Table 14-3 Nurse Manager's Interruption Log

Name	Purpose	Time	Topics	Importance	Actions
Joan, RN	Stopped in manager's office to talk	10 minutes	Kids' baseball games, husband's new job	Not related to work activities, but helps build relationship with staff	Proactively plan time for occasional personal conversations with staff to build relationships; plan to eat lunch with staff in break room 1 day per week in order to have informal conversations
Bill, janitor	Ask manager if he/she has seen any furniture in hallways because a chair was missing from a patient room	5 minutes	Patient's room furniture was missing	Patient rooms need a chair so the patient can get out of bed and have a place to sit. There is an issue with furniture that is sent for repair being misplaced when returned to the unit.	Ask the unit clerk to keep a log of all furniture sent off the unit for repair. When the furniture is returned, rather than putting it in the hallway until someone says a chair is needed in a room, the unit clerk proactively finds out where the chair belongs and takes it to that location.
Jason, nurse aide	Tells the manager that he has tried four different machines, but no one machine can measure blood pressure, temperature, and oxygen saturation	15 minutes	When equipment fails, manager works with employee to call bio med department to get equipment in for repairs; four rental machines are brought to unit while others are being fixed	Staff need functioning equipment to do their jobs efficiently	Partner with bio med department to have unit equipment checked once per week to ensure each component of the machines is functioning properly

get to business first. Be warm, friendly, and courteous, but do not allow others to waste time with inappropriate or extensive small talk. Calls placed and returned just prior to lunchtime, at the end of the day, and on Friday afternoons tend to result in more business and less socializing.

- ***Plan calls.*** The person who plans phone calls does not waste anyone's time, including that of the person called. Note the topics you want to discuss before you make the call. That way, you will not need to call back to give additional information or ask a forgotten question.
- ***Set a time for calls.*** You may have a number of calls to return and make. It is best to set aside a time for routine phone calls, especially during your downtime. Try not to interrupt what is being done at the moment. If an answer is necessary before your work can be continued, phone immediately; if not, phone for the information at a later time.
- ***State the reason for the call and ask for preferred call times.*** If a party is not available, explain why you are calling and provide several time frames when you will be available for a return call. Find out when the person you are calling is available. This makes it easier for him or her to be prepared for the call and helps prevent phone tag.

Voice mail is an excellent way to send and receive messages when a real-time interaction is not essential. For example, one person or a large group of people can learn about an upcoming meeting in one voice mail message. They can phone in their responses at their convenience (with no need to reach each other directly). Like other forms of communication, voice mail must be used appropriately. Long messages or

sensitive information is better conveyed one-on-one. Moreover, another person (e.g., unit clerk) may be responsible for taking voice mail messages off the system, so it is important to state the message in a professional manner, omitting personal or confidential information.

TEXT MESSAGES Text messages demand attention unless the phone's notification feature is turned off. Even then, frequently glancing at the phone's screen alerts you to new messages. Few of us can resist checking "just this one" message. Text messages are a combination of voice messages and email, so establish a time to return them.

EMAIL Email can enhance time management or be a further time-waster. Email minimizes the time you waste trying to contact individuals, enables you to contact many people simultaneously, and allows you to code the urgency of the message. Tone, however, is difficult to convey by email. Therefore, it is better to use more personal forms of communication, such as the phone or in-person contact, for potentially sensitive or troublesome issues.

Incoming Messages. Checking email too often can waste time. Each time you read a message, you are forced to think about it and you lose your focus on the task at hand. Turn off your email alert and set specific times of day to check your in-box.

Also discourage people who forward you unwanted messages. Set your email filter to direct these messages to your spam folder or tell the sender that you cannot receive personal messages at work (Merritt, 2009).

Outgoing Messages. Writing clear messages helps increase prompt and useful responses. Here are some tips:

- Direct messages only to the people involved (e.g., committee members) and copy others (e.g., the department chair).
- Title the subject line appropriately. For example, write "Meeting Friday morning" rather than "Information."
- Avoid salutations, if possible. "Dear" and "Hi" are often not needed on routine messages.
- Craft your message succinctly but politely: "The division meeting will be held in conference room C at 9:00 a.m."

In-person Interruptions

Although often friendly and seemingly harmless, the typical "Got a minute?" interruption is rarely as short as that. Of course, some interruptions are important, urgent, or both. You must attend to those. For others, however, you can control the duration of the in-person interruption (Jones & Loftus, 2009). Take charge of the visit by identifying the issue or question, arranging an alternative meeting, referring the visitor to someone else, or redirecting the visitor's problem-solving efforts.

Paperwork

Healthcare organizations cannot function effectively without good information systems. In addition to phone calls and face-to-face conversations, nurses and managers spend considerable time writing and reading communications. Implementing aspects of the Affordable Care Act, increasing regulations, measures to avoid legal action,

stronger privacy requirements, new treatments and medications, data processing, work processing, and electronics place pressure on everyone to cope with increasing paperwork (including electronic "paperwork").

1. ***Plan and schedule paperwork.*** Writing and reading reports, forms, email, letters, and memos are essential elements of a job. They will, however, become a major source of frustration if their processing is not planned and scheduled as an integral part of daily activities. Learn the organization's information system and requirements, analyze the paperwork requirements of the position, and make significant progress on that part of the job daily.
2. ***Sort paperwork for effective processing.*** A system of file folders for paper mail, document files, or email can be very helpful (Raso, 2010). Here is a system to handle it:
   - Place all paperwork (or email) requiring personal action in an "action" folder on your tablet, computer, or phone. Handle that according to its relative importance and urgency.
   - Place work that can be delegated in a separate file, and distribute it appropriately.
   - Place all work that is informational and related to present work in an "informational" folder on your tablet, computer, or phone.
   - Place other reading material, such as professional journals, technical reports, and other items that do not relate directly to the immediate work, in a "read" file.

   The informational file contains materials that must be read immediately, whereas the reading file materials are not as urgent and can be read later.

   Do not be afraid to throw things away or delete them from your tablet or computer. Do not let them become clutter when they no longer have value. Use recycle receptacles for paper. Delete electronic files.
3. ***Send every communication electronically.*** Unless a paper memo, report, or letter is required, send your work electronically.
4. ***Analyze paperwork frequently.*** Review filing policies and rules regularly and purge files at least once each year. All standard forms, reports, and memos should be reviewed annually. Each should justify its continued existence and its present format. Do not be afraid to recommend changes and, when possible, initiate those changes.
5. ***Do not be a paper shuffler.*** "Handle a piece of paper only once" is a common adage, but impossible to follow if taken literally. Rather, each time you handle a document (paper or online) or an email message, take action to further process it. Paper shufflers are those who continually move documents around or accumulate unread emails. They delay action unreasonably, and the problem mounts.

Controlling Time in Meetings

Meetings consume much time for nurses and managers, and much of that time is wasted. To manage meetings follow these rules (Merritt, 2009):

- Do not meet simply because you always meet on Monday morning. If no meeting is needed, cancel it.
- Invite only key people to initial meetings. Others can be sent the minutes or invited to future meetings.

- Establish the meeting's goal and outcomes expected at the outset.
- Send information before the meeting so time is not spent reading it.
- Set a time limit for all meetings. Routine meetings should last no more than 1 hour. If more time is needed, schedule another meeting.
- Determine the agenda and keep to the topic.
- Follow up with actions assigned.

Respecting Time

The key to using time-management techniques is to respect one's own time as well as that of others. Using the preceding suggestions for time management communicates to those who interact with you that you expect them to respect your time. You, however, must reciprocate by respecting their time, too. If you need to talk to someone, make an appointment, particularly for routine matters.

You should continually ask, "What is the best use of my time right now?" Then you should answer in three ways:

- For myself and my goals
- For my staff and their goals
- For the organization and its goals

Efforts to manage time may seem to take more time, but the reverse is true. Any activity that helps set goals, determine priorities, organize activities, and minimize interruptions will pay off in increased efficiency and effectiveness.

What You Know Now

- The first step in time management is to analyze how you use your time by keeping a time log.
- Daily planning and scheduling help determine priorities and set goals.
- Personal organization strategies help use time productively.
- An interruption log helps identify patterns that can be used to reduce unnecessary interruptions.
- Phone calls can be controlled by minimizing small talk and planning calls; voice mail and email should be used efficiently.
- Written communication can also cause interruptions that can be minimized by planning and scheduling paperwork and emails and using an effective filing system.
- People who respect their own time are likely to find others respecting it, too.

Tools for Managing Time

1. Recognize that there will never be enough time to accomplish everything you want.
2. Use a time log to identify and reduce time-wasters.
3. Use a planning system to list goals, determine priorities, and schedule activities.
4. Monitor interruptions and decide on ways to minimize them.

Questions to Challenge You

1. What are your major time-wasters? Keep a time log for 1 week. Compare how you thought you wasted time with what your time log revealed.
2. Write down your goals for the next week. What action steps can you take to realize your goals? At the end of the week, evaluate your progress. Then write down the next week's goals.
3. What is keeping you from accomplishing your goals? Think about how you can change the circumstances to better reflect your priorities.
4. Do you use a planner or other scheduling device? If not, investigate the choices and select the one that will work best for you. Then use it!
5. Think about how you handle interruptions. During the next week, try various strategies to minimize the effect of interruptions.

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Chapter 15

Budgeting and Managing Fiscal Resources

The Budgeting Process
Timetable for the Budgeting Process

Approaches to Budgeting
Incremental Budget
Zero-based Budget
Fixed or Variable Budgets

The Operating Budget
The Revenue Budget
The Expense Budget

Determining the Salary and Nonsalary Budget
The Salary Budget
The Supply and Nonsalary Expense Budget

The Capital Budget

Monitoring and Controlling Budgetary Performance During the Year
Variance Analysis
Position Control

Staff Impact on Budget
Improving Performance

Learning Outcomes

After completing this chapter, you will be able to:

1. Describe how the budgeting process works.
2. Differentiate among different approaches to budgeting.
3. Describe components of an operational budget.
4. Demonstrate how to plan a salary and nonsalary budget.
5. Explain the nurse manager's role with capital budgeting.
6. Demonstrate how to monitor and control budgetary performance.
7. Describe how staff affects budgetary performance.

Key Terms

benefit time
budget
budgeting
capital budget
cost center
direct costs
efficiency variance
expense budget
fiscal year
fixed budget
fixed costs
incremental (line-by-line) budget
indirect costs
nonsalary expenditure variance
operating budget
position control
profit
rate variances
revenue budget
salary (personnel) budget
variable budget
variable costs
variance
volume variances
zero-based budget

Introduction

Budgeting is the process of planning and working to meet or exceed the goals of the plan (Finkler, Jones, & Kovner, 2012). A budget is a detailed, quantitative plan that communicates these expectations and serves as the basis for comparing them to actual results. The budget shows how resources will be acquired and used over some specific time interval; its purpose is to allow management to project activities into the future so that the objectives of the organization are coordinated and met. It also helps ensure that the resources necessary to achieve these objectives are available at the appropriate time. In addition, a budget helps management control the organization.

Budgeting is performed by businesses, governments, and individuals. In fact, nearly everyone budgets, even though he or she may not identify the process as such. Even if a budget exists only in an individual's mind, it is nonetheless a budget. Anyone who has planned how to pay a particular bill at some time in the future—say, 6 months—has a budget. Although it is very simple, that plan accomplishes the essential budget functions. One now knows how much of a resource (money) is needed and when (in 6 months) it is needed. Note that the "when" is just as important as the "how much"—the money has to be available at the right time.

Demands for patient safety, reimbursement changes with healthcare reform, technological advances, and the changing roles of healthcare providers require that budgets be constructed as accurately as possible and for nurse managers to understand financial implications (Dunham-Taylor & Pinczuk, 2015). This is no small task. Attention to the budgeting process is the first step in understanding how to use resources most effectively.

The Budgeting Process

A **budget** is a quantitative statement, usually in monetary terms, of the plans and expectations of a defined area over a specified period of time. Budgets provide a foundation for managing and evaluating financial performance. Budgets detail how

resources (money, time, people) will be acquired and used to support planned services within the defined time period.

The budget process also helps ensure that the resources needed to achieve these objectives are available at the appropriate time, and that operations are carried out within the resources available. The budgeting process increases the awareness of costs and also helps employees understand the relationships among goals, expenses, and revenues. Open dialogue between a nurse manager and staff nurse about the budget can help raise awareness for nurses about where money comes from or how money functions in an organization. As a result, employees are committed to the goals and objectives of the organization, and various departments are able to coordinate activities and collaborate to achieve the organization's objectives. Budgets also help management control the resources expended through an organizational awareness of costs. Finally, budget performance provides management with feedback about management of resources and the impact on the budget.

Budgeting involves planning and controlling future operations by comparing actual results with planned expectations. Planning first involves reviewing established *goals* and *objectives* of both nursing and the organization. Goals and objectives help identify the organization's priorities and direct the organization's efforts. To plan, the organization must know the following:

- Demographics of the population served, community influences, societal trends, and competitors
- Sources of revenue, especially with changes in reimbursement due to enactment of healthcare reform
- Statistical data, including:
  - Number of admissions or patient appointments
  - Average daily census
  - Average length of stay
  - Patient acuity
  - Projected volume base for ambulatory or procedure-based units or home care visits
- Wage increases of market adjustments
- Price increases, including inflation rate, for supplies and other costs
- Costs for new equipment or technologies (e.g., communication devices, IV pumps, monitoring equipment)
- Staff mix (e.g., RNs, LPNs, UAPs)
- Regulatory changes (e.g., legislation mandating nurse-to-patient ratios, state board of health regulations) for the budgetary period
- Organizational changes (e.g., decentralization of pharmacy or respiratory therapy services) that result in salary and benefit dollars being charged in portion to the unit

Management normally uses the past as the common starting point for projecting the future, but in today's evolving payment environment, the past may be a poor predictor of the future. This is one of the major drawbacks of the budgeting process. In a rapidly changing industry, basing budgets on historical data often requires readjustment during the actual budget period.

Controlling is the process of comparing actual results with the results projected in the budget. (See Monitoring and Controlling Budgetary Performance During the Year later in this chapter.) Two techniques for controlling budgetary performance are *variance analysis* and *position control*. By measuring the differences between the projected and the actual results, management is better able to make modifications and corrections. Therefore, controlling depends on planning.

Timetable for the Budgeting Process

Depending on the size and complexity of the organization, the budgeting process takes between 3 and 6 months. The process begins with the first-level manager. The individual at this level of management may or may not have formalized budget responsibilities but is nevertheless key to identifying needed resources for the upcoming budget period.

The manager seeks information from staff about areas of needed improvement or change and reviews unit productivity and the need for updated technology or supplies. The manager uses this information to prepare the first draft of the budget proposal.

Depending on the levels of organizational management, this proposal ascends through the managerial hierarchy. Each subsequent manager evaluates the budget proposal, making adjustments as needed. By the time the budget is approved by executive management, significant changes to the original proposal usually have been made so the budget fits into the grand scheme of the budget for the whole organization.

The final step in the process is approval by a governing board, such as a board of directors or designated shareholders. Typically, the budget process timetable is structured so that the budget is approved a few months before the beginning of the new fiscal year.

Clearly articulating budgetary needs is essential for the manager to be successful in budget negotiations. Senior management must prioritize budget requests for the entire organization, and they base those decisions on strong supporting documentation. Nurse managers should not expect to receive all of their budget requests, but they need to be prepared to defend their priorities.

Approaches to Budgeting

Budgets may be developed in various formats depending on how the organization is structured. They may be considered as:

- ***Cost centers.*** Managers are responsible for predicting, documenting, and managing the costs (staffing, supplies) of the area of responsibility.
- ***Revenue centers.*** Managers are responsible for generating revenues.
- ***Profit centers.*** Managers are responsible for generating revenues and managing costs so that the department shows a profit, which means that revenues exceed costs.
- ***Investment centers.*** Managers are responsible for generating revenues and managing costs and capital equipment and assets.

Nursing units are typically considered to be cost centers, but they may also be viewed as revenue centers, profit centers, or investment centers. How the unit is

viewed is crucial in determining the manager's understanding of responsibility and approach to budgeting.

Also, some nursing managers are responsible for service lines, and their staff are from multiple disciplines and departments. Other nurse managers are responsible for a single unit, such as a telemetry unit or the staff in a multiple-physician office.

The organization may choose various approaches, or combinations of approaches, for requesting departmental managers to prepare their budget requests. These approaches are incremental (line-by-line), zero-based, fixed, and variable.

Incremental Budget

With an **incremental (line-by-line) budget**, the finance department distributes a budget worksheet listing each expense item or category on a separate expense line. The expense line is usually divided into salary and nonsalary items. A budget worksheet is commonly used for mathematical calculations to be submitted for the next year. It may include several columns for the amount budgeted for the current year, the amount actually spent year-to-date, the projected total for the year based on the actual amount spent, increases and decreases in the expense amount for the new budget, and the request for the next year with an explanation attached.

The base or starting point for calculating next year's budget request may be either the previous year's actual results or projected expenditures for the current year. For salary expenses, the adjustment might be the average salary increase projected for next year. For nonsalary expenses, the finance department may provide an estimate of the average increase for supplies or opt to use a standard measure of cost increases, perhaps the consumer or medical price index projected for the next year.

To complete budget worksheets accurately, managers must be familiar with expense account categories and what type of expenses, such as instruments and minor equipment, are included under each line item. In addition, the manager must keep abreast of different factors that have affected the expenditure level for each expense line during the current year. The projected impact of next year's activities will be translated into increases or decreases in expense levels of the nursing unit's expenditures for the coming year.

The advantage of the line-by-line budget method is its simplicity of preparation. The disadvantage of this method is that it discourages cost efficiency. To avoid budget cuts for the next year, an astute manager learns to spend the entire budget amount established for the current year, because this amount becomes the base for the next year.

Zero-based Budget

The **zero-based budget** approach assumes the base for projecting next year's budget is zero. Managers are required to justify all activities and programs as if they were being initiated for the first time. Regardless of the level of expenditure in previous years, every proposed expenditure for the new year must be justified under the current environment and its fit with the organization's objectives.

The advantage of zero-based budgeting is that every expense is justified. The disadvantage is that the process is time-consuming and may not be necessary. For that reason, organizations may not use this process every year. An adaptation of the zero-based budget is to start the budget with a lower base—for example, 80%—of the current expenses. Managers then have to justify any budgetary expenses requested above the 80% base.

Fixed or Variable Budgets

Budgets can also be categorized as fixed or variable. In a **fixed budget**, the budgeted amounts are set without regard to changes that may occur during the year, such as patient volume or program activities, that have an impact on the cost assumptions originally used for the coming year. In contrast, the **variable budget** is developed with the understanding that adjustments to the budget may be made during the year based on changes in revenues, patient census, utilization of supplies, and other expenses.

The Operating Budget

The **operating budget**, also known as the annual budget, is the organization's statement of expected revenues and expenses for the coming year. It coincides with the **fiscal year** of the organization, a specified 12-month period during which the operational and financial performance of the organization is measured. The fiscal year may correspond with the calendar year—January to December—or another time frame. Many organizations use July 1 to June 30; the federal government begins its fiscal year on October 1. The operating budget may be further divided into smaller periods of 6 months or into four quarters (3 months each); each quarter may be further separated into three 1-month periods. The revenues and expenses are organized separately, with a bottom-line net profit or loss calculated.

The Revenue Budget

The **revenue budget** represents the patient care income expected for the budget period. Most commonly, healthcare payers pay a predetermined rate based on discounts or allowances. In many cases, actual payment generated by a given service or procedure will not equal the charges that appear on the patient bill. Instead, the healthcare provider will be reimbursed based on a variety of methods, including the following:

- Reimbursement of a predetermined amount, such as fixed costs per case (Medicare recipients)
- Bundled payments (e.g., total knee replacement paid with predetermined fee to cover the operation, hospital stay, and outpatient therapy)
- Negotiated rates, such as per diems (a specified reimbursement amount per patient, per day)
- Negotiated discounts
- Capitation (one rate per member, per month, regardless of the service provided).

Revenue projections for the next year are based on the volume and mix of patients, rates, and discounts that will prevail during the budget period. Projections are developed from historic volume data, impact of new or modified clinical programs, shifts from inpatient to outpatient procedures, market changes, and other influences. Today, however, these projections may not be viable, especially in the light of healthcare reform.

Medicare is changing the way hospitals are paid (Medicare.gov, 2016). Payment is no longer based solely on services provided by a hospital. It is based on the quality of

service that is provided. Quality metrics such as readmission rates and hospital-acquired infections are factored into payments rendered for services.

The Expense Budget

The **expense budget** consists of salary and nonsalary items. Expenses should reflect patient care objectives and activity parameters established for the nursing unit. The expense budget should be comprehensive and thorough; it should also take into consideration all available information regarding expectations for the next year. Described in the next sections are several concepts and definitions related to the budgetary process in a healthcare setting.

COST CENTERS In healthcare organizations, nursing units are typically considered cost centers. A **cost center** is the smallest area of activity within an organization for which costs are accumulated. Cost centers may be revenue producing, such as laboratory and radiology, or non–revenue producing, such as environmental services and administration. Nursing managers are commonly given the responsibility for costs incurred by their department, but they have no revenue responsibilities.

In contrast, if managers are responsible for controlling both costs and revenues and if their financial performance is measured in terms of **profit** (the difference between revenues and expenses), then the manager is responsible for a profit center. Customarily, nursing is not directly reimbursed for its services. Nursing costs today are included in the room charge, although that may change as methods to match nurses' skills to patient needs improve.

CLASSIFICATION OF COSTS Costs are commonly classified as fixed or variable. **Fixed costs** are costs that will remain the same for the budget period regardless of the activity level of the organization, such as rental payments and insurance premiums. **Variable costs** depend on and change in direct proportion to patient volume and patient acuity, such as patient care supply expenses. If more patients are admitted to a nursing unit, more supplies are used, causing higher supply expenses.

Expenditures may also be direct or indirect. **Direct costs** are expenses that directly affect patient care. For example, salaries for nursing personnel who provide hands-on patient care are considered direct costs. **Indirect costs** are expenditures that are necessary but do not affect patient care directly. Salaries for security or maintenance personnel, for example, are classified as indirect costs.

Determining the Salary and Nonsalary Budget

Budgets include expenses for both salary and nonsalary costs. Salary costs include expenses related to personnel. Nonsalary costs include supplies and other operations expenses.

The Salary Budget

The **salary (personnel) budget** projects the salary costs that will be paid and charged to the cost center in the budget period. Managing the salary budget is directly related to the manager's ability to supervise and lead the staff. Strong managers tend to have more

stable staff with fewer resources spent on supplementary staff, turnover, or absenteeism. In addition to anticipated salary expenses, factors such as benefits, shift differentials, overtime, on-call expenses, and bonuses and premiums may affect the salary budget.

BENEFITS A full-time equivalent (FTE) is a full-time position that can be equated to 40 hours of work per week for 52 weeks, or 2,080 hours per year. After the number of required FTEs is determined for an organization, it is also necessary to determine how many FTEs are necessary to replace personnel for **benefit time** (e.g., vacations, holidays, personal days). This factor can be calculated by determining the average number of vacation days, paid holidays, personal days, bereavement days, sick days, or other days off with pay that the organization provides to employees.

To determine FTEs required for replacement, calculate the following:

1. Determine hours of replacement time per individual.
2. Then determine FTE requirement.

Benefit Time	Hours/shift	Replacement Hours
15 vacation days	× 8 hours	= 120
8 holidays	× 8 hours	= 64
4 personal days	× 8 hours	= 32
5 sick days	× 8 hours	= 40
	Total	= 256

Divide replacement time by annual FTE base

$$\frac{256}{2{,}080} = 0.12$$

An FTE budget is calculated from the FTE calculations (see Table 15-1). This budget provides the base for the salary budget. However, shift differentials, overtime, and bonuses or premiums may also affect budget performance and need to be considered.

Table 15-1 Monthly Salary Budget and Year-to-Date Budget Comparison Report
Fiscal Year Ending June 30

Position	June Actual Salary	June Budgeted Salary	June Variance	Year-to-Date Actual Salary	Year-to-Date Budgeted Salary	Year-to-Date Variance
Nurse Manager	$6,250	$6,250	$0	$68,750	$75,000	$6,250
Registered Nurses	95,722	93,825	(1,897)	1,048,813	1,125,878	77,065
Licensed Practical Nurses	19,025	20,800	1,775	231,426	249,600	18,174
Nursing Assistants	14,886	13,200	(1,686)	159,500	158,400	(1,100)
Unit Clerks	5,483	5,495	12	60,391	65,273	4,882
Float Pool RNs	1,426	1,000	(426)	16,800	12,500	(4,300)
TOTAL SALARY:	**$142,792**	**$140,570**	**($2,222)**	**$1,585,680**	**$1,686,651**	**$100,971**

SHIFT DIFFERENTIALS Some facilities use a set percentage to determine shift differential: 10% for evenings, 15% for nights, and 20% for weekends and holidays, for example. If the hourly rate is $22.00, for instance, then the cost for a nurse working evenings would be $22.00 plus $2.20 for each hour worked. On an 8-hour shift, the total cost would be $193.60, and for the year, $50,336. Other facilities use a set dollar amount per hour as the shift differential. For instance, evenings adds $2.50 per hour to base pay, night shift $4.00 per hour, and weekends $2.50 per hour additional pay.

OVERTIME Fluctuations in workload, patient volume, variability in admission patterns, and temporary replacement of staff due to illness or time off all create overtime in the nursing unit. A projection of overtime for the next year can be calculated by determining staff classification (RN, LPN, nursing assistant, and other employee classifications), then the historical or typical number of hours of overtime worked and multiplying that number by 1.5 times the hourly rate. For example, if the average number of overtime hours paid in a unit for RNs is 35 hours per two-week pay period, and the average hourly rate is $22.00, the projected overtime cost for the year would be $30,030 for the RN category.

To determine overtime costs:

1.	Multiply average salary for classification	$22.00
	by factor	× 1.50
	to obtain overtime rate	$33.00
2.	Multiply average overtime hours	35
	by overtime rate	× $33.00
	to obtain expenditure per pay period	$1,155.00
3.	Multiply number of pay periods	26
	by overtime expenditure	× $1,155.00
	to obtain annual overtime costs	$30,030.00

Clearly, overtime can rapidly deplete finite budget dollars allocated to a nursing unit. The nurse manager should explore options to overtime, such as using part-time or PRN (staff scheduled on an as-needed basis) workers in order to keep the cost per hour more in line with the regular hourly rates. A competent manager certainly would also evaluate unit productivity to decrease overtime.

ON-CALL HOURS If the nursing unit uses a paid on-call system, the approximate number of hours that employees are put on call for the year should be estimated and that cost added to the budget. Typically under the on-call system, staff members are requested to be available to be called back to work if patient need arises, and the number of hours on call are paid at a flat rate per hour.

PREMIUMS Some organizations offer premiums for certifications or clinical ladder steps. In this situation, a fixed dollar amount may be added to the base hourly rate of eligible personnel; for example, an additional $1.00 per hour paid for professional certifications. This would result in the hourly rate of the employee being adjusted from a base of $22.00 to $23.00. In this case, if the employee is full time and works 2,080 hours a year (40 hours a week multiplied by 52 weeks a year), the annual new salary would be $47,840, or $23.00 multiplied by 2,080.

SALARY INCREASES Merit increases and cost-of-living raises also need to be factored into budget projections. These increases are usually calculated on base pay. For example, if a 3% cost-of-living raise is projected and the base salary for an RN is $45,000, then the new base becomes $46,350.

ADDITIONAL CONSIDERATIONS Other important factors to consider when developing the salary budget are changes in technology, clinical supports, delivery systems, clinical programs or procedures, and regulatory requirements. Changes in patient care technology or the introduction of new equipment may influence the number, skill, or time that unit personnel may spend in becoming trained to use the new equipment and, later, operating and maintaining it. If significant, the projected number of additional labor hours for the new budgetary period should be incorporated into the request.

Departments such as environmental services, dietary, transport, or laboratory may provide the nursing unit with support in performing certain tasks, such as transporting patients or specimens. Any change in the level of support they provide should be reviewed, and the effect of such change on the unit's staffing levels should be quantified for the next year's budget request. Changes in staffing can place new demands on the unit. Therefore, orientation and additional workload needs should also be considered.

In addition, changes might be made to the way the organization charges costs. For example, some direct or indirect costs formerly charged under other divisions might now be allocated to the various units. You might find your unit charged for its fair share of the heating or security budget. Major changes, of course, are planned ahead of time, but some changes occur during the budget year, and the unit might be expected to absorb those additional costs within its original budget.

The Supply and Nonsalary Expense Budget

The supply and nonsalary expense budget identifies patient-related supplies needed to operate the nursing unit. In addition to supplies, other operating expenses—such as office supplies, rental fees, maintenance costs, and equipment service contracts—may also be paid out of the nursing unit's nonsalary budget.

An analysis of the current expense pattern and a determination of its applicability for the next budget period should be performed first. Any projected changes in patient volume, acuity, and patient mix should also be considered because they will affect next year's supply use and other nonsalary expenses. For example, if a new surgery is being performed at your hospital and a special expensive type of dressing is used on the patients, you would plan this cost into the next year's budget.

Increases due to an inflation rate index, or at a rate estimated by the finance or purchasing department, are included as part of the budget request. A simple way of calculating the effect of a price increase is to take the estimated total ending expense for the year and multiply it by the inflationary factor.

To determine projected price increases, perform the following calculation:

Multiply current total line item	
expense	$12,758
by inflation factor plus 1.0	× 1.05
	$13,396

Increases in expenses, such as maintenance agreements and rental fees, should also be incorporated as part of the budget request. The introduction of new technology and changes in programs and regulatory requirements may require additional resources for supplies as well as increased salaries.

The Capital Budget

The **capital budget** is an important component of the plan to meet the organization's long-term goals. This budget identifies physical renovations, new construction, and new or replacement equipment planned within a specified time period. Organizations define capital items based on certain conditions or criteria. Usually, capital items must have an expected performance of 1 year or more and exceed a certain dollar value.

The capital budget is limited to a specified amount, and decisions must be made regarding how best to allocate available funds. The capital budget fund is determined by profit that the organization has had and the amount it can afford to reinvest in itself. Some organizations also gain additional capital budget dollars through philanthropy support. Priority is given to those items needed most. Not all items that fall under the capital budget will necessarily get funding in a given year.

The role of a nurse manager in the capital budget process is often to identify capital needs that exist in his or her areas of responsibility. Many healthcare organizations have departments that coordinate bringing in selected vendors and items and limit choices to that equipment. The nurse manager would then be responsible for reporting what needs exist and helping to select and determine the amount of equipment needed. The capital pool is expensed out across all units that use the equipment.

The nurse manager is also asked to play a role in the prioritization process. A nurse manager might request new televisions for her unit because the old televisions are breaking down often and patients complain that the picture is blurry. At the same time, the nurse manager could request a new piece of lift equipment that will improve staff safety when moving patients. The manager is allowed a set amount from the capital budget and has to decide between buying televisions and improving patient satisfactions or the new lift and potentially improving staff safety.

The impact of the new equipment on the unit's expenses, such as the number of staff needed to run the equipment, use of supplies, and maintenance costs, must be considered as part of the operating budget, not the capital budget. Likewise, the need for additional nursing and nonnursing personnel to operate the new equipment, additional workload, and training of personnel should be quantified for the next year's budget.

Monitoring and Controlling Budgetary Performance During the Year

The difference between the amount that was budgeted for a specific revenue or cost and the actual revenue or cost that resulted during the course of activities is known as the **variance**. Variance might occur in the actual cost of delivering patient care for a certain expense line item in a specified period of time. Nurse managers are commonly asked to justify the reason for variances and present an action plan to reduce or eliminate these variances.

Managers receive reports summarizing the expenses for the department (see Table 15-1). In the past, monthly reports on paper were sent to managers. Today these reports are most often generated in electronic form, allowing them to be compiled and communicated rapidly and for managers to adjust more quickly than with paper reports.

Monthly reports show expense line items with the budgeted amount, actual expenditure, variance from budget, and percentage from the budgeted amount that such variance represents. Often, they also show the comparison between actual year-to-date results and the year-to-date budget.

To assess variance, follow these steps:

- Identify items that are over or under budgeted amounts.
- Find out why the variance occurred (e.g., a one-time event or an ongoing occurrence).
- Keep notes on what you have learned in preparation for next year's budget.
- Examine the payroll and note overtime or use of agency personnel.
- Validate the use of overtime or additional personnel and keep a note for your files.

Keeping notes throughout the year will help prevent the annual budget process from becoming an overwhelming challenge. Trying to reconstruct what happened and why during the past 12 months is unlikely to present a complete and accurate picture of events and makes creating a future budget more difficult.

Variance Analysis

In the daily course of events, it is unlikely that projected budget items will be completely on target in all situations. One of the manager's most important jobs is to manage the financial resources for the department and to be able to respond to variances in a timely fashion.

When expenses occur that differ from the budgeted amounts, organizations usually have an established level at which a variance must be investigated and explained or justified by the manager of the department. This level may be a certain dollar amount, such as $500, or it may be a percentage, such as a 5% or 10% increase from the budgeted amount.

In determining causes for variance, the nurse manager must review the activity level of the unit for the same period. There may have been increases in census or patient acuity that generated additional expense in salary and supplies.

Also, in many situations, variances might not be independent of one another. Variances can result from expenses that follow a seasonal pattern and occur only at determined times in the year (renewal of a maintenance agreement is one example). Expenses can also follow a tendency or trend either to increase or to decrease during the year. Even if the situation is outside the manager's usual responsibility or control, the manager needs to understand and be able to identify the cause or reason for the variance.

To determine when a variance is favorable or unfavorable, it is important to relate the variance to its impact on the organization in terms of revenues and expenses. If more earnings came in than expected, the variance is favorable; if less, the variance is negative. Likewise, if less was spent than expected, the variance is favorable; if more was spent, the variance is negative.

For instance, the nurse manager might receive the following expense report:

Budgeted Expenditures	Actual Expenditures	Variance (in $)	Percent (in %)
$34,560	$36,958	(2,398)	(6.9)

This expense variance is considered unfavorable because the actual expense was greater than the budget. In this example, more money was spent on medical/surgical supplies than was projected in the budget.

If the variance percentage of the actual budgeted amount is not presented in the reports, it can be calculated as follows:

$$\frac{\$2{,}398}{\$34{,}560} = 0.069$$

Divide the dollar variance by the budget amount, then multiply by 100:

$$0.069 \times 100 = 6.9\% \text{ over budget}$$

SALARY VARIANCES With salary expenditures, variances may occur in volume, efficiency, or rate. Typically these factors are related and have an impact on each other. **Volume variances** result when there is a difference in the budgeted and actual workload requirements, as would occur with increases in patient days. An increase in the actual number of patient days will increase the salary expense, resulting in an unfavorable volume variance. Although the variance is unfavorable, concomitant increases in revenues for the organization should be apparent. Thus, the impact to the organization should be welcomed, even though it generated higher salary costs at the nursing unit level.

Efficiency variance, also called quantity or use variance, reflects the difference between budgeted and actual nursing care hours provided. Patient acuity, nursing skill, unit management, technology, and productivity all affect the number of patient care hours actually provided versus the original number planned or required. At the same time, if the census had been higher than expected, it would be understandable if more hours of nursing care were provided and paid. A favorable efficiency, or fewer nursing care hours paid, could suggest that patient acuity was lower than projected, that staff was more efficient, or that higher-skilled employees were used. An unfavorable efficiency may be due to greater patient acuity than allowed for in the budget, overstaffing of the unit, or the use of less experienced or less efficient employees.

Rate variances, also known as price or spending variances, reflect the difference in budgeted and actual hourly rates paid. A favorable rate variance may reflect the use of new employees who were paid lower salaries. Unfavorable rate variance may reflect unanticipated salary increases or increased use of personnel paid at higher wages, such as agency personnel.

NONSALARY EXPENDITURE VARIANCES A **nonsalary expenditure variance** may be due to changes in patient volume, patient mix, supply quantities, or prices paid. New, additional, or more expensive supplies used at the nursing unit because of technology changes or new regulations could also influence expenditure totals.

Position Control

Another monitoring tool used by nurse managers is the position control. The **position control** is used to compare actual numbers of employees to the number of budgeted FTEs for the nursing unit. The position control is a working tool that is a list of approved, budgeted FTE positions for the nursing cost center. The positions are displayed by category or job classification, such as nurse manager, RNs, LPNs, and so on. The nurse manager updates the position control with employee names and FTE factors for each individual with respect to personnel changes, new hires, and resignations that take place during the year.

The position control is often color coded for easy viewing and interpretation. For example, the nurse manager may designate blue as the color code for medical leave. She would highlight in blue the two nurses who are on maternity leave. This cues the manager that while all positions are filled, two nurses will not be working shifts for 12 weeks. The manager knows to plan for a PRN or overtime shift to cover these open positions until the nurses return to work.

Staff Impact on Budget

Staff can acutely affect the organization's finances, making accurate patient care documentation very important. Misuse of sick time, excessive overtime or turnover, and wasteful use of resources can result in negative variance. (See Leading at the Bedside: Managing Resources.) The manager plays a key role in explaining the unit's goals, the organization's financial goals, and how each individual is responsible for helping the organization meet those goals.

Improving Performance

It is important for the nurse manager to raise the awareness of staff about how critical accurate, thorough documentation is for reimbursement. For example, a nurse manager may get a call from a billing coder who asks why a patient has not been discharged. When reviewing the documentation, the coder notes normal vital signs and that the patient is ambulating and has showered. After discussion with the nurse about the patient, the nurse manager learns that the patient had been vomiting, did not eat breakfast or lunch, and has not urinated today. This information was not documented

Leading at the Bedside: Managing Resources

You have been managing resources your whole life. From the time you received your first allowance to being paid for lawn mowing or babysitting to managing your money in college, you know that resources are finite. Healthcare organizations, too, must conserve precious resources. You have a key role in helping your organization use its resources wisely.

Your time is your organization's most valuable resource. How you use it affects your patients and your colleagues. How you use (or misuse) supplies and equipment also affects your organization's financial situation. In addition, you have a responsibility to inform management about needed equipment, supply shortages, or protocols that waste staff time. You are the front line of budget control. Manage it wisely.

in the patient's chart by the nurse. By documenting accurate care activities, the nurse can demonstrate the rationale for why the patient is still in need of hospital care.

Organizations can implement a number of different programs and incentives for increasing employee awareness and minimizing costs. Techniques to decrease absenteeism and turnover can be instituted. Displaying equipment costs on supply stickers or requisitions and indicating medication costs on medication sheets increase staff awareness of costs. Participation in quality improvement and action teams serves to inform staff of cost factors. Bonuses based on net gains can be shared with employees, in addition to cost-of-living raises.

When one staff member wants to take time off, the shift still must be covered. Nurse managers must hire enough staff to cover the unit when people are on vacation without using excessive overtime. Float pool or PRN staff (staff scheduled on an as-needed basis) are often used to cover staff time off. Managers must plan how to cover each employee's nonproductive time (e.g., vacation, sick days, education) in the least expensive way.

MAGNET HOSPITAL PERFORMANCE In Magnet-certified hospitals, staff are taught about budgeting and how the unit's money "works." Bedside staff make excellent, informed decisions about what resources should be used, and understand the give-and-take of budget management. Bedside staff are empowered to make decisions that impact how they work. For example, the charge nurse on the unit takes phone

CASE STUDY 15-1 | Budget Management

Jeff Tate is a nurse manager for the surgical recovery department of a private orthopedic hospital. Jeff has received notice from the vice president of clinical services that next year's budget is due to her for review at the end of the month. Jeff has kept careful records during the previous 12 months for use in preparing the department budget.

Each month, Jeff has received and reviewed monthly reports of revenues and expenses for his department. He validated each month's budget targets, carefully noting areas that did not meet budget projections. For example, when pharmacy charges for the month of April were 15% above budget projections, Jeff noted that surgery volume was up 30% over the previous year, accounting for the increase in postoperative drug charges. Nursing salaries were also over budget for the year, but again, increased surgery volume had resulted in the addition of two full-time recovery nurses to the department. When summer vacations resulted in agency staffing in the OR, Jeff saved copies of the approval from the vice president and the human resources department and noted the total cost to his department.

Jeff will use the budget information for the past 12 months to project the next fiscal year's budget for his department. Information from the human resources department provides data for cost-of-living and merit increases in salary, while materials management has projected a 10% across-the-board increase in surgical supplies and pharmaceutical charges. Jeff will also request an additional ice-and-water machine and three gurneys as part of the capital budget. These items were requested by staff during the last department meeting when Jeff asked for changes and improvements in the budget. He learned that the staff were walking to the unit down the hall for ice and water for their patients because the machine on the unit currently was not large enough to keep up with the demand. He also learned that staff spent excess time searching for additional gurneys. Both of these issues led to staff spending time doing tasks that did not add value to patient care.

Budget discussion is part of each staff meeting, and Jeff provides copies of actual budget numbers to the staff each month. He has found that showing revenue and expense reports to staff increases compliance with overtime expenses and supply usage; it also generates good discussion on how to be most productive in patient care.

With monthly preparation, good record keeping, and accurate analysis, Jeff is confident that his budget presentation will be on time and on target.

calls about unit staffing. The float pool might have an additional aide coming in to work who is not assigned yet. The charge nurse takes the call from the staffing office to ask if the unit needs another aide and makes the decision.

Another example includes flexing staff for needs on the unit. The charge nurse, along with the coworkers, decides whether someone can be sent home on a slow day or another staff member should be called in if the unit is excessively busy.

NURSING RELATIONSHIP IN PATIENT CARE Nursing care is one of the largest expenditures in healthcare organizations (Welton & Harper, 2015). Being in tune to the patient population the nursing staff serves is as important as planning the budget for the nurse manager. Many aspects of nursing care are not captured in the hours per patient day (HPPD). Caring, empathy, trust, and building a relationship with patients are all important pieces of the nursing relationship. As well, the intensity of care for one patient on the unit may be higher than the intensity of care for another patient with the same diagnosis (Jenkins & Welton, 2014). Understanding these complexities of nursing care can help a manager perform better.

Managing fiscal resources is a challenge for all nurse managers. This is even truer today as healthcare payment reform continues to evolve. Close attention to costs, balanced by awareness of quality and patient safety, is essential.

Case Study 15-1 illustrates how one nurse manager handled his budget.

What You Know Now

- A budget is a quantitative statement, usually written in monetary terms, of plans and expectations over a specified period of time.
- The operating or annual budget is the organization's statement of expected revenues and expenses for the coming year.
- The revenue budget represents the patient care revenues expected for the budget period based on volume and mix of patients, rates, and discounts that will prevail during the same period of time.
- Nursing units are typically considered cost centers but may be considered revenue centers, profit centers, or investment centers.
- Nurse managers may be responsible for service lines and staff from multiple disciplines and departments.
- Nurse managers have input into capital expenses and are responsible for salary and operating costs related to new equipment.
- A full-time equivalent (FTE) is a full-time position that can be equated to 40 hours of work per week for 52 weeks, or 2,080 hours per year.
- The position control is a list of approved, budgeted FTEs that compares the budgeted number of FTEs by classification (RN, LPN), shift, and status to the actual available employees of the unit.
- Variance is the difference between the amount that was budgeted for a specific revenue or cost, and the actual revenue or cost that resulted during the course of activities.
- Monitoring the budget throughout the year requires attention to variances and the reasons they occurred.

Tools for Budgeting and Managing Resources

1. Understand the budgeting process in your organization.
2. Determine the number of full-time equivalents necessary to staff the unit.
3. Compute the salary and nonsalary budget, including salary increases and various additional factors.
4. Monitor variances over the budget period and identify negative variances, keeping notes in your files.
5. Understand that factors out of your control, such as changes in technology or indirect or direct costs that may be assigned to your budget, affect your budget and its performance.
6. Encourage staff to monitor resource use, including time and supplies.

Questions to Challenge You

1. Do you have a budget for your personal and professional income and expenses? If so, how well do you manage it? If not, begin next month to track your income and expenses for one month. See if you are surprised at the results.
2. How well does your organization manage its resources? Can you make suggestions for improvement?
3. Are there tasks or functions in your work that you believe are redundant, unnecessary, or repetitive or that could be done by a lesser-paid employee? Explain.
4. Does your organization waste salary or nonsalary resources? If not, think of ways that organizations could waste resources. Describe them.

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Chapter 16

Recruiting and Selecting Staff

The Recruitment and Selection Process

Recruiting Applicants
Where to Look
How to Look
When to Look
How to Promote the Organization
Cross-training as a Recruitment Strategy

Selecting Candidates

Interviewing Candidates
Principles for Effective Interviewing
Involving Staff in the Interview Process
Interview Reliability and Validity

Making a Hire Decision
Education, Experience, and Licensure
Integrating the Information
Making an Offer

Legality in Hiring

Learning Outcomes

After completing this chapter, you will be able to:

1. Identify the important elements of the recruitment and selection process.
2. Describe how to recruit applicants.
3. Delineate how to select candidates.
4. Explain how to interview prospective candidates.
5. Determine how to make a hiring decision.
6. Examine the legal issues involved in hiring.

Key Terms

Age Discrimination Act
Americans with Disabilities Act
behavioral interviewing
bona fide occupational qualification (BFOQ)
business necessity
four Ps of marketing
interrater reliability
interview guide
intrarater reliability
negligent hiring
position description
validity
work sample questions

Introduction

Recruiting and selecting staff who will contribute positively to the organization is crucial in the fast-paced world of healthcare and in the face of ever-increasing nursing shortages (U.S. Department of Labor, 2015). The direct costs of recruiting, selecting, and training an employee who must later be terminated because of unsatisfactory performance are expensive and unnecessary. The hidden costs may be even more expensive and include poor quality of work, disruption of morale, and patients' ill will and dissatisfaction, which may contribute to later liability.

The Recruitment and Selection Process

The purpose of the recruitment and selection process is to match people to jobs. Responsibility for selecting nursing personnel in healthcare organizations is usually shared by the human resources (HR) department, which may include a nurse recruiter, and nursing management. First-line nursing managers are the most knowledgeable about job requirements and can best describe the job to applicants. HR performs the initial screening and monitors hiring practices to be sure they adhere to legal stipulations.

