Effective Leadership and Management in NURSING

Ninth Edition

Eleanor J. Sullivan

Effective Leadership and Management in Nursing

Ninth Edition

Eleanor J. Sullivan
PhD, RN, FAAN

330 Hudson Street, New York, NY 10013

Vice President, Health Science and TED: Julie Levin Alexander
Portfolio Manager: Pamela Fuller
Development Editor: Pamela Lappies
Portfolio Management Assistant: Erin Sullivan
Vice President, Content Production and Digital Studio: Paul DeLuca
Managing Producer Health Science: Melissa Bashe
Content Producer: Michael Giacobbe
Operations Specialist: Maura Zaldivar-Garcia
Creative Director: Blair Brown
Creative Digital Lead: Mary Siener
Managing Producer, Digital Studio, Health Science: Amy Peltier
Digital Studio Producer – REVEL and e-text 2.0: Jeff Henn
Digital Content Team Lead: Brian Prybella
Digital Content Project Lead: Lisa Rinaldi
Vice President, Product Marketing: David Gesell
Executive Field Marketing Manager: Christopher Barry
Field Marketing Manager: Brittany Hammond
Full-Service Project Management and Composition: iEnergizer Aptara®, Ltd.
Inventory Manager: Vatche Demirdjian
Printer/Binder: LSC Communications, Inc.
Cover Printer: Phoenix Color/Hagerstown

Acknowledgments of third-party content appear on pages 398–400, which constitutes an extension of this copyright page.

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.

Contributors

Michael Bleich, PhD, RN, FAAN
President, Maxine Clark and Bob Fox Dean and Professor
Goldfarb School of Nursing
Barnes Jewish College
Chapter 2: Designing Organizations

Debra J. Ford, PhD.
Program Director, Leadership, and Research Assistant Professor
The University of Kansas Medical Center
Chapter 10: Communicating Effectively
Chapter 13: Handling Conflict

Rachel A. Pepper, RN, DNP, NEA-BC
Senior Director of Nursing
The University of Kansas Hospital
Chapter 15: Budgeting and Managing Fiscal Resources
Chapter 17: Staffing and Scheduling

Pamela Klauer Triolo, PhD, RN, FAAN
Former Chief Nursing Officer (Corporate) and Associate Dean
University of Pittsburgh Medical Center
Chapter 19: Evaluating Staff Performance
Chapter 20: Coaching, Disciplining, and Terminating Staff

Reviewers

Wendy Bailes, PhD, RN
Associate Director, Undergraduate Programs
University of Louisiana at Monroe
Monroe, Louisiana

Diane Daddario, MSN, ANP-C, ACNS-BC, RN-BC, CMSRN
Adjunct Faulty, College of Nursing
Pennsylvania State University
University Park, Pennsylvania

Teresa Fisher, MSN, RN, PBT (ASCP)
Assistant Professor of Nursing
Arkansas State University
Jonesboro, Arkansas

Ruth Gladen, MS, RN
Associate Professor
RN Faculty & Director
North Dakota College of Science
Wahpeton, North Dakota

Lisa Harding, RN, MSN, CEN
Professor
Bakersfield College
Bakersfield, California

Mary Alice Hodge, PhD, CNL-C, RN
Director, Graduate Program
The University of South Carolina Upstate
Spartanburg, South Carolina

Mona P. Klose, MS, RN, CNE, CPHQ
Director of Quality Management
Assistant Professor of Nursing
University of Jamestown
Jamestown, North Dakota

Tara O'Brien, PhD, RN, CNE
Assistant Professor
The University of North Carolina
Charlotte, North Carolina

Jennifer O'Connor, RN, MS, CFCN, CNE
Instructor
Northeastern State University
Tahlequah, Oklahoma

Rose M. Powell, PhD, RN
Associate Professor
Stephen F. Austin State University
Nacogdoches, Texas

Joyce A. Shanty, PhD, RN
Associate Professor
Indiana University of Pennsylvania
Indiana, Pennsylvania

Deborah Smitherman, MSN, RN, CCM
Assistant Professor of Nursing
Belhaven University
Jackson, Mississippi

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

Brief Contents

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
www.EleanorSullivan.com

Contents

Chapter 1
Introducing Nursing Management

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?