Before recruiting or selecting new staff, those responsible for hiring must be familiar with the **position description**. The position description describes the skills, abilities, and knowledge required to perform the job. (See Box 16-1 for an example.)

The position description should reflect current practice guidelines and include the following:

- Principal duties and responsibilities involved in a particular job
- Tasks required to carry out those duties
- Personal qualifications (skills, abilities, knowledge, and traits) needed for the position
- Competency-based behaviors (perhaps).

Box 16-1 Position Description: Registered Nurse Adult Medical Intensive Care Unit (MICU)

Job Overview

The medical intensive care unit registered nurse is responsible for direct patient care of adults admitted to the MICU for management of complex life-threatening illness. The RN reports directly to the MICU nurse manager.

Qualifications

- Current licensure in good standing in the state of practice
- Minimum of 1 year previous adult ICU experience within the past 3 years or 2 years telemetry experience within the past 3 years
- Current BLS mandatory, ACLS or TNCC preferred. ACLS must be obtained with 6 months of employment.

Responsibilities

- Performs complete, individualized patient assessment within unit time frames and determines patient care priorities based on assessment findings
- Completes additional patient assessments as required, based on patient status, protocols, and/or physician orders
- Administers medications and appropriate treatments as ordered by the physician accurately and within specified time frames
- Initiates and maintains an individualized patient plan of care for each patient, using nursing interventions as appropriate
- Provides ongoing education to the patient and the patient's family
- Documents patient assessments, medication and therapy administration, patient response to treatments, and interventions in an accurate and timely manner
- Initiates emergency resuscitation procedures according to ACLS protocols
- Maintains strict confidentiality of all information related to the patient and the patient's family
- Provides nursing care in a manner that is respectful and sensitive to the needs of the patient and the patient's family and protects their dignity and rights
- Communicates changes in patient condition to appropriate staff during the shift
- Maintains (or obtains within 6 months of initial hire) certification in ACLS
- Completes unit-based training modules for critical care competency on an annual basis

Recruiting Applicants

The purpose of recruitment is to locate and attract enough qualified applicants to provide a pool from which the required number of individuals can be selected. Even though recruiting is primarily carried out by HR staff and nurse recruiters, nurse managers and nursing staff play an important role in the process. Recruiting is easier when current employees spread the recruiting message, reducing the need for expensive advertising and reward methods.

The best recruitment strategy is the organization's reputation among its nurses. Aiken and colleagues (Kutney Lee et al., 2015) found that a positive hospital care environment not only reduced patient mortality but also improved nurses' perception of the work setting. Kelly, McHugh, and Aiken (2011) found that nurses in Magnet hospitals demonstrated higher levels of job satisfaction than those in non-Magnet hospitals. It follows that satisfied nurses are more likely to speak highly of the organization.

Individual nurse managers also affect how well the unit is able to attract and retain staff. A nurse manager who is able to create a positive work environment through leadership style and clinical expertise will have a positive impact on recruitment efforts, because potential staff members will hear about and be attracted to that area (e.g., hospital unit, home health team), as described in Leading at the Bedside: Recruiting Is Your Job, Too. In contrast, an autocratic manager is more likely to have a higher turnover rate and less likely to attract sufficient numbers of high-quality nurses.

Leading at the Bedside: Recruiting Is Your Job, Too

You may think you have little to do with recruitment. You're not a manager; nor are you involved in hiring. But you would be wrong. You are a walking, talking, caring representative of the healthcare organization for which you work. Think about it. You tell your friends and neighbors where you work. They know someone who's looking for a nursing position; they think of you. What do they see? A competent professional? A nurse who knows the profession is a career, not just a job?

Don't fool yourself. You are a recruiter.

Any recruiting strategy includes essentially four elements:

1. Where to look
2. How to look
3. When to look
4. How to sell the organization to potential recruits

Each of these elements may be affected by market competition, nursing shortages, reputation, visibility, and location.

Where to Look

Today many organizations use social media for recruitment. Using the organization's social media platforms (e.g., Facebook, Twitter), a recruitment plan may be designed to reach qualified nurses (Holland, 2015). If one platform or strategy has been successful in the past, it indicates a likely source of applicants.

Because proximity to home is a key factor in choosing a job, recruitment efforts should focus on nurses living nearby (Mooneyham et al., 2011). The state board of nursing can provide the names of registered nurses by zip code to allow organizations to target recruitment efforts to surrounding areas. Also, personnel officers in large companies or other organizations in the area can be asked to assist in recruiting nurse spouses of newly hired employees.

Collaborative arrangements with local schools of nursing offer opportunities for recruitment. Providing preceptors or mentors for students during their clinical rotation or offering externships or residencies encourages post-graduation students to consider employment in the organization. Nurses who work with students play a key role in recruitment. Students are more likely to be attracted to the organization if they see nurses' work valued and appreciated and perceive a positive impression of the work group.

Employing students as aides may provide another recruitment tool because it allows students to learn firsthand about the organization and what it has to offer. In turn, the organization can evaluate the student as a potential employee post-graduation. Some organizations provide assistance with student loan payments if the student continues to work after graduation. Of major importance to new graduates is the orientation program. Graduates look for an orientation that provides successful transition into professional practice. Other top factors they consider are the reputation of the agency, benefits, promotional opportunities, specialty area, and nurse–patient ratio.

How to Look

Posting online on general job search sites or on nurse-specific job referral sites is a common practice. Professional associations such as Sigma Theta Tau International and the American Nurses Association offer job search services. Specialty organizations such as the American Organization of periOperative Registered Nurses could be used for a surgical nurse position.

Employee referrals, advertising in professional journals, attendance at professional conventions, job fairs, career days, visits to educational institutions, employment agencies (both private and public), and temporary help agencies are all recruiting sources. Advertising in professional journals, in newspapers, or on websites or public access TV can be an effective recruiting tool as well.

During extreme nursing shortages, some organizations offer bonuses to staff members who refer candidates and to the recruits themselves. Direct applications and employee referrals are quick and relatively inexpensive ways of recruiting people, but these methods also tend to perpetuate the current cultural or social mix of the workforce. It is both legally and ethically necessary to recruit individuals without regard to their race, ethnicity, gender, or disability. In addition, organizations can benefit from the diversity of a staff composed of people from a wide variety of social, experiential, cultural, generational, and educational backgrounds.

On the other hand, nurses referred by current employees are likely to have more realistic information about the job and the organization and, therefore, their expectations more closely fit reality. Those who come to the job with unrealistic expectations may experience dissatisfaction. In an open labor market, these individuals may leave the organization, creating high turnover. When nursing jobs are less plentiful or the economy is in a recession, dissatisfied staff members tend to stay in the organization because they need the job, but they are not likely to perform as well as other employees.

When to Look

The time lag in recruiting is a concern to nursing because of the shortage. Positions in certain locations (e.g., rural areas) or specialty areas (e.g., critical care) may be especially difficult to fill. Careful planning is necessary to ensure that recruitment begins well in advance of anticipated needs.

How to Promote the Organization

A critical component of any recruiting effort is marketing the organization and available positions to potential employees. The nursing division and/or HR should develop a comprehensive marketing plan. Generally, four strategies are included in marketing plans and are called the **four Ps of marketing**:

- Product
- Place
- Price
- Promotion

The consumer is the key figure toward which the four concepts are oriented, and in the recruiting process, the consumer is the potential employee.

Product is the available position(s) within the organization. Consider several aspects of the position and organization, such as these:

- Professionalism
- Standards of care
- Quality
- Service
- Respect
- Reputation
- Organizational culture

Place refers to the physical qualities and location, such as these:

- Accessibility
- Scheduling
- Parking

Price includes the following:

- Pay and differentials
- Benefits
- Sign-on bonuses
- Insurance
- Retirement plans

Promotion includes the following:

- Advertising
- Public relations
- Direct word of mouth
- Personal selling (e.g., job fairs, professional meetings)

Developing an effective marketing message is important. Sometimes the tendency is to use a "scatter-gun" approach (recruit everywhere), sugarcoat the message, or make it very slick. A more balanced message, which includes honest communication and personal contact, is preferable. Overselling the organization creates unrealistic expectations that may lead to later dissatisfaction and turnover.

Realistically presenting the job requirements and rewards improves job satisfaction, in that the new recruit learns what the job is actually like. Promising a nurse every other weekend off and only a 25% rotation to nights on a severely understaffed unit, then scheduling the nurse off only every third weekend with 75% night rotations is an example of unrealistic job information. It is important to represent the situation honestly and describe the steps that management is taking to improve situations that the applicant might find undesirable. The applicant can then make an informed decision about the job offer.

Cross-training as a Recruitment Strategy

In today's rapidly changing healthcare environment, the patient census fluctuates rapidly, and staffing requirements must be adjusted appropriately. These conditions may bring about layoffs and daily cancellations and contribute to low morale. Offering

cross-training so potential employees can be oriented to more than one unit may increase the applicant pool.

Cross-training can provide a number of benefits: increased morale and job satisfaction, improved efficiency, increased flexibility of the staff, and a means to manage fluctuations in the census. It gives nurses, such as those in obstetrics and neonatal areas, an opportunity to provide more holistic care. On the other hand, some nurses do not want to be cross-trained, and thus requiring cross-training could reduce retention.

If cross-training is used, care should be taken to provide a didactic knowledge base in addition to clinical training. How broadly to cross-train is an important decision, because training in too many areas may overload the nurse and reduce the quality of care.

Selecting Candidates

Once an applicant makes contact with the organization, HR reviews the application and may conduct a preliminary interview (see Box 16-2). If the applicant does not meet the basic needs of the open position or positions, he or she should be so informed. Rejected applicants may be qualified for other positions or may refer friends to the organization and thus should be treated with utmost courtesy.

Reference checks and managerial interviews are next. In most cases, the interview is last, but practices may vary. Even if an applicant receives poor references, it is prudent to carry out the interview so the applicant is not aware that the reference checking led to the negative decision. In addition, applicants may feel they have a right to "tell their story" and may spontaneously provide information that explains poor references.

The nurse manager should participate in the interview process for two reasons:

- He or she is best able to assess applicants' technical competence, potential, and overall suitability
- He or she is able to answer applicants' technical, work-related questions more realistically.

In some organizations, the candidate's future coworkers also participate in the interview process to assess compatibility.

The nurse manager must keep others involved in the selection process informed. The manager is usually the first to be aware of potential resignations, requests for transfer, and maternity or family medical leaves that require replacement staff. The manager is also aware of changes in the work area that might necessitate a redistribution of staff, such as the need for a night rather than a day nurse. Communicating these needs to HR promptly and accurately helps ensure effective coordination of the selection process.

Box 16-2 Selection Process

1. Review application (nurse manager and HR).
2. Conduct screening interview (HR).
3. Contact references (HR).
4. Conduct second interview (nurse manager).
5. Compare applicants (nurse manager/nursing department).
6. Make hire/no hire decision (nurse manager/nursing department).
7. Perform background check (HR).
8. Make phone offer, conditional on clean drug test within 24 hours (nurse manager).
9. With clean drug test, offer is official.

Interviewing Candidates

The most common selection method, the interview, is an information-seeking mechanism between an individual applying for a position and a member of an organization doing the hiring. After the applicant's initial screening with HR, the nurse manager usually conducts an interview.

The interview is used to clarify information gathered from the application form, evaluate the applicant's responses to questions, and determine the fit of the applicant to the position, unit, and organization. In addition, the interviewer should provide information about the job and the organization. Finally, the interview should create goodwill toward the employing organization through good customer relations.

An effective interviewer must learn to solicit information efficiently and to gather relevant data. Interviews typically last between 60 and 90 minutes and include an opening, an information-gathering and information-giving phase, and a closing. The opening is important because it is an attempt to establish rapport with the applicant so she or he will provide relevant information.

Gathering information, however, is the core of the interview. Giving information is also important because it allows the interviewer to create realistic expectations in the applicant and sell the organization, if that is needed. However, this portion of the interview should take place after the information has been gathered so that the applicant's answers will be as candid as possible. The interviewer should answer any direct questions the candidate poses. Finally, the closing is intended to provide information to the candidate on the mechanics of possible employment.

Principles for Effective Interviewing

Interviewing is the opportunity for candidates to learn about the organization and for managers to get to know the candidate. It is an especially important time to determine if the candidate would fit within the organization.

DEVELOPING STRUCTURED INTERVIEW GUIDES Unstructured interviews present problems: if interviewers fail to ask the same questions of every candidate, it is often difficult to compare them. The interview is most effective when the information on the pool of interviewees is as comparable as possible. Comparability is maximized via a structured interview supported by an interview guide. An **interview guide** is a written document containing questions, interviewer directions, and other pertinent information so that the same process is followed and the same basic information is gathered from each applicant. The guide should be specific to the job, or job category.

Instead of the traditional interview questions, such as "Tell me about yourself," "What are your strengths and weaknesses?" and "Why do you want to work for us?" specific questions that target job-related behaviors are more common today. **Behavioral interviewing**, also called competency-based interviewing, uses the candidate's past performance and behaviors to predict behavior on the job. The questions are based on requirements of the position. Examples of specific behaviors expected of staff nurses and related sample questions are found in Table 16-1.

In addition, you can develop questions based on the specific job. For example, you may want to add questions on teamwork and collaboration as they relate to the position. Box 16-3 lists job-related questions for a medical telemetry unit position that candidates could be asked.

Table 16-1 Examples of Behavioral Interview Questions

Behavior	Sample Question
Decision making	What was your most difficult decision in the last month, and why was it difficult?
Communication	What do you think is the most important skill in successful communication?
Adaptability	Describe a major change that affected you and how you handled it.
Delegation	How do you make the decision to delegate? Describe a specific situation.
Initiative	What have you done in school or in a job that went beyond what was required?
Motivation	What is your most significant professional accomplishment?
Negotiation	Give an example of a negotiation situation and your role in it.
Planning and organization	How do you schedule your time? What do you do when unexpected circumstances interfere with your schedule?
Critical thinking	Describe a situation in which you had to make a decision by analyzing information, considering a range of alternatives, and selecting the best choice for the circumstances.
Conflict resolution	Describe a situation in which you had to help settle a conflict.

Box 16-3 Job-related Questions for Medical Telemetry Unit

Describe your actions in the following situations.

1. You are documenting your patient's heart rhythms in his medical record for the shift. A peer is sitting near you and doing the same. You see that RN document the patient's heart rhythm as sinus rhythm, when you know the patient has had atrial fibrillation the entire shift.
2. The physician is rounding on your patient. The patient has had an elevated blood pressure of 160/90 despite already having received all of her antihypertensive medications for the day. The patient has reported to you that she is also experiencing a headache. You tell the doctor about the blood pressure reading and the patient's headache. You request that the physician order another medication to help lower the patient's blood pressure. The physician says to you, "Oh, she'll be fine," and begins to walk away.
3. You are caring for an elderly woman. Her daughter is at her bedside. The patient has been having recurrent flare-ups of congestive heart failure and has been readmitted to the hospital three times in the last month. Each time she returns, the swelling in her extremities and her difficulty breathing are worse than the time before. The physician rounds on the patient and her daughter and shares that the healthcare team will work to help her, but it appears that her heart is getting weaker again, and the congestive heart failure is going to continue to get harder to manage. After the doctor leaves, you enter the room. The patient is sleeping, and the daughter is quietly crying.
4. You run to the room of a patient where the code blue alarm has been activated. Your team is doing CPR and attaching the code cart to the patient. You put on gloves and step in to help. As you approach the bed of the patient, you look at the patient's wrist and see a do-not-resuscitate bracelet on his arm.
5. You are caring for a patient with paranoid schizophrenia and a heart dysrhythmia. It is time to administer his 9:00 a.m. meds. When you enter the room with the medications that the patient takes to prevent ventricular tachycardia, he begins screaming, "No, I won't take those medications, you're trying to poison me!"
6. You are caring for a patient who is recovering from a myocardial infarction. You have been talking to her about her new cardiac diet and what she can do to be healthy when she leaves the hospital. You discuss eating low amounts of salt, a well-rounded diet rich in fruits and vegetables, and avoiding fried and sugary foods. Later in the day, you pass the patient's room and see her eating fried chicken and French fries that her family brought.

Interview guides reduce interviewer bias, provide relevant and effective questions, minimize leading questions, and facilitate comparison among applicants. Space left between the questions on the guide provides room for note taking, and the guide also provides a written record of the interview. An example of an interview script is shown in Box 16-4.

PREPARING FOR THE INTERVIEW Most managers do not adequately prepare for the interview, which should be planned just like any business undertaking. All needed materials should be on hand, and the interview site should be quiet and pleasant. If others are scheduled to see the applicant, their schedules should be checked to make sure they are available at the proper time. If coffee or other refreshments are to be offered, advance arrangements need to be made. Lack of advance preparation may lead to insufficient interviewing time, interruptions, or failure to gather important information. Other problems include losing focus in the interview because of a desire to be courteous or because the interviewee is particularly dominant. This typically keeps the interviewer from obtaining the needed information.

In general, when time is limited, it is better to use part of it for planning rather than spend it all on the interview itself. Before the interview, the interviewer should review job requirements, the application and résumé, and note specific questions to be asked. Planning should be done on the morning of the interview or the evening before for an early morning interview. If you are sure that time will be available, planning is best done immediately before an interview or between interviews. Unfortunately, a busy manager may have to deal with unexpected crises between interviews and may not be able to use the time to plan the next interview.

A cardinal rule is to review the application or résumé before beginning the interview.

Box 16-4 Interview Script for Hiring

1. Why did you choose to become a nurse?
2. Why would you like to work at this hospital?
3. What about this patient specialty interests you?
4. Tell me about your previous work experiences.
5. How do your previous work experiences prepare you for this job?
6. How would your previous coworkers describe you?
7. What does teamwork mean to you?
8. Tell me about a time when you were successful because of great teamwork.
9. Tell me about a time you experienced a lack of teamwork. Describe what happened.
10. Describe a situation in which you had a conflict with a patient or family member. What happened?
11. Tell me about a time you had a conflict with a coworker or teacher. Explain what happened.
12. Tell me about a time you were working with someone who was not putting his or her full effort forward, and it was impacting patient care. What did you do?
13. What makes you most nervous about coming to this job?
14. What do you find exciting about coming to this job?
15. What are you most proud of professionally?
16. What is something about you that makes you better than any other candidate for this job?
17. What are you looking for from your manager?
18. What do you plan to do in the next five and ten years of nursing and beyond? What are your goals?
19. What questions do you have about this job?

If the interviewee arrives with the résumé or application in hand, ask him or her to wait for a few minutes while you review the material. In doing a quick review, look for the following four things:

- Clear discrepancies between the applicant's qualifications and the job specifications. If you find them, then only a brief interview may be necessary to explain why the applicant will not be considered. (If a preliminary screening is performed by HR, such applicants should not be referred to nurse managers.)
- Specific questions to ask the applicant during the interview.
- A rapport builder (something you have in common with the applicant) to break the ice at the beginning of the interview.
- Areas where you need more information. Remember that the résumé is prepared by the applicant and is intended to market an applicant's assets to the organization. It does not give a balanced view of strengths and weaknesses. So, examine the résumé critically for gaps.

The setting of the interview is important in order to provide a relaxed, informal atmosphere. Both you and the applicant should be in comfortable chairs, as close together as comfortably possible. No table or desk should separate you. If you are using an office, arrange the chairs so that the applicant is at the side of the desk. There should be complete freedom from distracting phone calls and other interruptions. If the view is distracting, seat the applicant so that she or he cannot look out a window.

OPENING THE INTERVIEW Begin the interview on time. Give a warm, friendly greeting, introduce yourself, and ask the applicant for her or his preferred name. Try to minimize your status; do not patronize or dominate. The objective is to establish an open atmosphere so applicants reveal as much as possible about themselves. Establish and maintain rapport throughout the interview by talking about yourself, discussing mutual interests such as hobbies or similar experiences, and using nonverbal cues, such as maintaining eye contact. Finally, start the interview by outlining what will be discussed and setting a limit on the meeting time.

Be careful not to form hasty first impressions. Interviewers tend to be influenced by first impressions of a candidate, and such judgments often lead to poor decisions. First impressions may degrade the quality of the interview; interviewers may search for information to justify their first impressions, good or bad. If you have gotten a negative first impression and thus decide not to hire a potentially successful candidate, you have wasted an hour or so and possibly lost a good recruit. If you hire an unsuccessful candidate based on a positive first impression, problems may continue for months. Conversely, your personal characteristics may influence the applicant's decisions. You create first impressions with your tone of voice, eye contact, personal appearance, grooming, posture, and gestures.

Take notes, using the structured interview guide. Explain that you are doing this in order to remember more about what is discussed in the interview, and tell the candidate that you hope he or she does not mind. There are various ways to ask questions, but ask only one at a time. When possible, ask open-ended questions, such as those listed in Table 16-1. Open-ended questions cannot be answered with a yes, no, or one-word answer and usually elicit more information about the applicant. Closed questions (e.g., what, where, why, when, how many) should only be used to elicit specific information.

Work sample questions are used to determine an applicant's knowledge about work tasks and his or her ability to perform the job. It is easy to ask a nurse whether she or he knows how to care for a patient who has a central intravenous line in place. A yes answer does not necessarily prove the candidate's ability, so you might ask some very specific questions about central lines. Avoid leading questions, in which the answer is implied by the question (e.g., "We have lots of overtime. Do you mind overtime?"). You may also want to summarize what has been said, use silence to elicit more information, repeat the applicant's statements to clarify an issue, or indicate acceptance by urging the applicant to continue.

GIVING INFORMATION Before reaching the information-giving part of the interview, consider whether the candidate is promising enough to warrant spending a lot of time on this. Unless the candidate is clearly unacceptable, be careful not to communicate a negative impression, because your evaluation of the candidate may change when the entire packet of material is reviewed or if more promising candidates decline the job offer. You must also know what information you should give, and what is being provided by others. Detailed benefit or compensation questions are usually answered by HR. If you cannot answer a promising candidate's questions, arrange for someone to contact the candidate later with that information.

CLOSING THE INTERVIEW You may want to summarize the applicant's strengths at the end of the interview. Make sure to ask the applicant whether she or he has anything to add or ask about the job and the organization. You may also want to mention the candidate's weaknesses, particularly if they are objective and clearly related to the job (such as lack of experience in a particular field). Mentioning a perception of a subjective weakness, such as poor supervisory skills, may lead to legal problems. Wrap up by thanking the applicant and completing any notes that you have been taking.

Involving Staff in the Interview Process

Today's trend toward decentralization of decision making may lead to sharing interview responsibilities with staff. Involving staff in interviews helps strengthen teamwork, improves work-group effectiveness, increases staff involvement in other unit activities, and increases the likelihood of selecting the best candidate for the position.

If staff are involved in interviews, several steps must be taken to protect the integrity of the interview process. An organized orientation to interviewing should be given that includes the following:

- Federal, state, and local laws and regulations governing interviewing, as well as any collective-bargaining agreements that may affect the process
- Tips on handling awkward interviewing situations
- Time for rehearsing interviewing skills; like the manager, staff should follow a structured interview guide to help standardize the process

Graham Nelson is nurse manager of a dialysis center. Training a new renal dialysis nurse is an expensive process. To reduce turnover among nursing staff, Graham includes peer interviews as part of the overall interview process. Peer interviews can help ensure that potential employees will interact well with existing staff and ensure a cultural fit with the dialysis team. In addition, an interviewee can gain a better understanding of the day-to-day workflow of the center.

Interview Reliability and Validity

Numerous research studies have been performed on the reliability and validity of employment interviews. In general, agreement between two interviews of the same measure by the same interviewer (**intrarater reliability**) is fairly high, agreement between two interviews of the same measure by several interviewers (**interrater reliability**) is rather low, and the ability to predict job performance (**validity**) of the typical interview is very low. Research has also shown the following:

- Structured interviews are more reliable and valid.
- Interviewers who are under pressure to hire in a short time or meet a recruitment quota are less accurate than other interviewers.
- Interviewers who have detailed information about the job for which they are interviewing exhibit higher interrater reliability and validity.
- The interviewer's experience does not seem to be related to reliability and validity.
- There is a decided tendency for interviewers to make quick decisions and therefore be less accurate.
- Interviewers develop stereotypes of ideal applicants against which interviewees are evaluated. Individual interviewers may hold different stereotypes, which decreases interrater reliability and validity.
- Race and gender may influence interviewers' evaluations.

The greatest weakness in the selection interview may be the tendency for the interviewer to try to assess an applicant's personality characteristics. Although it is difficult to eliminate such subjectivity, evaluations of applicants are often more subjective than they need to be. Information collected during an interview should answer three fundamental questions:

- Can the applicant perform the job?
- Will the applicant perform the job?
- Will the candidate fit into the culture of the unit and the organization?

The best predictor of the applicant's future behavior in these respects is past performance. Previous work and other experience, past education and training, and current job performance should be considered rather than personality characteristics, which even psychologists cannot measure very accurately.

Making a Hire Decision

A number of criteria are involved in making the hiring decision. These include the candidate's education and experience and validating that the person is licensed. References, on the other hand, are not as useful as most people think.

Education, Experience, and Licensure

Education and experience requirements for nurses have long been important screening factors and bear a close relationship to work sample tests. Educational requirements are a type of job knowledge sample because they tend to ensure that applicants have at least a minimal amount of knowledge necessary for the job.

Educational preparation is particularly important for nurses. For example, nurses who are graduates of associate degree and diploma programs are prepared to care for individuals in structured settings and use the nursing process, the decision-making process, and their management skills in the care of those individuals. Baccalaureate graduates can provide nursing care for individuals, families, groups, and communities using the nursing and decision-making processes. Baccalaureate graduates are also prepared for beginning community health positions and possess the leadership and management skills needed for entry-level management positions.

Avoid making assumptions about the type of experience and number of years of experience that an applicant has. Factors such as job requirements, patient acuity, clinic populations, autonomy, and degree of specialization vary from organization to organization. Therefore, careful interviewing is needed to determine the applicant's knowledge and skill level.

References and letters of recommendation are also used to assess the applicant's past job experience, but there is little evidence that these have any validity. Because few people write unfavorable letters of recommendation, such letters do not really predict job performance. Criticisms are likely to be mild and may be reflected by the lack of positive language. Letters with any criticism should be verified with a telephone call, if possible, to avoid overreacting to an unusually honest author.

To avoid legal problems, many organizations only include employment dates, salary, and whether the applicant is eligible for rehire in letters of recommendation. Many organizations do not allow supervisors to write letters of recommendation. Negative references may be viewed as a potential for slander or other legal recourse. Almost every organization will at least verify position title and dates of employment, which helps detect the occasional applicant who falsifies an entire work history. Unfortunately, leaving out a position from a work history is more common than including a position not actually held. The only way to detect such omissions is to ask that candidates list the year and month of all their educational and work experiences. Caution is necessary when asking about time between jobs; be careful not to inquire about marital or family status.

In almost every selection situation, an applicant fills out an application form that requests information about previous experience, education, and references. As application forms are reviewed, the critical question to be asked is whether the applicant has distorted responses, either intentionally or unintentionally. Studies indicate that there is usually little distortion, at least not on the easily verifiable information. Applicants may stretch the truth a bit, but rarely are there complete falsehoods. Relative to other predictors, the application form may be one of the more valid predictors in a selection process.

Licensure status can be verified online with the state board of nursing. Because results of the computerized NCLEX-RN examination are available within 7 to 10 days, most organizations wait for new graduates to obtain a license before starting employment.

Integrating the Information

When comparing candidates, first weigh the qualities required for the job in order of importance, placing more emphasis on the most important elements. Second, weigh the qualities desired on the basis of the reliability of the data. The more consistent the observation of behavior from different elements in the selection system, the more

weight that dimension should be given. Third, weigh job dimensions by trainability—consider the amount of education, experience, and additional training the applicant can reasonably be expected to receive, and consider the likelihood that the behavior in that dimension can be improved with training. Dimensions most likely to be learned in training (e.g., using new equipment) should be given the least weight so that more weight is placed on dimensions less likely to be learned in training (e.g., being emotionally able to care for terminally ill children).

Attempt to compare data across individuals in making a decision. It is more accurate to make decisions based on a comparison of several persons than to make a decision for each individual after each interview. Analysis of the entire applicant pool requires good interview records but lessens the impact of early impressions on the hiring decision because the interviewer must consider each job element across the entire pool.

Making an Offer

Before an offer is made, most organizations obtain permission to do criminal background checks. After the interview, if the nurse manager wants to offer a position to a candidate, HR is notified. HR then does a thorough background check on the candidate to confirm reported criminal history, licensure, and employment history. After that clears, the candidate is called and offered the position, with the condition that a drug screen completed within 24 hours of the phone offer is clean. If so, the offer is official.

Organizations are liable for the character and actions of the employees they hire. To satisfy this requirement, the employer must check applicants' backgrounds before hiring in regard to licensure, credentials, and references. Failure to do so constitutes **negligent hiring** if that employee harms a patient, visitor, or another employee.

Legality in Hiring

As a result of Title VII of the Civil Rights Act of 1964 as amended in 1991, the Equal Pay Act of 1963, the **Age Discrimination in Employment Act of 1967**, and Title I of the **Americans with Disabilities Act of 1990** and its amendments of 2009, recruitment and selection activities are subject to considerable scrutiny regarding discrimination and equal employment opportunity. Title VII of the Civil Rights Act specifically prohibits discrimination in any personnel decision on the basis of race, color, sex, religion, or national origin. "Any personnel decision" includes not only selection but also entrance into training programs, performance appraisal results, termination, promotions, compensation, benefits, and other terms, conditions, and privileges of employment.

The Act applies to most employers with more than 15 employees, although there are several exemptions—among them, a **bona fide occupational qualification (BFOQ)**, a **business necessity**, and the validity of the procedure used to make the personnel decision. These exemptions allow discrimination on the basis of national origin (citizenship or immigration status), religion, sex, and age if that discrimination can be shown to be a "bona fide occupational qualification reasonably necessary for the normal operation of a business." Examples include a woman playing a female part in a play, a Sunday school teacher of a certain religion, or a female correctional counselor at a women's prison. Claims of "customer preference" for female flight attendants or gross gender characteristics such as "women cannot lift over 30 pounds" have not been supported as BFOQs.

A BFOQ allows an organization to exclude members of certain groups (such as all men or all women) if the organization can demonstrate that a selection method is a business necessity. A business necessity is likely to withstand a legal challenge only in the unusual instances when a selection method that discriminates against a protected group is necessary to ensure the safety of workers or customers.

The Equal Employment Opportunity Commission (EEOC) is charged with enforcing and interpreting the Civil Rights Act and has issued Uniform Guidelines on Employee Selection Procedures (43 Fed. Reg., 1978). The guidelines specify the kinds of methods and information required to justify the job relatedness of selection procedures. These guidelines are not described in detail here; however, the methods of selection discussed in this chapter do follow their specifications. Remember that the law does not say one cannot hire the best person for the job. What it says is that race, color, sex, religion, disability, national origin, or any other protected factor must not be used as selection criteria. As long as the decision is not made on the basis of protected status, one is complying with the Equal Employment Opportunity (EEO) law.

EEO law and successive court decisions have had three major impacts on selection procedures. First, organizations are more careful to use predictors and techniques that can be shown not to discriminate against protected classes. Second, organizations are reducing the use of tests, which may be difficult to defend if they screen out a large number of minority applicants. Third, organizations are relying heavily on the interview process as a selection device. Interviews are also subject to EEO and other regulations.

Table 16-2 presents appropriate questions to ask in an interview. The basic rule of thumb for interviewing is when you are in doubt about a question's legality, ask "How is this question related to job performance?" If it can be proved that only job-related questions are asked, EEO law will not be violated.

The **Age Discrimination Act** prohibits discrimination against applicants and employees over the age of 40. Questions in recruitment and selection that are appropriate with respect to age are also presented in Table 16-2.

The Americans with Disabilities Act that took effect in July 1990 prohibits discrimination based on an individual's disability. A disability is defined as a physical or mental impairment that substantially limits one or more of the major life activities, or has a record of such impairment (e.g., attended a school for the deaf), or is regarded as having such an impairment (e.g., uses a cane to walk). A qualified individual is one who, with or without reasonable accommodation, can perform the essential functions of the position under consideration.

The Act was amended in 2009 (U.S. Department of Justice, 2009). The definition of a disability was broadened in several ways beneficial to employees: The amended Act includes disabilities not previously covered (e.g., epilepsy, diabetes, bipolar disorder). The amendments expand the definition of major life activities to include major bodily functions (e.g., immune system, brain functions) and eliminate the ameliorative effects of mitigating measures from consideration (e.g., medication, prosthetics).

Employers with 15 or more employees are required to make accommodations to the known disability of a qualified applicant if it will not impose "undue hardship" on the operation of the business. Reasonable accommodations may include making existing facilities used by employees readily accessible to and usable by individuals with disabilities; job restructuring; part-time or modified work schedules; reassignment to a vacant position; acquiring or modifying equipment or devices; adjusting or modifying examinations, training materials, or policies; and providing qualified readers and interpreters.

Table 16-2 Preemployment Questions

	Appropriate to Ask	Inappropriate to Ask
Name	Applicant's name. Whether applicant has school or work records under a different name.	Questions about any name or title that indicate race, color, religion, sex, national origin, or ancestry.
		Questions about father's surname or mother's maiden name.
Address	Questions concerning place and length of current and previous addresses.	Any specific probes into foreign addresses that would indicate national origin.
Age	Requiring proof of age by birth certificate after hiring. Can ask if applicant is over 18.	Requiring birth certificate or baptismal record *before* hiring.
Birthplace or national origin		Any question about place of birth of applicant or place of birth of parents, grandparents, or spouse.
		Any other question (direct or indirect) about applicant's national origin.
Race or color	Can request *after* employment as affirmative action data.	Any inquiry that would indicate race or color.
Sex		Any question on an application blank that would indicate sex.
Religion		Any questions to indicate applicant's religious denomination or beliefs.
		A recommendation or reference from the applicant's religious denomination.
Citizenship	Questions about whether the applicant is a U.S. citizen; if not, whether the applicant intends to become one.	Questions of whether the applicant, parents, or spouse are native born or naturalized.
	Questions regarding whether applicant's U.S. residence is legal; requiring proof of citizenship *after* hiring.	Requiring proof of citizenship *before* hiring.
	Appropriate to Ask	Inappropriate to Ask
Photographs	May require after hiring for identification purposes only.	Requesting a photograph *before* hiring.
Education	Questions concerning any academic, professional, or vocational schools attended.	Questions specifically asking the nationality, racial, or religious affiliation of any school attended.
	Inquiry into language skills, such as reading and writing of foreign languages.	Inquiries as to the applicant's mother tongue or how any foreign language ability was acquired (unless it is necessary for the job).
Relatives	Name, relationship, and address of a person to be notified in case of an emergency.	Any unlawful inquiry about a relative or residence mate(s) as specified in this list.
Children		Questions about the number and ages of the applicant's children or information on child-care arrangements.
Transportation		Inquiries about transportation to or from work (unless a car is necessary for the job).
Organization	Questions about organization memberships and any offices that might be held.	Questions about any organization an applicant belongs to that may indicate the race, age, disabilities, color, religion, sex, national origin, or ancestry of its members.
Physical condition/ disabilities	Questions about being able to meet the job requirements, with or without some accommodation.	Questions about general medical condition, state of health, specific diseases, or nature/severity of disability.
Military service	Questions about services rendered in armed forces, the rank attained, and which branch of service.	Questions about military service in any armed forces other than the United States.
	Requiring military discharge certificate *after* being hired.	Requesting military service records *before* hiring.
Work schedule	Questions about the applicant's willingness to work the required work schedule.	Questions about applicant's willingness to work any particular religious holiday.
References	General and work references not relating to race, color, religion, sex, national origin or ancestry, age, or disability.	References specifically from clergy (as specified above) or any other persons who might reflect race, age, disability, color, sex, national origin, or ancestry of applicant.
Financial		Questions about banking, credit rating, outstanding loans, bankruptcy, or having wages garnished.
Other qualifications	Any question that has direct reflection on the job to be applied for.	Any non–job-related inquiry that may present information permitting unlawful discrimination. Questions about arrests or convictions (unless necessary for job, such as security clearance).

The 2009 amendments included some employer-friendly provisions as well. Although the pool of individuals covered in the amendments is expanded, the reasonable accommodation features remain the same, as do existing exclusions for criminal behavior and current drug use.

Recruiting and selecting the most appropriate staff is one of the most important jobs in an organization. Candidates whose qualifications fit the job requirements are more likely to be productive and to remain on the job. The tendency, especially during times of shortages, is to shortcut the process, but this is ill-advised. The effort to attract and select the best candidates pays off over time for the organization.

One nurse manager used the recommendations in this chapter to hire a nurse as shown in Case Study 16-1.

CASE STUDY 16-1 | Selecting Staff

Jack Turner is nurse manager of the emergency department (ED) in a large metropolitan area hospital. He has four full-time RN positions open in his department. Three nursing programs are located in the city: a state university program, a community college program, and an RN-to-BSN completion program.

Jack recently participated in a nursing job fair hosted by his hospital. The event was well attended by nursing students, and he received several promising résumés of soon-to-be graduate nurses. Jack notes that one of the applicants, Sabrina Ashworth, will graduate next month with a BSN. She has been working for the past year as a nursing assistant in the ED of another local hospital. In addition to her ED work, Sabrina has a high grade point average and indicates a strong interest in trauma and critical care. Jack contacts the HR department to set up an interview with Sabrina.

Sabrina agrees to an interview for an RN position in the ED. Jack schedules a conference room adjacent to the ED for the interview. Prior to Sabrina's arrival, he reviews her résumé and application, noting her educational background, previous work history, and recent volunteer trip to Mexico to assist with a vaccination program. Jack has assembled a packet for Sabrina, including a job description and materials from human resources that outline the application process.

The interview begins promptly. Jack warmly greets Sabrina and establishes rapport. He follows the interview guide provided by HR. Jack informs Sabrina that he will be taking notes during the interview process. After reviewing her educational and work history, Jack asks Sabrina several situational questions related to work in the ED. He also allows time for Sabrina to ask questions about the RN position. Jack also has two RN staff members give Sabrina a tour of the ED. Finally, Jack outlines the next steps in the application process and indicates that he will follow up with Sabrina in 7 to 10 days.

Following the interview, Jack works with HR and asks for transcript and reference checks for Sabrina. After verifying her transcript and receiving positive references, Jack extends an offer to Sabrina, which she accepts.

What You Know Now

- The selection of staff is a critical function that requires matching people to jobs, and responsibility for hiring is often shared by HR and nurse managers.
- Position description is fundamental to all selection efforts because it defines the job.
- Recruitment is the process of locating and attracting enough qualified applicants to provide a pool from which the required number of new staff members can be chosen.
- Selection processes should be job related and most often include screening application forms, résumés, medical examinations, reference and background checks, and interviews.
- Interviewing is a complex skill that is intended to obtain information about the applicant and

to give the applicant information about the organization.

- Successful interviews require planning, implementation, and follow-up in order for them to lead to making the best decisions.
- Developing a structured interview guide is a critical element in interviewing.
- Selection decisions are subject to provisions in the Civil Rights Act of 1964 as amended in 1991, the Equal Pay Act of 1963, the Age Discrimination Act of 1967, and the Americans with Disabilities Act of 1990 as amended in 2009.

Tools for Recruiting and Selecting Staff

1. Conduct or modify a job description as needed.
2. Coordinate recruitment efforts with HR as well as technical support for social media platforms.
3. Ensure that your area of responsibility sends the message you want (see Box 16-1).
4. Prepare adequately for interviews.
5. Conduct interviews following recommendations presented in this chapter.
6. Process the information obtained in interviews and reference and background checks to make a final decision.

Questions to Challenge You

1. What approach does your organization use to recruit employees? Is it effective? How could the process be improved?
2. Imagine that a potential candidate asks you to describe your present workplace. What would you say?
3. Have you ever participated in a staff interview, either as a candidate or as a member of the staff? Describe your experience. Would you do anything differently now that you have read this chapter?
4. Cross-training has been used as a recruitment strategy. What are the pros and cons of using this strategy?
5. Consider the last interview you had for a job or school. Did the interviewer follow the principles discussed in this chapter? Explain.

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Chapter 17
Staffing and Scheduling

Staffing
Patient Classification Systems
Determining Nursing Care Hours

Planning FTE Workforce
Determining Staffing Mix
Determining Distribution of Staff

Scheduling
Self-staffing and Scheduling
Shared Schedule
Open Shift Management
Weekend Staffing Plan
Automated Scheduling

Supplementing Staff
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External Pools

Learning Outcomes

After completing this chapter, you will be able to:

1. Determine staffing needs using evidence-based tools.
2. Plan workforce full-time equivalents (FTEs).
3. Describe the various ways to schedule staff.
4. Explain how to supplement staff when needed.

Key Terms

block staffing
demand management
full-time equivalent (FTE)
nursing care hours (NCHs)
patient classification systems (PCSs)
pools
self-scheduling
staffing
staffing mix

Introduction

Staffing and scheduling are important responsibilities of the nurse manager and critical aspects of providing nursing care for several reasons. Decreasing nurse-to-patient ratios are associated with higher patient survival rates (McHugh et al., 2016). Furthermore, failing to match patient needs to nurses' skills also increases patient mortality (Needleman et al., 2011).

Staffing and scheduling are also important factors in job satisfaction for nurses. (See Leading at the Bedside: Staffing and Scheduling.) Nurses' perceptions of workload and feelings of burnout have been tied to job dissatisfaction, increased turnover, and nurse-reported quality of care (Van Bogaert et al., 2014). Not only have higher nurse staffing levels translated into lower mortality, but hospitals reported better nurse retention rates as a result (Aiken et al., 2010). In addition, Magnet hospitals report higher nurse staffing levels (Hickey, Gauvreau, Connor, Sporing, & Jenkins, 2010) and improved teamwork (Kalisch & Lee, 2011).

Staffing

The goal of **staffing** is to provide the appropriate number and mix of nursing staff (nursing care hours) to match actual or projected patient care needs (patient care hours) to provide effective and efficient nursing care. There is no single or perfect method to achieve this. In addition, variability in patient census requires continuous fine-tuning.

A hospital unit may experience a steady census during the 7 days of the week or a higher census from Monday to Friday. Its patient days may be distributed evenly during the year, or it may consistently experience peaks in occupancy in certain months (seasonality pattern) such as during an outbreak of influenza. Outpatient clinics may be busier on days when specialists are available or vaccines are offered. Staffing is a challenge in all healthcare settings.

To determine the number of staff needed, managers must examine workload patterns for the designated unit, department, or clinic. For a hospital, this means determining the level of care, average daily census, and hours of care provided 24 hours a day, 7 days a week.

The Joint Commission, a hospital accrediting body, identifies staffing expectations and requires that the right number of competent staff be provided to meet patients' needs based on organization-selected criteria (Joint Commission, 2016). Nurse leaders

Leading at the Bedside: Staffing and Scheduling

Being responsible for staffing and scheduling is incredibly difficult in healthcare because the number of patients and their needs are so variable. Nonetheless, organizations try to schedule nurses so patients are adequately cared for without having more nurses than needed'not an easy task.

You can help. How you respond to staffing and scheduling decisions affects the use of the valuable nursing resources of your unit and your organization. You can offer suggestions when the inevitable scheduling problems occur. You can be sensitive to an individual nurse's needs as well as help your colleagues understand the whole unit's needs. Working together with management, you can ensure that your organization uses its human resources wisely.

have worked to develop evidence-based data-driven staffing plans that can be budgeted for and communicated to nursing staff (Dent, 2015). Midland Memorial Hospital in Midland, Texas, created "Nine Principles for Improved Nurse Staffing" to guide its staffing, and the document is flexible and geared at achieving optimal patient satisfaction and patient quality outcomes, as shown in Box 17-1 (Dent, 2015).

Patient Classification Systems

Patient classification systems (PCSs), sometimes referred to as patient acuity systems, use patient needs to objectively determine workload requirements and staffing needs. To be most effective, patient classification data are collected midpoint for every shift by the unit nursing staff and analyzed before the next shift to ensure appropriate numbers and mix of nursing staff.

Ideally, this system would accurately predict the number and skill level of nurses needed for the next shift. However, other factors impact staffing needs. Some nurses may call in sick; the nurses scheduled may not have the skill set necessary for a specific surgery; or, most important, the patient's condition may change.

Welton and Harper (2015) suggest that information from electronic health records (EHRs) now allows us the opportunity to measure for nursing care needs in a way not possible in the past. Using this data to inform better operational and clinical decision making could improve cost and quality (Welton & Harper, 2015). This topic has long been discussed. (Picard and Warner [2007] suggested fine-tuning PCS systems to predict the demand for nursing expertise several days in advance. Their system, called **demand management**, uses best-practices staffing protocols to predict and control the demand for nurses based on patient outcomes. Based on historical data, a

Box 17-1 Nine Principles of Nurse Staffing at Midland Memorial Hospital

1. The Nurse Staffing Advisory Council (NSAC) will meet at least quarterly and review nurse staffing along with nurse-sensitive outcomes including any patient grievances associated with nurse staffing.
2. Budget nursing resources and reconcile the position control or hiring plan created on a National Database of Nursing Quality Indicators (NDNQI) 50th percentile for registered nurse hours per patient day (RNHPPD).
3. Forecast turnover at a predetermined rate and pre-hiring into on-boarding positions.
4. Maintain an internal resource team.
5. Budget the use of temporary traveler nurses during an identified peak census time period, December through April.
6. Nurses self-schedule within an electronic staffing and scheduling system using predictive volume patterns.
7. Assignments are acuity-based using a patient classification system mapped from the electronic health record with Nursing Outcomes Classification.
8. Minimum staffing identified to be the NDNQI 25th percentile for RNHPPD and maximum staffing identified at the NDNQI 75th percentile for RNHPPD.
9. Assure nursing staff practice within a fatigue management guideline.

Source: Dent, B. (2015). Nine principles for improved nurse staffing. *Nursing Economics*, *33*(1), 41–66.

patient progress pattern typifies expected patient outcomes throughout a stay. Deviations are tracked and staffing adjusted accordingly. This system allowed the manager to staff into the next few days with more assurance than predicting from one shift to the next.) Whatever system is used, the next step is to determine the necessary nursing care hours.

Determining Nursing Care Hours

Patient workload trends are analyzed for each day of the week (each hour in critical care) or for a specific patient diagnosis to determine staffing needs, known as **nursing care hours (NCHs)**. For example, if 26 patients with the following acuities required 161 nursing care hours, then an average of 6.19 nursing hours per patient per day (NHPPD) are required. NHPPD are calculated by dividing the total nursing care hours by the total census (number of patients).

	Number of Patients	Acuity Level	Associated Hours of Care	Total Hours of Care
	3	I	2	6
	10	II	6	60
	11	III	7	77
	2	IV	9	18
Total	*26*			*161*

There are no specific standards for NCHs for any type of patient or patient care unit. NCHs may vary on the average from 5 to 7 hours of care for patients on medical and surgical units, to 10 to 24 hours of care for patients in critical care units, to 24 to 48 hours of care for selected patients, such as new patients suffering from severe burns.

Planning FTE Workforce

Positions are defined in terms of a **full-time equivalent (FTE)**. One FTE equals 40 hours of work per week for 52 weeks, or 2,080 hours per year. In a 2-week pay period, one FTE would equal 80 hours. For computational purposes, one FTE can be filled by one person or a combination of staff with comparable expertise. For example, one nurse may work 24 hours per week, and two other nurses may each work 8 hours per week. Together, the three nurses fill one FTE ($24 + 8 + 8 = 40$).

Several methods are available for determining the number of FTEs required to staff a unit 24 hours a day, 7 days a week. One technique incorporates information regarding the hours of work for the staff for 2 weeks, average daily census, and hours of care. The average daily census can be determined by dividing the total patient days (obtained from daily census counts for the year) by the number of days in the year.

- **EXAMPLE**

$$\text{Total patient days} = \frac{9490}{365} = 26 \text{ patients per day}$$

Data

Number of hours worked per FTE in 2 weeks = 80
Number of days of coverage in 2 weeks = 14
Average daily census = 26
Average nursing care hours (from PCS) = 6.15

Formula

$$x = \frac{\text{average nursing care hours} \times \text{days in staffing period} \times \text{average patient census}}{\text{hours of work per FTE in 2 weeks}}$$

$$x = \frac{6.15 \times 14 \times 26}{80} = \frac{2238.6}{80} = 27.98, \text{ or } 28 \text{ FTEs}$$

A second technique uses nursing care hours and annual hours of work provided by 1 FTE:

Data

Number of hours worked per FTE in 1 year = 2,080
Total nursing care hours (from PCS) = 161

Formula

$$x = \frac{\text{Total nursing care hours} \times \text{days in a year}}{\text{Total annual hours per 1 FTE}}$$

$$x = \frac{161 \times 365}{2080} = \frac{58{,}765}{2080} = 28.25, \text{ or } 28 \text{ FTEs}$$

One person working full-time usually works 80 hours (ten 8-hour shifts) in a 2-week period. However, to staff an 8-hour shift takes 1.4 FTEs, one person working ten 8-hour shifts (1.0 FTE) and another person working four 8-hour shifts (0.4 FTE) in order to provide for the full-time person's 2 days off every week. For 12-hour shifts, it takes 2.1 FTEs to staff one 12-hour shift each day, each week; two people each working three 12-hour shifts and one person working one 12-hour shift each week (0.9 FTE + 0.9 FTE + 0.3 FTE = 2.1 FTEs). Therefore, the same number of FTEs is required to staff a unit for 24 hours a day for 2 weeks, regardless of whether or not the staff are all on 8-hour shifts (1.4 FTEs × 3 shifts = 4.2 FTEs) or 12-hour shifts (2.1 FTEs × 2 shifts = 4.2 FTEs).

Determining Staffing Mix

The same data used to determine FTEs are used to identify **staffing mix**. For example, for patient care needs involving general hygiene care, feeding, ambulating, or turning patients, licensed practical nurses (LPNs) or unlicensed assistive personnel (UAPs) can be used. For patient care needs involving frequent assessments, patient education, or discharge planning, RNs will be needed because of the skills required. A high RN-skill mix allows for greater staffing flexibility. Again, information on typical or usual patient needs is obtained by using trends from the patient classification system.

Determining Distribution of Staff

For many patient care units, the distribution of staff varies from shift to shift and by days of the week. Patient census on a surgical unit will probably fluctuate

throughout the week, with a higher census Monday through Thursday and a lower census over the weekend. In addition, some surgical units may have more complex cases earlier in the week and short-stay surgical cases later in the week. Surgical patients may have a shorter length of stay (LOS) than many medical patients. The patient census on a medical unit rarely fluctuates Monday through Friday, but it may be less on weekends when diagnostic tests are less commonly performed.

The workload on many units also varies within the 24-hour period. The care demands on a surgical unit will be heaviest early in the morning hours prior to the start of the surgical schedule; midmorning, when the unit receives patients from critical care units; late in the afternoon, when patients return from the postanesthesia recovery unit; and in the evening hours, when same-day surgical patients are discharged.

Critical care units may have greater care needs in the mornings when transferring patients to medical or surgical units and in the early afternoon hours when admitting new complex surgical cases. Medical units usually have the heaviest care needs in the morning hours, when patients' daily care needs are being met and physicians are making rounds. On skilled nursing and rehabilitation units, care needs are greatest before and immediately after mealtimes and in the evening hours; during other times of the day, patients are often involved in various therapeutic activities.

In contrast with the medical, surgical, critical care, and rehabilitation units, which have definite patterns of patient care needs, labor-and-delivery and emergency department areas cannot easily predict when patient care needs will be most intense. Thus, labor-and-delivery and emergency department areas must rely on block staffing to ensure that adequate nursing staff are available at all times.

Here is what a nurse manager told a new nurse candidate when asked about the nurse-to-staff ratio:

> *On the surgical step-down floor, we most typically staff at a one-RN-to-four-patient ratio. We also plan to have a charge nurse who is not taking patients to assist staff with extra tasks and needs. On occasion, a nurse may have three patients or five patients. We always work to be flexible, looking at the acuity of the patients and the competencies of the staff who are working. During each shift, we reassess every 4 hours and as needed to ensure assignments are still appropriate and patient needs haven't significantly changed, necessitating a reassignment of patients. We also have nurse aides on this floor. They help with vital signs, bed changes, baths, and ambulation. There is most typically one aide for every eight to twelve patients. Also, a unit clerk answers the phones and greets guests. This team dynamic creates great patient care.*

BLOCK STAFFING **Block staffing** involves scheduling a set staff mix for every shift. However, there may be trends in peak workload hours in emergency departments, when additional staff (RN, UAP, or secretary) beyond the block staff are necessary. Examples of peak workload hours within the emergency department may be from 6:00 p.m. to 10:00 a.m. to accommodate patient needs after physicians' offices close, or from 12:00 a.m. to 3:00 a.m. to accommodate alcohol-related injuries. All these needs in patterns of care must be known when staffing requirements and work schedules are established. Data reflecting peak workload times must be continuously monitored to maintain the appropriate levels and mix of staff.

Scheduling

Nurse shortages and current restrictions in salary budgets have made creative and flexible staffing patterns necessary and probably everlasting. Combinations of 4-, 6-, 8-, 10-, and 12-hour shifts and schedules that have nurses working 6 consecutive days of 12-hour shifts with 9 days off, and staffing strategies, such as weekend programs and split shifts, are common.

Flexible staffing patterns can be a major challenge and, in some cases, a mathematical challenge. However, once a schedule is established and agreed to by the nurse manager and the staff, it can become a cyclic schedule for an extended period of time, such as 6 to 12 months. This allows staff members to know their work schedule many months ahead of time.

The use of 8-hour and 12-hour shifts is fairly straightforward. Problems with combined staffing patterns may include the following:

- The perception that nurses do not work full-time when they work several days in a row, then are off for several days in a row
- Disruption in continuity of care if split shifts are used (7:00 to 11:00 a.m.; 11:00 a.m. to 3:00 p.m.; 3:00 p.m. to 7:00 p.m.; 7:00 p.m. to 1:00 a.m.; 1:00 a.m. to 7:00 a.m. shifts)
- Immense challenges for nurse managers to communicate with all staff in a timely manner

Advantages of using combined staffing patterns are that it achieves the following:

- Better meets patient care needs during peak workload times
- Improves staff satisfaction
- Maximizes the availability of nurses

Ten-hour shifts provide greater overlap between shifts to permit extra time for nurses to complete their work; for this reason, they may increase salary expenditures. There are a few specialty units in which 10-hour shifts would be cost-efficient—for example, post-anesthesia recovery areas, operating departments, and emergency departments.

Self-staffing and Scheduling

Some hospitals have instituted self-staffing. This is an empowerment strategy that allows unit staff the authority to use their backup staffing options if the patient workload increases or if unscheduled staff absences occur. Likewise, staff can and must go home early if the patient workload decreases.

SELF-SCHEDULING **Self-scheduling** allows the staff to create and manage the schedule by indicating their preferred shifts to work and noting what shifts they are not available (Russell, Hawkins, & Arnold, 2012). Self-scheduling allows staff to feel satisfied because they play a large role in choosing their schedules. The manager's role with self-scheduling is to pay close attention to the proposed schedule and balance staffing if the proposed self-schedule draft is not balanced to meet patient care needs. After a schedule is completed and balanced, it is posted for staff to see, well in advance of when the schedule starts. Posting of the schedule may be done on paper on the unit and also online in electronic format.

Shared Schedule

Another tool currently in use is a shared schedule: Two people share one full-time schedule by splitting the day of 12 hours into half days of 6.5 hours each, alternating morning and afternoon shifts. This allows nurses who might not be able to work the full 12 hours to share the shift. This option might be attractive to parents of young children who want to work but do not want to be away from home long hours. It can also be helpful to nurses who are close to retiring from their nursing career but still want to work some hours.

Open Shift Management

Open shift management is a technique that allows staff to schedule additional shifts beyond their expected shifts. With the schedule posted online, staff members can select assignments and shifts that fit their expertise and accommodate their personal schedules. Healthcare systems, with multiple hospitals, might use open shift management so staff can select assignments at multiple care locations within the system.

Case Study 17-1 shows how one hospital used open scheduling to decrease its use of agency staff and improve staff morale.

Weekend Staffing Plan

Hospitals can no longer arbitrarily staff patient care units for weekends or nights with marginal numbers or levels of qualified staff. The acuity of patients in hospitals, including medical and surgical patients, mandates staffing units on the weekends by the same principles used for weekdays. Thorough trend analysis of patient data can

CASE STUDY 17-1 | Scheduling

Tori Abraham and Jillian Moore are both nurse managers of general med/surg units at separate hospitals that are part of a large metropolitan healthcare system. Staffing among the med/surg units has been problematic due to increased patient volume and cost control measures enacted by the healthcare corporation. Staff members have complained numerous times that extra shifts are only offered to part-time employees, and that premium pay shifts are given to those with more seniority. As the holidays approach, staff tension increases as a lottery system has traditionally been used to assign shifts for major holidays. In addition, since employees are free to transfer within any of the eight metropolitan hospitals, there has been significant turnover on the med/surg units as employees decide to transfer to ambulatory care and same-day surgery facilities.

Tori and Jillian have volunteered to be part of a new scheduling system for their healthcare system. Nurses and nursing assistants will be able to view open shifts on each unit and e-mail Tori or Jillian with requests to staff shifts for which they are qualified. By allowing staff to have greater control over which additional shifts and at which facility they prefer to work, the nurse managers hope to decrease agency staffing and increase employee satisfaction. Additional units are expected to come online, which will also allow staff to have experience on oncology, skilled nursing, and orthopedic patients. The education department will provide a database of employee certifications to managers to ensure that staff wishing to work away from their home units are qualified for the job.

After 90 days of using the new open shift scheduling system, Tori and Jillian are pleased with the results. Agency staff use has decreased by 60%, and staff members report they are happier with the ability to schedule their own additional shifts as well as work at a different facility without having to transfer. Holiday staffing has been easier, as those employees who prefer to work holidays for premium pay are able to self-schedule. Tori and Jillian present their findings to the chief nursing officer and will be part of the team implementing systemwide use of open shift scheduling.

provide the justification necessary to appropriately decrease the number of RNs, at least for some levels, because of differences in patient care needs throughout the day.

Automated Scheduling

Technology today makes automated scheduling feasible (Douglas, 2010). Matching patient demand to nurse staffing is better done by automated systems than by individuals. To aid in scheduling decisions, data should include patient information, nurse characteristics, and hospital data (Frith, Anderson, & Sewell, 2010). Automated systems improve patient care outcomes because nurses spend more time with the patients who need the most nursing care. In addition, using nurses' time appropriately improves financial outcomes (Barton, 2011).

Data are often displayed on a dashboard. A dashboard is a computer display of real-time data collected from various sources and categorized for use in decision making.

Supplementing Staff

When there is a need for additional staff because of scheduled or unscheduled absences, increased workload demands, or existing staff vacancies, the nurse manager must find additional staff. Options include using PRN staff (staff scheduled on an as-needed basis), part-time staff, internal float pools, or outside agency nurses.

Supplemental staff are needed when workload increases beyond that which the existing staff can manage, staff absences and resignations occur, and staff vacancies exist. Chronic staffing problems must be addressed in a proactive manner involving the nurse manager, the chief nurse executive, and the nursing personnel on the unit with the problem.

Internal Pools

Acute staffing problems can be addressed by establishing internal float pools using nursing staff and unlicensed assistive personnel (UAPs). Internal float **pools** of nurses can provide supplemental staffing at a substantially lower cost than external agency nurses. In addition, internal staff are familiar with the organization. All staff participating in the internal float pool must be adequately trained for the type of patient care they will be giving.

Internal float pools can be centralized or decentralized. A centralized pool is the most efficient. A pool of RNs, LPNs, UAPs, and unit clerks are available for placement anywhere in the institution. However, it may be difficult to place the person with the correct skills for a particular unit at the needed time.

In decentralized pools, a staff member usually works only for one nurse manager or on only one unit. The advantages of decentralized pools include better accountability, improved staffing response, and improved continuity of care. Critical care units, operating rooms, maternal–child units, and other highly specialized or technical areas tend to use a decentralized system.

In addition, staff can receive cross-training in preparation for assignment to another unit. A critical-care nurse might be cross-trained for the step-down unit, for example. Dual-unit positions could be established in the recruiting phase to give the organization the maximum flexibility in scheduling and the employee an opportunity to acquire additional skills.

External Pools

For some institutions, agency nurses become part of the regular staff contracted to fill vacancies for a specified period of time (e.g., a nurse on maternity leave). However, most agency nurses are used as supplemental staff. All agency nurses require orientation to the facility and unit, and they must work under the supervision of an experienced in-house nurse. Management must verify valid licensure, ensure that either the agency or agency nurse has current malpractice insurance, and develop a mechanism to evaluate the agency nurse's performance. Although an agency nurse may meet an urgent staffing need, continuity of care may be compromised, and there may be some staff resentment because these nurses may earn two to three times the salary of in-house nurses.

Concern about the quality of agency nurses appears to be unfounded, according to a study analyzing mortality outcomes and failure to rescue (Aiken, Shang, Xue, & Sloane, 2013). Rather, hospitals with poor work environments were found to have higher numbers of agency nurses, and the work environment appeared to contribute to the poor patient outcomes.

Ensuring that sufficient staff are available and appropriately scheduled is a demanding task, one that is constantly in flux. Nevertheless, such activities are critical to achieving positive patient outcomes and providing safe, effective, and cost-conscious staffing.

What You Know Now

- The goal of staffing and scheduling is to provide an adequate mix of nursing staff to match patient care needs.
- The Joint Commission requires that organizations determine criteria for nurse staffing and provide adequate numbers of competent staff to meet that criteria.
- Patient classification systems use patient needs to determine workload requirements and staffing needs.
- Scheduling involves assigning available staff in a way that patient care needs are met.
- Flexible and creative staffing and scheduling techniques are increasingly necessary.
- Self-staffing and scheduling, including open shift management, are options in which nursing staff participate in designing the schedule and accept responsibility for ensuring attendance.
- Automated scheduling improves patient outcomes and uses fiscal resources appropriately.

Tools for Handling Staffing and Scheduling

1. Familiarize yourself with the current patient classification system, acuity system, or automated system in use.
2. Determine the nursing care hours needed.
3. Determine the FTEs needed.
4. Create or modify a schedule that best meets your patients' needs.
5. Supplement staff as needed.
6. Consider self-staffing if appropriate.

Questions to Challenge You

1. What has been your experience with staffing? Use any work setting where you are or have been an employee. How well did it work? Was there adequate coverage to meet the needs of the organization? Explain.
2. Using the formulas for calculating FTEs in the chapter, create your own examples and work the problems from them. Were you able to compute needed FTEs? Now calculate the hours needed when nursing staff work 8-hour or 12-hour shifts.
3. On occasion, more staff are available than are needed. As a nurse manager, how would you handle this? How might the staff respond?
4. No one is ever completely satisfied with the schedule. How would you handle a staff member who repeatedly asks to have his schedule changed?

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Chapter 18
Motivating and Developing Staff

A Model of Job Performance
Employee Motivation
Motivational Theories

Staff Development
Orientation
On-the-job Instruction
Preceptors
Mentoring
Coaching
Nurse Residency Programs
Career Advancement
Leadership Development

Succession Planning

Learning Outcomes

After completing this chapter, you will be able to:

1. Describe the factors that influence job performance.
2. Compare and contrast the use and effectiveness of various staff development methods.
3. Discuss why succession planning is essential to the future.

Key Terms

content theories
equity theory
expectancy theory
extinction
goal-setting theory
horizontal promotion
motivation
on-the-job instruction
orientation
preceptors
process theories
punishment
reinforcement theory (behavior modification)
shaping

Introduction

A continual and troublesome question today is why some employees perform better than others. Making decisions about who performs what tasks in a particular manner without first considering individual behavior can lead to irreversible, long-term problems.

Each employee is different in many respects, and those differences influence behavior and performance on the job. Ideally, the manager assesses the new employee when the person is hired. In reality, however, many employees are placed in positions without the manager having adequate knowledge of their abilities and interests. This often results in problems with employee performance as well as conflict between employees and managers. Employee performance literature ultimately reveals two major dimensions as determinants of job performance: **motivation** and ability (Hersey, Blanchard, & Johnson, 2012).

A Model of Job Performance

Nurse managers spend considerable time making judgments about the fit among individuals, job tasks, and effectiveness. Such judgments are typically influenced by the characteristics of both the manager and the employee. For example, ability, instinct, and aspiration levels—as well as age, education, and family background—account for why some employees perform well and others poorly. Based on these factors, a model that considers motivation and ability as determinants of job performance is presented in Table 18-1.

This performance model identifies six categories likely to be viewed as important:

- Daily job performance
- Attendance
- Punctuality
- Adherence to policies and procedures
- Absence of incidents, errors, and accidents
- Honesty and trustworthiness

Table 18-1 A Simplified Model of Job Performance

Motivation	+	Ability	=	Employee Performance
Compensation		Responsibilities		Daily job performance
Benefits		Education—basic/advanced		Attendance
Job design		Continuing education		Punctuality
Leadership style		Skills/abilities		Adherence to policies and procedures
Recruitment and selection				Absence of incidents/errors/accidents
Employee needs/ goals/abilities				Honesty and trustworthiness

Although there is conceptual overlap in these categories, separate designation of each helps emphasize their importance.

When using this model, carefully consider several factors. First, the healthcare organization should establish and communicate clear descriptions of daily job performance so that deviations from expected behaviors can be easily identified and documented. Second, behaviors considered troublesome on one unit may be acceptable on another. Finally, some behaviors are viewed as serious only when repeated (e.g., being late to work), whereas others are classified as troublesome following only one incident (e.g., a medication error with severe consequences).

Employee Motivation

Motivation describes the factors that initiate and direct behavior. Because individuals bring to the workplace different needs and goals, the type and intensity of motivators vary among employees. Nurse managers prefer motivated employees because they strive to find the best way to perform their jobs. Motivated employees are more likely to be productive than are unmotivated workers. This is one reason that motivation is an important aspect of enhancing employee performance.

Motivational Theories

The usefulness of motivational theories depends on their ability to explain motivation adequately, to predict with some degree of accuracy what people will actually do, and, finally, to suggest practical ways of influencing employees to accomplish organizational objectives. Motivational theories can be classified into at least two distinct groups: content theories and process theories.

CONTENT THEORIES **Content theories** emphasize individual needs or the rewards that may satisfy those needs. Content theories are less useful today because they specify neither what rewards would motivate an individual nor how people vary in perceiving the importance of the reward.

PROCESS THEORIES Whereas content theories attempt to explain why a person behaves in a particular manner, **process theories** emphasize how the motivation process works to direct an individual's effort into performance. These theories add another dimension to the understanding of motivation and help predict employee behavior in certain circumstances. Examples of process theories are reinforcement theory, expectancy theory, equity theory, and goal-setting theory.

Leading at the Bedside: Know Yourself

What motivates you? Motivation, you've learned, combines with ability to predict how well you are able to do your job. If you don't have the skills for a job, no amount of motivation will inspire you to do it. On the other hand, you may have all the skills necessary to do the tasks involved in your position, but you have little motivation to do it. When considering a new position, remember these two conditions: If the position meets both your ability and your motivation, you are more likely to be satisfied in your job.

Know yourself, and then find your place in nursing. You and your profession will be the better for it.

Reinforcement theory (behavior modification) views motivation as learning (Skinner, 1953). According to this theory, behavior is learned through a process called operant conditioning, in which a behavior becomes associated with a particular consequence. In operant conditioning, the response—consequence connection is strengthened over time—that is, it is learned.

Consequences may be positive, as with praise or recognition, or negative. Positive reinforcers are used for the express purpose of increasing a desired behavior.

Kyle, a staff nurse, offered a creative idea to redesign work flow on the unit. His manager supported the idea and helped Kyle implement the new process. In addition, the manager praised Kyle for the extra effort and publicly recognized him for the idea. Kyle was encouraged by the outcome and sought other solutions to work-flow problems.

Negative reinforcers are used to inhibit an undesired behavior. **Punishment** is a common technique.

To get Rose to chart adequately, the manager supervised Rose's charting daily until Rose achieved an acceptable level of charting. Rose found the task laborious and humiliating. As a result, Rose was soon charting appropriately.

Because punishment is negative in character, an employee may instead fail to improve and also may avoid the job. Undesirable behavior will be suppressed only as long as the employee is monitored and the threat of punishment is present. Conversely, positive reinforcement is the best way to change behavior.

Extinction is another technique used to eliminate negative behavior. By removing a positive reinforcer, undesired behavior is extinguished.

Jasmine was a chronic complainer. To curb this behavior, her manager chose to ignore her many complaints and not try to resolve them. Initially, Jasmine complained more, but eventually she realized her behavior was not getting the desired response and stopped complaining.

A problem with behavior modification is that there is no sure way to elicit the desired behavior so that it can be reinforced. In addition, staff and the manager may view consequences differently.

As a new employee, Thad conscientiously completed critical paths for his assigned patients. When the manager recognized Thad for his good work, his peers began to exclude him from the group. Although the manager was attempting positive reinforcement, Thad quit completing critical paths because he felt the manager had alienated him from his coworkers.

Another procedure is shaping. **Shaping** involves selectively reinforcing behaviors that are successively closer approximations to the desired behavior. When people become clearly aware that desirable rewards are contingent on a specific behavior, their behavior will eventually change.

Behavior modification works quite well, provided that rewards can be found that employees, in fact, see as positive reinforcers, and provided that such rewards are contingent on performance. This does not mean that all rewards work equally well or that the same rewards will continue to function effectively over a long time. If someone is praised four or five times a day every day, the praise would soon begin

to wear thin: It would cease to be a positive reinforcer. Care must be taken not to overdo a good thing.

Like reinforcement theory, **expectancy theory** (Vroom, 1964) emphasizes the role of rewards and their relationship to the performance of desired behaviors. Expectancy theory regards people as reacting deliberately and actively to their environment.

In an effort to improve the amount of delegation by the nurses on her unit, Andrea approached the situation from an expectancy theory perspective. She identified that the nurses wanted to assign more duties to assistive personnel but were reluctant because of concerns about liability. Once Andrea was able to clarify liability issues, the nurses were eager to delegate tasks that could be performed by nonlicensed staff in order to devote more time to their professional responsibilities.

Expectancy theory also considers multiple outcomes. Consider the possibility of a promotion to nurse manager. Even though a staff nurse believes such a promotion is positive and is a desirable reward for competent performance in patient care, the nurse also realizes there are possibly some negative outcomes (e.g., working longer hours, losing the close camaraderie enjoyed with other staff members). These outcomes may influence the staff nurse's decision.

Similarly, **equity theory** suggests that a person perceives that one's contribution to the job is rewarded in the same proportion that another person's contribution is rewarded. Job contributions include such things as ability, education, experience, and effort, whereas rewards include job satisfaction, pay, prestige, and any other outcomes an employee regards as valuable (Adams, 1963, 1965).

Unlike expectancy theory and equity theory, **goal-setting theory** suggests that it is not the rewards or outcomes of task performance per se that cause a person to expend effort but, rather, the goal itself (Locke, 1968).

Timothy was new to a home care hospice program. An important skill in care with the terminally ill is therapeutic communication. Timothy and his manager recognized that he needed help to improve his skills in communicating with these patients and their families. His manager asked him to write two goals related to communication. Timothy expressed a desire to attend a communications workshop and also indicated he would try at least one new communication technique each week. Within a month, Timothy's therapeutic communication skills had already improved. As a result, Timothy was more satisfied with his position, his patients received more compassionate care, and Timothy found his work more rewarding.

Each theory of work motivation contributes something to our understanding of, and ultimately our ability to influence, employee motivation.

Staff Development

Developing staff begins as soon as employees are hired. Orientation begins the process, followed by on-the-job-instruction and the use of preceptors. In addition, nurse residency programs help nurse graduates transition into the nursing role, and mentors and coaches can be helpful during the nurse's career. Career progression and leadership advancement are additional development approaches.

Orientation

Getting an employee started in the right way is essential. **Orientation** is the training a new employee undergoes on organizational structure and expectations as well as job-specific tasks. A well-planned orientation reduces the anxiety that new employees feel when beginning the job. In addition, socializing the employee into the workplace contributes to unit effectiveness by reducing dissatisfaction, absenteeism, and turnover.

Orientation is a joint responsibility of both the organization's staff development personnel and the nurse manager. In most organizations, the new staff nurse completes the orientation program, whereupon the nurse manager (or someone appointed to do this) provides an on-site orientation. Staff development personnel and unit staff should have a clear understanding of their respective, specific responsibilities so that nothing is left to chance. The development staff should provide information involving matters that are organization-wide in nature and relevant to all new employees, such as benefits, mission, governance, general policies and procedures, safety, quality improvement, infection control, and common equipment. The nurse manager should concentrate on those items unique to the employee's specific job.

New employees often have unrealistically high expectations about the amount of challenge and responsibility they will find in their first job. If they are assigned fairly undemanding, entry-level tasks, they feel discouraged and disillusioned. The result is job dissatisfaction, turnover, and low productivity.

So, one function of orientation is to correct any unrealistic expectations. Specifically what is expected of the new employee should be delineated. Such realistic job previews help prevent early departures from the organization and, possibly, the nursing profession.

Socializing new employees can sometimes be difficult because of the anxiety people feel when they first come on the job. They simply do not hear all of the information they are given. They spend a lot of energy attempting to integrate and interpret the information presented, and consequently they miss some of it. So repetition may be necessary the first few days or weeks on the job. Ongoing follow-up is important.

Trina Prescott, RN, joined the pediatric oncology unit of a large university teaching hospital. Her nurse manager, Lily Yuen, scheduled a lunch with Trina 30 days after she started. Lily had a relaxed conversation with Trina about the first 30 days of her employment. Trina expressed how much she enjoyed her new job, but that she still felt uncomfortable accessing implanted vascular ports without assistance. Lily makes a note to schedule one-on-one teaching for Trina with a nurse from the IV team. Scheduling a lunch with new employees approximately 30 to 60 days into their employment has improved new employee retention and increased open communication between Lily and her staff.

On-the-job Instruction

The most widely used educational method is **on-the-job instruction**, which often involves assigning new employees to experienced nurse peers, preceptors, or the nurse manager to learn by observing the experienced employee and by performing the actual tasks under supervision.

On-the-job instruction has several positive features, one of which is its cost-effectiveness. New nurses learn effectively at the same time they are providing care. Moreover, this method reduces the need for outside instructional facilities and reliance

on professional educators. Transfer of learning is not an issue because the learning occurs on the actual job. However, on-the-job instruction often fails because there is no assurance that accurate and complete information is presented, and the instructor may not know learning principles. As a result, presentation, practice, or feedback may be inadequate or omitted.

On-the-job instruction fulfills an important function; however, staff members involved may not view it as having equal value to more standardized and formal classroom instruction.

To implement effective on-the-job instruction, the following are suggested:

- Employees who function as educators must be convinced that educating new employees in no way jeopardizes their own job security, pay level, seniority, or status.
- Individuals serving as educators should realize that this added responsibility will be instrumental in attaining other rewards for them.
- Teachers and learners should be paired to minimize any differences in background, language, personality, attitudes, or age that may inhibit communication and understanding.
- Teachers should be selected on the basis of their ability to teach and their desire to take on this added responsibility.
- Staff nurses chosen as teachers should be carefully educated in the proper methods of instruction.
- Assignments should be formalized so nurses do not view on-the-job instruction as happenstance or second-class instruction.
- Learners should be rotated to expose each one to the specific know-how of various staff nurses or education department teachers.
- Employees serving as teachers should understand that their new assignment is by no means a chance to get away from their own jobs but that they must build instructional time into their workload.
- The efficiency of the unit may be reduced when on-the-job instruction occurs.
- The learner must be closely supervised to prevent him or her from making any major mistakes and carrying out procedures incorrectly.

Preceptors

One method of orientation is the preceptor model, which can be used to assist new employees and to reward experienced staff nurses. **Preceptors** continue the new nurse's orientation by socializing the individual to the organization and the unit, being available to answer questions, and helping the new nurse to problem solve. In addition, being selected as a preceptor is a way to recognize exceptionally competent staff nurses. Staff nurses who serve as preceptors are selected based on their clinical competence, organizational skills, ability to guide and direct others, and concern for the effective orientation of new nurses.

The primary function of the preceptor is to orient the new nurse to the unit. This includes proper socialization of the new nurse within the group as well as familiarizing her or him with unit functions. The preceptor teaches any unfamiliar procedures and helps the new nurse develop any necessary skills. The preceptor acts as a resource person on matters of unit functions as well as policies and procedures. The

preceptorship is for approximately 3 weeks, although the time may vary depending on the nurse's individual learning needs or the organization's policies.

New graduates may need to use their preceptors as counselors as they make their transition to the unit. If new graduates experience discrepancy between their educational preparation or their expectations and the realities of working in the unit, the preceptor's role as counselor can prove invaluable in helping them cope with "reality shock."

The preceptor also serves as a staff nurse role model, demonstrating work-related tasks, how to set priorities, solve problems and make decisions, manage time, delegate tasks, and interact with others. In addition, the preceptor evaluates the new nurse's performance and provides both verbal and written feedback to encourage development.

The staff development department's function is to teach the experienced nurse the role of a preceptor, principles of adult education applicable to learning needs, how to teach necessary skills, how to plan teaching, how to evaluate teaching and learning objectives, and how to provide both formal and informal feedback.

Mentoring

Mentoring is another strategy to help nurses flourish in their careers (Patten, 2012). Mentors play a greater role than preceptors in developing staff. Precepting usually is associated with orientation of staff, whereas mentoring occurs over a much longer period and involves a bigger investment of personal energy.

A mentor is a wiser and more experienced person who guides, supports, and nurtures a less experienced person. Mentors are usually the same sex as the protégé, 8 to 15 years older, highly placed in the organization, powerful, and willing to share their experiences. They are not threatened by the mentee's potential for equaling or exceeding them. Mentees are selected by mentors for several reasons: good performance, loyalty to people and the organization, a similar social background or a social acquaintance with each other, appropriate appearance, an opportunity to demonstrate the extraordinary, and high visibility.

Mentor–mentee relationships typically advance through several stages. The initiation stage usually lasts 6 months to a year, during which the relationship gets started. During the mentee stage, the mentee's work is not yet recognized for its own merit but, rather, as a by-product of the mentor's instruction, support, and encouragement. The mentor thus buffers the mentee from criticism.

A breakup stage may occur between 6 months and 2 years after a significant change in the relationship, usually resulting from the mentee taking a job in another department or organization so that a physical separation of the two individuals occurs. It also can occur if the mentor refuses to accept the mentee as a peer or when the relationship becomes dysfunctional for some reason. The lasting friendship stage is the final phase and will occur if the mentor accepts the mentee as a peer or if the relationship is reestablished after a significant separation. The complete mentoring process usually includes the last stage.

Coaching

Coaching is a strategy that helps the recipient focus on solving a specific problem or conflict (Thorn & Raj, 2012). Coaches are often nurses or human resources staff within the organization prepared to help resolve conflicts. Conflicts could be occurring

between two nurses, between a nurse and a patient, or between a nurse and a physician. In a confidential environment, the coach helps the staff member explore the exact nature of the problem, consider various alternatives (e.g., transfer, quit, do nothing), delve into embedded issues (e.g., values conflict with organization, unmatched expectations), discover links (e.g., working with friends), and identify the disadvantages of leaving (e.g., start over with vacation time, benefits, leave friends). The goal is to reduce turnover from issues that can be resolved.

Nurse Residency Programs

Residency programs, typically 12 or 18 months in length, are designed to acclimate new graduates to the work environment (Little, Ditmer, & Bashaw, 2013). Residency programs appear to be beneficial to both the nurse and the organization (Fiedler, Read, Lane, Hicks, & Jegler, 2014). Surveying members of the American Organization of Nurse Executives, Pittman and colleagues (2013) found that approximately one third of reporting hospitals offered nurse residency programs for new graduates. Chappell (2014) found that residency fellowship programs supported an institution's goal toward Magnet certification. Furthermore, residencies may encourage nurses to stay with the organization (Rosenfeld, Glassman, & Capobianco, 2015).

Career Advancement

One example of a career advancement development strategy is the clinical ladder program. It uses a system of performance indicators to advance an employee within the organization. The following are the key components:

- Horizontal promotion
- Clinical ladder
- Clinical mentee

Horizontal promotion rewards the excellent clinical nurse without promoting the nurse to management. A clinical ladder, based on Benner's (2000) novice-to-expert concepts, includes the following:

- Clinical apprentice—new nurse or nurse new to the area
- Clinical colleague—a full partner in care
- Clinical mentee—demonstrates preceptor ability
- Clinical leader—demonstrates leadership in practice
- Clinical expert—combines teaching and research with practice

The strength of the system is that superb, clinical nurses can remain at the bedside, clinical excellence can be rewarded, and nurses can move back and forth among the levels based on their personal and professional goals and needs.

Another example of a clinical advancement program was used at a Magnet-certified institution, Cincinnati Children's Hospital Medical Center (Allen, Fiorini, & Dickey, 2010). The program's goal was to improve the quality of patient care, provide career opportunities for participating nurses, and enhance job satisfaction and nurse retention. Evaluation of the program illustrated that goals were met. An additional finding revealed that the program had a substantial positive fiscal impact on the organization as well.

Leadership Development

Developing internal staff is a cost-effective way to build leaders within the organization. The advantages include knowledge of the skills and strengths of the candidates, the cost saving in retaining high-performing staff, and the ability to design a program that fits the organization's specific needs. In fact, many nurse leaders fail not because they do not want to do the job, but because they do not have the leadership tools required.

Built around Benner's novice-to-expert concepts (Benner, 2000), one hospital designed a leadership curriculum that targeted the learning needs of staff at different developmental levels—for example, 200 level for charge nurses, 300 level for assistant nurse managers, 400 level for nurse managers (Swearingen, 2009). As a result, the organization developed a pool of candidates available for promotion to higher-level positions. In addition, they found nurse retention rates improved.

CASE STUDY 18-1 | Motivating Staff

Jamie Edgar is nurse manager of the mental health outpatient clinic for a large county health department. Her staff includes nurses, licensed clinical social workers, licensed mental health technicians, and clerical support staff. State funding for mental health services has been drastically cut. Jamie had a difficult decision to make regarding who on the staff would receive pay increases, and who would not. Compounding her problem is the shortage of qualified psychiatric nurses and two vacant nursing positions that she has been unable to fill due to the low starting salary.

Jamie decides that the nursing staff will receive a 4% raise and the licensed clinical social workers will receive a 3% raise. The mental health technicians and clerical staff will not receive a wage increase this year. The mental health technicians and clerical staff members are upset when Jamie tells them there will not be any pay increases this year. Kevin Adams, a licensed mental health technician, and Charlotte DuBois, an administrative assistant, have both expressed frustration about the disparity in pay increases. Over the past two workweeks, Kevin has been clocking in 10 minutes late each workday and taking longer lunch periods than scheduled. The quality of Charlotte's work has decreased, and she is using more business time for personal telephone calls and personal business.

Jamie is concerned that the negative attitudes exhibited by Kevin and Charlotte will continue to affect their work as well as the morale of the staff. Initially, she tried more frequent praise of their work, but after 3 weeks she noted no improvement in their attitude or performance. She counseled each employee individually about performance expectations; however, neither employee made an effort to improve behavior. After receiving a final budget for her clinic, Jamie allocated $800 for training of clerical staff and mental health technicians. She met with Kevin, Charlotte, and two other staff members. Jamie asked the group to assist her in determining how to best spend the $800 training budget. The group agreed that time-management skills could be improved among many of the staff. After reviewing the cost associated with several time-management training programs, the group was surprised at the expense. Jamie challenged her group to think of alternative ideas other than sending staff members to a seminar and offered a restaurant gift certificate for the most creative ideas.

At their next meeting, Kevin produced reviews of several interactive CD-ROM training programs. Kevin had searched the Internet for the best price for the programs and brought in several demonstration CDs of the top two time-management programs. Charlotte proposed purchasing planners for those staff members who did not already have a planner or electronic calendar. Charlotte had spoken to the supplier who had the contract for county office supplies. They had agreed to a price of $12 per planner for a complete year of time-planning supplies. The group agreed that the ideas submitted by both Kevin and Charlotte were excellent, in addition to them coming in under the $800 limit.

Kevin and Charlotte were responsible for implementing their ideas with staff who requested training in time management. Although neither employee received a raise in base salary, Jamie was able to secure approval for both to work extra hours to complete training for the clinic staff. Jamie continued to praise both employees for their commitment to the clinic and their coworkers. Kevin began to arrive promptly for each work shift and kept his lunch periods to 30 minutes. Charlotte was eager to demonstrate to coworkers how her new planner helped her prioritize work and personal tasks. Her use of work time for personal business greatly decreased.

Succession Planning

Due to an aging nursing workforce, as well as the overall shortage of nurses, succession planning at all levels of nursing management is essential to ensure a smooth transition after a manager leaves or retires (Ponti, 2009). Succession planning is a strategic process that is a natural outgrowth of leadership development. It involves identifying core competencies required at each level of management, recognizing potential recruits, and providing opportunities for development and growth.

One institution developed a nurse management internship program to prepare first-line managers from an internal pool of interested nurses (Wendler, Olson-Sitki, & Prater, 2009). The 1-year program successfully prepared several nurses for management positions in its first year. Those costs were recouped when a long-term management opening was filled b y one of the nurses who completed the internship.

There is no single way to motivate people. The organization and the manager must use various tools to offer incentives and rewards that satisfy their staff. Increased productivity, patient care quality, job satisfaction, and retention are all outcomes that can result in appropriate motivational activities.

Case Study 18-1 illustrates how one nurse manager used her ingenuity to motivate staff.

What You Know Now

- Job performance is determined by motivation and ability.
- Motivational theories (e.g., reinforcement, expectancy, equity, and goal-setting theories) describe the factors that initiate and direct behavior.
- Orientation methods include on-the-job instruction and the use of preceptors.
- Nurse residencies, career advancement opportunities, and leadership development programs can help motivate staff members.
- Succession planning is a strategic process to develop future nurse leaders.

Tools for Motivating and Developing Staff

1. Recognize that an employee's job performance includes both ability to do the job and motivation.
2. Become familiar with various theories of motivation and use the information to help you motivate others.
3. Be aware that you may be a role model to other staff regardless of your formal position.
4. Identify core competencies involved in specific positions and high performers with the potential to fill those positions.
5. Encourage staff development at all levels, including your own.

Questions to Challenge You

1. What motivational theory appeals to your sense of how you learn? Why?
2. You are a new nurse manager:
   a. How would you discover what motivates the individuals on your staff?
   b. How could you utilize the organization's resources to motivate your staff?
   c. What staff development programs are available in your organization or community?
   d. How could you make those resources available to your staff?
3. What recommendations would you make to a new nurse manager regarding motivating staff? Have you seen any of these work? Explain.

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Chapter 19
Evaluating Staff Performance

Performance Management

The Performance Evaluation Process

Management Responsibilities
Components of the Annual Performance Evaluation
Developing Evaluation Tools

Methods for Collecting Performance Data

Peer Review
Self-evaluation
Skill Competency
Manager's Evaluation

Facing the Challenges of Performance Review

Conducting the Annual Performance Review

Learning Outcomes

After completing this chapter, the learner will be able to:

1. Describe the manager's role in performance management.
2. Explain the components of a successful performance evaluation process.
3. Examine a variety of methods for collecting performance data.
4. Anticipate and address the challenges of performance review.
5. Set the stage for a successful performance review that clearly identifies performance strengths and weaknesses within a trusting environment.

Key Terms

behavior-oriented performance evaluation
developmental plan
performance evaluation
performance management
peer review
self-evaluation
skill competency

Introduction

The evaluation process, both formative and summative, provides a pivotal opportunity to grow and develop staff, enhance workplace health, and improve patient satisfaction, physician satisfaction, and patient care quality. A high-functioning unit, free of performance issues, results in the most cost-effective healthcare. A unit burdened by tardy staff, staff who abuse paid time off (PTO) or sick leave, or staff who bully and produce turnover, is expensive to run.

Performance evaluation is one of the most important accountabilities of the nurse manager. The nurse manager who gets into the rhythm of evaluation, considering it a part of daily work, will be highly successful.

Organizations manage the formal evaluation process in many ways. Some have transitioned the process to the same time of the year. To prepare for the formal review, all meetings scheduled for the previous month are cancelled to allow the manager and staff to focus on performance review. The manager should be rewarded for conscientiousness and timely reviews. The manager, in addition, should be allowed to reward high-performing staff members within the structure of organizational policy.

Performance Management

Performance management includes the systems, policies, procedures, positions descriptions, and evaluation components essential to providing consistent, high-quality nursing practice. The key to successful performance management is setting up systems that create what Daniels and Daniels (2004) call the "ABC Model." "A" is for *antecedents*—those tangibles and intangibles that prompt behaviors, like position descriptions, career ladders, journal clubs, and performance evaluations. "B" is for *behaviors*—what a staff member says and does. Perhaps the most important is "C" for *consequences*, which can be positive and negative—salary increases, feedback, being able to attend a conference or work off-site, staying flat on the clinical ladder, being passed over for a promotion, receiving a small or no salary increase, or denial of a specific vacation request due to performance. Performance management systems without consequences are doomed to fail because behavior will never change.

At the unit level, a manager who does not use the ABC model will generally not be successful in improving unit performance.

The Performance Evaluation Process

Performance evaluation, or appraisal, is one component of performance management. As stated, it can be an antecedent, or a guide for behavior, and, in the ABC model, a consequence. Therefore, it is a pivotal process. The goal of performance evaluation is to support nursing practice development (Schoessler et al., 2008). Evaluating performance by comparison to standardized behavioral expectations enables the manager to identify developmental needs of the employee. Performance-related behaviors should be directly associated with the role and must be accomplished to achieve a job's objectives (Topjian, Buck, & Kozlowski, 2009). Evaluating performance is both a daily and annual role of the manager. Excellent performance assessment ensures patient safety, addresses performance issues when they arise, and provides staff with a clear view of management expectations for performance. Unit quality and workplace health will be superior with consistent performance evaluation.

The best performance evaluations are based on transparent behavioral criteria (see Table 19-1), provide an opportunity for input by not just management but by the individual and team members, include positive and constructive feedback, and finally, provide a developmental plan for performance improvement. Performance appraisals serve as tools to grow staff as well as to provide vital information for salary increases and career progression.

Table 19-1 Employee Performance Evaluation Form

Employee Name: _____

Position: Clinical Nurse I

Department: _____

Hire Date: _____

Evaluation Period: _____

Manager Reviewer: _____

This appraisal contains a five-point scale rating for each performance expectation. The description of the ranking on the five-point scale is as follows:

5 Significantly Exceeds Expectations: Staff member consistently goes above and beyond ordinary expectations. Mentors or coaches staff in this category. Staff member is a role model of excellence—in the top 5% of nurses.

4 Exceeds Expectations: Staff member frequently does things that are beyond routine expectations. Peers, patients, colleagues (including physicians) comment that staff member goes beyond what others do and exceeds routine expectations.