References

Amer, K. S. (2013). *Quality and safety for transformational nursing: Core competencies.* Upper Saddle River, NJ: Pearson.

American Nurses Credentialing Center. (2008). Announcing a new model for ANCC's Magnet Recognition Program. Retrieved April 9, 2015, from http://www.nursecredentialing.org/Magnet/MagnetNews/2008-MagnetNews/NewMagnetModel.html

American Nurses Credentialing Center. (2015). National recognition of Magnet®. Retrieved April 9, 2015 from http://www.nursecredentialing.org/Magnet/ProgramOverview

American Nurses Credentialing Center. (2016). Magnet Recognition Program Overview. Retrieved February 26, 2016, from http://www.nursecredentialing.org/Magnet/ProgramOverview

Andel, C., Davidow, S. L., Hollander, M., & Moreno, D. A. (2012). The economics of health care quality and medical errors. *Journal of Health Care Finance*, *39*(1), 39–50.

Blumenthal, D., & Collins, S. R. (2014). Health care coverage under the Affordable Care Act—A progress report. *New England Journal of Medicine*, *37*(3), 275–281.

Budden, J. S., Zhong, E. H., Moulton, P., & Cimiotti, J. P. (2013). Highlights of the national workforce survey of registered nurses. *Journal of Nursing Regulation*, *4*(2). Retrieved April 13, 2015, from http://www.njccn.org/sites/default/files/news/attachments/highlights_of_the_national_workforce_survey_of_registered_nurses.pdf

Centers for Medicare & Medicaid Services. (2015). *National health expenditure projections, 2013–2023.* Retrieved April 8, 2015, from http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2013.pdf

Cronenwett, L., Sherwood, G., Barnsteiner, J., Disch, J., Johnson, J., Mitchell, P., . . . Warren, J. (2007). Quality and safety education for nurses. *Nursing Outlook*, *55*(3), 122–131.

Den Bos, J., Rustagi, K., Gray, T., Halford, M., Ziemkiewicz, E., & Shreve, J. (2011). The $17.1 billion problem: The annual cost of measurable medical errors. *Health Affairs*, *30*(4), 596–603.

Emanuel, E. J. (2015). *Reinventing American health care: How the Affordable Care Act will improve our terribly complex, blatantly unjust, outrageously expensive, grossly inefficient, error prone system.* New York, NY: Public Affairs.

Fineberg, H. V. (2014). Pandemic preparedness and response: Lessons from the H1N1 influenza of 2009. *New England Journal of Medicine*, *370*, 1335–1342. Retrieved April 17, 2015, from http://www.nejm.org/doi/full/10.1056/NEJMra1208802#t=article

Gallup. (2014). Americans rate nurses highest on honesty, ethical standards. Retrieved April 14, 2015, from http://www.gallup.com/poll/180260/american-rate-nurses-hightest-honesty-ethcial%20stands.aspx

Hader, R. (2010). The evidence that isn't . . . interpreting research. *Nursing Management*, *41*(9), 23–26.

Hassmiller, S. B., & Reinhard, S. C. (2015). A bold new vision for America's health care system: The Future of Nursing report becomes a catalyst for change. *Nursing Outlook*, *63*(1), 41–47.

Health Resources and Services Administration. (2013). The U.S. nursing workforce: Trends in supply and education. Retrieved April 16, 2015, from http://bhpr.hrsa.gov/healthworkforce/reports/nursingworkforce/nursingworkforcefullreport.pdf

Houser, J., & Oman, K. S. (2010). *Evidence-based practice: An implementation guide for healthcare organizations.* Sudbury, MA: Jones & Bartlett.

Huston, C. (2013). The impact of emerging technology on nursing care: Warp speed ahead. *The Online Journal of Issues in Nursing*, *18*(2). Retrieved June 15, 2015, from http://nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol-18-2013/No2-May-2013/Impact-of-Emerging-Technology.html

Institute of Medicine. (1999). *To err is human: Building a safer health system.* Washington, DC: National Academy Press.

Institute of Medicine. (2003). *Health professions education: A bridge to quality*. Washington, DC: National Academic Press.