3 Meets Expectations: Staff member meets expectations of the position.

2 Usually Meets Expectations: Staff member meets performance expectations at times yet not consistently.

1 Does Not Consistently Meet Expectations: Performance is below the standard behaviors in the position description.

Core Performance Expectations	Does Not Consistently Meet Expectations 1	Usually Meets Expectations 2	Meets Expectations 3	Exceeds Expectations 4	Significantly Exceeds Expectations 5	Examples
1. Demonstrates accountability for the regulatory obligations of a licensed professional nurse including procurement and renewal of license, continuing education, and other regulatory requirements, including the identification and potential reporting of violations of the nurse practice act						
2. Practices solid communication skills and is able to translate the patient's condition to physicians and other colleagues, negotiate and make recommendations for changes in patient care						
3. Seeks constant feedback on performance, adjusts behavior, and actively participates in peer review						
4. Serves as an active member of the multidisciplinary team						
5. Role models the professional image of a nurse through the eyes of a patient at all times and in all settings						
6. Practices continuous learning to enhance performance and shares opportunities with staff.						
7. Maintains a healthy working environment by demonstrating respect and dignity for all, creating positive relationships, and supporting patients, families, and team members						

(*Continued*)

Table 19-1 Employee Performance Evaluation Form (*Continued*)

8. Serves as a leader in clinical nursing practice, identifying patient- and staff-focused opportunities for improvement	
9. Flexible with staffing and works with peers to meet the needs of patients	
10. Works in harmony with coworkers, settles conflict professionally, and serves as an active member of the team	

Position-Specific Performance Expectations	Does Not Consistently Meet Expectations 1	Usually Meets Expectations 2	Meets Expectations 3	Exceeds Expectations 4	Significantly Exceeds Expectations 5	Examples
1. Consistently uses the nursing process as a framework for planning and coordinating patient care that provides continuity and patient involvement						
2. Serves as a leader in clinical practice, identifying patient- and staff-focused opportunities for improvement and leads efforts for change						
3. Practices participatory leadership and actively serves in shared leadership						
4. Demonstrates critical thinking in the analysis of clinical, social, safety, psychological, and spiritual issues for the patient within the episode of care						
5. Practices solid communication skills and is able to articulate and translate the patient's condition to physicians and other colleagues						
6. Serves as an active member of at least one professional organization						
7. Mentors and supports the development of other staff						
8. Disseminates new professional knowledge and innovations through presentations, posters, and publications						
9. Integrates best practices and research into daily work through study and application of research						
10. Creates a caring and compassionate patient-focused experience by building healthy relationships						

Development Goals for Coming Year

Describe three realistic and measurable goals that address opportunities for improvement and professional growth. Examples of goal categories might be education, relationships, attitude, leadership, and so on. How can your manager support this goal?

_____

_____

_____

Signatures

This verifies that this review was completed and does not necessarily signify agreement or disagreement with the contents of the review.

_____

Employee's Signature

Date _____

Manager's Signature _____ Date _____

Human Resource's Signature _____ Date _____

There should be no surprises at the performance appraisal. The annual formal performance evaluation should be a pool of observations collected for a year, an opportunity to dialogue about performance improvement, and finally, the time for setting goals for the coming year with a plan for achievement.

Management Responsibilities

Timely completion of annual performance evaluations for all staff is one of the most important issues in responsible management. Creating, with the staff member, an annual developmental plan with clear and measureable goals that will be used in the performance evaluation in the coming year is critical to the performance appraisal process. Other responsibilities of the manager include the following:

- Being consistently present and visible on the unit to directly assess individual employee performance throughout the year (A manager who is never on the unit cannot assess the overall performance of the unit. Feedback from physicians, patients, and colleagues about the performance of the staff member should be collected on a regular basis, not just once a year. Feedback should be shared with the staff member as it occurs.)
- Providing concrete examples of performance that clarify the numeric rating
- Assessing employee performance within the dedicated position description, or on a career ladder, as compared to others with like experience and position descriptions
- Coordinating a peer review process that, if used, is open, transparent, and fosters unit trust
- Collecting information from patients as well as other nonnursing colleagues—such as physicians, pharmacists, and others—about the performance of the staff member
- Coaching the staff member in how to write a self-evaluation with measurable goals for the coming year
- Consistently following policies and procedures for evaluation of staff in order to comply with regulatory, union, and other standards
- Preparing for the evaluation by reviewing all materials for concrete patterns, writing the evaluation, and setting the stage for a respectful dialogue about performance
- Asking for help, if needed, from a mentor, seasoned colleague, or human resources professional about a strong performance evaluation

Components of the Annual Performance Evaluation

The five primary components of the formal evaluation are (1) multifaceted behavior-oriented criteria, (2) feedback on the level of performance of the criteria against a rating scale, (3) concrete examples of performance or the lack of performance, (4) staff member self-evaluation of performance, and (5) developmental plan for performance improvement.

The role of the nurse has many dimensions. The performance evaluation should mirror the expectations of these dimensions. Expectations fall into different categories and can be clustered in any number of ways, but all performance evaluations should share core behaviors, and the expectations of all staff within a certain job category

should be the same. In addition, evaluations should include performance or domain clusters that reflect higher or unique expectations related to the functions of nursing. These might include the nursing process, teaching, research, leadership, and clinical quality (Honour, 2013). Each major cluster will have subcategories that may be clinical or unit specific.

Developing Evaluation Tools

In order to clarify expectations and drive performance improvement, the evaluation tools should link to the position description, be behavior oriented, and focus on the values of the organization and the expectations of staff required to create a healthy workplace and a culture of quality and safety. Some examples of *generic* behaviors that might be included in all performance evaluations are described in Table 19-1. This table also provides examples of behaviors that might be unique to certain position descriptions.

Although there are many varieties of **behavior-oriented performance evaluation**, effective systems will include the following elements:

- ***Values of the Organization.*** Each organization has a mission statement, and often a values statement. Hospitals pursuing Magnet Recognition focus their evaluation systems around creating exemplary professional practice that includes the application of research in the clinical setting. Common threads in the performance evaluation for staff would include such areas as leadership, evidence-based practice, shared governance, mentoring and developing staff, and improving quality.
- ***Position Descriptions.*** Career ladders include specific position descriptions that clarify expectations for performance. The performance evaluation is then directly linked to the behaviors in the performance evaluations.
- ***Cluster Behaviors.*** Group behaviors within the performance evaluation are clustered within performance categories. Opportunities for performance improvement become clearer when a weakness is visible in a performance category, such as leadership or building relationships (with patients and colleagues).
- ***Examples.*** The evaluator should provide specific examples of behaviors that speak to the rating given.
- ***Developmental Goals.*** The evaluation should include the individual's goals for the past year and how they were met. Goals should be realistic, measurable, and attainable. Goals for the next year should be set at the annual evaluation.

Methods for Collecting Performance Data

Evidence of an individual's performance should be collected in a variety of ways. These methods include peer review, self-evaluation, skill competency, and the manager's notes and evaluation.

Peer Review

The American Nurses Association (ANA) first published Peer Review Guidelines in 1988 and defined **peer review** as "the process by which practicing registered nurses systematically assess, monitor, and make judgments about the quality of nursing care

provided by peers as measures against professional standards of practice" (American Nurses Association, 1988). Peer review is seen as an essential component of contemporary nursing practice by the Magnet Recognition Program, the ANA, and the Institute of Medicine (Burchett & Spivak, 2014). The purpose of peer review is to reinforce the quality of patient care and the caliber of professional nursing practice by evaluating practice by peers. Peer review principles are listed in Box 19-1 (Haag-Heitman & George, 2011).

The role of the manager in peer review is as follows:

- Set the stage for a positive and trusting peer review by creating a transparent process with the staff.
- Work with the staff member to select peers who can provide current and unbiased feedback.
- Coach staff members on how to write constructive and positive feedback that speaks to the expertise of the nurse and the domains of practice.
- Review peer comments and circle back with staff if comments are unclear, punitive, disrespectful, or not focused on professional practice.
- Coach the staff member on how to receive feedback from peers, including expressing thanks.
- Share the peer review feedback with the staff member, or create a safe space for the delivery of peer review, in person or peer to peer.

Self-evaluation

Self-evaluation is a critical component of performance evaluation because it fosters reflection, an essential component of professional nursing practice and a strategy for learning. Reflection is the deliberate process of critically thinking about a clinical experience. This self-analysis leads to insights in performance that may change professional practice. Nursing scholars propose that reflection provides the nurse with the opportunity to build on existing knowledge through clinical experiences, develop clinical judgment, promote strong communication skills, build collaborative practice, and improve patient care (Miraglia & Asselin, 2015). Reflection tools,

Box 19-1 Components of a Successful Peer Review Process

1. The peer is someone of the same rank as the person evaluated.
2. Peer review is practice focused.
3. Feedback is timely, routine, and a continuous expectation.
4. Peer review fosters a continuous learning culture of patient safety and best practice.
5. Feedback is not anonymous.
6. Feedback considers the nurse's developmental stage.

Source: Haag-Heitman, B., & George, V. (2011). Nursing peer review: Principles and practice. *American Nurse Today*, *6*(9). Retrieved April 29, 2015, from http://www.americannursetoday.com/nursing-peer-review-principles-and-practice

Leading at the Bedside: Being Evaluated

Everyone dreads the inevitable performance evaluation, managers and staff alike. You read in this chapter how managers can improve evaluations by keeping up with day-to-day issues and addressing performance problems when they occur. In the same way, you can keep track of your progress throughout the year using your organization's criteria. Be sure to include positive events as well as problems, and try to be as honest as possible. Problems are opportunities for growth.

By following the guidelines in this chapter and appraising your own performance, you will be prepared for your formal evaluation.

techniques, and strategies can be found in many resources and textbooks (Sherwood & Horton-Deutsch, 2015).

It is the manager's responsibility to guide the staff member through self-evaluation. The self-evaluation always includes the employee's assessment of individual performance as measured against the criteria in the performance appraisal. Self-evaluation may also include a portfolio created by the staff nurse to provide concrete examples of professional practice. The portfolio might include formal education completed, conferences attended, articles written, classes taught, letters from patients, and journal entries. It is best to accumulate the portfolio contents throughout the year rather than at the end of the year. The self-evaluation may point out blind spots of the employee—that is, performance areas where the nurse is not aware of the need for improvement. (See Leading at the Bedside: Being Evaluated.)

DEVELOPMENTAL PLAN The final component of the self-evaluation is the staff member's goals for the coming year, which are the basis of the developmental plan. The goals are derived from a process of looking back at past performance and looking forward at performance improvement. These goals become a part of the developmental plan. The **developmental plan** is built around the goals to create not only a benchmark for measuring performance next year but also a hopeful career trajectory for the staff member. The ability of staff members to crystallize their analysis of behavior through goal development is an important piece of the developmental process. It will give the manager great insight into further blind spots of the staff member and/or their ambitions for the future. (See Box 19-2 for a sample developmental plan.)

Skill Competency

Skill competency is the ability to perform a skill knowledgeably and safely. Healthcare organizations are required to assess their employees' ability to perform the functions, skills, and tasks of the position. Validation of competency is an ongoing process, initiated in orientation, followed up by development, and assessed on an annual basis. Skill evaluation should be carried out through a variety of methods, including simulation, testing, direct observation, and case studies. The manager plays a key role in determining the competencies required for each position in the manager's span of control. Evidence of skill competency provides additional data for the performance review as well as the developmental plan.

Box 19-2 Sample Developmental Plan

Name: _____

Position: _____

Review Year: _____

Goal Category	Goal	Results
Education	Enroll in a master's in nursing program for this fall semester, take courses and successfully complete them.	
Evidence-Based Practice	Once a month, search the literature for one professional article, from any health science, that relates to the care of patients on our unit. Post the article on the unit intranet site and in the staff lounge.	
Relationships	Practice conflict management skills that are win—win in nature. Keep a journal of examples and review with nurse manager once a quarter.	

Staff Member Signature: _____ Date: _____

Manager Signature: _____ Date: _____

Manager's Evaluation

The manager's evaluation is the final piece in the performance evaluation process. Manager evaluation is formative, meaning ongoing, and summative at the conclusion of a period of time. Since managers are accountable for the evaluation and development of all of their staff, the annual evaluation process can be daunting if the manager does not view performance evaluation as a daily responsibility.

The manager should create a file for each staff member. This can be done electronically or on paper. The file can include anecdotal notes that describe, in detail, the performance of the staff member, as a situation occurs. These can be notes of concern or positive feedback. If constructive feedback is given, a note should be made and should include the staff member's response to the feedback. The manager might slip into the file articles posted by the staff member, presentations given, and notes from patients or medical staff. The file should be full of evidence by the time the annual performance review comes around.

The manager prepares for the review by studying the material in the staff folder, reviewing the skill competency checklist, the staff member's self-evaluation, and the results of the peer review. After considering all of the information, the manager writes the final evaluation and a draft of the developmental plan. The final developmental plan will be constructed with the staff member and agreed upon together.

Facing the Challenges of Performance Review

Contemporary managers have many demands on their time. There are regulations to meet, meetings to attend, budgets to develop and monitor, unannounced accreditation surveys, patient complaints, and challenging issues that arise between staff and

physicians. It is easy to become swept away by the putting-out-fire mentality of managing operations. The successful manager makes performance assessment a daily focus and a leadership priority (see Table 19-2).

Conducting the Annual Performance Review

The evaluation interview is the capstone of a process that has been conducted all year long and includes feedback from a variety of sources. Even though the evaluation process should be transparent, it might still be an anxiety provoking time for even the highest performing employee.

The following are six recommendations for conducting a successful performance review:

1. ***Create a safe and respectful location in which to conduct the evaluation, and begin by reminding the staff member how the process works and why performance appraisal is important.*** Choose a private location for the meeting. Since most individuals are nervous at the start of the appraisal, especially new employees who are facing their first evaluation or those who have not received frequent performance feedback over the course of the evaluation period, begin by giving an overview of the type of information that was used in making the performance ratings,

Table 19-2 Performance Evaluation Dos and Don'ts

DO	DON'T
Make performance evaluation a priority. It is the finest tool for high unit performance and management success.	**Do it just once a year.**
Stay visible on the unit. A key accountability of the manager is development of staff. If the manager is never on the unit, staff's performance cannot be assessed, given timely feedback, and coached to improve.	**Lose track of employee performance**, spend most of the time off the unit or behind a closed door.
Give timely feedback. Feedback should be given to the staff member when the behavior, positive and negative, occurs.	**Blindside the staff member.** Allow time to remediate behavior.
Provide positive as well as constructive feedback. Positive feedback is a strong reinforcer of behavior. Catch staff doing things right, then recognize and reward the behavior.	**Surprise** the staff member at the annual evaluation with information that has not been shared earlier.
Prepare all year. Keep a file on every employee, take relevant and clear notes, and respectfully check in with other team members about employee performance.	**Procrastinate** and wait until the annual evaluation window.
Take notes that are behavior oriented and linked to the position description and/or evaluation.	**Take notes** that are vague or judgmental—for example, the nurse was "disorganized," "careless," or "insubordinate."
Encourage the employee to engage in serious reflection on performance through self-evaluation.	**Skip** the self-evaluation.
Collect feedback from a variety of viewpoints.	**Assess performance** strictly from the manager's point of view (POV). The employee works across many relationships: peers, managers, patients, physicians, other clinicians, and so on. Assessment only from the manager's point of view will be incomplete and potentially inaccurate.
Be prepared. Prepare notes and documents, review all materials, and appear composed and confident at the performance appraisal.	**Be flustered and disorganized.**
Be clear about process. Knowledge of process steps creates trust among staff.	**Be secretive.** Spring the evaluation process on the staff.

such as "In preparing for this review, I relied on the notes I have taken and shared with you throughout the year. In addition, we have the results of the peer review process as well as your self-evaluation." If the self-evaluation was superior, the manager should specially comment—for example, "You did a great job! I especially liked how concrete you were with your examples. And your developmental plan is quite ambitious."

2. ***Go through the ratings one by one with the employee.*** Provide a number of specific examples of behavior that led to each rating. Be careful not to rush. By systematically going through the ratings and providing behavioral examples, nurse managers project an image of being prepared and professional. This is important for getting the staff nurse to accept the ratings and act on them. In addition, comment when your ratings might be different from the staff member's—for example, "You were a little hard on yourself on this rating. Your peers think you're one of the best in managing conflict—even the physicians comment about how cool and respectful you are and how you create win–win situations. Dr. Jones reminded me of how well you did with Mr. Madden's family—how upset they were when his echo wasn't on time. You diffused the situation beautifully."
3. ***Ask the staff member to respond to the ratings.*** For example, "So what do you think so far? Are we on target?" Listen, accept, and respond to the employee's opinion. This aspect of the evaluation is important as it gives the manager feedback on the employee's ability to reflect on the year's performance. To carry out this phase of the interview effectively, the manager must have confidence in the accuracy of the ratings.

   When asked to express reactions, individuals who have received low ratings might challenge the rater's judgment—for example, "Don't you think your standards are a little high?" If the manager's judgment is questioned, it is important not to get defensive. Listen and consider whether the rating was correct. Adjust if it was not backed up by solid evidence of performance. Ask the nurse about it—for example, "Can you give me an example? Why do you think this rating is too low?"

   The manager also might say something like "I hear you, but if you look at the peer review results, your teammates think that you could lighten up on the new graduates—adjust your expectations and be a little kinder and gentler with feedback. Remember when you were a new graduate? Just being a clinical expert doesn't make us good teachers or mentors."

   The staff member might say, "Could you be more specific? Give me an example." The manager could reply with something like "Remember Susie Mathis? She was the new graduate I found crying in the bathroom. We talked about it—you and I. Remember, your feedback to her was quite harsh, and frankly it particularly upset her when you told her that she would never make a good nurse."
4. ***Decide on specific ways in which performance areas can be strengthened.*** The focus of the interview should now shift to the future. No one is perfect. Every person has room for improvement, even the highest performing clinicians. Deficiencies or opportunities for improvement should be addressed jointly, creating an action plan to improve. This should become a part of the developmental plan. Such developmental activities may include formal training, academic course work, or on-the-job coaching. Together, you and the staff nurse should write down the resulting plans.

Because the evaluation may become part of the evidence for career planning or disciplinary action that might include termination, careful documentation of performance is essential. If a staff member never receives feedback, the staff member may question any decision of the manager.

5. ***Create an action plan and evaluate the process.*** Creating an action plan might include a follow-up meeting to review a revised developmental plan. The manager might have offered to find a mentor for the nurse in another area or help research education options for professional growth. Or the manager might request a meeting in a month to talk about how a performance deficiency has been addressed. Keep an open door and invite the employee to check in with the manager on a regular basis, especially if the employee has questions about how the manager is viewing performance. *It is important that the search for feedback is not just the manager's responsibility but also the staff member's.*
6. ***Ask for feedback.*** Ask for the employee's opinion about the process. This is another valuable evaluation step—for example, "Can you give me some feedback about the process? How can we improve it for future evaluations?" Allowing the staff member to provide opinions provides feedback to the manager from the staff they serve.

What You Know Now

1. Performance evaluations are one component of a performance management system.
2. Performance evaluation is much more than the annual review. It should be frequent and regular, providing immediate feedback, both positive and constructive.
3. Evaluation tools should be behaviorally oriented, based on concrete criteria such as position descriptions, and include a rating scale and the opportunity for providing concrete examples.
4. There should be no surprises at the annual performance review. It should be a time of reflection and planning developmental goals for the coming year.
5. Evaluating performance should include multiple sources of feedback, such as peer review, self-evaluation, skill competency, and the manager's evaluation.
6. Conducting an effective performance appraisal is one of the most challenging yet important responsibilities of the manager.

Tools for Evaluating Staff Performance

1. Familiarize yourself with the performance evaluation policies and procedures, requirements, and deadlines used in your organization.
2. Keep a file on every staff member with notes and evidence of performance.
3. Seek assistance from a colleague, mentor, or human resources professional if unsure how to conduct a performance review.
4. Conduct the peer review process according to the accepted guidelines of the American Nurses Association.
5. Follow the guidelines for conducting a successful performance appraisal and ask for feedback at the end of the process.

Questions to Challenge You

1. What was your best evaluation experience? What was important to you? How can you incorporate the positive aspects of evaluation into your reviews?
2. What might be the challenges of peer review? Why should you be aware of them before you begin the process?
3. What could be the consequences of not including a variety of viewpoints in the performance evaluation?
4. How would you manage a very defensive staff review without becoming defensive in return?

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Chapter 20

Feedback and Coaching, Disciplining, and Terminating Staff

Feedback
Coaching
Feedback versus Coaching
Confronting Behavior
Discipline
Termination

Learning Outcomes

After completing this chapter, you will be able to:

1. Define feedback and the keys to successful feedback.
2. Describe the essentials for effective coaching.
3. Contrast the differences between coaching and feedback.
4. Explain how to address performance issues with confrontation.
5. Apply the guidelines for progressive discipline.
6. Identify the essential components of an equitable termination.

Key Terms

discipline
feedback
coaching
confrontation
progressive discipline
termination
verbal warning
written warning

Introduction

One of the most important yet challenging roles of a manager is being in touch with employee performance, providing timely and constructive feedback, and coaching for success. Many managers, especially in their early years, can be conflict averse and uncomfortable with providing feedback. The effective manager realizes that learning creates a change in behavior. Often this teachable moment comes through feedback. The savvy manager focuses on not just poor performance but also on the most important reinforcer of behavior: positive feedback. The consequences of ignoring the development of staff through feedback and coaching are inevitable. A unit riddled with patient quality concerns, rising costs, poor workplace morale, and declining patient and physician satisfaction is a unit void of feedback and performance management.

Feedback

Feedback is the day-to-day process of helping employees evaluate and improve their performance. Feedback is both positive and constructive. Study after study has reported that the best prepared nurses provide the finest patient care (Drenkard, 2010). Therefore, the high-performing nurse manager selects the right blend of staff for the patient population and makes staff performance improvement a priority. The nurse manager is only one point of view in providing feedback. The best feedback is comprehensive and includes feedback from peers, colleagues (physicians, pharmacists, and others), and sometimes patients.

Yet collecting information about an employee and providing feedback are probably among the most difficult responsibilities of a manager. The manager who lacks the confidence to address performance or is never on the unit tends to avoid, neglect, or poorly execute feedback. Feedback can address minor and major issues in performance. A minor issue might be a new nurse who texts on the job or publicly flirts with one of the medical students. A major issue ripe for feedback might be sleep impairment, examples of poor judgment, recurrent absenteeism or tardiness, poor sterile technique, unsafe clinical care, or conflict with peers.

In any situation where a nurse is not performing up to par, the manager must first "peel the onion" and identify the "why" behind the "what" of behavior. Why is the nurse performing at this level? Is there something else going on in the nurse's life? Did the nurse not receive appropriate training? Is anxiety at work here? Sleep deprivation? Family problems? The dynamic healthcare environment as well as the mental health and sometimes toxic issues of the workforce, such as substance abuse and bullying, compound the complexities of feedback. The manager who leads by walking around, by being physically present on the unit, will be alert to workplace health, quality, and performance issues.

Wiggins (2012) describes essentials for successful feedback and performance improvement. These and other essential components are listed in Box 20-1.

Coaching

Coaching is a collaborative relationship between a coach and a willing individual that supports continuing personal, professional and career development through the acquisition of appropriate skills, actions, and abilities that are crucial to professional practice. Coaching is an interactive, interpersonal process. It is usually time limited

Box 20-1 Keys to Successful Feedback

1. **Timely and Ongoing:** Feedback should be given as close to the event or observation as possible. Effective feedback is given frequently throughout the year, not just at the performance evaluation. There should be no surprises at the time of the performance evaluation.
2. **Goal-referenced:** Feedback should be linked to a behavioral goal, include steps to achieve the goal, and give the staff member information and time to achieve the goal. For example, "Jenny, this is the third shift you've come late to work. We need you here on time. Patients are waiting for your care. The night shift nurse sometimes can't leave until you arrive. By missing report, you are missing vital information on your patients. Can you tell me what's going on here?"
3. **Constructive and Positive:** Feedback should not be limited to constructive feedback that addresses performance issues. Give feedback through praise when the employee does something well. Positive feedback is a powerful reinforcer. For example, "I saw you sitting down with Mrs. Garcia and talking with her about her end-of-life choices and her beliefs. I went in to see her afterward, and she told me she was so relieved to know you told her she had choices and listened to her concerns. I wish that every patient had a nurse like you who is not afraid to have the hard conversations. Great work. Thank you!"
4. **Tangible and Transparent:** Describe the behavior clearly. For example, "When Dr. Jones entered Mrs. Marten's room, I noticed that you left immediately. Can you talk to me about what was going on?" In this particular situation, the nurse manager knows that Dr. Jones has raised his voice with young nurses who tend to scatter when he comes on the unit. The manager is giving the nurse the opportunity to reflect on past behavior. Later, the nurse manager will need to provide coaching to help the young nurse learn to manage relationships with physicians. This coaching may take the form of one-on-one with a mentor or an educational program.
5. **Respectful, Encourages Reflection:** Pick a private or appropriate location. Do not humiliate the employee by correcting in front of others, whether patients or staff. The nurse manager's tone of voice should be even and low. Regardless of what happened, the nurse manager should keep emotions in check and avoid jumping to conclusions. Always provide the employee an opportunity to reflect and explain the problematic behavior. Reflection increases the potential for learning and change of behavior. Ask how the employee plans to improve the behavior. Partner with the employee in changing behavior by providing coaching.

and focused on achievement of goals. It demands skill on the part of the coach in facilitating meaningful conversations and letting the nurse learn and, thereby, change performance (Donner & Wheeler, 2009).

Staples (2012) described the essentials for coaching success, and the author has adapted the list. For coaching to be effective, the nurse must be ready, willing, and able:

- ***Ready.*** The nurse needs to be psychologically able to accept coaching. *Coaching is not therapy or counseling.* The chemically impaired nurse or the nurse suffering from abuse at home may not be ready for coaching on professional development and usually will require outside intervention. It is very important that the nurse manager not take on the role of therapist or counselor.
- ***Willing.*** The nurse must be open to the process, interested in changing, and motivated to improve performance. The nurse has to want to learn and improve. (See Leading at the Beside: Learning from Coaching.)
- ***Able.*** The nurse must be capable of changing performance. The nurse must have the right aptitude to learn the new process. For example, the new graduate in the operating OR who repeatedly cries after a surgeon makes a gruff remark may not be a fit for the OR. On the other hand, a new graduate who privately cries, then asks for help, may have the resilience for the role.

Leading at the Bedside: Learning from Coaching

Although no one wants to hear about a weakness, coaching is a positive way to improve. In this chapter, you learn that in order to benefit from coaching, you must be ready to learn, willing to improve, and able to change. Of course you'll make mistakes. You're human. If you have a conscientious manager, that person will meet with you and calmly explain the problem, ask for your suggestions for improvement, and follow up later. Your task is to help your manager problem solve and then carry out agreed-upon activities. In this way, you will learn new skills of adaptation and change, a lesson that will serve you well in the future.

It is important to note that the manager is not always the coach in the relationship. Coaches may be a peer expert or a nurse off the unit. Coaching may involve a path of education, a connection with a mentor, or partnering with a person from another discipline.

Feedback versus Coaching

Feedback and coaching go hand in hand, but they are different. Feedback without coaching may not result in a change in behavior. Table 20-1 lists the differences.

Confronting Behavior

If a staff member has been given feedback on a behavior and that behavior does not change, the manager needs to move to a more serious level of interaction called **confrontation**. Confrontation should put the employee on high alert, and the manager must carefully document the process. The steps in confrontation are applied when the progressive disciplinary process of the organization begins. A manager who has never conducted an interview with confrontation might seek coaching from a professional colleague or a contact in human resources. Recommended steps are described in Table 20-2.

Discipline

Discipline is a fact of life in management. **Discipline** calls the employee's attention to behavior that is not appropriate and must be corrected, and advises how to correct the behavior. The process of discipline is progressive and highly dictated by organizational policies and procedures. The manner in which discipline is delivered is as

Table 20-1 Feedback versus Coaching

FEEDBACK	COACHING
Focuses on behavior that has occurred	Future forward; creates a trajectory for future performance
Assesses performance against a performance standard and alerts the staff member	Improves and/or develops performance
Constructive with consequences	May include remediation through skill development and always includes behavior modification
Positive with rewards	May include career advancement or development—for example, through further education and continuing education

Table 20-2 Steps in Confrontation

1.	Prepare before the meeting.	Is the employee aware of the policy and procedure? Desired behavior? Has the policy/procedure been consistently enforced? How will the employee react? Seek advice or role play the meeting if uncertain of approach.
2.	In a neutral voice, objectively describe the behavior without attacking the person. Tie the behavior to the consequences for the patients, organization, or employee.	"Jane, did you know that it is clinic policy to notify *both* the clinic manager and the hospital supervisor when you will be absent from work? Not only were we worried about you, but we had to reschedule patient procedures because we did not have the staff to attend to both clinic appointments and special procedures."
3.	Solicit and openly listen with empathy to the employee's reasons for the behavior.	"Can you tell me why you didn't notify someone about your absence?"
4.	Explain why the behavior cannot continue, and ask for suggestions in solving the problem. If none are offered, suggest solutions. Agree on steps each will take to solve the problem.	"In the future, you will need to notify both the clinic manager and the hospital supervisor if you cannot come in. Can you do this?"
5.	Place an anecdotal note in the file, noting the issue and employee response, and set and record a specific follow-up date. Ask the employee to reflect back on the conversation and make sure you are both on the same track.	"Jane, since this is concerning, I'm going to put a note in your file. Let's set a date to meet in a month and see how you're doing. If you don't follow the policy about call-ins during this period of time, we'll talk sooner. Can you tell me, in your own words, why this is important and what you are going to do about it?"

important as the process. Discipline is not punishment, but it is a consequence of employee behavior. It is a warning. It is not designed to embarrass an employee. It can provide a course correction for an employee, a wake-up call, leading toward improvement, or it can lead to termination.

Discipline is not personal and not about whether an employee is liked or not liked. It is about addressing behavior. The consistent delivery of discipline sets the tone for manager expectations about staff performance on the unit. Discipline can set an example that will call peers to attention. (See Box 20-2.)

Box 20-2 Guidelines for Effective Discipline

1. Carefully and thoroughly obtain the facts. The cause of discipline might be a series of incidents or a major event. Verify the policies and procedures about progressive discipline and at what level.
2. Check in with your supervisor or human resources, as your work culture requires. Ask for advice, and clarify if your expectations are reasonable.
3. Never act while angry.
4. Be consistent in the application of discipline across all staff.
5. Discipline in private. In neutral and behavioral terms, make the offense clear. Specify what appropriate behavior is. Give examples.
6. Get the other side of the story, but set a limit and avoid excuses.
7. Create an action plan for remediation. Let the employee know what potential future consequences will be if the behavior continues.
8. Ask the employee to reflect on past behavior and describe a personal view of the interview and what must change.
9. Document the interview and place it in the employee file. Many organizations will have the employee sign the anecdotal note.
10. Circle back with your supervisor or human resources. Give them feedback on how the interview went while reflecting on your performance as a manager.

Progressive discipline is the formal process of increasingly severe warnings for repeated violations that can lead to termination. The astute manager builds a case that begins with notes about performance that document feedback and includes the employee response to feedback and a plan of action. The notes should also include any relevant coaching or remediation. Progressive discipline moves in a stepwise fashion unless the infraction is egregious, life threatening, or deadly. Progressive discipline may begin and end with a precursor: an oral warning. The oral warning is a call to action for the staff member. It is beyond feedback and draws attention to a behavior that should not continue. Most managers will make an anecdotal note of the oral warning and place it in the employee's file.

The formal steps in the progressive discipline process are verbal warning and written warning. While the warning is called "verbal," it is documented. It means step one in the formal disciplinary process. Questions to consider in determining progression include the following:

- What is the nature and seriousness of the behavior?
- When, where, and how many times did the behavior occur?
- What is the previous work history? Has this emerged before?
- Are there complicating factors to consider, such as chemical dependency or other mental health issues?

A **verbal warning** (see Box 20-3) is given for unacceptable behavior that is repeated or serious behavior that occurs one time. For example, a manager may give a verbal warning to a staff member who has a pattern of calling in sick on the weekend. Or the manager may jump to a **written warning** (see Box 20-4) if a staff member falls asleep on the job and seriously jeopardizes patient care. Though the pathway is clear, discipline itself is often a gray area, open to interpretation. That is why it is best to discuss the plan of action with an experienced supervisor and acquire input.

Box 20-3 Verbal Warning Form

Employee's name:
Date of verbal warning:
Specific offense or rule violation:
Specific statement of the expected performance:

Any explanation given by the employee or other significant information:

_____ _____
Supervisor Signature and Date

This information was discussed with me and I was given a copy of this document.

_____ _____
Employee Signature and Date

Box 20-4 Written Warning Form

Employee's name:
Date of conversation:
Specific rule violation or performance problem:

Previous conversations about the rule violation or performance problem:

Specific change in the employee's performance or behavior expected:

Employee's comments:

Supervisor's comments:

Continuation of this behavior may include termination.

_____ _____
Employee's Signature and Date:

-or-

Employee was asked to sign this written warning on _____ but declined to sign.

_____ _____
Supervisor's Signature and Date

In some cases, the progressive discipline system is bypassed. Swift action may be required to protect patient safety or the workplace environment. The seriousness of the behavior may be grounds for immediate termination or suspension that allows for due process. These serious behaviors may include theft of equipment or drugs, violating patient privacy by accessing the records of a patient, bringing a firearm to work, administering the wrong drug resulting in a patient fatality, or substance abuse on the job. Regardless, the incident should be meticulously documented and advice sought from the immediate supervisor, human resources, and in some cases hospital legal counsel.

At each stage of the disciplinary process documentation is essential, and equitable treatment of all staff on the unit is expected. That means if one employee receives a verbal warning for calling in sick to attend a rock concert, then all employees who called in sick for the same reason receive a verbal warning. Case Study 20-1 shows how one nurse manager correctly handled a disciplinary issue in a progressive fashion.

CASE STUDY 20-1 | Progressive Discipline

Katie Connors is nurse manager of the birthing center in a metropolitan hospital. A student nurse, Amber Schroeder, was assigned to work for her clinical shift with Natalie Cole, RN. Their patient arrives at the birthing center for induction of labor. During the admission process, the patient confides to Natalie and Amber that she is terrified she might need a cesarean birth. Amber whispered to the patient that a young woman and her baby recently died at the hospital during an emergency cesarean birth. The patient begins to hyperventilate, refuses to let Natalie continue with the admission, and threatens to leave the birthing center. Natalie is so angry at Amber for scaring the patient that she grabs her by the arm and pulls her out of the room. Natalie loudly berates Amber in the hallway to the point that Amber is crying.

Katie hears the commotion in the hallway and instructs Amber to sit in the staff lounge until her instructor can return to the unit. Katie and Natalie reassure the patient, and Natalie completes the admission process. Throughout the shift, Natalie tells every staff member and physician about Amber's "stupid comment." Katie speaks with the nursing instructor and Amber about the incident. She also checks back with the patient and gently gathers facts about the incident.

Katie is concerned about Natalie's response to the situation. While Natalie has excellent nursing skills, she has often been abrupt or rude to other staff members. Katie has given feedback to Natalie on her communication skills and coached her, yet the behavior has continued, resulting in three other incidents. Katie had already given Natalie a verbal warning for lack of professional communication. After discussing the incident with the human resources manager, Katie agrees that a written warning will be placed in Natalie's personnel file.

At the end of the shift, Katie requests that Natalie come to her office to discuss what happened with the student nurse. Katie informs Natalie that she is very concerned about how she reacted to the inappropriate comment made by the student nurse. Specifically, physically grabbing the student and verbally attacking her in front of patients and staff was unacceptable and violates hospital policy. Further, Natalie continued to disparage the student to other staff and physicians, which is also unacceptable. Natalie expresses her frustration at the thoughtlessness of Amber's comment. Katie tells Natalie that while Amber's comment was inappropriate, Natalie's response was also unprofessional. Katie reinforces to Natalie the importance of professional communication at all times and reviews the communication points she had provided to Natalie in the past. She also informs Natalie that she will have a written warning placed in her personnel file. Natalie apologizes for her actions and assures Katie she will work on her communication skills. Katie documents the incident and follow-up action in Natalie's personnel file.

Termination

Termination is a serious and difficult management responsibility with emotional, legal and financial consequences. **Termination** is the process that ends employment. Since it often becomes a part of the permanent record, it must be conducted carefully, objectively without emotion, and in concert with hospital policy. Termination without due process, with poor documentation, or outside of hospital policy can be fuel for an employee grievance or lawsuit. This section covers termination due to unresolved performance issues and not termination due to organizational downsizing. Though many of the steps may be similar, employees terminated due to downsizing may not have performance issues and may have benefits that require different conversations. As with a disciplinary action, nurse managers must maintain close contact with the organization's HR department and nursing administration. They must discuss the termination and seek approval for it.

Preparation before terminating an employee is essential. To prepare, consider the following:

- Review the employee file. Do you have a track record of documented conversations with the employee about the specific issues that are leading to termination?
- Do you give employees on the unit feedback on a regular basis?

- Are you being consistent in the application of performance standards against all employees in your span of control?
- Did you offer remediation or coaching to address the performance issues?
- How might the employee challenge the termination? Prepare for the challenge.
- Is your supervisor aware of and behind your decision to terminate? Is human resources aware of and behind your decision to terminate?

Each organization will vary in what it does during and after termination. Generally, employee access to email and any internal intranet web access is stopped during or immediately before the interview. The ID badge and any hospital-sensitive entry cards or keys are collected. The manager may accompany the staff member to the staff member's locker to collect personal items and then escort the terminated employee out of the building, or the employee may be escorted by a member of human resources or hospital security. Regardless of the reason for termination, this is usually a devastating event for the employee, and it should be conducted firmly but with compassion. When the staff member leaves the building, the manager must document the incident and the reaction of the staff member in the personnel file. (See Box 20-5.)

Box 20-5 Suggested Script for a Termination Conversation

Manager: Lucy, we are here today to have the conversation I told you we would be having about your attendance. I'm not confident in your ability to be successful in your position. We're going to go over the details of repeated absences. We've talked about each one of them. Do you have any questions before I begin?

On March 13, you received a written warning for your attendance. Since then, you have accumulated the following unscheduled absences: March 17, you missed work because of car problems. Then on May 2, you didn't report to work because you said you forgot you were working, and then refused to come in. You have now accumulated eight incidents of unscheduled absence this year. Our hospital attendance policy states that the hospital relies on employees being dependable to take excellent care of patients and that when employee attendance interrupts the ability to provide excellent care, we must advance the corrective action process. At our hospital, eight absences in a 12-month period is considered an unacceptable, very serious violation of our hospital's policy.

Prior to today, you received a verbal warning and a written warning regarding your attendance. At the time of your verbal warning, you had accumulated the following unscheduled absences: August 23, last year, you missed your shift at work, stating you had a family issue. September 8, you missed work, stating you were ill. September 24, you called in reporting GI illness and did not come to work. November 20, you called in to work reporting you had overslept and wouldn't be reporting to work.

On November 25, you were given a verbal warning concerning your attendance. A copy of the policy was given to you at that time, your absences were reviewed, and you acknowledged that you understood you should not miss more work unplanned.

You continued to accumulate unscheduled absences and were given a written warning on February 1. These absences included the following: On December 16, you called in to work reporting a scheduling conflict. On January 27, you called in and said you had a cold and weren't coming to work.

In addition to your verbal and written warnings, I spoke with you on other occasions as well to remind you about the attendance policy and the seriousness of your current attendance situation. You have continued to accumulate absences and have seriously violated the attendance policy despite multiple attempts at coaching. Therefore, today, May 3, your employment is terminated. Human resources is here with us to provide you with all information on your benefits and retirement fund, and to answer any questions you have.

What You Know Now

1. Feedback is the regular practice of helping employees evaluate and improve their performance. It is a management obligation. Staff should be encouraged to seek feedback on a regular basis.
2. Coaching goes hand in hand with feedback and provides the support to improve performance.
3. Confrontation is the process of addressing consistent, unrelenting behavioral issues.
4. Discipline is a consequence of poor performance. It is a management tool that is challenging to use but essential in order to improve the quality of professional practice, patient care, and the health of the workplace.
5. Progressive discipline is the orderly process of an organization, according to policy, and usually includes an oral warning, formal verbal warning, and written warning, and it may end in termination of employment.
6. Termination of employment is a serious management act that should be conducted in concert with hospital policy and with the support of nursing administration and human resources.

Tools for Feedback and Coaching, Disciplining and Terminating Staff

1. Successful feedback is:
   a. Timely and ongoing.
   b. Goal referenced.
   c. Positive as well as constructive.
   d. Respectful and encourages reflection.
2. For coaching to be effective, the nurse must be ready, willing, and able to learn.
3. To conduct an interview that involves discipline:
   a. Be prepared. Have your notes in order. Be poised and calm.
   b. Ensure privacy of the dialogue.
   c. Get both sides of the story.
   d. Keep the focus on the behavior, not the person.
   e. Arrange for follow-up. Keep your supervisor and HR in the loop.
   f. Document the conversation.
4. To prepare for a termination:
   a. Work with your supervisor and administration to verify the documentation, determine how equitable the situation is being managed, and be consistent in the application of policies and procedures.
   b. Be prepared, calm, and poised. In a private location, state the behavior of concern and review the documentation of behavior. Explain the termination process.
   c. Follow hospital procedure in the exit of the employee.
   d. Document the interview and follow up with your supervisor and human resources.

Questions to Challenge You

1. Have you ever received career-changing feedback? How was it delivered? How did it change you?
2. What do think might be your personal challenges in disciplining and terminating staff?
3. Select a situation regarding feedback, discipline, or termination and role play with a trusted and experienced colleague how you would manage it.
4. Do you ask for feedback about your performance on a regular basis? Why is that important?

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Chapter 21

Managing Absenteeism, Reducing Turnover, Retaining Staff

Absenteeism

A Model of Employee Attendance
Managing Employee Absenteeism
Absenteeism Policies
Selecting Employees and Monitoring Absenteeism
Family and Medical Leave

Reducing Turnover

Cost of Nursing Turnover
Causes of Turnover
Understanding Voluntary Turnover

Retaining Staff

Job Satisfaction
Improving Salaries
Retention Strategies

Learning Outcomes

After completing this chapter, you will be able to:

1. Explain absenteeism and how to manage it.
2. Describe how nursing turnover affects the organization.
3. Examine what organizations can do to improve retention of nurses.

Key Terms

absence culture
absence frequency
attendance barriers
engagement
involuntary absenteeism
involuntary turnover
retention
salary compression
total time lost
turnover
voluntary absenteeism
voluntary turnover

Introduction

Keeping higher-performing nurses is a priority in healthcare. Appropriate hiring decisions begin the process, but once employment begins, organizations can do much to ensure that they retain their best performers. Several methods of accomplishing this are mentoring, coaching, nurse residency programs, and clinical ladder advancement programs, which are discussed elsewhere in this text. In order to understand why nurses are absent or leave the organization, and to develop ways to retain them, it is necessary to consider absenteeism, turnover, and retention.

Absenteeism

Although the extent or the cost of nurse absenteeism is difficult to determine, it is well established that absenteeism in healthcare organizations is both pervasive and expensive. The costs of absenteeism, however, can also have a detrimental effect on the work lives of the other staff. Working shorthanded, especially for an extended period of time, can create both physical and mental strain. Even if temporary replacements are called in, the work flow of the unit will still be disrupted as hurried staff must take time to explain standard organizational procedures to replacement nurses.

A Model of Employee Attendance

To understand employee absenteeism, it is important to distinguish voluntary from involuntary absenteeism. For example, not coming to work in order to finish one's income taxes would be seen as **voluntary absenteeism** (i.e., absenteeism under the employee's control). In contrast, taking a sick day because of food poisoning would be considered **involuntary absenteeism** (i.e., largely outside of the employee's control). Although this distinction seems reasonable in theory, in practice it is often difficult to distinguish these two categories because of a lack of accurate information, as few employees will admit to abusing sick leave.

Some organizations try to distinguish voluntary from involuntary absenteeism by the way they measure absenteeism. Traditionally, healthcare organizations have measured absenteeism in terms of **total time lost** (i.e., the number of scheduled days an employee misses). Given that one long illness can drastically affect this absenteeism index, total time lost is clearly not a perfect measure of voluntary absenteeism. In contrast, **absence frequency** (i.e., the total number of distinct absence periods, regardless of their duration) is somewhat insensitive to one long illness.

This distinction between absence frequency and total time lost should make sense. For example, an employee who missed nine Mondays in a row would have nine absence frequency periods as well as nine total days absent. In contrast, a person who missed nine consecutive days of work would have nine total days lost but only one absence frequency period. Intuitively, it seems likely that the first individual was much more prone to being absent voluntarily than the second.

An employee's attendance at work is largely a function of two variables: the individual's ability to attend and motivation to attend as shown in Figure 21-1.

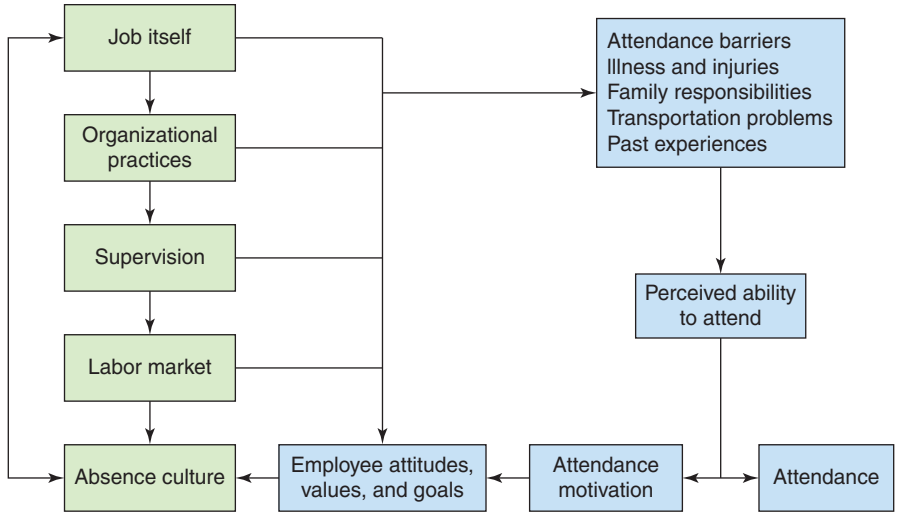

Figure 21-1 A diagnostic model of employee attendance.

As seen in Figure 21-1, an employee's ability to attend can be affected by such attendance barriers as the following:

- Personal illness or injury
- Family responsibilities (e.g., a sick child)
- Transportation problems (e.g., an unreliable automobile)

Although it is natural to view such barriers as resulting in involuntary absenteeism, sometimes this is too simplistic a judgment. For example, an employee whose car was not running may consciously have not made alternative arrangements to get to work the next day because he or she was not motivated to attend. This example illustrates that some of the distinctions portrayed in Figure 21-1 are not always clear-cut. In trying to understand employee absenteeism, a manager will have to make assumptions about why the behavior is occurring (e.g., a manager cannot be certain that a person was actually ill).

According to the attendance model, an employee's motivation to attend is affected by several factors: the job itself, organizational practices, the absence culture, generational differences, management, the labor market, and the employee's personal characteristics.

THE JOB ITSELF Employees holding more enriched jobs are less likely to be absent than those with more mundane jobs. An enriched job is one that engages many of an employee's abilities, provides a sense of meaning, and offers autonomy. Enriched jobs may increase attendance motivation because employees believe that what they are doing is important and they know that other employees are depending on the job holder (i.e., if the job holder does not do his or her job, other employees cannot do theirs).

The nature of a job also influences attendance through its potential for **attendance barriers** (i.e., illness and injuries). For example, a job that requires heavy lifting (e.g., moving patients from beds to stretchers) may increase the likelihood that a staff nurse will be injured. Similarly, a job that exposes a nurse to patients with highly contagious conditions, such as in an outpatient clinic, may increase the likelihood of illness.

ORGANIZATIONAL PRACTICES As portrayed in Figure 21-1, organizational practices can also influence attendance motivation. Some healthcare organizations have absence control policies that reward employees for good attendance, punish them for excessive absenteeism, or both. An organization may also be able to increase attendance motivation by carefully recruiting and selecting employees. In addition to affecting attendance motivation, organizational practices may influence an employee's ability to attend. Organizational activities, such as offering wellness programs, employee assistance programs, van pools, on-site child care, or coordinating car pools can influence an employee's ability to attend work.

ABSENCE CULTURE The **absence culture** of a work unit (or an organization)—the general attitude toward and tolerance of absenteeism—can also influence employee attendance motivation. Some work units have an absence culture that reflects a tolerance for absenteeism; other units have a culture in which being absent is frowned upon. Although an organization's absence culture can be affected by organizational practices (e.g., attendance policies) and the nature of the jobs involved (e.g., people in higher-level jobs tend to be less accepting of coworkers calling in sick), it is also affected by informal norms that develop among work-group members. For example, people in a cohesive work group may develop an understanding that missing work, except for an emergency or a serious illness, is unacceptable. Such an attendance culture is likely to emerge if the employees work in jobs that they see as important (e.g., providing direct patient care) and if an employee's being absent causes a hardship for coworkers (e.g., forced overtime, being called in on a day off).

GENERATIONAL DIFFERENCES Today's workforce includes nurses from three generations, and each cohort (baby boomers; generation X; and generation Y, also known as millennials) has different expectations in the workplace (Dols, Landrum, & Wieck, 2010). Generation Z (teenagers in grades 7 through 12) will soon join these older cohorts (Levit, 2015).

Older nurses may resent the younger ones, especially their technology skills and their lower need for social interaction. Here is an example:

> *Kirsten McNamara is 24 years old. She spends her lunch break relaxing and returning text and email messages on her phone while she eats; she uses the quiet time to rejuvenate. Her older coworkers are offended and complain that she was "on her phone and rude" the entire lunch hour.*

Generational differences affect **retention** as well. Generation X and Y nurses want challenging careers that offer opportunities for growth and advancement as well as time for lives outside of work. Flexible schedules and time off are valued by these cohorts, and organizations can expect high turnover if these expectations are not met (Edge et. al., 2011).

Expectations of the younger generational cohorts affect supervision as well. They expect independence and to be involved in decision making (Farag, Tullai-McGuinness, & Anthony, 2009). Thus, shared governance is an appropriate structure, and consultation is an effective management strategy.

MANAGEMENT Management can also influence attendance motivation of all staff. A nurse manager can influence the nature of a staff nurse's job (e.g., the degree of responsibility given and participation in decision making), decisions about personnel, the consistency with which organizational practices are applied (e.g., whether

sanctions are enforced for abuse of sick leave), and—by stressing the importance of good attendance—a work unit's absence culture.

A shared governance organizational model encourages attendance because of the emphasis on cooperative decision making. The manager who consults frequently with staff supports this model. Knowing that their input is valuable to the unit's functioning promotes participation and, thus, attendance.

LABOR MARKET Another factor that influences attendance is the labor market. If the nurse believes that plenty of equivalent jobs are available locally, he or she might be less motivated to attend than if fewer jobs were available.

To the extent that the local employment market for nurses leads an employee to perceive it would be easy to find an equivalent job if she or he lost or disliked the current one, one would expect a lower level of attendance motivation than if market conditions were less favorable. This might happen during a nursing shortage.

PERSONAL CHARACTERISTICS Although features of the job itself, organizational practices, absence culture, generational differences, supervision, and the labor market can all have a direct effect on employee attendance motivation, these factors can also interact with an employee's attitudes (e.g., job satisfaction), values (e.g., personal work ethic), or goals (e.g., desire to get promoted). If a person who seeks variety works in a job that does not provide it, the employee may become dissatisfied and thus more likely to abuse sick leave.

The reverse is also true. Employees' attitudes, values, and goals can also have a direct effect on attendance motivation. For example, a staff nurse with a high personal work ethic or a goal of getting promoted should be more highly motivated to attend work than a nurse who lacks such a work ethic.

An employee's attendance behavior is also influenced by past experiences. For example, if an employee's perfect attendance in the previous year was not recognized, we might expect the employee's attendance motivation to decrease in the coming year. Conversely, if a coworker with an outstanding attendance record received a promotion, peers who value a promotion and who witnessed this link between performance and reward would be more motivated to attend work in the upcoming year.

Managing Employee Absenteeism

The attendance model in Figure 21-1 is useful not only for understanding why absenteeism occurs, but also for developing strategies to control it. Some causes of absenteeism, such as transportation difficulties or child care problems, may be beyond the control of the organization.

To diagnose the key factors leading to absenteeism, the organization needs information from several sources, including staff, the human resources department, other nurse managers, and administration. Absence patterns can answer such questions as the following:

- Is absenteeism equally distributed across all nurses?
- In comparison to other units, does your area of responsibility have a high absenteeism rate?
- Are most absences of short or long duration?
- Does the absenteeism have a consistent pattern (e.g., occur predominantly on weekends or shortly before a person quits)?

Clearly, the best way for nurse managers to control absenteeism is by encouraging their staff's motivation to attend, including the following:

- Enriching the staff nurse's job by increasing its responsibility, variety, or challenge
- Reducing job stress (e.g., by providing timely and more concrete information)
- Creating a norm of excellent attendance (e.g., by emphasizing the negative impact of a nurse not coming to work)
- Enhancing advancement opportunities (e.g., by providing developmental experiences so that the best employees are promotable)
- Improving coworker relations (e.g., by considering coworker compatibility when scheduling work and/or creating work teams)
- Trying to select employees who will be satisfied with and committed to their jobs
- Being a good role model by rarely taking sick days
- Discussing the employee's attendance during the performance appraisal interview
- Rewarding good attendance with salary increases and other rewards
- Enforcing absenteeism control policies (e.g., carrying through on employee discipline when there is an attendance problem)

Absenteeism Policies

Most organizational policies allow employees to accrue paid sick days—typically, one sick day for every month employed. Unused sick days accrue across time to some maximum number (e.g., 60 days). Typically, if an employee leaves the organization with accumulated sick leave or days above the maximum, the person simply loses them.

Although such a policy may seem reasonable, it may actually encourage unwanted behavior. For example, once a nurse has reached the maximum limit for accrued sick days, the person may see no reason for not using sick days that would otherwise be lost. Such a policy also encourages employees who know they will be leaving the organization (e.g., those about to retire or change jobs) to use accumulated sick leave.

An innovative approach for managing absenteeism is substituting personal days for unused sick days. Two problems arise if personal days are not given: Employees are forced to lie (i.e., say they are sick when they are not) to carry out what they see as legitimate activities (e.g., attending a conference with their child's teacher), and their manager has no warning and therefore may have difficulty covering for the absent employee.

By substituting personal days for sick days, the employee no longer has to lie, and the nurse manager may have time to plan for a replacement. In moving to a policy that incorporates the use of personal days, an organization typically allocates fewer paid sick days but adds personal days. For example, instead of 12 sick days, an employee may annually receive 9 sick days and 3 personal days. With the availability of personal days, a staff nurse can inform the manager in advance of the need for a personal day off. In many cases, the two of them can arrive at a day off that is optimal for both of them.

Realizing that they have not been motivating good attendance, some progressive organizations have allowed sick days to accumulate without an upper limit. Then, when an employee leaves the organization, she or he is paid for unused sick days

(e.g., one-half of a day's pay for each unused sick day). Other organizations allow retiring employees to add unused sick days to days worked. Still other organizations have paid employees for their sick days, or allowed the conversion of sick days to vacation days or additional pay.

Selecting Employees and Monitoring Absenteeism

Controlling absenteeism begins with recruitment. Given a realistic job preview, a new hire will be aware of the job characteristics and employer expectations. Similarly, basing merit pay and advancement opportunities on an employee's overall performance appraisal rating (which is partly based on attendance) will motivate better attendance.

Strategies for dealing with employees with excessive absences include the following:

- Set expectations with each new employee. Give her or him the attendance policy in writing, and clarify any questions.
- Monitor each individual's attendance, and document it.
- Intervene early and consistently, coaching and dealing with policy or procedure violations as appropriate.
- Be sure to reward staff who have good attendance. Ensure any organizational rewards are delivered, and give your personal reward through feedback in performance appraisals.
- Be a role model for good attendance yourself.

Family and Medical Leave

The Family and Medical Leave Act (FMLA) took effect in 1993 and has been amended by federal statute as well as court decisions (U.S. Department of Labor, 2011). Under this act, all public employers (federal, state, and local) and all private employers employing 50 or more individuals must provide their eligible employees with leave of up to 12 weeks during any 12-month period for the employee's own serious illness, the birth or adoption of a child, the placement of a foster child into the household, or the care of a seriously ill child, spouse, or parent.

Employees are eligible to take leave if they meet the following conditions:

- Have worked for the employer for at least 12 months
- Have worked at least 1,250 hours during the previous 12 months
- Are at a work site with 50 or more employees, or at a site where 50 workers are employed within 75 miles of the work site (50 employees/75 miles rule).

The FMLA also allows eligible employees to maintain health insurance coverage while on leave and allows them to return to the same or equivalent position at the end of the leave period. The leave may be taken all at once, intermittently, or by working a reduced work schedule, if available. The employee must be allowed to take leave for qualified purposes without pressure or discouragement by the employer or manager. More generous collective bargaining agreements or state laws supersede the FMLA, but the FMLA supersedes any inconsistent or less generous provisions. FMLA may run concurrently with other leaves, including state workers' compensation leave.

Reducing Turnover

Closely related to absenteeism is employee **turnover**, the number of staff members who vacate a position. Reducing turnover begins with recruitment and selection and continues with motivation and development of staff. Retaining both experienced nurses and new graduates is essential (Hill et al., 2010; Hirschkorn, West, Hill, Cleary, & Hewlett, 2010).

Cost of Nursing Turnover

Two interrelated factors affect the nurse turnover rate: market opportunities and the economy. When the economy is robust, healthcare organizations tend to hire more staff; during a recession, the hospital may cut staff or leave positions vacant. At the same time, nurses are more apt to stay in a position if the economy is poor or if few other opportunities exist (Healthcare Association of New York State, 2010).

Data from a national survey in 2009 found that turnover rates that year (7.1%) had declined from the 10.1% of the previous year (Healthcare Association of New York State, 2010). The surveyors attributed the change to the poor economy and the lack of opportunities.

Given the expense in hiring a new nurse (e.g., recruiting, selection, orientation, on-the-job training) and temporarily replacing a nurse who quits or is fired (e.g., paying other nurses to work overtime or filling the vacancy with a temporary replacement), the costs are sizable (Oyeleye, Hanson, O'Connor, & Dunn, 2013). Thus, nursing turnover must be understood better and controlled more effectively.

Turnover has been thought of in simplistic terms and seen as universally negative. Such a primitive view of turnover is not helpful to organizations as they attempt to deal with this costly problem. Rather, varieties of turnover need to be differentiated:

- Did the employee leave of her or his own accord, or was the person asked to leave?
- Was the departed individual's performance exceptional or mediocre?
- Did the employee leave for career development (e.g., return to school) or because of dissatisfaction with the organization?
- Will the departed nurse be easy or difficult to replace?

Turnover has consequences that go far beyond direct dollar costs. Turnover can have a number of repercussions among other nurses who worked with the departed nurse. Those others may have to work longer hours or simply work harder to cover for a departed nurse; this can cause both physical and mental strain, and may result in additional departures. Thus, departed nurses may begin a cycle of nurses leaving, resulting in a turnover spiral. If temporary replacements are used, problems still can result as the work flow of the unit is disturbed, and communication patterns within the unit are disrupted.

Turnover is not always undesirable. Anyone with work experience can remember some individual (e.g., coworker, administrator) whose departure would have improved the organization's functioning significantly. Furthermore, what may be seen as a desirable departure by some (e.g., the nurse manager) may be viewed as a loss by others (e.g., a subset of coworkers). If the departed nurse was a poor performer, performance may improve. Recently hired staff may be more enthusiastic, long-running conflicts between people may be reduced or eliminated, or administration may be challenged to improve the work environment.

Causes of Turnover

Before turnover can be managed, its causes must be understood. **Voluntary turnover** occurs when an employee chooses to leave an organization, which for many reasons can occur (e.g., a better job, moving). Termination of employment by the employer is called **involuntary turnover**. This can occur because of poor performance by the employee, a change in organizational structure, or staff cuts. If an organization finds a significant amount of involuntary turnover (i.e., employees being terminated), then it needs to carefully examine the way it recruits, selects, motivates, and develops employees.

Understanding Voluntary Turnover

Traditionally, organizations have attempted to determine the reasons for voluntary turnover through two sources: by asking the exiting employee's supervisor why the employee is leaving, and by an exit interview with the departing employee conducted by someone in the human resources department.

Such an approach for determining the cause of voluntary turnover is certainly straightforward, but departing employees may not give honest answers in their exit interviews because they know that future employers will ask for references. Thus, exiting employees may provide safe responses (e.g., "a better opportunity came along") during an exit interview.

Although this tendency for departing employees to make safe responses is understandable, it makes it difficult to determine why turnover is occurring. Surveys sent to former employees several weeks after they have resigned may be more useful. Former employees need to be assured that their responses will not influence any future reference information furnished about them but, rather, will be used only to help the organization identify the reasons why nurses are leaving. Another way to attempt to discover the cause of nurse turnover is to conduct interviews with the former employee's coworkers, who often know why an employee left.

The goal should be to reduce voluntary turnover. The manager's first opportunity to reduce turnover is when the decision to hire is made. An individual's length of stay at past employers is an indication of how long the person could be expected to stay on a new job.

Turnover is a direct function of a nurse's perceptions of both the ease and the desirability of leaving the organization. Perceived ease of movement depends on the nurse's personal characteristics, such as the following:

- Education
- Area of specialization
- Age
- Geographic mobility
- Contacts at other hospitals
- Transportation

External forces also have an effect on ease of movement, such as the following:

- Job openings at other organizations
- Non-healthcare organizations hiring nurses for nursing or non-nursing positions
- The economy

As with ease of movement, perceptions of the desirability of movement can be affected by several factors. One is the opportunity for movement within the organization. If other positions exist within the organization, the less turnover there should be—that is, a nurse may be able to leave the current position by means of a lateral transfer, promotion, or demotion. For example, a nurse who is having problems with a coworker may be able to transfer to a new unit rather than leave the organization.

Turnover and employee absenteeism have been referred to as withdrawal behaviors because they allow an employee to leave the workplace, in one case temporarily and, in the other, permanently. In many cases, these withdrawal behaviors share a common cause: job dissatisfaction.

Retaining Staff

Job satisfaction is a key component to retaining staff (Wisotzkey, 2011). Job satisfaction is affected by various facets of the work environment, including the following:

- Relationships with the nurse manager, other staff nurses and unit employees, patients, and physicians
- Shift worked (e.g., day versus evening, rotating versus fixed)
- Fit between nurse values and institutional culture
- Expectations of practice setting
- Compensation level
- Equal and fair distribution of rewards and punishments

Job Satisfaction

Numerous factors affect job satisfaction for nurses. Patients' satisfaction with their care, nurses' commitment to their colleagues and the organization, and environmental conditions all affect nurses' satisfaction with their jobs.

PATIENT SATISFACTION Patient satisfaction was found to be linked to nurses' job satisfaction in a survey of more than 95,000 nurses (McHugh, Kutney-Lee, Cimiotti, Sloane, & Aiken, 2011). Nurses employed in Magnet hospitals report significantly higher job satisfaction scores than nurses employed in non-Magnet hospitals (Kelly, McHugh, & Aiken, 2011). Employee engagement was found to be correlated with employee retention as well as patient satisfaction (McHugh et al., 2011).

EMPLOYEE ENGAGEMENT Rivera, Fitzpatrick, and Boyle (2011) studied factors that affect employee **engagement**, or the degree to which an employee is inspired by, willing to invest effort for, likely to recommend, and plans to remain in an organization. These factors were control over practice, professional development and growth, teamwork, and nurse–physician collaboration. The least important factors related to engagement were salary and benefits, a finding supported in McHugh et al. (2011). The implications suggest that an organizational structure which encourages staff input, frequent communication and attention to problems as soon as they occur, and development opportunities encourages employee engagement.

HEALTHY WORK ENVIRONMENT A healthy work environment increases nurse job satisfaction, a necessary condition for retaining nurses (Paris & Terhaar, 2011; Weston, 2010). Environmental factors can improve job satisfaction and reduce the intention to leave. Such factors as noise, light, and odor affect environmental stress and contribute to nurses' dissatisfaction (Applebaum, Fowler, Fiedler, Osinubi, & Robson, 2010).

The American Association of Critical Care Nurses (2016) established the following six criteria for a healthy work environment to "foster excellence in patient care" (p. 1):

- Skilled communication—This trait is as important as clinical skills.
- True collaboration—Collaboration exists between and among nurses and other healthcare professionals.
- Effective decision making—Nurses are involved as partners in making policy and leading organizations.
- Appropriate staffing—An effective match between patient needs and nurse competencies occurs.
- Meaningful recognition—Nurses are recognized for the value of their work.
- Authentic leadership—Leaders embrace, live, and engage others in the process.

Leading at the Bedside: Supporting Your Organization

As a staff nurse, you affect how your hospital, clinic, or agency maintains an adequate number of employees to care for patients. Your own attendance, your encouragement of others, and your support for the unit and organization all contribute to how well the organization functions and, thus, its ability to care for and support patients, families, and, even, you. On the other hand, if you engage in gossip or encourage others' complaints, but do nothing to solve problems or take the problem to the appropriate person, you are undermining the organization's ability to function. You may not realize that you have that much power, but as the largest group of employees in a healthcare organization, nurses have the power to support or undermine an organization.

Respect yourself, your colleagues, and your organization.

Improving Salaries

As the largest group of healthcare professionals, nurses' wages account for the majority of an organization's salary budget. It is reasonable (although not cost-effective) that organizations imagine they can reduce expenses by constraining nurses' salaries or allowing open positions to go unfilled. Thus, nurses employed for many years find their salaries only slightly greater than (or even less than) nurses with only a few years of experience. This effect is known as **salary compression**. Paying new nurses a higher starting salary, or rewarding those with fewer years of experience with higher increases, results in the salaries of long-term employees being at or below those of less-experienced nurses.

Sign-on bonuses and loan-forgiveness programs, for example, are strategies used to attract new graduates. They are, however, only quick fixes that serve to disadvantage already employed nurses whose salary ceilings remain fixed. Pay scales, however, can be reconfigured to reflect achievement and accomplishment.

Retention Strategies

To retain nurses, the Children's Hospital of Philadelphia implemented the following five strategies that reduced turnover by 91% (Hinson & Spatz, 2011):

- On-boarding—This process welcomed new hires to the organization and the unit.
- Employee rounding—Weekly rounds with team leaders and monthly rounds with administrators were made to identify and resolve problems.
- Social networking—Team-building social events encouraged and developed relationships among staff members.
- Employee recognition—Notices were distributed and events held to commend exceptional performance and achievements.
- "Stretch" assignments—Specific activities based on an employee's proposal were designed to help the employee reach career goals.

RECOGNIZING STAFF PERFORMANCE Recognizing the contributions of staff is not necessarily expensive or time-consuming. Some strategies, such as the following, can be integrated into the everyday managing of staff:

- Provide personalized, immediate feedback for a job well done.
- Write a personal note acknowledging an employee's good performance. Leave it in the employee's mailbox or mail it to a home address.
- Publicly recognize an employee's good performance—at a staff meeting, in an email to all, with kudos on the unit bulletin board.
- Encourage staff to post notes on the bulletin board to thank a coworker for a great job or to recognize a peer for impressive work with a patient.
- Design a bulletin board to highlight one employee. Change it every 2 weeks or once per month. The employee can bring in personal and family photos as well as post facts about them. This facilitates employee recognition and a sense of camaraderie as employees get to know each other better.

Examples of low-cost and formal rewards for staff are shown in Box 21-1.

ADDITIONAL RETENTION STRATEGIES In addition to creating a healthy work environment, making salary adjustments, and recognizing staff, managers can use several other strategies to retain valued employees in the organization, including providing realistic job previews to new hires, facilitating movement within the organization, and, if necessary, adapting to the turnover rate.

Provide Realistic Job Preview and Follow-up. Retaining nurses begins with the interview, when the manager has an opportunity to present the job realistically. Retention continues with orientation and socialization of the new nurse to the unit (Hatler, Stoffers, Kelly, Redding, & Carr, 2011). Both clinical advancement programs and preceptorships have been found to improve retention (Allen, Fiorini, & Dickey, 2010).

Facilitate Intraorganizational Movement. If a staff nurse is "burned out" from working at a difficult job, such as on an oncology floor, one option is to allow a transfer to another service area in the organization (e.g., home care). Unfortunately, some managers hinder or even prohibit such a transfer, due to not wanting to lose a good nurse, particularly if the potential transferee is an excellent performer. However, this perspective is

Box 21-1 Rewarding Employees

Low-Cost Rewards for Employees

- Allow staff to have a half day, whole day, or Friday off for excellent performance by flexing hours and completing hours for a week in fewer days. For example, allow an employee to choose four 10-hour shifts one week as a treat instead of five 8-hour days.
- Give magazine subscriptions.
- Have a monthly birthday celebration potluck to recognize all employees with a birthday that month—rotate the theme for different kinds of food/activities.
- Initiate an employee-of-the-month program—reward the employee with a gift card, certificate of recognition, or some other small gift.
- Start a newsletter and devote a section to describing excellent employee performance and including staff kudos to one another.

Formal Rewards for Employees

- Give awards for perfect attendance, patient advocate, clinical leader, expert nurse, most cost-effective, for example. Present the awards at a hosted annual awards banquet, with food and formal recognition.
- Start a reward points system in which employees earn points for great customer service and teamwork. Make a "treat box" that contains small gift items such as snacks, pens, or notepads, for example. Assign a point value to each gift item and let staff accumulate points. Staff can then "buy" items with their points.
- Provide continuing education opportunities presented by physician sponsors or nurses from the community. Start a program that gives staff the opportunity to take time off to attend an educational offering once per year or a set number of times as determined by the group.
- Help with tuition reimbursement for continuing education.
- Give customer service awards based on years of service.

shortsighted. If the staff nurse cannot transfer to another area (intraorganizational mobility), she or he may leave the organization entirely (interorganizational mobility).

One nurse manager decreased voluntary turnover on her unit without incurring additional costs (see Case Study 21-1).

CASE STUDY 21-1 | Retention

Mona Karnes is nurse manager of labor and delivery at a suburban hospital. Over the past 12 months, the voluntary turnover rate among full-time RNs has been 25% for her unit and 15% for the hospital as a whole. Despite increasing starting salary rates and offering signing bonuses, turnover rates have remained high. Administration recently conducted an annual salary and benefits review.

Mona collected information from the exit interviews conducted during the annual review. From these data, Mona has developed three strategies to aid in retention for her unit:

1. Rotate leadership responsibilities on the unit to offer all nurses the opportunity to develop leadership and management skills. These responsibilities currently include a weekly charge nurse role for each shift, education committee chair, physician relations liaison, women's health service line representative, and information technology representative. Other leadership roles will be added as appropriate.
2. Survey staff to determine interests and strengths and connect staff members with a mentor. For example, Debbie Edwards, RN, enjoys developing patient education modules. Debbie will work with Heather Adams, new nurse graduate, to develop Heather's patient education skills.
3. Schedule free monthly CEU offerings during staff meetings that are presented by staff members, physicians, or pharmaceutical company representatives. By attending monthly staff meetings, most RNs will complete 90% of state-required CEUs for license renewal.

All three strategies are at no cost to the unit or hospital. After 6 months, the voluntary turnover rate on Mona's unit had decreased to 8%.

Adapt to Turnover Rate. Sometimes the organization may simply need to adapt to a high turnover rate. Even if this is the case, potential problems can be lessened in two ways:

1. ***Manage beliefs about why a nurse left.*** Sometimes, the reason is unclear, and the grapevine will often provide an inaccurate and less attractive reason from the organization's perspective (e.g., "He left for $1.05 more an hour at another institution").
2. ***Provide human resources with a preferred list of replacement workers.*** Some organizations keep an up-to-date list of former nurses who will fill in on an occasional basis. Such former employees are familiar with organizational procedures and can handle the work more efficiently.

The strategies outlined in this chapter have been shown to be effective in addressing absenteeism and reducing turnover. However, not all are equally applicable to all situations. Situational factors determine what is appropriate. For example, flexible work hours may be suitable for a clinic but not for an around-the-clock operation. By being creative and providing incentives for exceptional nurses to stay and doing less to retain mediocre nurses, nurse managers not only can reduce absenteeism and turnover but also can influence nurses' attendance and which nurses leave.

What You Know Now

- Employee attendance is affected by the job, organizational practices, absence culture, generational differences, labor market, management, and employee characteristics.
- Innovative solutions to absenteeism problems include substituting personal days for sick days, allowing sick days to accrue and unused days to be paid to the employee, or converting unused sick days to paid days at retirement.
- Turnover may be voluntary or involuntary, but it is always costly to the organization.
- Many factors cause voluntary turnover, including job dissatisfaction, undesirable work environment, and ease of movement.
- Organizations can help retain nurses by promoting job satisfaction, encouraging employee engagement, providing healthy work environments, improving salaries, and recognizing performance.
- Managers can help reduce turnover by providing realistic job previews and follow-up, and facilitating intraorganizational movement, but they may have to adapt to turnover rate.

Tools for Reducing Turnover, Retaining Staff

1. Become familiar with your organization's policies on employee attendance.
2. Identify attendance problems and monitor them, if necessary.
3. Monitor turnover and evaluate the causes.
4. Provide realistic job previews to new hires, especially new graduates.
5. Monitor new graduates' performance and offer additional support and training as needed.
6. Consider ways to improve the work environment.

Questions to Challenge You

1. What suggestions do you have to reduce absenteeism in your school or workplace?
2. Can you recall instances when an employee's leaving has benefited the organization? Describe what happened.
3. Have you voluntarily left a job?
   a. What was the reason? Was there more than one reason?
   b. What reason did you give your supervisor?
   c. Was it the same rationale that you answered in part a of this question?
4. In addition to ideas presented in this chapter, can you think of other ways to reduce voluntary turnover?
5. Have you seen managers be effective in retaining staff? What did they do that worked especially well?
6. If you were a manager, what specific actions would you take to retain staff?

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Chapter 22
Dealing with Disruptive Staff Problems

Harassing Behaviors
Bullying
Lack of Civility
Horizontal Violence

How to Handle Problem Behaviors
Marginal Employees
Disgruntled Employees

The Employee with a Substance Abuse Problem
State Board of Nursing
Strategies for Intervention
Reentry
The Americans with Disabilities Act and Substance Abuse

Learning Outcomes

After completing this chapter, you will be able to:

1. Identify harassing behaviors, including bullying, incivility, and horizontal violence.
2. Describe strategies to manage staff with problem behaviors.
3. Explain how to handle staff with a substance abuse problem.

Key Terms

horizontal violence

marginal employees

Introduction

A major challenge confronting managers today is improving individual performance and productivity while also enhancing the efforts of the entire work group. Some of the general techniques for enhancing performance are ineffective because individual problems affect group functioning.

Harassing Behaviors

Harassing behaviors include bullying, lack of civility, and horizontal violence. All of these behaviors affect staff and the functioning of the healthcare setting.

Bullying

Bullying in healthcare threatens not only the victim (the "target") but also poses a danger to patients (Stokowski, 2010). Furthermore, bullying increases staff dissatisfaction and can lead to absenteeism and turnover (Wilson, Diedrich, Phelps, & Choi, 2011). Called bullying, incivility, verbal abuse, relational aggression, or horizontal violence, all such behaviors are examples of bullying (Dellasega, Volpe, Edmonson, & Hopkins, 2014).

Bullying can occur online, via text messages, or in person. Bullies use words and nonverbal behaviors, and they sometimes involve other people, as with gossiping. Bullying behaviors can range from mildly irritating to dangerously violent (Stokowski, 2010). The following are some examples:

- Ignoring someone or giving the silent treatment
- Treating someone in a condescending or patronizing manner
- Making derogatory remarks about someone within that person's hearing
- Using dismissive body language, such as eye rolling
- Ridiculing and using sarcasm
- Verbally abusing someone
- Scapegoating someone
- Isolating the target
- Failing to assist
- Sexually harassing
- Physically attacking

Policy efforts to combat bullying in healthcare settings have been launched by the Joint Commission and the American Nurses Association. Joint Commission recommends zero tolerance of disruptive or abusive behavior (Joint Commission, 2015). The American Nurses Association (ANA) recommends strategies to combat hostility, abuse, and bullying in the workplace (American Nurses Association, 2010).

Several states are considering healthy workplace bills that would allow workers to sue for harm from abusive treatment (Stokowski, 2010). As widespread reports of abuse surface, it is hoped that swift legal action will offer redress for victims (Sullivan, 2013).

Lack of Civility

At times, an instance of bullying is not so obvious. Lack of civility is an example. Uncivil behavior creates an environment that also endangers patients (Covell, 2010). Lack of civility includes any of the following behaviors:

- Rude
- Disrespectful
- Impolite
- Ill-mannered

Aggressive behaviors, such as the following, are also forms of bullying:

- Yelling
- Swearing
- Spreading rumors
- Destroying or taking another's property

Here's an example:

Reid Martin, nurse manger, has encouraged new graduate nurse Joy Gabriel to develop an informational presentation for a staff meeting as a strategy to improve her self-confidence. At the next monthly staff meeting, Joy presents information about a new occlusive dressing. Joy is shy, and public speaking is difficult for her. Her voice shakes, and she drops the box of new dressings she has brought to demonstrate. Kristi Sanderson, RN, has been rolling her eyes and sighing loudly throughout Joy's presentation. At the end of the meeting, Kristi makes a point of telling several other staff members that it was "painful" to sit through Joy's presentation. Joy overhears Kristi's comments.

This example is a situation that does not quite rise to the level of bullying. Nonetheless, the manager must confront Kristi and explain why nonverbal signals are inappropriate. Kristi must be also told that even softly voiced criticisms will not be tolerated. Following the suggestions on coaching and progressive discipline, the manager must explain the consequences for repeated instances of discourtesy to her fellow staff members and insist that Kristi conduct herself in a civil manner. The manager also followed up with Joy and shared that her presentation was excellent and apologized for the inappropriate comments. The manager told Joy that the issue was being handled so another staff member would not face such uncivil behavior in the future.

Horizontal Violence

Another example of the complexity of bullying is **horizontal violence**, or harassment between employees of equal rank. See the following example:

Jeana Rossi, RN, is a staff nurse on a medical unit. At 0700, she took over care for five patients from Greg Robeson, RN, an agency nurse who had worked the 7p—7a shift. During her review of patient medication administration records, Jeana noted that an IV antibiotic scheduled to be administered at 2300 had not been charted. Checking the IV bin, Jeana found the 2300 dose. Greg had already left the unit. Per hospital policy, Jeana completed a missing dose report and turned it in to her manager. Two days later, Greg cornered Jeana in the staff lounge and loudly berated her in front of other staff members for completing a missing dose report. "You're so stupid!" Greg shouted. "You just wanted to make me look bad, didn't you?"

This example shows how difficult some staff problems can be to manage. If you were the manager on this unit, how would you handle the situation? Here are some alternatives: The manager could report Greg to the agency and request that he no longer be assigned to the unit, but then a replacement must be found and the manager may have concerns about the competency of other nurses this agency might send. Remember, Greg was the only nurse on the night shift. The manager could also discuss the event with Greg and counsel him on violating hospital policy. In the end, the manager reported the situation to her supervisor and called the director of the agency, who

Leading at the Bedside: Solving Staff Problems

You've probably experienced problems in your school or workplace. You may have seen bullies disrupt a group's functioning, or had to do more because a marginal individual didn't do the job, or tried to ignore a disgruntled person. Sadly, you may have noticed someone impaired by alcohol or drugs in the workplace.

Probably you thought you could do nothing to change those individuals' behavior, but you can do more than you realize. Here's how: After checking the employee handbook for organizational policies on these problems, resolve to do all you can to help individuals and your workgroup.

Then if you see someone being harassed or bullied, speak up to the bully and/or a supervisor. Report a marginal employee's actions without judgment. Just state the facts. Do your best to ignore the disgruntled individual. Such people rely on listeners to validate their claims. Don't allow them that.

One note of caution: If you find a colleague impaired by alcohol or drugs at work, report that person immediately. Do not intervene yourself, but you cannot allow the person to continue to work in a healthcare setting. Allow a supervisor to handle this difficult situation.

Problems in the workplace are common, but many can be solved or ameliorated with careful attention to the problem and its solution.

assured the manager that the agency would provide a competent nurse for the next shift. Involving the supervisor is always indicated (see Leading at the Bedside: Solving Staff Problems).

The manager has a special duty to protect staff from bullying by others, to each other, or to students. Take every report of verbal aggression seriously, document events, and use the appropriate conflict strategy to resolve it. Left on its own, bullying is likely to continue and escalate. One caveat regarding bullying: If the situation becomes threatening, seek help immediately, preferably from security.

How to Handle Problem Behaviors

Here is another example of a complex staff problem.

> *The staff at the outpatient imaging center all share a common break room. Over the past several months, several staff members have complained to their nurse manager, Julie Fredrickson, that their lunches or particular items such as desserts or cans of soda are missing from the break room refrigerator. One afternoon, Julie enters the break room to get a cup a coffee and sees one of the radiologists, Dr. Gibson, eating a brownie and looking through several lunch bags. "I never get a chance to get out for lunch," Dr. Gibson said. "I'm sure your staff doesn't mind sharing with a hungry physician."*

If you were the nurse manager at this outpatient center, how would you handle this situation? Dr. Gibson was committing theft, even if the items he stole were inexpensive. Nonetheless, his behavior caused nurses to go without some of their own food, and, more important, it was disrespectful to them. It implied that he thought his needs were more important than theirs. When informed, the manager alerted his supervisor then confronted Dr. Gibson who, after threatening to report the manager to administration, calmed down, said he would donate pizza for the staff the next day, and agreed to stop stealing (yes, the manager used the word *stealing*).

Managers and nurses are faced with any number of other problems presented by employees, including staff who are marginally competent, perpetually complaining, verbally abusive, or lack civility in the workplace. Still others may have a substance-abuse problem.

Marginal Employees

Some staff, no matter how many times they are coached or disciplined, never seem to reach the level of competence expected of an experienced nurse. These are **marginal employees**. Work habits may be sloppy, communication skills poor, or decision making inadequate. Discipline does not help either in spite of the employee's attempts to improve.

Marginal employees present a unique challenge. Ignoring the problem and hoping that the employee will improve is generally ineffective. This also leaves the unit vulnerable to complaints from other staff who must cover for the marginal employee, and high-performing employees may be discouraged (Weston, 2009).

The organization's procedures for progressive discipline and termination must be followed if the problem behaviors do not improve. If the manager is persistent, fair, and consistent, employees are more likely to perceive the policies as just (Henle, Kohut, & Booth, 2009).

Disgruntled Employees

Disgruntled employees are those who are always complaining; their behavior affects morale on the unit. They complain about anything and everything, but they direct most of their complaints against the organization. They may air them in public, which can affect how others view the organization. Although the temptation is to label this as an attitude problem, complaining is a behavior and as such can be addressed by the following:

- Set standards of performance and communicate them to the employee.
- Keep notes about incidents of complaining in behavioral terms.
- Take action early, and be consistent among employees.
- Follow up as scheduled.

Case Study 22-1 describes one manager's experience with an employee with another problematic behavior.

The Employee with a Substance Abuse Problem

As substance abuse has become increasingly prevalent in society, nursing has not remained immune. Substance abuse not only is detrimental to the impaired nurse, but it also jeopardizes patients' care, thereby also exposing the employing agency to greater liability (Monroe, Vandoren, Smith, Cole, & Kenaga, 2011).

Early recognition of alcohol or drug dependency and prompt referral for treatment are essential. Some general signs and symptoms may become evident as a nurse's dependency progresses (Boxes 22-1 and 22-2).

In addition to the signs and symptoms listed in Boxes 22-1 and 22-2, the nurse manager should be alert for workplace indications of drug abuse as shown in Box 22-3.

CASE STUDY 22-1 | Problem Staff

Gene Marshall is the nurse manager for a general medical—surgical unit in a Veterans Affairs (VA) hospital. His busy unit primarily serves elderly male patients. Felicia Ralston, RN, has worked on the medical—surgical unit for 3 years. Since her hiring, Felicia has obtained several body piercings, including her nose, eyebrow, and tongue. She usually wears large hoops or bars in her facial piercings. Not long ago, Felicia added a visible tattoo to the back of her neck and upper shoulder. The tattoo on her lower back can often be seen despite her uniform. Recently, she came to work after adding purple highlights to her hair.

As the number and prominence of Felicia's piercings and body art have increased, several patients and their family members have told Gene that they were "uncomfortable" having Felicia as their nurse. Some patients feel intimidated by her unusual appearance. Gene speaks with Felicia about the patient and family member concerns and reviews the hospital's dress code with her. Felicia becomes angry and tells Gene that hair color, body piercings, and tattoos are a form of individual expression and have nothing to do with her performance as a nurse.

Later, Felicia tells everyone on the unit about her discussion with Gene, speaking loudly and inappropriately in patient care areas. She asks the unit clerk if she knows which patients or family members complained to Gene about her appearance. The following day, Felicia asks each of her assigned patients if they "have a problem" with her. Felicia reports back to Gene that none of her patients said they had any problems with her or her appearance. After discussing the situation with the human resources department, Gene meets with Felicia and provides her with a written warning regarding her body piercings, tattoos, and hair color as well as her unprofessional behavior following their initial meeting. Gene tells Felicia that she must remove jewelry from her nose and eyebrows prior to reporting for work and that her hair color must be a natural color. He also tells her that her tongue jewelry must be small and unnoticeable. Felicia's uniforms are to cover her tattoos completely.

Gene also provides Felicia with a copy of the federal court ruling in which the court ruled that body piercings and tattoos are not considered protected as free speech, and that employers have the right to set standards of dress and appearance for their employees. Gene tells Felicia that not only has her behavior been inappropriate and unprofessional, but because it made staff and patients uncomfortable, it could be considered harassment or workplace violence. Finally, Gene emphasizes to Felicia that she should speak directly with him regarding any performance issues or problems and not involve staff or patients in the situation. If Felicia does not comply with these standards within 10 working days, she will be terminated from her position.

Box 22-1 Signs of Alcohol or Drug Dependency

- Family history of alcoholism or drug abuse
- Frequent change of work site (same or other institution)
- Prior medical history requiring pain control
- Conscientious worker with recent decrease in performance
- Decreased attention to personal appearance
- Frequent complaints of marital and family problems
- Reports of illness, minor accidents, and emergencies
- Complaints from coworkers
- Mood swings, depression, or suicide attempts
- Strong interest in patients' pain control
- Frequent trips to the bathroom
- Increasing isolation (night shift request; eating alone)
- Elaborate excuses for tardiness
- Difficulty in meeting schedules and deadlines
- Inadequate explanation for missing work

Box 22-2 Physical Symptoms of Alcohol or Drug Dependency

- Shakiness, hand tremors, jitteriness
- Slurred speech
- Watery eyes, dilated or constricted pupils
- Diaphoresis
- Unsteady gait
- Runny nose
- Nausea, vomiting, diarrhea
- Weight loss or gain
- Blackouts (memory losses while conscious)
- Continuous wearing of long-sleeved clothing

Box 22-3 Workplace Indications of Drug Abuse

- Incorrect narcotics counts
- Alterations of narcotics containers
- Discrepancies on medication records or frequent corrections on them
- High wastage of narcotics
- Marked shift variations in the quantity of narcotics required on the unit
- Excessive patient reports that pain medication was ineffective

If the manager discovers signs or symptoms in an employee or becomes aware of the unit changes described in Box 22-1, Box 22-2, and Box 22-3, further investigation is warranted, and administration should be informed.

State Board of Nursing

State boards of nursing are charged with protecting the public, including the practice by nurses impaired by substance abuse. Reporting laws vary from state to state, as do consequences, but most state boards require the nurse manager to report an impaired colleague.

Diversion programs offering referral, assistance, and monitoring may be offered in lieu of disciplinary action in some states. For example, the Kansas Nurses Assistance Program (KNAP) is offered to nurses whose practice is impaired by substance abuse (Kansas State Board of Nursing, 2015). Nurses who successfully complete the program are not reported to the Kansas State Board of Nursing.

Strategies for Intervention

Once a nurse has been identified with a substance abuse problem, intervention with that nurse must be planned. With the assistance of the human resources department and administration, the manager should examine the organization's policies and procedures and licensure laws as well as determine if a diversion program exists. Then documentation about the nurse's behavior must be collected, including records of absenteeism and tardiness (especially recent changes), patient complaints about ineffective medications or poor care, staff complaints about job performance, records of controlled substances, and physical signs and symptoms noticed at different times. Dates, times, and behaviors should be carefully noted. Any one behavior means very little; it is the composite pattern that identifies the problem.

Next, appropriate resources to help the nurse should be identified. Resources include an employee assistance program counselor, if available; treatment center contacts; other recovering nurses (if known); and Alcoholics Anonymous or Narcotics Anonymous. It is absolutely essential to provide several sources in order for the nurse to feel confident that help from someone who knows how he or she feels is available, and the nurse also knows how to get help. This support cannot be emphasized enough. Failing to offer this assistance is like telling a diabetic he has diabetes and failing to tell him where he can get insulin.

The goal of the intervention is to get the nurse to an appropriate place for an evaluation of the possible problem. Most experts in treating nurses with addictions recommend that the nurse be offered the option of substance abuse evaluation and, if needed,

treatment. If she or he does not agree to that, then the usual disciplinary process must be followed and a report made to the state board of nursing.

The intervention should be scheduled as soon as possible at a time and place when and where interruptions can be avoided. Treatment centers or therapists who specialize in substance abuse are recommended to conduct the evaluation. It is important to focus on the problem behaviors, not on the inadequacy of the person. If the nurse is using alcohol or drugs at the time, immediate removal from patient care is necessary.

Reentry

Reentry to the workplace must be carefully planned. State law or organizational policy may require that recovering nurses in the early posttreatment period be restricted from handling controlled substances, carrying narcotic keys, being in charge, or working overtime. Thus, the individual could be reassigned for a period of time to a job or a unit where few mood-altering drugs are given, such as the nursery, department of education, rehabilitation, home care, dialysis, or patient care audits. Each case should be individually decided based on the amount of stress in the job, the need for rotating shifts, and other factors that may inhibit recovery. The reentry contract also may require documentation of participation in recovery groups and random urine drug tests.

The Americans with Disabilities Act and Substance Abuse

The Americans with Disabilities Act (ADA) went into effect in 1990 and was amended in 2009 (U.S. Department of Justice). Because alcohol or drug dependency limits one or more of a nurse's activities, it is considered a disability under the ADA. Furthermore, the employee's drug abuse history must be kept private. The ADA confidentiality provisions require the employer to keep records (i.e., disability) on employee substance abuse in separate, locked files with access limited to a need-to-know basis.

Dealing with employee problems presents ongoing challenges for nurse managers. You must identify the problem, intervene appropriately, and follow up as necessary. In addition, the manager must be persistent, fair, and consistent when intervening with problem employees.

What You Know Now

- Bullying increases staff dissatisfaction and turnover and can pose a danger to patients as well.
- Incivility and horizontal violence are examples of bullying.
- The behavior of employees who harass others, are marginal performers, are disgruntled, or abuse substances affect coworkers as well as patient care.
- Staff problems must be identified early and intervention planned, if necessary.
- Identifying, intervening, and returning nurses with substance abuse problems to the workplace help the organization, the manager, and the affected nurse.
- The manager must be persistent, fair, and consistent when intervening with problem employees.

Tools for Managing Staff Problems

1. Identify bullying behavior promptly and intervene as appropriate.
2. Document all instances of problem behavior.
3. Try to resolve conflicts and deal with problems as they appear.
4. Consult administration and the human resources department before intervening in serious problems, such as substance abuse.
5. Follow up problem behaviors with coaching, disciplining, or terminating if needed.

Questions to Challenge You

1. Have you ever worked or shared a class with a person who caused problems? (Most of us have.) How did the problem manifest itself? How was it handled? How do you wish the problem had been handled?
2. Have you ever experienced bullying or seen others bullied? How did you or they handle it?
3. Are you familiar with the signs and symptoms of substance abuse? Have you seen someone exhibit these characteristics? What signs or symptoms did they exhibit? What happened?
4. Using the examples in this chapter, consider how you would respond to the problem behaviors.