Institute of Medicine. (2010). *The future of nursing: Leading change, advancing health.* Retrieved April 14, 2015, from http://www.thefutureofnursing.org/IOM-Report

Keepnews, D. M., Brewer, C. S., Kovner, C. T., & Shin, J. H. (2010). Generational differences among newly licensed registered nurses. *Nursing Outlook*, *58*(3), 155–163.

Leapfrog Group. (2015). *About Leapfrog.* Retrieved April 9, 2015, from http://www.leapfroggroup.org/about_leapfrog

Levit, A. (2015, March 28). Make way for Generation Z. *New York Times*. Retrieved April 13, 2015, from http://www.nytimes.com/2015/03/29/jobs/make-way-for-generation-z.html

Milstein, A. (2009). Ending extra payment for "never events"—Stronger incentives for patients' safety. *New England Journal of Medicine*, *360*(23), 2388–2390.

Murray, E. J. (2013). Generational differences: Uniting the four-way divide. *Nursing Management*, *44*(12), 36–41.

Nolte, E. (2011). *International benchmarking of healthcare quality: A review of the literature.* Rand Corporation. Retrieved April 9, 2015, from http://www.rand.org/pubs/technical_reports/TR738.html

Papa, A. M., & Venella, J. (2013). Workplace violence in healthcare: Strategies of advocacy. *Online Journal of Issues in Nursing*, *18*(1). Retrieved April 14, 2015, from http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol-18-2013/No1-Jan-2013/Workplace-Violence-Strategies-for-Advocacy.html

Quality and Safety Education for Nurses Institute. (2015). *Competencies.* Retrieved April 10, 2015, from http://qsen.org/competencies

Russell, G. E. (2014). The United States health care system. In D. J. Mason, J. K. Leavitt, & W. Chaffee (Eds.), *Policy & politics in nursing and health care* (6th ed., pp. 122–134). St. Louis, MO: Elsevier.

Sullivan, E. J. (2013). *Becoming influential: A guide for nurses* (2nd ed.). Upper Saddle River, NJ: Pearson.

U.S. Bureau of Labor Statistics. (2014). Occupational employment statistics. Retrieved April 16, 2015, from http://www.bls.gov/oes/current/oes291141.htm#nat

U.S. Census Bureau. (2015, March). *Projections of the size and composition of the U.S. population: 2014–2060*. Retrieved April 13, 2015, from https://www.census.gov/content/dam/Census/library/publications/2015/demo/p25-1143.pdf

U.S. Department of Health and Human Services. (2015a). *What is a medical home? Why is it important?* Retrieved April 8, 2015, from http://www.hrsa.gov/healthit/toolbox/Childrenstoolbox/BuildingMedicalHome/whyimportant.html.

U.S. Department of Health and Human Services. (2015b). About pandemics. Retrieved April 17, 2015, from http://www.flu.gov/pandemic/about

Zapatochny-Rufo, R. (2010). Good-better-best: The virtual ICA and beyond. *Nursing Management*, *41*(12), 38–41.

Chapter 2

Designing Organizations

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.

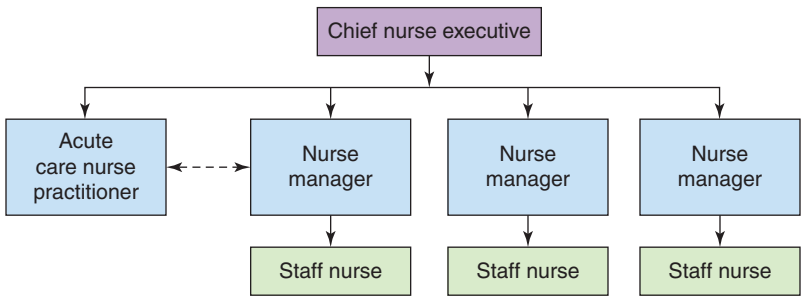

Figure 2-1 Chain of authority.