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Chapter 23
Preparing for Emergencies

Types of Emergencies
- Natural Disasters
- Man-made Disasters
- Levels of Disasters

Hospital Preparedness for Emergencies
- All-hazards Approach
- Emergency Operations Plan
- Surge Capacity
- Disaster Triage
- Continuation of Services

Staff Utilization in Emergencies

Learning Outcomes

After completing this chapter, you will be able to:

1. Identify examples of disasters that require preparation.
2. Determine emergency preparedness for hospitals.
3. Discuss staff requirements to respond to emergencies.

Key Terms

all-hazards approach
emergency operations plan (EOP)
mass casualty events (MCE)
surge capacity

Introduction

Terror attacks, wars in the Middle East, mass shootings, and violence in the United States and around the world have been the focus of national and local efforts in emergency preparedness. At the national level, the Joint Commission and the federal government have created initiatives to help prepare first responders and health-care organizations to handle emergencies (Sauer, McCarthy, Knebel, & Brewster, 2009). The Joint Commission expanded its emergency management standards to include

mitigation, preparedness, response, and recovery (The Joint Commission, 2016). The executive branch of the U.S. government issued executive orders establishing, among other initiatives, the Office of Homeland Security. The U.S. Congress passed legislation addressing bioterrorism and pandemics. Congress also directed the Federal Emergency Management Agency (FEMA) to coordinate disaster relief efforts.

Types of Emergencies

Emergencies can be natural disasters (e.g., tornadoes, hurricanes, earthquakes, or floods), or they may be man-made accidents (e.g., hazardous material spill) or intentionally created (e.g., acts of terrorism). Regardless of the cause, healthcare organizations must be prepared to deal with the mass casualties (MC) that may occur due to any type of emergency (see Box 23-1).

Natural Disasters

Natural disasters include any disaster that is not man-made. Floods, hurricanes, tornadoes, volcanoes, heat waves, and blizzards are examples of natural disasters. Location is a key element in preparing for natural disasters. Coastal areas must prepare for hurricanes, river towns should prepare for flooding, and plains areas should plan for tornado disasters.

Health disasters are also natural disasters. Disease epidemics that spread rapidly through the population and pandemics that spread disease around the planet are health disasters. Severe acute respiratory syndrome (SARS), AIDS, antibiotic-resistant bacteria, Ebola, H1N1 influenza, and the Zika virus are examples of health threats that can cause epidemics and pandemics.

Man-made Disasters

Man-made disasters can be accidental or intentional. Industrial hazards, structural collapses of buildings or bridges, and power outages are examples of accidental hazards. Subways, sports stadiums, and airplanes may be attacked. Chemical, physical,

Box 23-1 Examples of Disasters

Natural Disasters	Man-made Disasters
Floods	Accidental
Hurricanes	Structural collapse of buildings or bridges
Earthquakes	Industrial spills
Landslides and mudslides	Power outages
Wildfires	Intentional
Epidemics and pandemics (influenza, SARS, H1N1)	Explosive or incendiary devices
	Sniper or mass casualty shootings
	Release of toxins (chemical, physical, biological, radiological, nuclear)
	Arson fires

biological, radiological, or nuclear toxins may spread to the population, causing illness and death. Anthrax, a bacterial toxin, and asbestos, a physical toxin, are examples of poisonous substances that can cause environmental disasters. Cybersecurity is an increasing issue, and infiltration of a health organization's computer systems can cause disruption to individuals as well as to the computer infrastructure.

Levels of Disasters

Disasters are further categorized by level as follows (Smeltzer, Bare, Hinkel, & Cheever, 2010):

- Level I: Local level response and containment suffice.
- Level II: Regional level response is necessary.
- Level III: Statewide or national assistance is needed.

Every healthcare organization must prepare for both natural and man-made disasters and the resulting **mass casualty events (MCE)**. Unfortunately, efforts sometimes fall short of the goal.

Hospital Preparedness for Emergencies

Plans for emergency management are required of all hospitals (The Joint Commission, 2016). Key to successful emergency management is preparation. The organization, however, does not need to prepare for any and all possible catastrophic events.

All-hazards Approach

The **all-hazards approach**, contrary to popular thinking, does not mean that every organization must be prepared for every possible catastrophic event (Canton, 2013). Such preparation is impossible due to the amount of resources (time, money) required and unnecessary and could lead to staff confusion during an actual event. Instead, Canton suggests that a risk analysis of the community's vulnerability to specific threats should direct the organization's planning efforts. In fact, preparedness for one type of event (e.g., disease pandemic) correlates with preparedness for all other types of events (Adini, Goldberg, Cohen, Laor, & Baar-Dayan, 2012).

The Institute of Medicine's report entitled *Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response* (Hanfling, Altevogt, & Gostin, 2012) recommends that hospitals, emergency services, and local government agencies integrate their plans to respond to disastrous events. In addition, the report suggests that local community members become involved in the planning, and that nurses play a key role in developing the community's response to crises (Murray, 2012).

Emergency Operations Plan

A hospital **emergency operations plan (EOP)** includes preparation, education and training, and implementation of the hospital's response to emergency situations. The hospital's EOP includes the following components:

- Activation response
- Communication plan

- Patient care coordination plan
- Security plan
- Traffic flow plan
- Data management strategy
- Resources availability (Smeltzer et al., 2010)

Finally, the EOP must include plans to deactivate the response and follow up with a post-incident review and a schedule for practice drills.

Implementation of the EOP includes three components: planning, preparing, and practicing (Smeltzer et al., 2010).

PLANNING Planning involves determining the hospital's top three to five vulnerabilities based on its geographic location. For example, if the hospital is near a factory, the EOP would include plans for possible industrial accidents. If the hospital is located in a city near the Atlantic Ocean, staff would prepare for hurricane victims. On the other hand, if the hospital sits on the Kansas plains, tornadoes are more likely. Once vulnerabilities have been determined, planning can proceed based on the possible patient injuries.

PREPARING Preparation includes staff education and training. Both knowledge and skills training are needed. Techniques may include computer simulations, video demonstrations, and disaster drills. (See Leading at the Bedside: Preparing for Disasters.) An incident command center must be identified, and the individuals in charge of operations during a disaster appointed and trained. All staff need a clear understanding of communication systems and the incident command center (Gardner & Frazier, 2013).

PRACTICING Hospitals are required to test their EOP twice a year (The Joint Commission, 2016). One practice can be a tabletop event, but one must involve realistic situations and simulated patients. The timing of exercises should include occasions when the hospital is at low capacity to test its readiness in the most adverse situations. The hospital's EOP and performance should be evaluated annually.

Surge Capacity

Surge capacity describes an institution's ability to mobilize when suddenly confronted with a vast increase in patient demand (Adams, 2009). By planning ahead for an influx of patients, strategies can be put in place to marshal emergency procedures. A surge system includes the following:

- Supplies
- Personnel

Leading at the Bedside: Preparing for Disasters

Have you participated in a disaster practice exercise? What about an actual mass casualty event? Did the organization function as well as could be expected in the exercise and/or in the event? What did you learn from your experience?

If you have neither practiced nor participated in an actual event, are you familiar with your organization's emergency operations plan? Do you know where to find it? Do you know what to do in emergencies? If your answer is no to any of these questions, then find out. Never take emergency preparedness for granted. Your life and those of your patients and colleagues may be at stake.

- Physical space
- Management infrastructure

These components are known as "stuff, staff, structure, and systems" (Adams, 2009). At the onset of a disaster and the impending arrival of mass casualties, a hospital incident command structure can be implemented, a rapid needs assessment conducted, and appropriate activities mobilized. Preparation and drills ensure that all components are in place. Post-incident follow-up is essential to continually evaluate performance and initiate improvements.

Disaster Triage

Similar to the triage system used by the military in war situations, hospitals must reverse their usual triage method of treating the most seriously injured person first. Instead, they must prioritize scarce resources to those who can benefit the most (Kirwan, 2011). The goal is to treat as many injured people as possible in the shortest time possible. Inundated with mass casualties, precious time must be directed to the *least* seriously injured first, then the more seriously injured, and so on.

Continuation of Services

Complicating emergency preparedness is the need to provide for continuation of services during an emergency. Routine services may be disrupted. Loss of electrical power may be countered by backup generators, but if computer capabilities close down, how will the electronic medical record and the medication system work? How will documentation continue? Resupply of medications, food, water, and supplies may be interrupted. What if resupply lines are impacted by a disaster (e.g., trucks delivering meds cannot get through due to flooded or washed-out roads)? Furthermore, how will the facility handle a large influx of patients and/or casualties? If needed, how will the evacuation of the facility be handled? The EOP must address all of these issues.

Risk assessment is necessary to identify the hospital's vulnerability. Hospitals are often the frontline responders to mass casualty events, but maintaining services in the face of overwhelming numbers of casualties can be challenging. Capabilities, resources, and education and training needs must be assessed.

Staff Utilization in Emergencies

Depending upon the nature of the emergency, staff may be required to help evacuate patients (e.g., because of flooding) or may need to shelter in place (e.g., because of a live shooter). Regardless, their lives will be affected. They may become ill themselves, for example, or a tornado may devastate their homes, such as in Joplin, Missouri, in 2011; they may need to get to their children or other family members. With the loss of staff, how will the agency continue to accept and care for new patients?

Employee fatigue and exhaustion, including mental fatigue, must be addressed. Personal protective equipment must be available, and staff must be trained to use the equipment and know how to access it in an emergency. Protective equipment includes respiratory protection, eye and face protection, and hand, arm, and body protection.

Education, training, and practice drills help staff prepare for an unanticipated crisis. Key to maintaining operational readiness is the staff's willingness to come to work

during a disaster (Davidson et al., 2009). The hospital's surge capacity includes a callback system for requesting staff to return to work during an emergency, but it does not address the staff member's willingness to come to work (Adams & Berry, 2012). Several factors determine staff members' decisions to come to work, including vulnerability of family, personal safety concerns, professional accountability, past experience with disasters, caring connection with the organization, and the desire to help (Davidson et al., 2009).

These factors suggest appropriate management responses. Developing a caring relationship with staff members and a compassionate response during and after a disaster may slightly help mitigate staff concerns about family vulnerability and personal safety. Worry about pets, children, dependent adults, and their own security will, of course, still affect employees' decisions to return to work (Davidson et al., 2009).

In addition to the complications of preparing for emergencies, the hospital also may not be reimbursed for care provided, standards of care may not be established or able to be maintained, and the hospital may incur liability for volunteers' safety or their performance (Hodge, Garcia, Anderson, & Kaufman, 2009). A natural disaster, a terrorism attack, an epidemic, or another mass casualty event may, and probably will, occur at some time. All healthcare organizations must be prepared to care for a surge in casualties while reducing the impact on patients and staff.

See how one hospital prepared for an impending emergency in Case Study 23-1.

CASE STUDY 23-1 | Preparing for an Impending Emergency

Weather forecasters were predicting 15 inches of snow to fall in the next 24 hours. It was likely to be the biggest snowstorm the town had seen in as many years as anyone could remember. Everyone was in an uproar over the impending severe storm that threatened to shut down the city. Mount Bethel Hospital administration wanted to make sure they were prepared for this blizzard ahead of time and had an effective emergency plan in place to provide patients with effective, uninterrupted care.

The snow was expected to start at 4:00 p.m. Hospital managers and administrators met early that morning at 7:00 a.m. to get a plan in place. It was decided that a message would go out to all staff who were scheduled to work that night, advising them to come into the hospital early for their night shift. The hospital would serve dinner in the cafeteria to those waiting for their shift to start. Getting night staff to the hospital before the blizzard was projected to be at its worst would allow the hospital to run in routine fashion overnight. The hospital also encouraged night shifters to bring a bag to stay over the next day at the hospital and asked them to consider working the following night shift, too.

The administration team increased its linen and grocery orders with vendors so the hospital would be well stocked in case deliveries couldn't be made for a few days. The grocery order was delivered and included all items requested. The linen order was delivered that day; it was only double the routine delivery, because many other facilities had also requested excess linens to be delivered. The administration made a note in its plan to notify staff to conserve linen resources if a normal linen delivery couldn't occur the next day.

The administration announced to the daytime staff that all staff had been invited to spend the night at the hospital after their shift and were asked to work the next day as well. Each staff member was provided with a cot to sleep on, blankets and pillows, meals, and clean scrubs. In addition, the hospital made shower facilities within the building available for staff, and even put up sign-up sheets for each shower so staff could schedule their time. Most day staff agreed to stay at the hospital to avoid driving home, and so they would be available the next day when people at home were likely not going to be able to drive in for their shift.

Mount Bethel was well prepared for the impending blizzard. With proper advance preparation, the hospital was able to operate under normal patient care standards. The staff had been so gracious to stay at the hospital and meet the staffing needs for patient care. Within 36 hours, the streets were cleared and the city was back to its usual operations. Staff were able to commute to work, deliveries of groceries and linens were back on schedule, and the hospital was operating under normal conditions again. Mount Bethel's administration was pleased that it had been able to successfully plan and work through the weather emergency.

What You Know Now

- Emergencies include natural disasters, man-made accidents, mass shootings, and acts of terrorism.
- Emergency preparedness is the focus of national efforts and is expected to increase in the coming decade.
- Every hospital is required to have an emergency operations plan (EOP).
- Triage in a mass casualty incident is the reverse of normal standards: The goal is to treat the most people in the shortest time with the resources available.
- Planning, preparing, and practicing are the steps necessary to manage potential emergencies.
- Surge capacity describes an institution's ability to mobilize when confronted with an influx of patients.
- Education, training, and practice drills help staff prepare for a sudden mass casualty incident.
- Employees' caring connection with the institution may help mitigate their concerns about family vulnerabilities and personal safety.

Tools for Preparing for Emergencies and Preventing Violence

1. Become familiar with your organization's emergency operations plan (EOP).
2. Participate in education and training sessions to prepare for emergencies.
3. Refresh your training regarding reverse triage.
4. Recognize that an actual disaster will challenge your ability to handle family situations and concerns about your personal safety and will affect your decision to come to work.
5. When an emergency occurs (practice or actual), recall your training and participate as required.

Questions to Challenge You

1. Do you know what to do in an emergency? List the steps you would take. Then locate a copy of your organization's policies and procedures for emergencies and evaluate yourself.
2. Create a fictitious emergency situation with a classmate or colleague. Challenge each other on how each of you would handle the situation. Share your experience with others.
3. Have you participated in disaster drills? How well did you follow your training? How well did the organization handle the drill? Did you see areas for improvement?
4. Have you been involved in an actual disaster experience? If so, share your experience with classmates or colleagues. Nothing makes a situation real better than a factual account.

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Chapter 24

Preventing Workplace Violence

Violence in Healthcare

Incidence of Workplace Violence
Horizontal Violence
Consequences of Workplace Violence
Factors Contributing to Violence in Healthcare

Preventing Violence

Zero-tolerance Policies
Reporting and Education
Environmental Controls

Dealing with Violence

Verbal Intervention
A Violent Incident
Other Dangerous Incidents
Post-incident Follow-up

Learning Outcomes

After completing this chapter, you will be able to:

1. Summarize components involved in workplace violence.
2. Explain strategies for preventing violence in healthcare organizations.
3. Describe responses to violent incidents.

Key Terms

bullying
horizontal violence
incivility
workplace violence

Introduction

Unfortunately, violence is all too common today. Terrorism, bombing, and mass shootings are reported frequently. Healthcare settings are no exception. Violence from coworkers, patients, family members, and even outsiders can invade the workplace and harm healthcare workers.

Violence in Healthcare

Workplace violence is any violent act, including physical assaults and threats of assault, directed toward persons at work or on duty. Those working in healthcare are among the most vulnerable to attack (Papa & Venella, 2013). Most assaults in healthcare are initiated by patients, but attacks are also made by disgruntled family members, coworkers, vendors, employers, or even colleagues (Gates, Gillespie, & Succop, 2011b). Some assaults are episodes of domestic violence that occur at work (Pollack et al., 2010).

Violence includes the following:

- Threatening actions, such as waving fists, throwing objects, or threatening body language
- Verbal or written threats
- Physical attacks, including slapping, hitting, biting, shoving, kicking, pushing, beating
- Violent assaults, including rape, homicide, and attacks with weapons such as knives, firearms, or bombs

Incidence of Workplace Violence

Violence in healthcare occurs more often than in other workplace settings (Occupational Safety and Health Administration, 2015). Public focus, however, has been on other occupational settings with violence in healthcare receiving little attention (Gates et al., 2011b). This is in spite of an increase in assaults in healthcare (U.S. Department of Labor, Bureau of Labor Statistics, 2014).

Horizontal Violence

Sadly, violent perpetrators are not always outsiders. In fact, healthcare workers commit acts of aggression against their coworkers (Sellers, Millenbach, Ward, & Scribani, 2012). Such aggression is known as **horizontal violence**. Regardless of who the perpetrator is, aggressive behavior known as **bullying** or **incivility** can be as mild as innocuously irritating or as extreme as dangerously violent (Stokowski, 2010). Such behaviors ranging from mild to severe include the following (Sullivan, 2013):

- Ignoring the person or giving the silent treatment
- Treating in a disdainful or belittling manner
- Making disparaging remarks purposely within hearing
- Ridiculing the individual
- Speaking sarcastically to or about the person
- Direct verbal abuse
- Sexual harassment
- Physical attack

Although the strategies differ, healthcare organizations must attend to acts of bullying against their employees with the same zeal they use to address violence from outsiders (Longo, 2010) as addressed in Leading at the Bedside: Keeping Everyone Safe.

Leading at the Bedside: Keeping Everyone Safe

As a staff nurse, you are the most important person in the organization to spot and handle potential violence. You are the front line to reduce aggression from patients, visitors, and coworkers. You can spot difficulties almost before they happen. In order to handle possible violence, you must know the signs of potential problems as enumerated in this chapter.

In addition to watching for potential violence from outsiders, bullying (horizontal violence) is a continuing problem in the profession. Again, you can identify problem behaviors and report them to the appropriate supervisor. If you see someone being bullied, you can intervene.

Vow that you won't allow anyone you work with to become a victim of bullying. Nursing is the profession the public considers the most trustworthy. Let's live up to that!

Consequences of Workplace Violence

Violence can range in intensity and cause physical injuries, temporary or permanent disability, psychological trauma, or death (Howard & Gilboy, 2009). Violence in healthcare organizations is more likely to occur in psychiatric settings, emergency departments, waiting rooms, and geriatric units.

In addition to harming employees, violence in the workplace can affect worker morale, increase staff stress, cause a mistrust of administration, and exacerbate a hostile work environment (Gates et al., 2011a). Furthermore, absenteeism and turnover are expensive, and the organization may incur additional costs for care of injured workers and settlements from lawsuits.

Factors Contributing to Violence in Healthcare

Working with the public carries with it inherent risks, and the added stress by staff, patients, and families in healthcare settings increases that risk (Gates et al., 2011a). Furthermore, hospitals have an open-door policy for visitors. Visiting hours are not restricted, and visitors are often not required to check in when they enter.

Patients with head trauma, seizure disorders, dementia, or alcohol or drug withdrawal, as well as those who are homeless, may lash out in violence. Crime victims and the perpetrators might be admitted to the same hospital, and gang violence could spill over into the hospital. In addition, family members' stress and fear as well as long waits can contribute to the possibility of violent actions. Finally, the absence of visible, armed, and adequately trained security personnel may make the setting less secure.

No workplace can be assured of freedom from violence—especially random violence. Some additional risk factors for potential violence in healthcare organizations include the following:

- Working understaffed, especially at mealtimes and during visiting hours
- Long waiting times
- Overcrowded waiting rooms
- Working alone
- Inadequate security
- Unlimited public access
- Poorly lit corridors, rooms, and parking lots

Injuries to nurses from violence are likely underreported for several reasons (Gacki-Smith et al., 2009). The definition of workplace violence may not be clear, reporting policies may not be in place, and employees may simply believe that assaults are part of the job. Staff also may fear that reporting an assault will be construed as poor job performance (Gacki-Smith et al., 2009).

Preventing Violence

Preventing violence, as with any other disruptive behavior, is best dealt with as soon as possible. The tendency to hope a problem will go away, although tempting, is usually fruitless. In fact, if problems are ignored, they tend to escalate (Occupational Safety and Health Administration, 2015).

Zero-tolerance Policies

The healthcare organization should cultivate a culture of intolerance to violence and set its violence prevention policies to reflect that position (Gates et al., 2011b). Appropriate personnel policies must state clearly what will happen if violence or the threat of violence occurs. Policies regarding patients and visitors must do the same. Specifically, anyone who becomes violent or who exhibits threatening behavior must be removed from the setting and the authorities contacted.

Also, the organization must develop a code of conduct specifying behaviors that will not be tolerated, and the consequences of violating the conduct code must be clearly stated (Longo, 2010). The code must include the reporting channel for addressing code violations. Leaders in the organization must be committed to monitoring and enforcing the code.

Reporting and Education

Employees must be educated to recognize the warning signs of violence and potential assailants or agitators, and they must be taught conflict resolution skills and de-escalation tactics (LaGrossa, 2015). They should also be alerted to use care when storing instruments that could be used as weapons (e.g., stethoscopes, hemostats, scissors).

Once adequate policies are in place, employees must be informed about them so that they are prepared in case of an event or crisis. In addition, employees need to know how to report an incident and to whom to report it as well as how to document problem situations. Employees should be reassured that reporting threatening behavior will not result in reprisals.

Environmental Controls

The organization should institute environmental controls to ensure patient, visitor, and employee safety. These include the following:

- Adequate lighting
- Security devices
- Bullet-resistant barriers in the emergency department
- Curved mirrors in hallways

In addition, safe work practices should be implemented, such as the following:

- Escort services
- Adequate staffing
- Judicious use of restraints or seclusion
- Staff alerts about patients with histories of violent behavior, dementia, or intoxication

Dealing with Violence

Despite all the efforts an organization takes to prevent violence, it may still occur. Patients, family members, visitors, and even staff can be unpredictable. Whether the problem is bullying or a threat of physical violence, intervening early is the organization's best strategy.

Verbal Intervention

Verbal intervention is appropriate for instances of bullying if the behavior is not physical or dangerous (e.g., disparaging remarks, eye rolling). To intervene, identify the person whose behavior is disruptive and speak with the person privately. Then follow the steps in Box 24-1.

Because verbal threats may precede a physically violent event, all employees should be trained in how to reduce aggression in people who are making verbal threats. When faced with a potentially violent situation, try to keep calm even when another person is screaming threats or abuse. Try to get the person away from others. A crowd might encourage the abuser, or the person might be afraid to lose face in the presence of others.

Nonverbal communication is more powerful than your words, so watch your body language and keep a distance from the person. Use clear and direct words; the person's anxiety could make comprehension difficult. Reflect the person's words back; this lets the person know that you hear him or her. Silence is often effective because it forces the person to think about what is being said and may be calming in itself. Finally, keep your tone of voice calm, keep your volume normal, and slow your rate of speech. Together, these strategies may reduce the person's anxiety and aggression (Gates et al., 2011b).

A Violent Incident

In spite of all that an organization and individuals do to try to prevent violence, the person's aggression may escalate. In the event that such a situation occurs, the organization

Box 24-1 Verbal Intervention Strategies

1. State the problem.
2. Tell how the problem is affecting the work unit and/or organization.
3. State what you want to have happen.
4. Ask if the person is willing to do what you asked.
5. Schedule follow-up.

should make certain that all employees are prepared. Each employee should be versed in the following:

- How to recognize the signs of escalating violence
- Familiarity with the organization's violence policies
- How to protect patients, visitors, and oneself

Every employee should learn how to watch for threatening behaviors in order to evaluate when a person is likely to become violent. Law enforcement personnel recommend watching for these behaviors:

- Clenched fists
- Blank stare
- Fighting stance (one foot back with arm pulled back ready to strike)
- Arms raised in a fighting position
- Standing too close or advancing toward you
- Holding anything that might be used as a weapon, such as a pen, letter opener, heavy object, or an actual weapon—a gun or knife
- Overt intent (saying they intend to "kick your—" or similar statements)
- Movement toward the exit to prevent you from leaving (Sullivan, 2013)

When these threatening behaviors are present, or if someone becomes physically violent, you must protect your patients, visitors, other staff, and yourself. Contact security immediately and follow the steps in Box 24-2.

Other Dangerous Incidents

An infant abduction, a bomb threat, or a gun on the unit are some examples of other dangerous incidents that could occur. Most organizations now have a specific code to alert staff to a potential or real infant abduction, such as Code Pink, and many hospitals now also place security bands on babies and parents to prevent abduction of a baby from the nursing unit.

Policies are in place in most hospitals to address bomb threats or a gun on the unit and indicate the procedures to follow, and the staff are trained to call the hospital's 911 number. Specific codes for alerting security and obtaining assistance for other threats are also used. In addition, drills for infant abductions, bomb threats, and firearms on the unit are practiced on a routine basis and included in yearly competency testing for employees. Keeping patients safe is always the focus.

Post-incident Follow-up

After a violent incident, everyone involved will suffer some degree of emotional, if not physical, trauma. Gates et al. (2011b) found that 94% of emergency department nurses

Box 24-2 How to Handle a Violent Incident

1. Notify security immediately.
2. Never try to disarm someone with a weapon.
3. If not armed, enlist staff help in restraining a violent person.
4. Put a barrier between you and the violent person.

experienced at least one symptom of posttraumatic stress disorder (PTSD) following an incident of violence, with 17% diagnosed with probable PTSD.

Post-incident follow-up is essential for the well-being of patients, visitors, and staff members. The steps to take are shown in Box 24-3.

A nurse manager used the steps in handling a violent incident and its follow-up in Case Study 24-1.

Violence in the workplace is a reality of life today, but organizations and individuals can take steps to reduce potential threats. Because the nursing shortage is continuing, and because nurses and women are more likely to be attacked, organizations must take all the necessary steps to ensure that their nurses are kept safe from harm. In addition, nurses themselves must be informed about how to recognize potential threats and how to prevent violence from escalating. In this way violence may be prevented or, at the least, reduced.

Box 24-3 How to Handle Post-incident Follow-up

1. Be certain that everyone is safe following a violent event.
2. Arrange immediate treatment for the injured.
3. Complete injury and incident reports.
4. Follow up with human resources regarding the workers' compensation process for the injured employees.
5. Contact security to determine if a police report should be filed.
6. Later, contact the injured employee at home to express concern for the person's well-being and follow up with any questions the person may have.

CASE STUDY 24-1 | Workplace Violence

Melanie Sanchez is nurse manager of a 30-bed skilled nursing unit (SNU) in an urban hospital. Patient confusion and aggression are not uncommon occurrences for her staff. Nursing and assistive staff have been trained in conflict resolution and methods for dealing with aggressive patients.

Sandra Porter, RN, has worked in the SNU for the past 6 years. Today, while administering medication to patients before lunch in the common dining room, Sandra noticed a newly admitted patient, Mr. B, yelling obscenities at another staff member. Sandra secured her medication cart and came to the aid of the nursing assistant. Sandra attempted to verbally de-escalate the situation, but Mr. B became increasingly aggressive. When Sandra turned to instruct the nursing assistant to clear patients from the dining room, Mr. B picked up a chair and struck Sandra in the arm and shoulder. The nursing assistant alerted Melanie and several nurses to the problem. Melanie immediately called the hospital operator to request that security respond to a violent patient on the SNU. Upon entering the dining room, nursing staff were able to restrain Mr. B while Melanie accompanied Sandra to the emergency department for treatment of her injuries. Sandra sustained a broken arm, a laceration to her shoulder, and several contusions.

As soon as Sandra's injuries were treated and she was released from the emergency department, Melanie contacted the medical/surgical nursing division director and the human resources department about the assault and filled out an incident report. She also completed an injury report for Sandra's workers' compensation claim. Melanie contacted the security department and requested a meeting with the security director to determine if a police report should be filed regarding Mr. B's assault of Sandra. The next day, Melanie contacted Sandra at home and informed her that a case manager from human resources would call her within the week regarding her workers' compensation claim. Melanie also checked to see how Sandra was doing and encouraged her to call Melanie directly if she had questions or concerns.

What You Know Now

- Healthcare organizations are vulnerable to violence in the workplace, including horizontal violence.
- Risk factors for violence in healthcare organizations include understaffing, patient's condition, family members' anxiety, unlimited public access, inadequate security, and an unsafe physical environment.
- The organization should establish a policy of zero tolerance for violence and make certain that all employees know it.
- All employees should be able to recognize potential threats and the warning signs of violence.
- All employees should know how to report threats and threatening behavior, to whom to report such episodes, and how to document the incidents.
- Employees should be assured that reporting potential threats will not result in reprisals.
- All employees should know the steps to take if a violent incident occurs.

Tools for Preventing Violence

1. Recognize potential threats and threatening behavior, including bullying, and know how to report them.
2. Alert staff and administration to these threats.
3. Learn how to respond to a person who becomes violent.
4. Know what to do following a violent incident.
5. Monitor the environment for dangerous areas and report your observations to administration.
6. Remain alert for potential violence and instruct staff to stay vigilant.

Questions to Challenge You

1. Evaluate your current workplace or clinical site. See if you can find potential opportunities that would allow violence to occur. Describe them.
2. Ask to see the workplace violence policies at your school, clinical site, and/or workplace. Evaluate them. Are they adequate? Can you suggest changes?
3. Have you ever been the victim of bullying? Did you report it? How did the authorities respond? Could you suggest changes for them?
4. Are you aware of specific action that your school, workplace, or clinical site has done to protect people from violence? What more could you suggest?

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Chapter 25
Handling Collective Bargaining Issues

Laws Governing Unions

Process of Unionization

Handling Grievances

Unfair Labor Practices

The Grievance Process

Collective Bargaining and Nurses

Legal Issues of Supervision

The Future of Collective Bargaining for Nurses

Learning Outcomes

After completing this chapter, you will be able to:

1. Discuss the laws that govern collective bargaining.
2. Describe the process of unionization.
3. Explain what is involved in handling grievances.
4. Summarize collective bargaining for nurses.

Key Terms

closed shop
collective bargaining
grievances
open shop
right-to-work state
strike

Introduction

The purpose of collective bargaining units is to protect employees from unfair practices, such as mandatory overtime or firing without cause. Collective bargaining units also may stipulate criteria for advancement that must be followed. Ambitious, career-minded nurses might chafe against these rigid standards that may not allow exceptions. So, both nurses and their employers have cause to complain about unions.

Laws Governing Unions

Before federal laws governing labor relations in this country were enacted, disputes between the owners or managers of a company and the company's labor force were settled by the judiciary branch of government. During this period of U.S. history, the courts often ruled that **collective bargaining**—collective action taken by workers to secure better wages or working conditions—was illegal. Today, however, labor laws enacted by Congress, decisions by the U.S. Supreme Court, and activities of the National Labor Relations Board (NLRB) guide labor relations between employers and employees. Since enactment of the National Labor Relations Act in 1935, nurses and other employees of private, for-profit healthcare institutions have been protected in their right to organize for collective bargaining purposes (National Labor Relations Act, 1935).

Under the provisions of the act, as amended in 1974, employees of voluntary, not-for-profit healthcare institutions also were granted the same rights and protections (National Labor Relations Board, 1974).

In the United States, a **closed shop** is a business in which union membership (often of a specific union and no other) is a precondition to employment. An **open shop** is a business in which union membership is not a component in hiring decisions and union members do not receive any preference in hiring.

A **right-to-work state** is a state in which no person can be denied the right to work because of membership or nonmembership in a labor union. Trade unions and employers cannot make membership in a union or payment of union dues or fees a condition of employment, either before or after hiring.

Collective bargaining laws differ depending on whether nurses are employed in the private sector—in either nonprofit or for-profit organizations—or in the public sector as city, county, state, or federal employees. Negotiations may be classified as mandatory, prohibited, or permitted. Parties are obligated to negotiate on mandatory subjects of bargaining.

In the private sector, wages, hours, and other terms and conditions of work are considered mandatory subjects for negotiation. In the public sector, the scope of mandatory subjects of bargaining is often far narrower.

The Civil Service Reform Act of 1978 gave certain federal employees the right to organize, bargain collectively, and participate through labor organizations of their choice in decisions affecting their work environment, depending on what federal agency employed them. Wages—a mandatory item in the private sector—is a prohibited subject (Civil Service Reform Act, 1978).

State or local employees, however, fall under state regulations, which vary greatly from state to state. Nurses in state hospitals, for example, would be governed by their state laws. Some states do not allow employees to strike or form collective bargaining units; other states do not allow wages or overtime pay to be part of a union contract.

Process of Unionization

The process of establishing a union in any setting begins when at least 30% of eligible employees sign a card to indicate interest in a union. (See Leading at the Bedside: The Right to Organize.) Then the union petitions the National Labor Relations Board (NLRB) to conduct an election. The NLRB meets with both the union and the employer.

At the conclusion of this meeting, the NLRB will determine who is eligible to participate in the union, will establish that the signers are employees of the organization, and will set a date for the union election.

The process of selecting a bargaining agent produces a tense, emotional climate that affects everyone in the organization. Both nurse managers and staff nurses need to remember that the rules of unfair labor practice apply during this period. Managers must refrain from any action that could be seen as interfering with the employees' right to determine their collective bargaining representative. Such actions include individually questioning staff nurses about their knowledge of collective bargaining activities and making promises or threats to individual staff members based on the outcome of the election.

Staff nurses also must be careful that their discussions regarding collective bargaining take place away from the work site and not on work time. Nor may employees use their employer's email system to communicate about unionizing activities.

Certification by the NLRB of a union to be the bargaining agent does not automatically mean employees have a contract. The contract is considered to be in effect when both management and employees of the organization agree on its content. The final agreement is subject to a ratification vote by a simple majority of eligible members who vote.

The role of administering the contract then falls to an individual designated as the union representative. This individual may be an employee of the union or a member of the nursing staff.

Handling Grievances

Grievances result when employees believe that the organization has violated the contract agreement. Healthcare organizations can avoid the time-consuming and costly process of resolving grievances by adhering to the specifications of the contract.

Unfair Labor Practices

Five categories of unfair labor practices are described by labor law:

- Interference with the right to organize
- Domination
- Encouraging or discouraging union membership

Leading at the Bedside: The Right to Organize

If your healthcare organization does not have a collective bargaining agreement for its nurses, you may think this chapter doesn't apply to you. But it might. Your colleagues or others might initiate organizing efforts. Do you know what to do if you decide to join them?

Here are a few guidelines:

- You have the right to organize.
- You have the right to be free of harassment either at work or at home due to your organizing efforts.
- You have the right to keep your job in spite of your organizing activities.

You may never need to use these guidelines, but if you do, remember: You have rights!

- Discharging an employee for giving testimony or filing a charge with the NLRB
- Refusal to bargain collectively

The Grievance Process

The grievance procedure will be specified in the agreement and will contain a series of progressive steps and time limits for submission and resolution of grievances. Grievances are formal complaints that must be resolved by the process delineated in the contract.

Grievances can usually be classified as one or more of the following:

- Contract violations
- Violations of federal or state law
- Failure of management to meet its responsibilities
- Violation of agency rules

To ensure a balance between the rights of employees and the rights of the public to healthcare, Congress passed a special set of dispute-settling procedures to be applied in the healthcare industry:

- Before changing or terminating a contract, one party must notify the other of its intent to do so 90 days prior to the contract expiration date. This is 30 days more than specified for other industries.
- If after 30 days of this notification both sides cannot agree, then the Federal Mediation and Conciliation Service (FMCS) must be notified.
- The FMCS will appoint either a mediator or an inquiry board within 30 days.
- The mediator or board must make recommendations within 15 days.
- If after 15 more days both sides cannot agree, then a strike vote can be conducted and a **strike**—the organized stoppage of work by employees—can be scheduled.

If a strike vote is affirmed, then a 10-day written notice indicating the date, time, and place of the strike must be given to management. This is intended to ensure a hospital has adequate time to provide for continuity of patient care in the event of a strike (Cohen, 2013).

Collective Bargaining and Nurses

The majority of nurses in the United States do not work under a collective bargaining agreement, but for those who do, National Nurses United represents the majority of nurses and has affiliates in every state. In addition, employees of individual healthcare organizations often form their own collective bargaining organization and include nurses. Nurses at some healthcare organizations have formed their own union. So, collective bargaining in nursing runs the gamut from national collaboration of state organizations, to coordination with other employees in healthcare, to individual units of nurses.

Conflicting results about how satisfied union nurses are with their jobs has been reported (Seago, Spetz, Ash, Herrara, & Keane, 2011). The researchers posit, however, that union nurses may simply be more willing to voice their dissatisfaction. In addition, no correlation has been found between unionization and patient outcomes (Spetz, Ash, & Seago, 2011).

Legal Issues of Supervision

The following three areas of supervision over subordinates have been debated for a number of years:

- Responsibility to assign
- Responsibility to direct
- Independent judgment

The NLRB issued several landmark decisions regarding the supervisory status of nurses (National Labor Relations Board, 2006). Three cases were considered together and have become known as the *Kentucky River* trilogy. They are *Oakwood Healthcare, Inc*., *Golden Crest Healthcare Center*, and *Croft Metal, Inc.* These rulings are important to nurses because those employees deemed as supervisors are prohibited from joining a union.

The NLRB clearly defined the supervisory status of nurses in its ruling in 2006, and that ruling stands today. It ruled as follows:

- The responsibility to assign includes nurses' responsibility to assign other nurses and assistants to patients.
- The responsibility to direct includes the responsibility for the actions of those to whom tasks have been assigned.
- Independent judgment includes the nurse's decision to match staff skills to patient needs.

This ruling has an impact on the eligibility of many nurses who heretofore were not considered supervisors and were thus eligible to be members of a collective bargaining unit. Nurses who are charge nurses, either permanently or part-time on a regular basis, and who meet the above criteria for assigning, directing, and using independent judgment are considered supervisors and therefore are not eligible to join a union (National Labor Relations Board, 2006).

Therefore, union nurses who meet the criteria of charge nurses may be forced to choose between the role of charge nurse to advance their career or decline such a role to maintain their membership in the union (Matthews, 2010).

Nurse managers in healthcare organizations in which nurses are organized into a collective bargaining unit may be involved in the agreement in several ways. For example, the manager could participate in helping resolve grievances. Furthermore, the manager must adhere to the terms of the agreement while carrying out supervisory responsibilities, such as coaching, disciplining, and, especially, terminating employees.

See how one nurse manager handled discipline in a hospital with a collective bargaining agreement in Case Study 25-1.

The challenge for healthcare organizations in a collective bargaining environment is to retain high-performing nurses and help them become more satisfied with their jobs (Lawson, Miles, Vallish, & Jenkins, 2011). Partnering nursing staff with management personnel is one strategy to improve nurse retention. For example, after a partnership between nursing and management was established at a Magnet-certified institution, turnover decreased and satisfaction improved (Porter, 2010; Porter, Kolcaba, McNulty, & Fitzpatrick, 2010). Such partnerships are supported by the trend toward labor—management partnerships in other occupational sectors (Hayter, Fashoyin, & Kochan, 2011).

CASE STUDY 25-1 | Discipline Procedure in a Hospital with a Collective Bargaining Unit

Maria Sanchez is the nurse manager for 4 South Pediatrics in a university medical center hospital, where the nurses established a collective bargaining agreement with the hospital several years ago. Maria has a disciplinary problem with Tia, a staff nurse, about not completing intake and output documentation or vital sign documentation on her patients during her last shift. Maria notes that Tia had a friendly reminder about failing to complete documentation last month. Per hospital policy, Susan, as Tia's manager, must complete verbal counseling with Tia.

During recent union negotiations between the hospital and the nursing union, it was agreed that when verbal counseling is needed, the manager must formally say to the staff member, "I am providing you with verbal counseling today about your performance. This is official, will be documented in your file, and if you fail to meet the expectation, the next step in this process is a written notice of warning about failure to meet your job expectations. Do you have any questions about the verbal counseling process before we proceed?" The manager then continues with the verbal counseling about the unmet specific performance issue and policies.

Maria follows the guidelines established in the current agreement in her meeting with Tia, and Tia agrees that she has not been consistent in completing documentation. Tia agrees that Maria should monitor her performance for a week, when they will meet again to determine if Tia has been completing documentation appropriately and consistently.

The Future of Collective Bargaining for Nurses

The use of collective bargaining as a way for nurses to influence the practice environment and to ensure their economic security presents both concerns and promises, especially with the radical changes occurring in healthcare today. The concerns are that the very processes of collective bargaining separate rather than unite nurses, notably between staff nurses and those in management. What the future holds for collective bargaining in nursing is uncertain and unknown.

What You Know Now

- Laws governing unions are administered by the National Labor Relations Board.
- Subjects for union negotiations may be mandatory, prohibited, or permissive.
- Private sector subjects differ from public ones, which are generally more restrictive.
- The process of unionization involves selecting a bargaining agent, developing a contract, and administering the contract.
- Grievances may be filed if employees believe that the organization has violated the terms of their contract.
- The grievance process is a set of specific steps and a timetable for resolution of grievances.
- The status of supervisory nurses has been a continuing legal issue.
- The future of collective bargaining for nurses is uncertain and unknown.

Tools for Handling Collective Bargaining Issues

1. Determine if your organization has a collective bargaining agreement with its registered nurse employees.
2. If so, become familiar with provisions of the policy and grievance procedure.
3. Contact administration for any questions you may have with contract policies.
4. If your organization does not have a union contract, be aware of the possibility that efforts to establish a collective bargaining unit may be initiated.
5. If attempts are made to unionize your workplace, obtain information on the legal obligations you have as an employee and/or manager.
6. Remember, collective bargaining is an agreement between an employer and its employees; it does not need to be adversarial.

Questions to Challenge You

1. Are you a member of a collective bargaining unit? Do you know anyone who is?
2. Have you been involved in union organizing? What happened during and after the process?
3. If you have not been involved in union organizing, find someone who has been and ask what happened.
4. What is your opinion of unions for nurses? Name the pros and cons.
5. You are negotiating a union contract on behalf of the nurses. List your demands in priority order.
6. You are negotiating a union contract on behalf of administration. Respond to the demands on your list generated in question 5.

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Chapter 26
Managing Stress

The Nature of Stress

Causes of Stress
Organizational Factors
Interpersonal Factors
Individual Factors

Consequences of Stress

Managing Stress
Personal Methods
Organizational Methods

Learning Outcomes

After completing this chapter, you will be able to:

1. Explain why stress is necessary.
2. Describe the organizational, interpersonal, and individual factors that cause stress.
3. Summarize the consequences of stress.
4. Examine how individuals and organizations can manage stress.

Key Terms

burnout
compassion fatigue
mindfulness
posttraumatic stress disorders (PTSD)
reality shock
role ambiguity
role conflict
role redefinition
stress

Introduction

Consider the following scenario:

> *Keandra is a medical nurse with 10 years of experience. She is married and has two children under the age of 6 who attend preschool while she is at work. As a nurse manager, Keandra has 24-hour responsibility for supervision of two 30-bed medical units. She frequently receives calls from the unit nurses during the evenings and nights,*

and approximately once a week she has to return to the unit to intervene in a situation or replace nurses who are absent. Keandra is responsible for scheduling all the nurses on her unit and has no approval to use agency nurses, in spite of a 20% staff vacancy rate. In addition, Keandra serves on four departmental committees and the hospital task force on consumer relations. She consistently takes work home, including performance appraisals, quality assessment reports, and professional journals. Although Keandra has an office, she has little opportunity to use it because of constant interruptions from nurses, physicians, other departmental leaders, and her clinical director. Recently, Keandra saw her family physician and complained of persistent headaches, weight loss, and a feeling of constant fatigue. After a complete diagnostic workup, she was found to have a slightly elevated blood pressure, with a resting pulse of 100. Her physician prescribed an exercise program, and she was advised to lighten her workload, take a vacation, and reduce her stress level.

Stress is the nonspecific reaction that people have to demands from the environment that pose a threat. Stress results when two or more incompatible demands on the body cause a conflict. Recognized as the pioneer of stress research, Selye (1978) suggests that the body's wear and tear result from its response to normal stressors. The rate and intensity of damage increase when an organism experiences greater stress than it is capable of accommodating.

Selye maintains that the physiological response to stress is the same whether the stressor is positive, *eustress*, or negative, *distress*. It is easy to see how negative events, such as job loss, can cause stress. However, positive events also may cause stress.

Anthony was the director of nursing for critical care in a 400-bed hospital. He was offered the opportunity to develop a hyperbaric unit. In assuming the additional responsibility, Anthony began putting in long hours and working weekends. As the project progressed, Anthony became unable to sleep and gained 10 pounds. After the unit opened, Anthony's sleep pattern and weight returned to normal. Clearly, Anthony displayed emotional and physical signs of stress although he was experiencing a "positive" promotion and career opportunity.

A certain amount of stress is essential to sustain life, and moderate amounts serve as stimuli to performance; however, overpowering stress can cause a person to respond in a maladaptive physiological or psychological manner.

The Nature of Stress

A balance must exist between stress and the capability to handle it. When the degree of stress is equal to the degree of ability to accommodate it, the organism is in a state of equilibrium. Normal wear and tear occur, but sustained damage does not. When the degree of stress is greater than the available coping mechanism, the individual experiences negative aspects of stress. The situation is often described metaphorically through such statements as "carrying a load on one's shoulders" or "bearing a heavy burden." This often leads to physiological and psychological problems for the person and poor performance for the organization. When the degree of stress is not stimulating enough, lack of interest, apathy, boredom, low motivation, and even poor performance can result.

The experience of stress is subjective and individualized. One person's stressful event is another's challenge. One individual can experience an event, positive or negative, that would prove overwhelming for someone else. Even a minor change in

organizational policy may cause some individuals to experience stress, whereas others welcome it. Some nurses seem to thrive on the demands of work, family, school, and community involvement, whereas others find even minimal changes in their expectations a source of great discomfort.

Causes of Stress

For nurses, stress in the workplace can develop from several sources and may be due to organizational, interpersonal, or individual (intrapersonal) factors.

Organizational Factors

Stress can result from job-related factors, such as task overload, conflicting tasks, inability to do the tasks assigned because of lack of preparation or experience, and unclear or insufficient information regarding the assignment. Nurses' jobs are often performed in life-or-death situations; emergencies may cause periods of extreme overload.

The physical environment may also be stressful. Consider the intensive care unit with its constant alarms, beeps, and other noises. Studying the effect of environmental factors (e.g., odor, noise, light, and color) on nurses' stress, Applebaum and colleagues found that noise, in particular, correlated with stress, job dissatisfaction, and intent to leave (Applebaum, Fowler, Fiedler, Osinubi, & Robson, 2010). In addition to noise levels, lighting and other comfort factors may increase stress within the environment. Tight quarters, poorly organized work environments, and lack of equipment also augment stress levels.

Today's technology demands that employees be in perpetual contact with their employers. Besides, most of us are compelled to check our communication devices many times a day, and once a message or email is read, it is difficult to forget it regardless of the time. It is as if we are tied to technology from an invisible cord, a cord nonetheless firmly attached.

Nurse managers, especially, are prone to stress due to the scope of their responsibilities. Shirey and associates (Shirey, McDaniel, Ebright, Fisher, & Doebbeling, 2010) found that experienced nurse managers used a combination of emotion-focused and problem-centered coping strategies to handle stress and had fewer negative outcomes from stress than novice managers. Furthermore, novice managers reported experiencing more physical exhaustion, sleep problems, and hypertension than did their more experienced colleagues.

Other organizational factors that can lead to stress include organizational norms and expectations that conflict with an individual's needs. Managers trying to do more with less, overworked staff, and more acutely ill patients can lead to an organizational environment that by its very nature is stressful. New technology, increased expectations from patients and their families, liability concerns, and increased pressures for efficiency, in addition to the dramatic changes in healthcare resulting from healthcare reform legislation, increase stress in nursing and make the role of nurses and nurse managers more difficult, conflicting, and stressful.

Interpersonal Factors

To add to the pressures created by organizational changes, nurses must contend with strained interpersonal relationships with other healthcare professionals and

administrators. Interprofessional difficulties may precipitate tension. As resources in healthcare continue to shrink, nurses are being asked or told to assume responsibility for tasks that had been performed by other departments (e.g., phlebotomy, electrocardiography, respiratory therapy).

In a rehabilitation setting, therapists expect the patients to be bathed, to have eaten breakfast, and to be dressed and ready to start therapy by 8:30 A.M. This expectation places undue stress on rehabilitation nurses, who must motivate patients who complain that they have had far too little sleep.

Here is another example of stress due to interprofessional conflict: A radiology technician responds to a 9:00 P.M. page for a chest x-ray examination and informs the registered nurse that the patient will have to be brought back down because the radiology department is understaffed.

Interactions between physicians and nurses are often strained. Most nurses have experienced an irate response from a physician who is awakened during the night for something the physician thinks should have been handled earlier or might have waited until morning.

An internist in a small community hospital was well known for his outbursts during middle-of-the-night calls. One experienced nurse dealt with necessary calls to him by directly stating when he answered the phone, "This is Jane Jones from St. Matthew's. I have two important things to tell you about Mrs. Smith . . . ." This helped the internist focus on the problem at hand and eliminated his outbursts.

The need to fulfill multiple roles is another source of stress. A role is a set of expectations about behavior ascribed to a specific position in society (e.g., nurse, spouse, parent). Conflict between family and professional roles results in stress. Adding to stress is the shift and weekend work required in nursing jobs in hospitals that must be staffed 24 hours a day, 7 days a week.

Nurses who work evening or night shifts may experience family problems if their spouse and children are on different schedules, especially if the nurse rotates shifts. It takes several weeks to adjust physiologically to a change in shifts; however, rotation patterns often require nurses to change shifts several times a month. Managers can reduce the physiological pressure by ensuring that nurses receive adequate rest and work breaks, rotating staff only between two shifts, and never scheduling "double backs" (working 8 hours, off 8 hours, working 8 hours).

Individual Factors

Stress can result from personal factors as well. One of these factors is the rate of life change. Changes throughout life, such as marriage, pregnancy, or purchasing a new home, generate stress. Each individual responds to stress differently, but the cumulative effects of stress often lead to the onset of disease or illness. The ways people interpret events ultimately determine whether the person sees the event as stressful or as a positive challenge.

New graduates, for example, often do not recognize that they have demonstrated a definitive set of skills and knowledge in having passed all the requirements to become a registered nurse. The stress they experience when changing from the student role to the professional practitioner role has been explained by Kramer (1974) as

reality shock. When students move from a familiar school culture to a work culture—where values, rewards, and sanctions are different and often seem illogical—they experience surprise and disequilibrium.

Moving from a staff nurse position to management also creates surprise and disequilibrium. New managers often experience a sense of isolation from the peer group of staff nurses who previously provided support. Doing a job and directing others to do a job are different. Directing others is stressful, and a person may be tempted to believe that it will be faster to complete a task by doing it herself or himself.

Role ambiguity results from unclear expectations for one's performance. Individuals with high tolerances for ambiguity can deal better with the strains that come from uncertainties and, therefore, are likely to be able to cope with role ambiguity. *Role underload* and *underutilization* can also occur. Being underutilized or not having much responsibility may be seen as stressful by a person who is a high achiever or who has high self-esteem.

Role conflict is the result of incompatibility between the individual's perception of the role and its actual requirements. Novice nurse managers experience this type of conflict when they find that administration expects primary loyalty to the organization and its goals, whereas the staff expects the nurse manager's first loyalty to be to their needs.

Role conflicts also occur when an individual has two competing roles, such as when a nurse manager both assumes a patient care assignment and needs to attend a leadership meeting. Another example is the conflict between nurses' personal role as a parent or spouse versus their role as a professional nurse.

Consequences of Stress

What happens to a person when he or she experiences stress overload? Both physiological and psychological responses can cause structural or functional changes, or both. The warning signs of too much stress include the following:

- Undue, prolonged anxiety; phobias; or a persistent state of fear or free-floating anxiety that seems to have many alternating causes
- Depression, which causes people to withdraw from family and friends; an inability to experience emotions; a feeling of helplessness to change the situation
- Abrupt changes in mood and behavior, which may be exhibited as erratic behavior
- Perfectionism, which is the setting of unreasonably high standards for oneself and leads to a feeling of constant stress
- Physical illnesses, such as an ulcer, arthritis, colitis, hypertension, myocardial infarction, and migraine headaches

Ineffective coping methods for reducing stress include excessive use of alcohol and other mood-altering substances, which can result in substance abuse or dependence (Epstein, 2010). Some people become workaholics in an attempt to cope with real or imagined demands.

The term **burnout** refers to the perception that an individual has used up all available energy to perform the job and does not have enough energy to complete the task (Epstein, 2010). Burnout is a combination of physical fatigue, emotional exhaustion,

and cognitive weariness. As a result, the individual may reduce hours worked or change to another profession.

Compassion fatigue is secondary traumatic stress experienced by caregivers (Newsom, 2010). Similar to posttraumatic stress disorder, the term includes those involved in caring for others who are suffering from physical or emotional pain (Yoder, 2010). Symptoms are similar to those of burnout but may be more severe if the caregiver is providing care to those traumatized by crime, war, or war-related traumatic stress or are emergency workers or first responders.

In addition, nurses themselves may experience **posttraumatic stress disorders (PTSD)**. Gates, Gillespie, and Succop (2011) found that 17% of emergency room nurses who had been involved in a violent incident were symptomatic for PTSD.

Job performance suffers during times of high stress; so much energy and attention are needed to manage the stress that little energy is available for performance. In addition, increased absenteeism and turnover may result. Although absenteeism and turnover have various causes, either or both may occur when the individual attempts to withdraw from a stressful situation. Such a situation is financially costly in industry but even more costly in human health and well-being.

A director of nursing at a 120-bed nursing home stated that she could no longer handle the overwhelming needs of the patients; the ever-present shortage of qualified, caring nurses; and the consistently dwindling resources. When a for-profit chain purchased the home and further reduced economic resources, the director of nursing left to become a real estate agent.

Managing Stress

We will always have situations in our lives that create stress. To manage those times effectively and keep stress at levels that enhance one's performance rather than deplete energy, the key is to develop resiliency. Stagman-Tyrer (2014) explains that nurses can "build resilience through equanimity, optimism, and perseverance" (p. 49). Resilient nurses keep their commitments, respond to problems with courage, and use difficulties as opportunities for self-growth.

Personal Methods

One of the first steps in managing stress is to recognize stressors in the environment. Nurses tend to think they can be "all things to all people." Therefore, it is important to improve one's self-awareness regarding stressors.

Keeping your life in balance is difficult, but it can be done (Sullivan, 2013). Effective habits include role redefinition, time management, and self-care. Development of interpersonal skills and identifying and nurturing social supports can also facilitate stress management.

Role redefinition involves clarifying roles and attempting to integrate or tie together the various roles that individuals play. If there is role conflict or ambiguity, it is important to confront others by pointing out conflicting messages. Role redefinition may also involve renegotiation of roles in an attempt to lessen overload.

Much of the stress that nurses and nurse managers experience results from the perception that staff, patient, and workgroup needs must be met immediately and simultaneously. A notable method of coping with and reducing this stress of time is

through time management. We determine how, where, and when our time is used. Time is the essence of living, and it is the scarcest resource. One lost hour a day every day for a year results in 260 hours of waste, or 6.5 weeks of missed opportunity, annually.

Caring for yourself physically (e.g., eating a well-balanced diet, exercising regularly, getting adequate sleep) and developing effective mental habits are important self-care strategies for coping with stress. To be able to care for others, nurses need to replenish themselves and practice relaxation techniques. This is not easy, especially for an individual with a high-stress job. Some relaxation methods are listening to music, reading, and socializing with friends. Developing outside interests, such as hobbies and recreational activities, can provide diversion and enjoyment and can also be a source of relaxation. Taking regular vacations, regardless of job pressures, is important for renewal and revitalization.

Mindfulness, yoga, and tai chi are other strategies for dealing with stress. Mindfulness, in particular, has been in the news in recent years. **Mindfulness** is the ability to attend to whatever is happening in the present moment, and to accept the situation as it is without judgment (Kabat-Zinn, 2013). Reducing stress is one of the benefits of mindfulness practice (Lindquist, Witt, & Crane, 2014). Ponte and Koppel (2015) found that nurses in a mindfulness pilot program reported less stress and improved interactions with patients and families. Another study found that relaxation practice restored nurses' energy levels (Hoolahan, Greenhouse, Hoffmann, & Lehman, 2012). Yoga and tai chi are additional practices that require attention to the present moment and are often used to help reduce stress.

Leading at the Bedside: Handling Stress suggests self-evaluation to assess the need to manage stress. More personal strategies can be found in Chapter 14, "Balancing Your Life," in Eleanor J. Sullivan's *Becoming Influential: A Guide for Nurses*, 2nd ed. (Sullivan, 2013).

Organizational Methods

When stress is job related, several strategies can be used. First, proper matching of the job with the applicant during the selection and hiring process is an important step in reducing stress. Adequate orientation about what to expect on the job and using more experienced nurses as preceptors can reduce stress in novice nurses (Epstein, 2010). Skills training also reduces stress and promotes better performance and less turnover.

Leading at the Bedside: Handling Stress

Stress is inevitable. How you react to it is up to you. Nurses tend to put others first. It's the hallmark of a caring professional. However, both work and self-care are equally important to keep life in balance.

Ask yourself the following:

- Do you engage in activities that relax and renew you?
- Do you feel you must answer every email or text message immediately?
- Do you take time to consider how you allocate your time and determine your priorities?

If you answered "no" to any of the above, reread this chapter. You will find many ideas to reduce stress and improve both your personal and work life.

In addition, the organization can provide employee assistance programs (EAPs). Organizations that not only provide EAPs but promote their use report greater use of the service than organizations that promote wellness and prevention instead of EAPs (Azzone, Hiatt, Hodgkin, & Horgan, 2009). It is essential, however, to help remove the stigma about using such services (Epstein, 2010). In addition, mindfulness, yoga, or tai chi classes can be offered to staff members.

Communication and social support are additional factors in reducing stress. Both upward and downward communication channels should be open. Keeping personnel informed about what is going on in an organization helps reduce suspicion and rumor. Team building encourages staff to build a network of support with each other.

Policies that reduce the stress of shift work are also important. The number of hours in the night shift, weekend, and holiday work assignments also affects the level of stress. Providing adequate opportunities for breaks and meals is an important function of the organization.

Nurse managers are also vulnerable to stress. Shirey and colleagues (2010) found lower stress among nurse managers with more experience, those with a greater span of control, and those empowered by their chief nurse. Thus, in addition to individual coping strategies, organizations can provide support for nurse managers and make them more likely to remain in their positions.

See Case Study 26-1 for an example of how one nurse managed her own stress and helped her staff manage theirs.

CASE STUDY 26-1 | Managing Stress

Madeline Mears, RN, is nurse manager of emergency services and critical care units at two corporately owned suburban hospitals. The corporation recently purchased three not-for-profit hospitals located in the urban center of the metropolitan area. Madeline and several other nurse managers at the suburban hospitals have been informed by the vice president for patient care services that they will now be responsible for managing the same service lines at the newly acquired hospitals. Managers at the urban hospitals will move into charge nurse roles on their respective units.

Madeline has the challenge of effectively and efficiently managing emergency services and critical care units at five separate facilities, all located within a 60-mile metropolitan radius. Her past experience in merging the management responsibilities at the two suburban hospitals will be extremely useful as she works to transition the new hospitals into the healthcare system.

Madeline anticipates that staff at the hospitals will be concerned over the changes in ownership and management. Some staff may be fearful of the unknown and worried about their jobs, while others may be excited at the opportunity for increased pay and job mobility in the healthcare system. Former managers at the hospitals may be angry about their demotion. Human resources representatives have indicated that they will offer former managers the opportunity to apply for open management positions in the healthcare system.

Myriad reactions among the staff members are expected, as well as the potential for increased stress. Madeline and the other nurse managers meet and develop a transition plan. The transition plan defines the tasks, time frames, and expectations for merging the patient care units. In addition, the plan helps decrease the stress Madeline and her fellow managers experience by organizing and delineating roles and responsibilities. Consistency in implementing change will help decrease stress among the staff at the urban hospitals. Each manager is committed to meeting with staff on each unit to address questions, concerns, and morale issues. Madeline plans to schedule a lunch meeting with each former manager to discuss the unit's strengths and weaknesses as well as her goals for the unit.

Three months into the transition, Madeline's units have had low turnover, and staff members report they are satisfied with the new management structure. In particular, staff nurses enthusiastically have accepted the clinical ladder promotion program and evidence-based practice implementation. Two of the former managers have moved into management roles in the healthcare system. The transition has been stressful, but Madeline has enjoyed the opportunity to stretch her leadership skills.

Regardless of the work or life situation, everyone experiences stress, both positive and negative. It is how stress is handled that makes life interesting or excessively difficult. Stress-management strategies enable nurses to improve job performance and professional satisfaction.

What You Know Now

- Stress is a person's reaction to demands from the environment.
- Stress can be both positive and negative; regardless, the physiological response is the same.
- Causes of stress come from organizational, interpersonal, and individual factors.
- Stress can cause physical and psychological problems, including burnout and compassion fatigue.
- Technology adds to stress with constant demands for immediate attention.
- Individuals can help manage stress by recognizing stressors, redefining roles, time management, and self-care.
- Mindfulness, yoga, and tai chi are attention-oriented strategies to help reduce stress.
- Relaxing activities, recreation, hobbies, and vacations are all necessary for a balanced life.
- Organizations can support employees to manage work-related stress by matching applicants to appropriate jobs, providing adequate orientation and skills training, and using experienced nurses to preceptor novice nurses.
- Organizations can provide employee assistance programs and relaxation classes to help their staff deal with stress.

Tools for Managing Stress

1. Recognize that stress is necessary for life.
2. Acknowledge the impact of stress, both positive and negative, on your professional and personal life.
3. Review your stress-management strategies and evaluate them for effectiveness.
4. Pay attention to your stress levels, and try to create opportunities to help deal with stress.
5. If you are experiencing an exceptional amount of stress, consider various ways to care for yourself.

Questions to Challenge You

1. What causes you the most stress?
2. What methods do you use to cope with stress?
3. Have you seen others respond negatively to stress? Explain what happened.
4. Have you experienced any of the consequences of stress described in this chapter? How did you handle it? Explain.
5. Have you experienced role ambiguity or role conflict? Describe the situation. How did you handle it?
6. What ways do you care for yourself? What other ways might you add to your repertoire of self-care skills?

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Chapter 27
Advancing Your Career

Envisioning Your Future

Acquiring Your First Position
Applying for the Position
The Interview
Accepting the Position
Declining the Position

Progressing in Your Career
Tracking Your Progress
Identifying Your Learning Needs
Finding and Using Mentors

Considering Your Next Position
Finding Your Next Position
Leaving Your Present Position

Adapting to Change

Learning Outcomes

After completing this chapter, you will be able to:

1. Describe how to envision your future.
2. Relate the steps needed to obtain your first job.
3. Explain how to create your career.
4. Plan for your next position.
5. Learn to adapt to change.

Key Terms

activity log
certification
mentor
résumé

Introduction

A nurse met with the advisor in a baccalaureate program designed for RNs. After talking about the requirements of the program, the classes she needed, and her own schedule, they concluded that by taking one course a semester, it would take the nurse 5 years to complete the program. The RN looked discouraged. The advisor asked her what was wrong.

"If I enroll in this program I'll be thirty-five in five years," she said.
The advisor smiled. "Yes, and you'll be thirty-five in five years if you don't."

Envisioning Your Future

The future seems like something over which we have so little control that planning for it does not seem realistic. Wait to see what happens, try to handle the circumstances, and hope for the best are as much planning as most people do.

Instead, imagine yourself in 1 year, creating in your mind the life you most desire. What are you doing? What have you done over the course of the past year?

Now imagine what you are doing in 5 years. How about what you are doing in 10 years? Finally, what will you be doing right before you retire? Will you be satisfied with what you've done? What will you wish you had done? (See Leading at the Bedside: Your Future.)

Searching for your first job after graduation is a priority. Worrying about your career can wait. Or so you think. Shirey (2009) advises otherwise. She divides a nursing career into three stages:

- **Phase 1: Promise (first 10 years).** Initial experiences in the promise phase are essential building blocks for a long-term, successful career.
- **Phase 2: Momentum (11 to 29 years).** Continuing to learn and grow, choosing multiple experiences, and becoming visible in the profession are all important for continued success.
- **Phase 3: Harvest (last years of career).** While continuing to grow and learn, nurses also share their experiences and expertise with younger nurses and leave a legacy for the next generation. Shirey (2009) further posits that a career does not just happen: It is planned and cultivated.

Acquiring Your First Position

The first step, after you have completed your basic nursing education, is to select your first job. The purpose of this job is to learn as much as you can and to perfect your clinical skills. In addition, you will make contacts among your colleagues and supervisors.

Here are some criteria for choosing your first job:

- You will have opportunities to hone your skills in a clinical area of interest.
- You will learn from more experienced clinicians who are willing to teach you.

Leading at the Bedside: Your Future

This chapter is for you. If you are a novice nurse, it comes at the perfect time. You can build your career from the beginning. If you are more experienced, you can start now to think about what you want to do next. Where do you want to be in 1 year? 5 years? 10? When you retire? Take your time to consider your interests. Ponder the possibilities. Explore your options. Don't rush it, but don't wait too long because the future will happen regardless. Just let it be your preferable future.

- The culture of the organization and, especially, the administration are supportive of nursing.
- The organization's mission fits your values (e.g., a teaching hospital that serves the poor).
- The organization offers opportunities for advancement.

No job is perfect, just as no relationship, home, career, or family is perfect. Use the preceding criteria to assess the position and the organization. If the position and the organization fit most of them, especially the criteria most important to you, consider the following additional criteria:

- The schedule fits your lifestyle.
- The institution is near your home.

The least important criterion for selecting your first job is the salary. A small amount more in your hourly pay is worth much less than opportunities to help meet your future goals. Remember, you have a long time to be in your career; do not sacrifice opportunities in the future for a slight difference in salary now.

Applying for the Position

Some organizations ask you to fill out an application, either online, by mail, or in person; others request a résumé. A **résumé** is a written record of your educational achievements, employment, and accomplishments. (See Box 27-1 for a sample résumé.) Your résumé might also include your immediate professional goal, such as "gain clinical experience" and/or your long-term goal, such as "become a manager."

Education achievements include the following:

- Degrees, institutions, years attended, graduation date (actual or expected)
- Specialty training
- Continuing education

Employment includes the following:

- Positions held
- Names of employers
- Dates of employment

Accomplishments might include the following:

- Volunteer service, such as helping in a homeless shelter
- Organizational service, such as serving as student body president
- Awards won, such as Outstanding Junior Student

Once you have applied for a position and the organization contacts you to say a representative is interested in meeting you, you will agree on a time and place for an interview.

The Interview

The interview is your chance (sometimes your only chance) to sell yourself to a potential employer. Make no mistake: If you cannot sell yourself, no one can. You need to

Box 27-1 Sample Résumé

Chloe R. Stevenson, RN, BSN
5625 Summit Lane
Overland Park, KS 66222
913.555.2222
chloestevenson@anyprovider.net

Objective

To obtain a position as a professional registered nurse in a dynamic intensive care unit that will utilize my strong clinical skills, work ethic, problem-solving ability, and passion for providing superior patient care.

Work Experience

Registered Nurse
May 2009—Present
Telemetry Unit, Memorial Hospital, Overland Park, KS

- Currently provide direct patient care to a variety of cardiac and postoperative cardiac patients on a 30-bed telemetry unit
- Clinical duties: assessment, medication administration (including titration of cardiac IV medications), cardiac monitoring, and all other aspects of nursing care
- Actively develop, implement, and monitor individualized patient plans of care as well as document patient response and outcomes
- Became Advanced Cardiac Life Support (ACLS)—certified and serve as leader of unit's critical response team
- Participate as a member of an evidence-based practice committee for cardiology services

Patient Care Technician
January 2008—May 2009
Telemetry Unit, Memorial Hospital, Overland Park, KS

- Worked under the supervision of an RN to provide direct patient care, including taking vital signs, dressing changes, bathing, ambulation of patients, and assisting with the admission and discharge process
- Responsible for appropriate clinical documentation
- Trained to perform 12-lead EKGs as well as cardiac monitoring
- Served on unit's quality improvement team

Education

- B.S. in Nursing, May 2009, University of Kansas, GPA: 3.7/4.0
- R.N., licensed in Kansas, June 2009
- Advanced Cardiac Life Support (ACLS) certified, August 2009

Awards

- Jane Smith Award for Excellence in Clinical Nursing, May 2009; awarded by faculty to the senior nursing student who demonstrates excellence in clinical skills and academic coursework

References available upon request.

prepare for your interview just as you would for any other important meeting. That includes knowing who you are meeting, learning as much as you can about the organization, and anticipating questions you might be asked.

PREPARING FOR THE INTERVIEW The purpose of an interview is twofold: for a potential employer to learn about you and for you to learn about the organization. Ideally, the two of you will discover if there is a role for you in the organization, what is known as a good "fit."

To prepare, identify the following:

- What you want to know about the position and the organization
- What questions you might be asked about your education or past experiences (Be prepared to describe briefly your achievements.)
- What you think your strengths and weaknesses are and how those fit with your potential employer's needs
- What you want to know about the organization and the job

Find out who will be interviewing you and ask for the person's position and role in the organization. You may interview with someone in the human resources office as well as with the person who would be your supervisor.

Be especially courteous to office staff; they have the power to smooth your way or report your behavior to their boss. Try to schedule your interview for a time when you can be rested and unhurried, not right after a long day at work or when you must be somewhere else immediately afterward.

You will probably be sent some information about the organization (or you can request it). A position description is essential—you can compare it with your qualifications. The materials you receive may include the organization's mission statement, its vision for the future, and its goals.

An organizational chart also can be helpful but is not always available. The important information for you is where this position fits in the organizational structure. That will tell you to whom you would report and also explain that person's reporting relationship. The most direct line to top administration is the most powerful.

What to Wear to the Interview Most people anguish over what to wear to an interview—with good reason. The way you dress creates your first impression and can enhance or detract from your words. Keep it simple and conservative. You want the interviewer to focus on your qualifications, not your clothing.

Clean, pressed slacks and a tie and jacket for men are appropriate. Women can wear pants or a skirt with a jacket in neutral colors, low-heeled shoes, simple jewelry, and carry a handbag or briefcase. Wear something you feel comfortable in. Resist the urge to buy a new outfit unless you do not have anything suitable in your wardrobe.

At the Interview Take along a copy of your résumé even if you filled out an application. (You can refer to it if you are asked to explain an item.) Ask for explicit directions to the building and office where you will go, and plan to arrive a few minutes early. Prepare mentally by reminding yourself of the qualifications you bring to the position, noting items on the position description that fit you. Enter the office with confidence, smile, and shake hands firmly.

To consider what questions you might be asked in an interview, see examples of general questions in Table 27-1. In addition, you will be asked questions about your education and work history. Answer questions honestly, but do not feel you must explain anything you are not asked. You will have an opportunity to ask your questions about the position and the organization. Be sure you are prepared to do so. A candidate who has no questions suggests a lack of interest or expertise.

Table 27-1 Examples of Interview Questions

YOUR CURRENT JOB
What do you do in your present job?
What do you like best about your present job?
What do you like least?
Why do you want to leave your present job?
YOUR ACHIEVEMENTS AND GOALS
What are you most proud of accomplishing?
What do you think you do especially well?
What are your areas of weakness?
What are your long-term goals?
What do you plan to do to meet your goals?
YOUR INTEREST IN THE POSITION
Why are you interested in this position?
What do you see yourself doing next?
Why do you think you are right for this position?
Is there anything you would like to add about your qualifications that we haven't already discussed?

Source: From Sullivan, E. J. (2013). *Becoming influential: A guide for nurses* (2nd ed.). Upper Saddle River, NJ: Pearson. Used with permission.

Most interviewers today understand which questions are legal to ask and which are not—for example, you are not required to answer questions about how many children you have, their ages, or your marital status. Simply being asked such questions indicates an organizational bias, and if you are asked such questions you might want to reconsider your interest in the organization.

To practice for an interview, role play using the interview script in Box 27-2.

Telephone Interview It is becoming more common for employers to use a telephone interview to narrow the field of candidates prior to a face-to-face interview (Pagana, 2012). A telephone interview also might be appropriate if you are applying for a position out of town, possibly saving unnecessary travel if either you or your potential employer is no longer interested after the phone interview.

Pagana (2012) suggests preparing for a telephone interview much as you would for a personal interview:

1. Find out as much as you can about the organization.
2. Be sure you are in a quiet place where you will not be interrupted during the call.
3. Lay out your résumé and paper and pencil for notes.
4. Prepare a list of questions you want to ask.
5. Mirror a personal interview by dressing appropriately.
6. Stand so you sound confident, move around, and smile. (Yes, a smile can be heard.)
7. Listen carefully so you respond accordingly.
8. Try to end with an invitation for an in-person interview.

After the Interview Send a thank-you letter to everyone who interviewed you within 24 hours of either a telephone or in-person interview. Your letter can be handwritten

Box 27-2 Interview Script

Manager: Hi, I'm Takisha. I'm the nurse manager for the surgical care unit. Thank you for coming in today! I'd like to start by telling you a little about the surgical care unit, and then we'll talk about you and why you would like to work here.

The unit is a thirty-two-bed patient care unit that is open twenty-four hours a day, seven days a week. We provide care most typically to patients who have had abdominal surgeries or orthopedic surgeries. The average length of stay for a patient here is three days. All rooms are private, with one patient to a room. We encourage a family member to stay overnight in the sleeper chair if desired. We work hard to create a good experience for every patient.

Now, tell me about you and why you've chosen to consider working with us.

Interviewee: I'm Samuel Jones. I've been a nurse for three years. I went to school at Upstate University. I worked in the community hospital surgical unit after I graduated from nursing school—I had clinicals there during my studies.

Now I would like to move on to a larger facility that has a greater variety of patients. I've read a lot about your hospital and was very excited to see the job posting. I think this organization would be an excellent place for me to work.

Manager: Tell me more about why you think our hospital is a good fit for you.

Interviewee: Well, I know you keep adding more floors and services, and I want to be part of a growing place. I also know your website says you have just received Magnet designation. I want to be at a hospital where nursing is valued and growth is encouraged. A member of my family came here for care and loved it. He said everybody was very warm and professional.

Manager: That is very good to hear! So, let's talk about your work experience at the community hospital. Tell me about your role there.

Interviewee: Well, I'm a staff nurse in the surgical unit. I work the night shift. After working there about a year and a half, I took a preceptor class and began helping train new nurses. I am also the charge nurse there. I lead the shift, help my coworkers with their patients, get patients placed in a room when they're admitted, and talk to patients who have concerns about their care.

Manager: It sounds like you've done well in the last three years. Tell me about being the charge nurse leader. That's a large responsibility. Why do you like that responsibility, and how do you think your peers would describe you in that role?

Interviewee: I like working hard and being a role model to encourage the other staff members to work hard. I also think that most issues can be fixed with good communication, so I try to always get people to talk and to share information. I think my coworkers would say I'm always asking them if they need help with their patients. I want them to know I'm there for them.

Manager: Tell me about your strengths as a nurse.

Interviewee: I try to keep myself and everybody focused on the patient. I'm also very dependable. This is the third year in a row that I've had a perfect record of attendance at work.

Manager: Tell me about your weaknesses.

Interviewee: I think sometimes I don't ask for help and then I get overwhelmed with my work. I always try to help others but get embarrassed when I need to ask for help. I need to learn to give and take better.

Manager: We all have strengths and weaknesses. We can build on your strengths and help you learn to deal with your weaknesses. Would you like to tour the unit now?

on nice quality notepaper or typed on letter-size stationery. It should be brief, thanking the interviewer for interest in you and saying that you enjoyed the meeting. Include a few words summing up your qualifications that fit the position. Close the letter by saying that you are looking forward to hearing from her or him soon.

A Second Interview It is not unusual to have a second interview if you have passed initial scrutiny and appear to be an appropriate candidate for the position. The second interview usually includes colleagues and managers with whom you would work. You will probably tour the unit and meet potential coworkers, giving you an opportunity to assess the environment.

Situational questions are often asked at this time. For example, you are given a scenario and asked how you would handle the situation. Take your time to think through an answer. Obviously the interviewers think you can handle such a situation because you have been asked back. Keep your answer short and to the point. Your goal is to show you are a competent, confident professional.

Interviewing with potential coworkers is also your opportunity to find out what you want to know about the specific responsibilities and challenges of the position. You might ask "What are the most pressing problems facing the unit?" or "What do you need most from a nurse practitioner in this clinic?"

You will probably be asked if you are still interested in the position. If you are, ask when a hiring decision will be made. Following this interview, again send thank-you letters, but only to the new people who have interviewed you.

Accepting the Position

When you are offered the position, you have an opportunity to negotiate. Do not ignore this opportunity in your excitement about getting the job.

Salary is usually the main topic for negotiation. Most employers have some flexibility with salary if they have a justifiable reason for it, but they will seldom tell you that. It is much more common for an organization to offer the lowest salary in its range and see if the candidate asks for more. Ask for a number higher than your lowest acceptable figure, but do not get carried away. Asking for a salary that is a great deal higher than the offer is unprofessional and makes you appear to be more interested in the money than the job.

Follow up your verbal agreement with a formal letter of acceptance to the administrator who hired you. Thank the individual for having confidence in you and your potential, and state again how pleased you are to be joining the organization.

Declining the Position

Sometimes you will decide not to accept a position offered to you. It might not be the right job, at the right time, or in the right organization. Be sure to let the appropriate person know your intention as soon as possible. Thank him or her for the offer and the confidence the organization has in you. Explain briefly why you cannot accept the job at this time and state that you hope the organization will keep you in mind in the future. Follow up with a letter as well. Even if you are not interested in this position or this organization, someone there might prove valuable—for example, in referring another organization to you in the future. Your career will be long; never alienate potential connections.

Progressing in Your Career

Once you have accepted your first position, it is time to think about what you will need to advance in your career.

The first step is to assess yourself. Identify the following:

- Your personality, values, beliefs, likes, and dislikes
- Your lifestyle
- Your family
- Your friends and social life

- Your hobbies and personal activities
- Your vision of your future
- Your skills
- Your knowledge
- Your nursing preferences

The last item refers to the areas of nursing that suit you best. This may take some time and experience in practice. Then ask yourself the following:

- Do you like a fast-paced environment, such as an ED, OR, or trauma care?
- Do you prefer to have time with your patients? Rehabilitation nursing, a medical floor, or long-term care might suit you best.
- Which patient conditions and treatments do you prefer?
- Which patient conditions intrigue you the most (e.g., cardiac problems, psychiatric conditions, or diagnostics such as the GI lab)?
- Would you like to work in a clinic, medical office, home care, or public health?
- Would you enjoy school nursing? Or occupational health?

This assessment is not done quickly; it involves a period of time in practice, introspection, asking friends and family members for their thoughts about you, and learning from reading or attending programs. It is also flexible and responsive to ways in which you grow and change. Your family and social life change also, sometimes making adjustments in your plan necessary.

The next step is to assess the environment.

Consider what might change in the healthcare system (today, changes occur rapidly). How will the changes in the Affordable Care Act affect your future? Are any new medications or vaccines pending that might eliminate current jobs or create new opportunities for you? Are any new educational programs being proposed?

The clinical nurse leader is an example. As advances in transplant technology proliferate, new specialties of nurses and physicians are created. Today's noninvasive technology for monitoring and treating patients for a variety of ills and from a distance suggests that many changes in clinical care may be on the horizon.

There are many ways to learn about the environment. Certainly, paying attention to popular media reports on scientific breakthroughs and advances in technology is one way. Reading your professional literature, checking certain professional websites for updates, and attending programs in your interest area are others. Joining a professional or specialty organization and receiving its newsletters and journals is especially useful because those target your interests.

Observing others may prove worthwhile. Many people chose their career path after watching more experienced members of the profession. Nurses who pursue teaching and administration often do so after working with an especially competent role model.

Talking with experts, colleagues, and administrators is also valuable. Keep alert to what you hear, evaluate its credibility, and assess its usefulness to you. Gathering information is an ongoing process. Your plan will not be fixed; it will change in response to changes in your life, your goals, and the environment.

Once you have assessed yourself and the environment, determine what your options are. Include legal constraints or possibilities (e.g., Is the nurse practice law in your state going to be changed to allow more privileges for nurse practitioners?), new programs proposed (e.g., a local university is starting an acute care nurse practitioner program),

your own desires (e.g., doctoral education to become a nurse researcher), and how willing you are or might become to relocate, go into debt, or sacrifice the time to reach your goal. The latter issues are likely to change over time as your family life or lifestyle changes.

Evaluate what experiences you need and where you might get those from a continuing education program, on-the-job training, a certificate offered by your institution's education department, or a graduate degree. Is there a license or certification you need? What organizations, such as working at a trauma center or accepting a leadership position in your chapter of Sigma Theta Tau International, could help you achieve your goals? Are there publications or online resources that would help?

Nursing offers an incredible array of opportunities in clinical areas as diverse as cardiac surgery and trauma care to home health and rehabilitation nursing. You can be a clinician or a specialist, a teacher, administrator, or researcher. You can become an entrepreneur or an information systems specialist; you can branch into pharmaceutical sales; or, for that matter, you can write books about nursing—all the while being a nurse. See how one nurse advanced his career in Case Study 27-1.

Create a plan that is long term and flexible. No one knows what will happen in his or her own life, or in the environment over time, or what opportunities may emerge. Keep an open mind; talk to other professionals; explore your interests. What we do know is that we are contributing to our own future by what we do or fail to do today.

Tracking Your Progress

Keep an **activity log** to track everything you are doing so when the time comes to apply for a new position, you are not frantically trying to remember your accomplishments,

CASE STUDY 27-1 | Advancing Your Career

Trevor Briggs, RN, BSN, has worked as the operating room supervisor for the past 4 years. The department has used a stand-alone clinical information system for the past 2 years, and Trevor has been an integral part of the successful implementation of technology in the OR. In addition to training staff to use the system, Trevor has worked with the IT vendor to enhance the system's capabilities. Recently, Trevor was appointed by his nurse manager to serve on a hospital-wide clinical information system selection committee. Administration has initiated the process of selecting an integrated clinical information system and is seeking input from each service line.

Trevor enjoys working with the committee and learning about the implementation processes. The chief information officer met with the committee and announced the creation of a new role: clinical systems team leader. Clinical systems team leaders will be nurses who are specially trained to work with the IT department in implementing the new clinical information system. Trevor's background with the OR system makes him an excellent candidate for such a position. After interviewing with the IT department manager, Trevor is selected as a clinical systems team leader. Trevor also learns that the hospital is willing to pay for specialized training, including tuition reimbursement for graduate classes.

To increase his knowledge of information systems, Trevor enrolls in a master's of information management systems program at a local university. After completing the initial 12 hours of the master's program, Trevor must decide whether to pursue a specialty track in software development or project management. Trevor reviews market trends to determine the best option and also considers his personal preferences. He also takes the time to meet with an instructor in the master's program, who is an informatics nurse specialist and has worked in the IT field for 10 years. Trevor decides to pursue a track in project management, which will allow him to utilize his strong leadership and people management skills. After completing his master's degree, Trevor is promoted to clinical systems nurse manager and is now pursuing certification in nursing informatics.

Table 27-2 Activity Log for Career Progress

Activity	Content
Education earned	Include names of schools, location, dates attended, degrees
Employment	Include all positions, including summer jobs and part-time or full-time work while in school
Licenses	Include license number and state
Certificates/Credentials	Include name, date earned, sponsoring organization
Professional Organizations	Include name, date joined, any committees or offices held with dates
Publications	Include title, name of publication, date
Volunteer Activities	Include name of organization and your participation
Accomplishments	Include accomplishments from your job, professional activities, volunteer experiences

Source: From Sullivan, E. J. (2013). *Becoming influential: A guide for nurses* (2nd ed.). Upper Saddle River, NJ: Pearson. Used with permission.

what continuing education programs you took, or when you completed a course at your hospital. Note the name of the program, activity, certification, or accomplishments, add the dates, who sponsored it and where, and note anything special you received or learned. Include a list of accomplishments on your job, such as teaching a class or preceptoring students, or skills you have acquired. Include any cross-training as well. Table 27-2 shows an example of a format you could use.

Every item on your activity log will not go on every résumé. A résumé must be crafted to meet the purpose you have for submitting it. For example, the résumé you submit to an organization to be considered for membership differs from one you would use to apply to graduate school. Having a comprehensive list of all your activities and accomplishments helps ensure that when you put together an application or submit your résumé, you will be less likely to forget some of your achievements.

Keep track of your expenses as well. Note them in your activity log or in a separate file organized by year; this information comes in handy at tax time. You can use a document on your computer or in a notebook. It is helpful to keep continuing education (CE) certificates and receipts in a file as well.

Identifying Your Learning Needs

Pursuing a career involves lifelong learning. You can learn in many ways. Online courses, specialty certification, graduate school, books, journals, websites, and professional meetings are just a few of the ways you can acquire the knowledge you need. To develop skills, however, you need experience. Several options are possible.

BACCALAUREATE EDUCATION FOR RNS The Institute of Medicine (2010) recommends that 80% of nurses be prepared at the baccalaureate or higher level by 2020. Most baccalaureate programs in nursing have an option for RNs to complete their degrees without repeating content from their basic program, and many offer programs online.

Certification Certification is growing in nursing as clinical care becomes more specialized. **Certification** is a formal recognition that a nurse has acquired specialized knowledge, skills, and experience that meet identified standards. Nursing certification programs are accredited by either the National Commission for Certifying Agencies

(NCCA) or the American Board of Nursing Specialties (ABNS). Nursing certifications are available in a wide range of clinical specialties, including nurse practitioner, clinical nurse specialist, and clinical specialties such as cardiac rehabilitation, gerontological nursing, informatics, and primary care.

Nurses may be reluctant to pursue certification for several reasons (Watts, 2010), including the costs of the examination and study guides, lack of employer support, or absence of on-the-job rewards. However, the benefits to your long-term career may offset the immediate disadvantages.

Graduate Education Graduate school, in either a master's or doctoral program, offers both didactic content and experience, which might be clinical for a practitioner program or research in a doctoral program, depending on your goals. If you want to be a nurse practitioner, teach nursing, become a nurse researcher, or advance as an administrator, you will need graduate preparation.

Choosing a graduate program is a difficult and time-consuming endeavor. You must learn as much as you can about the program, its requirements, and its graduates' success to determine if the program will meet your needs. Gather literature, meet with admissions staff and faculty, and talk to students and colleagues. Compare national rankings of the schools that interest you. Request the names of recent graduates to contact for references and interview them. Ask your teachers, supervisors, and preceptors for advice.

This is one of the most important decisions you will make in your career. It can also be the most valuable. Take your time, consider your options, and be fully committed before you enroll.

Many options are available to pay for graduate school education. As with the decision to select a school and a program, finding sources of funding takes perseverance. The school's financial aid office can help you locate loans and scholarships. Service clubs, such as Rotary International, support nursing scholarships.

It is helpful to know your long-term goal, especially if you are interested in an area of need. For example, a nursing faculty shortage is increasing as retirements thin the ranks of today's instructors. Nurse practitioners are needed to work in disadvantaged areas; some scholarships exist for nurses who agree to provide care in these areas for a period of time after graduation. In addition, the military offers scholarships in return for a service commitment.

Continuing Education Finding continuing education to further your career is not difficult; determining the quality of the program is not as easy. If you receive information about a program that interests you and fits with your career goals, evaluate the information using the following:

- Is the program sponsored by a known organization, such as a college or professional association?
- Who are the speakers? Are their credentials appropriate to their presentations?
- Is the content appropriate to you at this stage in your development—neither too advanced nor too elementary?
- Can you obtain financial assistance to attend? If you do, what will you owe the organization? Bringing back a report of a program you've attended is an excellent way to reinforce your own learning. This will give you an opportunity to speak in public as well.

- Consider attending, even if you must pay your own way. You may be able to deduct the expense on your taxes and, after all, you and your career are the beneficiary.
- Can you arrange to be off work, if necessary, and can you afford the time and expense?

Professional Associations Membership in professional associations offers many opportunities for learning. Journals, newsletters, websites, blogs, listservs, meetings, conventions, and programs are just the beginning. The opportunity to meet and network with your colleagues and senior people in the profession and to learn by serving on committees, task forces, and boards is immense. Many successful nurses began their career by participating in a professional association.

Nursing associations cover every specialty and interest. Membership in the American Nurses Association (ANA) is open to all registered nurses through its constituent member associations. Sigma Theta Tau International has more than 400 chapters affiliated with schools of nursing around the world. Specialty organizations exist for nurses who work in many clinical areas, such as the American Association of Critical Care Nurses (AACCN) or the American Psychiatric Nurses Association (APNA). Each of these organizations has divisions, committees, and boards where your time and talents are welcome.

Finding and Using Mentors

One of the most important tasks in your career is to identify and cultivate mentor relationships. A **mentor** is a person who has more experience than you and is willing to help you progress in your career. A mentor introduces you to key people and tells you what you need to know and do to move ahead. A mentor provides opportunities for learning, counsels you on mistakes, and takes pride in your successes.

A mentor may be a senior nurse or someone in another closely aligned profession, mostly because the mentor must have contacts that can be useful to your career. Often you work for the same organization, but that is not a requirement. You can have more than one mentor but, usually, not at one time.

You might identify someone you would like to be your mentor, or the mentor might select you. The arrangement of mentor and mentee, however, is rarely named as such. Usually, you find yourself relying more and more on one or two people for advice, or a mentor singles you out for special opportunities or assignments. If any of those do not work out especially well, or if the two of you do not seem to be compatible, nothing is lost. You both go on your way without any bad feelings. A person becomes a mentor when positive experiences accumulate, bringing satisfaction to you both.

A number of benefits accrue for both you and your mentor. You gain a sense of accomplishment by working with a mentor, and the mentor acquires fulfillment from contributing to you and, by extension, to your profession. People who are senior in the field have a responsibility to pass along what they have learned and to prepare those who come after them. These are the satisfactions of a career done well.

The time will come, however, when you move away from your mentor. You take a new job or your mentor does; your relationship changes as a result. You may then become colleagues and friends, and you may acquire a new mentor in the new organization. Sometimes you will move ahead of the mentor, a situation that requires tact

and commitment from both of you. Accomplished professionals know that they will always owe a debt to their mentor, and they will continue to show their appreciation in large and small ways.

Considering Your Next Position

The time to think about your next job is when you accept the first one. Begin to assess how much you can learn in this job and think about your next step. Take every opportunity you can to learn.

> *One new grad had already determined that she wanted to teach nursing and knew that she needed clinical experience before she went on to graduate school. She used each clinical experience as a learning opportunity. She made notes on the patients she cared for and looked up their conditions, treatments, and meds on her time off from work. In less than a year, she had compiled a study guide of her own notes. She began graduate school full-time and continued to work part-time, continuing to add notes throughout her graduate school experience. By the time she graduated, she was an experienced clinician, although the actual hours she spent in clinical work were fewer than most of the other new nurse faculty.*

Finding Your Next Position

When jobs are plentiful, you have many opportunities for finding the next job in your career. This move must not be taken lightly, however, no matter how many jobs are available. This is where self-assessment is essential. You want to be certain you are ready to leave your current job, that you have learned and accomplished what you set out to do, that you will not be leaving at a crucial time (e.g., an imminent Joint Commission visit), and that you have selected the job that fits your needs now.

When you are ready, there are many ways to find potential positions. Career fairs, online ads, nursing websites, and faculty from the school where you graduated are additional ways to inquire about opportunities and to let others know you are interested in considering future options. (Also, see Online Resources at end of this chapter.)

Leaving Your Present Position

Just as there is a way to find a job, there is also a way to leave a job. First, check to see how much notice your employer requires. Tell your supervisor as soon as you have accepted the new position, and follow up with a formal letter of resignation. Add some friendly comments, regardless of how you feel about the organization, your coworkers, or the supervisor. Your goal is to leave on good terms.

Resist the urge to just walk out, regardless of the situation. The only reason for doing this would be that you are in physical danger and the organization is not providing adequately for your safety. This is a rare, though not unknown, situation.

Always be polite in your interactions with your coworkers and your supervisor. Resist, also, the urge to belittle the organization or the administration. Negative comments about others reflect mostly on you. Of course, do not say anything that is untrue. If the situation is difficult, the other employees know it as well. You do not need to say anything at all, even if you are asked. You never know what the future will bring, and ending relationships politely is best for your future.

Adapting to Change

Change occurs every day in healthcare, and the pace of change seems to come faster and faster. In order to pursue the career you want and to find satisfaction in that career, you must be able to adjust and respond to change. The most important attribute you can bring to this effort is to remain flexible.

> *Marika, experienced in psychiatric nursing and home care, entered a master's program, intending to work as a mental health clinical specialist for a home healthcare agency. While she was in graduate school, she learned that the agency would no longer be reimbursed by insurers for the services of a mental health specialist, and the position had been eliminated.*
>
> *Fortunately, Marika had a backup plan. She changed course, continued on in graduate school, and obtained her doctorate. She became a nursing faculty member and now researches mental health problems in patients with home care needs.*

Other events can change your future. Your spouse is offered a job in another part of the country. You find you are going to become a parent. Your parents need more care than you have been providing. When events intrude on your plan, you may need to adjust your time schedule, taking graduate classes more slowly, for example.

Life is a work in progress. We never know what our future will bring. Allow for unplanned events, such as illness, pregnancy, or the closing of your hospital. Plan for contingencies, but keep your eye on your vision. Remain flexible. You might discover that new opportunities await you, bringing a better future than one you had imagined.

Note: This chapter was adapted from content in Sullivan, E. J. (2013). *Becoming influential: A guide for nurses* (2nd ed.). Upper Saddle River, NJ: Pearson.

What You Know Now

- Envisioning your future is an important exercise to guide your first steps after graduation.
- Your career consists of three phases: promise, momentum, and harvest.
- Knowing your preferences (e.g., clinical area of interest, values, lifestyle) can guide you in selecting your first position. Take time to create your résumé, and before an interview learn about a potential employer and prepare questions. Follow up with thank-you notes. Accept a job offer after careful negotiations. If you decline an offer, always do so graciously and on good terms.
- Throughout your career, track your progress and identify your learning needs.
- Find and use mentors, especially early in your career.
- When the time is right to find a new job, explore the many ways (e.g., job fairs, nursing websites, faculty from your school) to find potential positions. Submit your resignation in compliance with your employer's requirements, and leave on good terms.
- Flexibility is needed to adapt to change.

Tools for Advancing Your Career

1. Select positions and professional activities that further your short- and long-term goals.
2. Keep a log of your activities and accomplishments.
3. Keep abreast of the healthcare and policy environment, noting possibilities for your future.
4. Evaluate educational opportunities for their appropriateness for your learning needs and career advancement.
5. Identify and cultivate mentor relationships.
6. Evaluate your progress periodically and update with new information or interests.

Questions to Challenge You

1. Answer the questions posed in this chapter about how you envision your future. Is the study or work you are currently doing helping you progress toward that future? If not, what do you need to do to help yourself?
2. Role play with a colleague the interview in Box 27-2 then reverse roles. How is the experience different if you are the interviewer versus the candidate being interviewed?
3. Create or review your résumé. Is it up to date? If not, add all the missing information. Take a few moments to ponder your accomplishments.
4. Begin an activity log. Periodically review your accomplishments.
5. Do you have a mentor? Evaluate that relationship. What more might you want from your interactions with your mentor? How might that occur?
6. What educational needs do you have? Investigate potential opportunities to acquire the necessary education or certification.
7. Have you ever had your professional plans fail? What, if anything, would you do differently in the future?

Online Resources

American Nurses Association: http://nursingworld.org/MainMenuCategories/Career-Center

Nurse.com: http://www.nurse.com/jobs

Sigma Theta Tau International: http://jobs.nursingsociety.org/home/index

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Chapter 28
Imagining the Future

Ways to Consider the Future
Possible Future
Plausible Future
Probable Future
Preferable Future

Societal Predictions About the Future

The Future of Healthcare
Technological Innovations
Healthcare Legislation
Demands of Consumerism

The Future of Nursing
Institute of Medicine Recommendations
New Careers in Nursing Project

Learning Outcomes

After completing this chapter, you will be able to:

1. Examine various ways to think about the future.
2. Evaluate predictions about society's future.
3. Assess changes affecting the future in healthcare.
4. Critique opportunities for nurses in the future.

Key Terms

plausible future
possible future
preferable future
probable future
wildcards

Introduction

The future is always uncertain, which leads many to believe they cannot do anything about it. The future, however, is shaped by human decisions and actions, including our own, made daily. Both individually and collectively, we are affecting the future by what we do today or what we fail to do.

Ways to Consider the Future

In the past, it was common to believe that the future would be a continuation of the past. That was not true then, and it is not true today. Rapid changes in healthcare, science, technology, and the populace are just a few of the revolutionary circumstances that are altering the future.

Different ways to think about the future include a possible future, a plausible future, a probable future, and a preferable future (Bezold, Hancock, & Sullivan, 1999).

Possible Future

The **possible future** includes anything that could happen, no matter how unlikely. Science fiction, in its use of the possible future, includes implausible occurrences. The possible future also includes **wildcards**, which are unforeseen events that have far-reaching effects. The World Trade Center attack on 9/11 is an example. Because they are unpredictable, wildcards are not useful to predict the future.

Plausible Future

The **plausible future** is narrower in scope and considers events that could happen. The Institute for Alternative Futures uses a plausible future orientation that considers values and beliefs to create the futures they prefer (Institute for Alternative Futures, 2016).

Probable Future

The **probable future** considers the future as an extension of the present. To understand how unlikely a probable future is, consider how healthcare professionals were paid only a decade ago: Hospitals and physicians were compensated for the amount of care they gave—period. If the patient improved, all the better. If not, healthcare providers were still paid.

Preferable Future

The **preferable future**, on the other hand, is what we want to have happen in the future. To create a preferable future, organizations, or individuals, must create a vision of that future then design strategies to actualize that vision.

Societal Predictions About the Future

Healthcare, including nursing, is embedded in the greater society, so it behooves us to consider what societal changes may affect nursing. Here is an abbreviated list of possibilities:

- Science will continue to explore both the minute world within and the expanded universe with untold possibilities emerging.
- Medical science will perfect targeted and individualized diagnostic tools and specific treatments to improve healthcare.
- Knowledge will continue to explode as heretofore marginalized peoples gain access to needed information in such areas as, for example, education, healthcare, agriculture, and manufacturing.

- Technology will evolve more and more rapidly as innovations are put into practice.
- Mobile devices in the hands of disadvantaged people in developing countries will provide access to information that in the past was unavailable to them.
- Industries will continue to become computerized, resulting in joblessness or underemployment for workers without the education, ability, or interest in technology.
- Education will target specific industries' emerging needs for employees.
- Education will become more specialized to meet individual interests.
- Online access to education will continue to proliferate, offering information to diverse populations.
- Learning from such mediums as YouTube videos and TED talks will expand, enabling anyone with a smartphone to access the expertise of a wide variety of authorities.
- Structured employment will decrease while fluidity of work will increase with more and more workers creating their own jobs with one company or several.
- Self-employment and startups will continue to grow.
- Disenfranchised populations are likely to continue their attacks on successful, Western countries.
- The need for surveillance to target potential threats will persist, and individual liberties may diminish as a result.
- Entertainment options will expand with print, online, streaming, and audio competing with traditional mediums.
- Entertainment modalities will directly target individuals' interests (e. g., playlists).
- Competition for scarce resources may force more cooperation, although it may do the reverse with the powerful dominating access.
- The rights of individuals versus the good of the public will continue to challenge policies locally, nationally, and worldwide.

None of these predictions may come true, or all of them may. What is known is that rapid change is occurring today and into the future. The individuals and organizations that prosper in the future will be those who take advantage of the opportunities in these changes to create their preferred future.

The Future of Healthcare

Rapid changes today can predict possible opportunities in the future. However, allowing today's trends to morph into the future without finding possibilities in them prevents us from taking advantage of these trends. Only a lack of imagination precludes us from considering and creating a preferable future in healthcare.

Technological Innovations

It seems as if technology is developing faster than it can be conceived. Mobile devices, virtual reality, and cloud computing are just three of the technologies changing now and expected to continue to change into the future. Healthcare technologies are progressing just as rapidly.

COMMUNICATIONS Only a few years ago, envisioning a mobile device that carried the contents of an entire computer inside was unthinkable. Today it is commonplace. In healthcare, patients can access their own records, see the results of their examinations, read about their treatments, and delve into the purpose and side effects of their medications through a portal into their health record. As a result, patients are able to become partners with their healthcare providers in planning and implementing their care. In addition, electronic communication speeds answers to patients' questions, schedules tests, and returns lab results, among other uses. In addition, cloud computing shifts data from devices to services and enables real-time data to be shared among healthcare providers as well as with patients (Sensmeier, 2013).

EXAMINATION AND MONITORING Bedside x-ray and scanning devices are commonplace. Distance exams, too, can be conducted via Skype, and mobile devices can monitor changes in a patient's condition from afar. Paperless prescriptions sent electronically to the pharmacy prevent costly mistakes (Woodard, 2009).

AUTOMATED TECHNOLOGY Automated technology makes medication administration safer and more convenient. Barcode scanning sends a medication order to the pharmacy. After the medication is verified, it is entered into the patient's record. Then bedside barcodes verify patient identification to match patient to medication and at the same time the codes enter the medication delivery into the patient's record. Invisible to the nursing staff but equally important is an inventory management system that replenishes medications automatically as they are removed.

Healthcare Legislation

Healthcare legislation known as the Affordable Care Act (ACA) was enacted in 2010 and mandated that individuals acquire insurance coverage or face penalties; it also changed how care is reimbursed. As a result, healthcare organizations are paid for the *value* of their care, rather than the *amount* of care. Patient satisfaction is assessed after discharge, and Medicare reimbursement is based on the results (Dempsey, Reilly, & Buhlman, 2014). However, the ACA may be repealed and what plan will replace it is unknown at this time.

Patient satisfaction efforts have spawned efforts for improvement. One such endeavor is to improve relationships between patients and nurses (Prescott, 2015). By introducing themselves by name and role when they first meet a patient, nurses encourage a positive connection between them. Wearing a visible "RN" nametag reinforces their importance to the patient's well-being.

Demands of Consumerism

Consumerism has grown simultaneously as products and services have become easily accessible and personalized. Amazon's algorithms allow the company to target individual consumers and to suggest additional items of interest based on their searches and purchases. Reviews of local or national products and services enable consumers to choose from an array of possibilities and then to make informed decisions before buying.

Savvy, educated consumers expect their healthcare to be as easily accessed as other products and services, especially their individual needs (Squires, 2012). Younger consumers, in particular, want to access information and interact with healthcare providers via their mobile devices (Morrison, 2015). Healthcare clinics are located in retail stores (e. g., Target, Walmart, CVS, Walgreens) to meet urgent care needs and consumers'

desire for quick, available service. Even the growth of the right-to-die movement is consumer driven (Childress, 2012).

What this means for those who work in healthcare is that we must continue to keep the patient (our customer) at the forefront of our considerations. What does the patient need at this moment? A medication? Information? Suggestions for discharge? Reassurance? Furthermore, we must make certain to follow up. Such a system is satisfying for patients and rewarding for nurses. In addition, healthcare organizations benefit economically.

The Future of Nursing

The nursing profession is perfectly poised to take advantage of opportunities to create its preferred future. Nurses are the frontline of contact and care of patients. It is the actions of nurses, more than any other healthcare providers, that affect patients' satisfaction with their care, which, in turn, affects healthcare organizations' reimbursement. Nothing could be more valuable to the healthcare organization.

Determined to improve nursing, and thus healthcare, the Robert Wood Johnson Foundation funded two projects: the Institute of Medicine (2011a) study to examine the nursing profession and make recommendations for its future, and a collaborative effort with the American Association of Colleges of Nursing to increase diversity in nursing's ranks (Krol, in press).

Institute of Medicine Recommendations

The Institute of Medicine (IOM) report entitled *The Future of Nursing*, released in 2011, recommended major changes in nursing education and practice that would transform healthcare (Hassmiller & Reinhard, 2015). Included in the IOM recommendations were demands for nurses to expand their education and to be full partners in the healthcare delivery system. Nurses must help shape and lead healthcare change, according to the report. (See Table 28-1 for IOM's recommendations.)

New Careers in Nursing Project

In response to nursing shortages and a nursing population lacking in diversity, the Robert Wood Johnson Foundation funded the New Careers in Nursing program (Krol, in press). It was designed to support individuals with degrees in other fields to enter accelerated baccalaureate or master's programs in nursing. In that way, numbers of new nurses could be educated in a relatively short time. Underrepresented groups and those from disadvantaged backgrounds were targeted for recruitment.

The program offered scholarships for entering students and numerous resources for schools involved. These resources include the following:

- Leadership Development Toolkit
- Pre-Entry Immersion Program Toolkit
- Mentoring Toolkit
- Recruitment Toolkit
- Doctoral Advancement in Nursing Toolkit
- New Careers in Nursing Scholar Alumni Toolkit (Krol, in press)

Table 28-1 Institute of Medicine's Recommendations for Nursing

Recommendations	Explanations
1. Remove scope-of-practice barriers.	1. Advanced practice RNs should be able to practice to the full extent of their education and training.
2. Expand opportunities for nurses to lead and diffuse collaborative improvement efforts.	2. Private and public funders, healthcare organizations, nursing education programs, and nursing associations should expand opportunities for nurses to lead and manage collaborative efforts with physicians and other members of the healthcare team to conduct research and to redesign and improve practice environments and health systems. These entities should also provide opportunities for nurses to diffuse successful practices.
3. Implement nurse residency programs.	3. State boards of nursing, accrediting bodies, the federal government, and healthcare organizations should take action to support nurses' completion of a transition-to-practice program (nurse residency) after they have completed a prelicensure or advanced practice degree program or when they are transitioning into new clinical practice areas.
4. Increase the proportion of nurses with a baccalaureate to 80% by 2020.	4. Academic nurse leaders across all schools of nursing should work together to increase the proportion of nurses with a baccalaureate from 50% to 80% by 2020. These leaders should partner with education accrediting bodies, private and public funders, and employers to ensure funding, monitor progress, and increase the diversity of students to create a workforce prepared to meet the demands of diverse populations across the lifespan.
5. Double the number of nurses with a doctorate by 2020.	5. Schools of nursing, with support from private and public funders, academic administrators and university trustees, and accrediting bodies, should double the number of nurses with a doctorate by 2020 to add to the cadre of nurse faculty and researchers, with attention to increasing diversity.
6. Ensure nurses engage in lifelong learning.	6. Accrediting bodies, schools of nursing, healthcare organizations, and continuing competency educators from multiple health professions should collaborate to ensure that nurses and nursing students and faculty continue their education and engage in lifelong learning to gain the competencies needed to provide care for diverse populations across the lifespan.
7. Prepare and enable nurses to lead change to advance health.	7. Nurses, nursing education programs, and nursing associations should prepare the nursing workforce to assume leadership positions across all levels, while public, private, and governmental healthcare decision makers should ensure that leadership positions are available to and filled by nurses.
8. Build an infrastructure for the collection and analysis of interprofessional healthcare workforce data.	8. The National Health Care Workforce Commission, with oversight from the Government Accountability Office and the Health Resources and Services Administration, should lead a collaborative effort to improve research and the collection and analysis of data on healthcare workforce requirements. The Workforce Commission and the Health Resources and Services Administration should collaborate with state licensing boards, state nursing workforce centers, and the Department of Labor in this effort to ensure that the data are timely and publicly accessible.

Source: Institute of Medicine. (2011b). The future of nursing: Campaign for action. Retrieved April 1, 2016 from http://campaignforaction.org/directory-of-resources/iom-report. Used with permission.

As of June 2015, 130 schools in 41 states and the District of Columbia had participated in the program, and more than 3,500 students had earned baccalaureate or master's degrees (Krol, in press). Participating institutions reported that their organizations had become more diverse and inclusive as a result of the program (Krol).

For the nursing profession to create its preferred future, individual nurses, nursing education, practice settings, and nursing science must contribute their expertise. Individual nurses must have educational opportunities to advance and be willing to take advantage of them. Furthermore, they must be able to practice at the highest level of their education. The practice setting must use nurses' expertise and make them full partners with other healthcare professionals to shape the healthcare system of the future. In order to meet the healthcare needs of an increasingly diverse population,

nursing education must continue to attract disadvantaged populations and men to the profession. Nursing science must continue to delve into ways that nursing care improves health and expands wellness. Nursing has the potential to enhance the health of the nation in ways only imagined today.

Leading at the Bedside: Imagining the Future

This chapter, more than any others, is for you. You are the future of nursing. What you do today has the potential to improve nursing care to patients, to enhance your practice, and to enrich the profession. Conversely, if you assume what has happened in the past will continue into the future—or if you ignore opportunities to change yourself, your practice, and your profession—you are unlikely to improve nursing care or its environment.

Which nurse do you want to be?

What You Know Now

- The future is unknown, but a preferred future can be created with vision and strategies.
- Science, knowledge, technology, education, employment, and entertainment are just a few of the areas that will experience considerable change in the future.
- Technology, healthcare legislation, and consumers' demands will continue to evolve and impact healthcare in multiple ways.
- Nursing's future will involve demands for higher levels of education, advances in nurses' practice opportunities, nurses' increased participation in workforce planning and creating healthcare's future, and more diversity in nursing's ranks.
- Nurses have exceptional opportunities to take advantage of changes in today's healthcare environment.

Questions to Challenge You

1. If you could design a brand-new healthcare system, what would it look like?
2. Can you add any societal predictions to the list in this chapter?
3. What other changes are occurring in healthcare that are not included in this chapter?
4. Have you seen any of the Institute of Medicine's recommendations in your practice or educational setting?
5. What specific changes could you imagine in your area of practice? If they occurred, would they improve or diminish your patients' care?

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Glossary

A

absence culture The informal norms within a work unit that determine how employees of that unit view absenteeism.

absence frequency The total number of distinct absence periods, regardless of their duration.

accommodating An unassertive, cooperative tactic used in conflict management when individuals neglect their own concerns in favor of others' concerns.

accountability The act of accepting ownership for results or the lack thereof.

accountable care organization (ACO) A group of healthcare providers who provide care to a specified group of patients.

activity log An ongoing record of professional progress, including educational programs, training, certifications, and accomplishments.

adaptive decisions The type of decisions made when problems and alternative solutions are somewhat unusual and only partially understood.

additive task A task in which group performance depends on the sum of individual performance.

adjourning The final stage of group development, when a group dissolves after achieving its objectives.

administrative law Public law made by administrative agencies that are granted authority to enact rules and regulations to carry out specific intentions of a statute.

advance directive A document that allows a competent patient to make choices prior to the need for medical treatment.

Affordable Care Act (ACA) Legislation implemented in 2010 that radically changed how healthcare is delivered and compensated in the United States.

Age Discrimination Act A law prohibiting discrimination against applicants and employees over the age of 40.

all-hazards approach Determining and acting upon a community's vulnerability to specific threats for emergency preparedness planning.

allocation A decision that society makes regarding how many of its resources will be devoted to a particular effort; also called macroallocation.

Americans with Disabilities Act A law prohibiting discrimination against qualified individuals who have physical or mental impairments that substantially limit one or more of the major life activities.

artificial intelligence Computer technology that can diagnose problems and make limited decisions.

assignment Allocating tasks appropriate to the individual's job description.

attendance barriers The events that affect an employee's ability to attend (e.g., illness, family responsibilities).

authority The right to act or empower.

autonomy The right of individuals to take action for themselves.

avoiding A conflict management technique in which the participants deny that conflict exists.

B

behavior-oriented performance evaluation A system for appraising employee performance based on organizational values, position descriptions, cluster behaviors, specific examples, and developmental goals.

behavioral interviewing Interview questions that use the candidate's past performance and behaviors to predict behavior on the job.

benchmarking A method of comparing performance using identified quality indicators across institutions or disciplines.

beneficence The duty to help others by doing what is best for them.

benefit time Paid time, such as vacation, holidays, and sick days, for which there is no work output.

block staffing Scheduling a set staff mix for every shift so that adequate staff are available at all times.

bona fide occupational qualification (BFOQ) A characteristic that excludes certain groups from consideration for employment.

brainstorming A decision-making method in which group members meet and generate diverse ideas about the nature of, cause of, definition of, or solution to a problem.

budget A quantitative statement, usually in monetary terms, of the expectations of a defined area of an organization over a specified period of time in order to manage its financial performance.

budgeting The process of planning and controlling future operations by comparing actual results with planned expectations.

bullying Aggressive behavior as mild as innocuously irritating or as extreme as dangerously violent.

bureaucracy A term proposed by Max Weber to define the ideal, intentionally rational, most efficient form of organization.

burnout The perception that an individual has used up all available energy to perform the job and feels that he or she does not have enough energy to complete the task.

business necessity Discrimination or exclusion that is allowed if it is necessary to ensure the safety of workers or customers.

C

capital budget A component of the budget plan that includes equipment and renovations needed by an organization in order to meet long-term goals.

capitation A fixed monthly fee for providing services to enrollees.

Centers for Medicare & Medicaid Services (CMS) The U.S. agency that oversees government payments for healthcare.

certification Formal recognition that the nurse has acquired specialized knowledge, skills, and experience that meet identified standards.

chain of command The hierarchy of authority and responsibility within an organization.

change agent One who works to bring about change.

change The process of making something different from what it was.

channels of communication Pathways for exchanging information that employ synchronous or asynchronous methods.

charge nurse An expanded staff nurse role with increased responsibility and the function of liaison to the nurse manager.

clinical nurse leader (CNL) A lateral integrator of care responsible for a specified group of patients within a microsystem of the healthcare setting.

closed shop A business in which union membership (often of a specific union and no other) is a precondition to employment.

coaching The day-to-day process of helping employees improve their performance.

coercive power Power based on penalties that a manager might impose if the individual or group does not comply with authority.

cohesiveness The degree to which the members are attracted to the group and wish to retain membership in it.

collaboration All parties working together to solve a problem.

collective bargaining Collective action taken by workers to secure better wages or working conditions.

committees Groups that deal with specific issues involving several service areas.

common law Type of law derived from earlier decisions made by courts; also referred to as legal precedent.

communication A complex, ongoing, dynamic process in which the participants simultaneously create shared meaning in an interaction.

compassion fatigue Secondary traumatic stress experienced by caregivers.

competing An all-out effort to win, regardless of the cost.

compromise A conflict management technique in which the rewards are divided between both parties.

confidentiality The right to privacy of records and information.

conflict The consequence of real or perceived differences in mutually exclusive goals, values, ideas, attitudes, beliefs, feelings, or actions.

confrontation The most effective means of resolving conflict, in which the conflict is brought out in the open and attempts are made to resolve it through knowledge and reason.

conjunctive task A task in which the group succeeds only if all members succeed.

connection power Power based on an individual's formal and informal links to influential or prestigious persons inside and outside an organization.

consensus A conflict strategy in which a solution that meets everyone's needs is agreed upon.

content theories Motivational theories that emphasize individual needs or the rewards that may satisfy those needs.

continuous quality improvement (CQI) The process used to improve quality and performance.

controlling The process of comparing actual results with projected results.

corporate liability An organization's responsibility for its own wrongful conduct.

cost center The smallest area of activity within an organization for which costs are accumulated.

creativity The ability to develop and implement new and better solutions.

critical pathways Tools or guidelines that direct care by identifying expected outcomes.

critical thinking A process of examining underlying assumptions, interpreting and evaluating arguments, imagining and exploring alternatives, and developing reflective criticism for the purpose of reaching a reasoned, justifiable conclusion.

D

decision making A process whereby appropriate alternatives are weighed and one is ultimately selected.

delegation The process by which responsibility and authority are transferred to another individual.

demand management A system that uses best-practices protocols to predict the demand for nursing expertise several days in advance.

descriptive rationality model A decision-making process that emphasizes the limitations of the rationality of the decision maker and the situation.

developmental plan A staff member's goals for the coming year against which performance will be judged.

diagonal communication Communication involving individuals at different hierarchical levels.

direct costs Expenses that directly affect patient care.

directing The process of getting the work within an organization done.

disjunctive task A task in which the group succeeds if one member succeeds.

distributive justice The concept of giving a person that which he or she deserves regardless of race, gender, religion, or socioeconomic status so no one bears a disproportionate share of benefits or burdens.

diversification The expansion of an organization into new arenas of service.

divisible task Tasks that can be divided into subtasks with division of labor.

DMAIC A Six Sigma process improvement method.

downward communication Communication, generally directive, given from an authority figure or manager to staff.

driving forces Behaviors that facilitate change by pushing participants in the desired direction.

durable power of attorney A legal document made by a competent adult that appoints a surrogate or proxy to make decisions in the event that the individual becomes unable to do so.

E

efficiency variance The difference between budgeted and actual nursing care hours provided.

electronic health records (EHRs) Integrated records that include information from all medical sources and can be accessed from multiple locations by sanctioned providers.

emergency operations plan (EOP) The EOP includes preparation, education and training, and implementation of the hospital's response to emergency situations.

emotional intelligence Personal competence (self-awareness and self-management) and social competence (social awareness and relationship management) that begin with authenticity.

empirical-rational model A change agent strategy based on the assumption that people are rational and follow self-interest if that self-interest is made clear.

engagement When an employee is inspired by an organization, willing to invest effort, likely to recommend the organization, and planning to remain in the organization.

equity theory The motivational theory that suggests effort and job satisfaction depend on the degree of equity or perceived fairness in the work situation.

ethics A science that deals with principles of right and wrong, good and bad; it governs our relationship with others.

evidence-based practice (EBP) Applying the best scientific evidence to a patient's unique diagnosis, condition, and situation to make clinical decisions.

expectancy theory The motivational theory that emphasizes the role of rewards and their relationship to the performance of desired behaviors.

expense budget A comprehensive budget that lists salary and nonsalary items that reflect patient care objectives and activity parameters for the nursing unit.

experimentation A type of problem solving in which a theory is tested to enhance knowledge, understanding, or prediction.

expert power Power based on the manager's possession of unique skills, knowledge, and competence.

expert systems Computer programs that provide complex data processing, reasoning, and decision making.

extinction The technique used to eliminate negative behavior, in which a positive reinforcer is removed and the undesired behavior is extinguished.

F

feedback The day-to-day process of helping employees evaluate and improve their performance.

felt conflict The negative feelings between two or more parties.

first-level manager The manager responsible for supervising nonmanagerial personnel and day-to-day activities of specific work units.

fiscal year A specified 12-month period during which operational performance and financial performance are measured.

fixed budget A budget in which amounts are set regardless of changes that occur during the year.

fixed costs Expenses that remain the same for the budget period regardless of the activity level of the organization.

followership An interactive and complementary relationship to leadership.

forcing A conflict management technique that forces an immediate end to conflict but leaves the cause unresolved.

formal committees Committees in an organization with authority and a specific role.

formal groups Clusters of individuals designated by an organization to perform specified organizational tasks.

formal leadership Leadership that is exercised by an individual with legitimate authority conferred by position within an organization.

forming The initial stage of group development, in which individuals assemble into a well-defined cluster.

four Ps of marketing Four strategies included in marketing plans: product, place, price, and promotion.

full-time equivalent (FTE) The percentage of time an employee works that is based on a 40-hour workweek.

G

goal setting The relating of current behavior, activities, or operations to an organization's or individual's long-range goals.

goal-setting theory The motivational theory that suggests that the goal itself is the motivating force.

grievances Formal expressions of complaints, generally classified as misunderstandings, contract violations, or an inadequate labor agreement.

group An aggregate of individuals who interact and mutually influence each other.

groupthink A negative phenomenon occurring in highly cohesive, isolated groups in which group members come to think alike, which interferes with critical thinking.

H

Hawthorne effect The tendency for people to perform as expected because of special attention.

health home With this arrangement, primary care providers facilitate access to specialty care when needed and monitor that care using electronic health records; also called medical home.

hidden agendas A group member's individual, unspoken objectives that interfere with commitment or enthusiasm.

horizontal integration Arrangements between or among organizations that provide the same or similar services.

horizontal promotion A program to reward a high-performing employee without promoting the employee to a management position.

horizontal violence Harassment between or among employees of equal rank.

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) A 32-item instrument to measure patient satisfaction across institutions after discharge.

I

incident reports Accurate and comprehensive reports on unplanned or unexpected occurrences that could potentially affect a patient, family member, or staff.

incivility Aggressive behavior; also called bullying.

incremental (line-by-line) budget A budget worksheet listing expense items on separate lines that is usually divided into salary and nonsalary expenses.

indicator A tool used to measure the performance of structure, process, and outcome standards.

indirect costs Necessary expenditures that do not affect patient care directly.

informal committees Committees with no delegated authority that are organized for discussion.

informal groups Groups that evolve from social interactions that are not defined by an organizational structure.

informal leadership Leadership that is exercised by an individual who does not have a specified management role.

information power Power based on an individual's access to valued data.

informed consent A statutory law that provides for patients to agree to treatment only when certain conditions are met.

innovation A strategy to bridge the gap between an existing state and a desired state.

innovative decisions The type of decisions made when problems are unusual and unclear and creative solutions are necessary.

integrated healthcare networks Organizational healthcare structures that deliver a continuum of care, provide coverage for a group of individuals, and accept fixed payments for that group.

intentional torts The type of tort law that applies when the intent to harm is present.

interrater reliability An agreement between two measures by several interviewers.

interruption log A journal of specific information regarding interruptions, analysis of which may help identify ways to reduce interruptions.

interview guide A written document containing questions, interviewer directions, and other pertinent information so the same process is followed and the same basic information is gathered from each applicant.

intrarater reliability An agreement between two measures by the same interviewer.

invasion of privacy The violation of a person's right to be left alone without being subjected to unwarranted or uninvited publicity and to make personal choices without interference.

involuntary absenteeism Absenteeism that is not under the employee's control.

involuntary turnover When an employee is terminated by his or her employers.

J

job reassignment The process of pulling nurses from one area of the hospital to another; also called floating.

just culture An environment for reporting of errors without fear of undue retribution.

L

lateral communication Communication that occurs between or among individuals at the same hierarchical level.

laws Rules of conduct, established and enforced by authority, that prohibit extremes in behavior so that one can live without fear for oneself or one's property.

leader Someone who uses interpersonal skills to influence others to accomplish specific goals.

Lean Six Sigma A quality program that focuses on improving process flow and eliminating waste.

Leapfrog Group A coalition of public and private employers organized to bring attention to consumers about quality indicators in healthcare and mobilize employers to reward healthcare organizations that demonstrate quality outcome measures.

legitimate power A manager's right to make requests because of authority within an organizational hierarchy.

licensure A credential provided for by state statutes that authorizes qualified individuals to perform designated skills and services.

line authority The linear hierarchy of supervisory responsibility and authority.

living will A form signed by a competent adult indicating what healthcare the person does and does not want in the event of terminal illness.

M

Magnet Recognition Program Recognition by the American Nurses Credentialing Center that an organization provides quality nursing care.

malpractice Professional negligence; evolved from negligence law; refers to any misconduct or lack of skill in carrying out professional responsibilities.

manager An individual employed by an organization who is responsible for efficiently accomplishing its goals.

marginal employees Employees who never reach the expected level of competence.

mass casualty events (MCE) Natural or man-made disasters that result in multiple injuries.

mediation Use of a third-party mediator to help settle disputes.

medical errors Preventable mistakes, including falls, wrong site surgeries, avoidable infections, pressure ulcers, and adverse drug events.

medical home A patient-centered model in which all services are provided by a group of healthcare professionals; also called health home.

mentor A more experienced person who guides, supports, and nurtures a less experienced person.

mindfulness The ability to attend to whatever is happening in the present moment and to accept the situation as it is without judgment.

mission A general statement of the purpose of an organization.

motivation The factors that initiate and direct behavior.

N

negative inquiry A communication technique used to clarify objections and feelings (e.g., I don't understand. . . .).

negligence The failure of an individual not to perform an act (omission) or to perform an act (commission) that a reasonable, prudent person would or would not perform in a similar set of circumstances.

negligent hiring Failure of an organization, responsible for the character and actions of all employees, to ascertain the background of an employee.

negotiation A conflict management technique in which the conflicting parties give and take on various issues.

nonmaleficence The principle of not to inflict harm or to risk harm to others.

nonsalary expenditure variances Deviation from the budget as a result of changes in patient volume, supply quantities, or prices paid.

normative-reeducative strategy A change agent strategy based on the assumption that people act in accordance with social norms and values.

norming The third stage of group development, in which group members define goals and rules of behavior.

norms Informal rules of behavior shared and enforced by group members.

nurse practice act A state's rules and regulations for the practice of nursing set into statutes and enforced by the state's board of nursing.

nursing care hours (NCHs) The number of hours of patient care provided per unit of time.

O

objective probability The likelihood that an event will or will not occur based on facts and reliable information.

on-the-job instruction An educational method using observation and practice by which employees learn new skills after being employed.

open shop A business in which union membership is not a component in hiring decisions and union members do not receive any preference in hiring.

operating budget An organization's statement of expected revenues and expenses for the upcoming year.

ordinary interacting groups Common types of groups; generally have a formal leader and are run according to an informal structure with the purpose of solving a problem or making a decision.

organization A collection of people working together under a defined structure to achieve predetermined outcomes.

organizational culture The basic assumptions and values held by members of an organization.

organizational environment The system-wide conditions that contribute to a positive or negative work setting.

organizing The process of coordinating the work to be done within an organization.

orientation A process by which staff development personnel and managers ease a new employee into an organization by providing relevant information.

outcome standards Standards that reflect the desired result or outcome of care.

overdelegation A common form of ineffective delegation that occurs when the delegator loses control over a situation by giving too much authority or responsibility to the delegate.

P

patient-centered care A nursing care delivery system that is unit based and consists of patient care coordinators, patient care associates, unit support assistants, administrative support personnel, and a nurse manager.

patient-centered medical home (PCMH) A model for delivering primary care to ensure that adequate and appropriate care is provided to a population of patients across all settings; also called patient-centered medical home.

patient classification systems (PCSs) Systems developed to objectively determine workload requirements and staffing needs.

pay for performance (P4P) Medicare reimbursement linked to hospitals' scores on HCAHPS; also called value-based purchasing (VBP).

peer review A process by which other employees assess and judge the performance of professional peers against predetermined standards.

perceived conflict One's perception of another's position in a conflict.

performance evaluation The process of interaction, written documentation, formal interview, and follow-up that occurs between managers and their employees to give feedback, make decisions, and cover fair employment practice law.

performance management Systems, policies, procedures, position descriptions, and evaluation components essential to providing consistent, high-quality nursing practice.

performing The fourth stage of group development, in which group members agree on basic purposes and activities and carry out the work.

personal liability The responsibility and accountability nurses have for their own actions or inactions.

personal power Power based on an individual's credibility, reputation, expertise, experience, control of resources or information, and ability to build trust.

philosophy The mission, values, and vision of an organization.

planning A four-stage process to establish goals, evaluate the present situation and predict future trends and events, formulate a planning statement, and convert the plan into an action statement.

plausible future An orientation for envisioning the future that takes into account values and beliefs.

policy Decisions that govern action and determine an organization's relationships, activities, and goals.

political decision-making model A decision-making process in which the particular interests and objectives of powerful stakeholders influence how problems and objectives are defined.

politics A means of influencing the allocation of scarce resources, events, and the decisions of others.

pooled interdependence A type of interdependence in which each individual contributes to the group but no one contribution is dependent on any other.

pools Internal or external groups of workers that are used as supplemental staff by an organization.

position control A monitoring tool used to compare actual numbers of employees to the number of budgeted FTEs for the nursing unit.

position description Describes the skills, abilities, and knowledge required to perform the job.

position power Power of an individual that is determined by the job description, assigned responsibilities, recognition, advancement, authority, the ability to withhold money, and decision making.

possible future A vision of the future that includes anything that could possible happen, no matter how unlikely.

posttraumatic stress disorders (PTSD) Disorders resulting from being present at a scary, shocking, or dangerous event.

power plays Attempts by others to diminish or demolish their opponents.

power The potential ability to influence in order to achieve goals.

power-coercive strategies Change-agent strategies based on the application of power by legitimate authority, economic sanctions, or political clout.

practice partnership A nursing care delivery system in which senior and junior staff members share patient care responsibilities.

preceptors An experienced individual who assists new employees in acquiring the necessary knowledge and skills to function effectively in a new environment.

preferable future A vision of the future built on what one desires to occur.

private law Civil law; further classified into tort law, contract law, and protecting and reporting law.

probability The likelihood that an event will or will not occur.

probability analysis A calculation of the expected risk made to accurately determine the probabilities of each alternative.

probable future A vision of the future built solely on what has occurred in the past or is occurring in the present.

problem solving A process whereby a dilemma is identified and corrected.

process standards Standards connected with the actual delivery of care.

process theories Motivational theories that emphasize how the motivation process works to direct an individual's effort into performance.

productivity A measure of how well the work group or team uses the resources available to achieve its goals and produce its services.

profit The difference between revenues and expenses.

progressive discipline The process of increasingly severe warnings for repeated violations that can result in termination.

public law Constitutional law, administrative law, and criminal law.

punishment A process used to inhibit an undesired behavior by applying a negative reinforcer.

Q

Quality and Safety Education for Nurses (QSEN) Quality and safety competencies, based on the recommendation of the Institute of Medicine and developed by a national advisory board of experts, designating targets of knowledge, skills, and attitudes (KSAs) for nursing education.

quality management A preventive approach designed to address problems efficiently and quickly.

quantum leadership A leadership style based on the concepts of chaos theory.

R

rate variances The difference between budgeted and actual hourly rates paid.

rational decision-making model A decision-making process based on logical, well-grounded, rational choices that maximize the achievement of objectives.

rationing A decision society makes regarding who gets a service or supply and who does not; also called microallocation.

real (command) groups Groups that accomplish tasks in an organization and are recognized as legitimate organizational entities.

reality shock The stress, surprise, and disequilibrium experienced when shifting from a familiar culture into one whose values, rewards, and sanctions are different (e.g., from a school culture to a work culture).

reciprocal interdependence A type of interdependence in which members must coordinate their activities with every other individual in the group.

redesign A technique that examines the tasks within each job with the goal of combining appropriate tasks to improve efficiency.

referent power Power based on admiration and respect for an individual.

re-forming A stage of group development in which the group reassembles after a major change in the environment or in which the goals of the group require the group to refocus its activities.

reinforcement theory (behavior modification) The motivational theory that views motivation as learning and proposes that behavior is learned through a process called operant conditioning.

reportable incident Any unexpected or unplanned occurrence that affects or could potentially affect a patient, family member, or staff.

resistance A behavior that can be positive or negative and may mean opposition to change or disobedience; at times, an effective approach to handling power differences.

resolution The stage of conflict that occurs when a mutually agreed-upon solution is arrived at and both parties commit themselves to carrying out the agreement.

respondeat superior A legal principle that allows the courts to hold the employer responsible for the actions of the employee when the employee is performing services for the organization. Literally means "let the master speak."

responsibility An obligation to accomplish a task.

restraining forces Behaviors that impede change by discouraging participants from making specified changes.

résumé A written record of an individual's educational achievements, employment, and accomplishments.

retail medicine Walk-in clinics that provide convenient services for low-acuity illnesses without scheduled appointments.

retention An organization's ability to hold onto employees and prevent them from leaving.

revenue budget A projection of expected income for a budget period based on volume and mix of patients, rates, and discounts.

reverse delegation A common form of ineffective delegation that occurs when someone with a lower rank delegates to someone with more authority.

reward power Power based on inducements offered by the manager in exchange for contributions that advance the manager's objectives.

right-to-work state A state in which no person can be denied the right to work because of membership or nonmembership in a labor union.

risk management A program directed toward identifying, evaluating, and taking corrective action against potential risks that could lead to injury.

robotics Using robots to deliver supplies and remote care.

role A set of expectations about behavior ascribed to a specific position.

role ambiguity The frustrations that result from unclear expectations for one's performance.

role conflict The incompatibility between an individual's perception of the role and its actual requirements.

role redefinition The clarification of roles and an attempt to integrate or tie together the various roles that individuals play.

root cause analysis A method to work backward through an event to examine every action that led to the error or event that occurred.

routine decisions The type of decisions made when problems are relatively well-defined and common and when established rules, policies, and procedures can be used to solve them.

S

salary (personnel) budget A budget that projects salary costs to be paid and charged to the cost center during the budget period.

salary compression The effect of a higher starting pay for new nurses, or rewarding those with fewer years of experience with higher increases, that results in the salaries of long-term employees being at or below those of less-experienced nurses.

satisficing A decision-making strategy whereby the individual chooses a less-than-ideal alternative that meets minimum standards of acceptance.

self-evaluation A critical component of performance evaluation that fosters reflection—the deliberate process of critically thinking about one's performance.

self-scheduling A staffing model in which managers and their staff completely manage staffing and schedules.

sequential interdependence A type of interdependence in which members must coordinate their activities with others in some designated order.

servant leadership The premise that leadership originates from a desire to serve; a leader emerges when others' needs take priority over one's own needs.

service-line structures Organizational structures in which clinical services are organized around patients with specific conditions.

shaping The selective reinforcement of behaviors that are successively closer approximations to the desired behavior.

shared governance An organizational paradigm based on the values of interdependence and accountability that allows nurses to make decisions in a decentralized environment.

shared leadership An organizational structure in which several individuals share the responsibility for achieving an organization's goals.

shared visioning An interactive process in which both leaders and followers commit to an organization's goals.

Six Sigma A quality management program that uses measures, goals, and management involvement to monitor performance and ensure progress.

skill competency The ability to perform a skill knowledgeably and safely.

smoothing Managing conflict by complimenting one's opponent, downplaying differences, and focusing on minor areas of agreement.

spaghetti diagram A drawing of the actual work flow in a specified area at a point in time.

span of control The number of employees that can be effectively supervised by a single manager.

staff authority The advisory relationship in which responsibility for actual work is assigned to others.

staff nurse A nurse who supervises LPNs, other professionals, and assistive personnel and thus is also a manager who needs management and leadership skills.

staffing mix The type of staff necessary to perform the work of an organization.

staffing The process of balancing the quantity of staff available with the quantity and mix of staff needed by an organization.

stakeholders People or groups with a direct interest in the work of an organization.

status The social ranking of individuals relative to others in a group based on the position they occupy.

status incongruence The disruptive impact that occurs when factors associated with group status are not congruent.

statutory law Law enacted by the legislative branch of government; designed to declare, command, or prohibit something.

storming The second stage of group development, in which group members develop roles and relationships; competition and conflict generally occur.

stress The nonspecific reaction that people have to threatening demands from the environment.

strike The organized stoppage of work by employees within the union.

structure standards Standards that relate to the physical environment, organization, and management of an organization.

subjective probability The likelihood that an event will or will not occur based on a manager's personal judgment and beliefs.

suppression The stage of conflict that occurs when one person or group defeats the other.

surge capacity An institution's ability to mobilize when suddenly confronted with a vast increase in patient demand.

synchronous and asynchronous channels Channels of communication that allow communication between two or more parties at the same time (synchronous) or at different times (asynchronous).

synergy model of care An organizational model that matches patients' needs to nurses' competencies.

T

task forces Ad hoc committees appointed for a specific purpose and a limited time.

task group Several individuals who work together to accomplish specific time-limited assignments.

team building A group development technique that focuses on the task and relationship aspects of a group's functioning in order to build team cohesiveness.

teams Real groups in which people work cooperatively with each other in order to achieve some goal.

telehealth Technologies used to assess, intervene, and monitor patients from remote locations.

termination The firing of an employee.

throughput A performance measure related to moving patients into and out of the healthcare system.

time logs Journals of activities that are useful in analyzing actual time spent on specific activities.

time-waster Something that prevents a person from accomplishing a job or achieving a goal.

to-do list A list of responsibilities to be accomplished within a specific time frame.

tort law A type of private law that covers unintentional and intentional events.

total quality management (TQM) A management philosophy that emphasizes a commitment to excellence throughout an organization.

total time lost The number of scheduled days an employee misses.

transactional leadership A leadership style based on principles of social exchange theory in which social interaction between leaders and followers is essentially economic, and success is achieved when needs are met, loyalty is enhanced, and work performance is enhanced.

transformational leadership A leadership style focused on effecting revolutionary change in an organization through a commitment to its vision.

transition The period of time between the current situation and when change is implemented.

trial-and-error method A method whereby one solution after another is tried until the problem is solved or appears to be improving.

turnover The number of staff members who vacate a position.

U

underdelegation A common form of ineffective delegation that occurs when full authority is not transferred, responsibility is taken back, or there is a failure to equip and direct the delegate.

upward communication Communication that occurs from staff to management.

V

validity The ability to predict outcomes with some accuracy.

value-based purchasing (VBP) Medicare reimbursement linked to hospitals' scores on HCAHPS; also called pay for performance (P4P).

values The beliefs or attitudes one has about people, ideas, objects, or actions that form a basis for behavior.

variable budget A budget developed with the understanding that adjustments to the budget may be made during the year.

variable costs Expenses that depend on and change in direct proportion to patient volume and acuity.

variance The difference between the amount that was budgeted for a specific cost and the actual cost.

vertical integration An arrangement between or among dissimilar but related organizations to provide a continuum of services.

vicarious liability Negligence that is ascribed to a person who is not negligent himself or herself but who is assumed to be negligent because of association with the negligent person.

vision A mental model of a possible future.

vision statement A description of the goal to which an organization aspires.

volume variances Differences in the budget as a result of increases or decreases in patient volume.

voluntary absenteeism Absenteeism that is under the employee's control.

voluntary turnover When an employee chooses to leave an organization.

W

wildcards Unforeseen events that have far-reaching effects.

withdrawal The removal of at least one party from the conflict, making it impossible to resolve the situation.

work sample questions Questions that are asked to determine an applicant's knowledge about work tasks and the ability to perform a job.

workplace violence Any violent act, including physical assaults and threats of assault, directed toward persons at work or on duty.

Z

zero-based budget A budgetary approach that assumes the base for projecting next year's budget is zero; managers are required to justify all activities and every proposed expenditure.

Credits

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