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

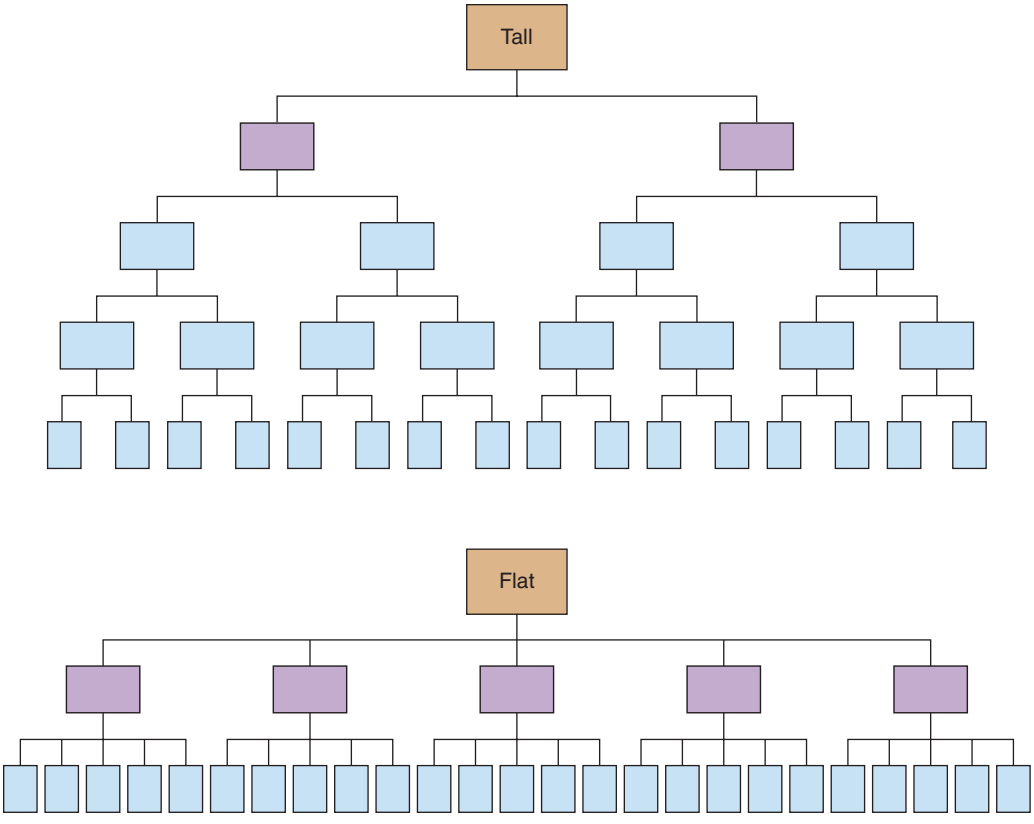

Figure 2-2 Contrasting spans of control.

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.

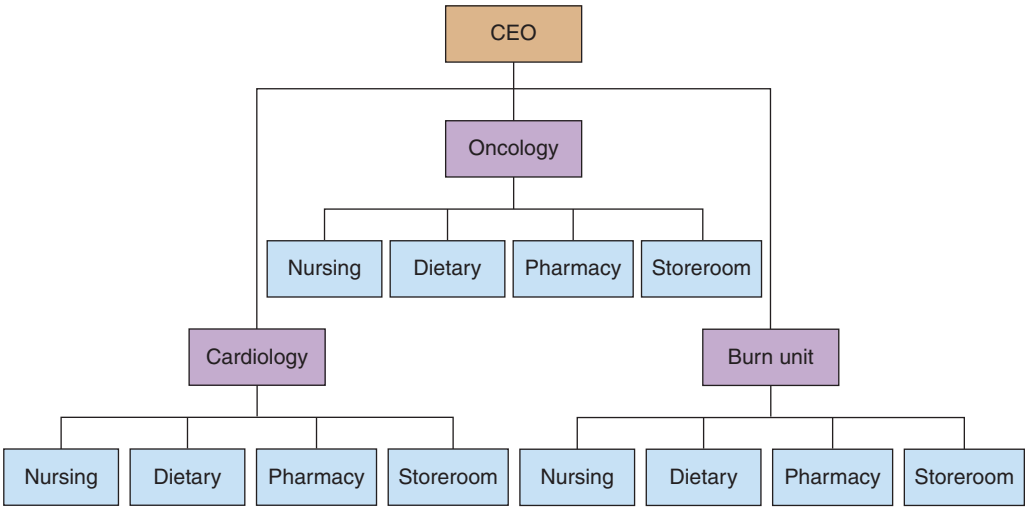

Figure 2-3 Service-line structure.

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

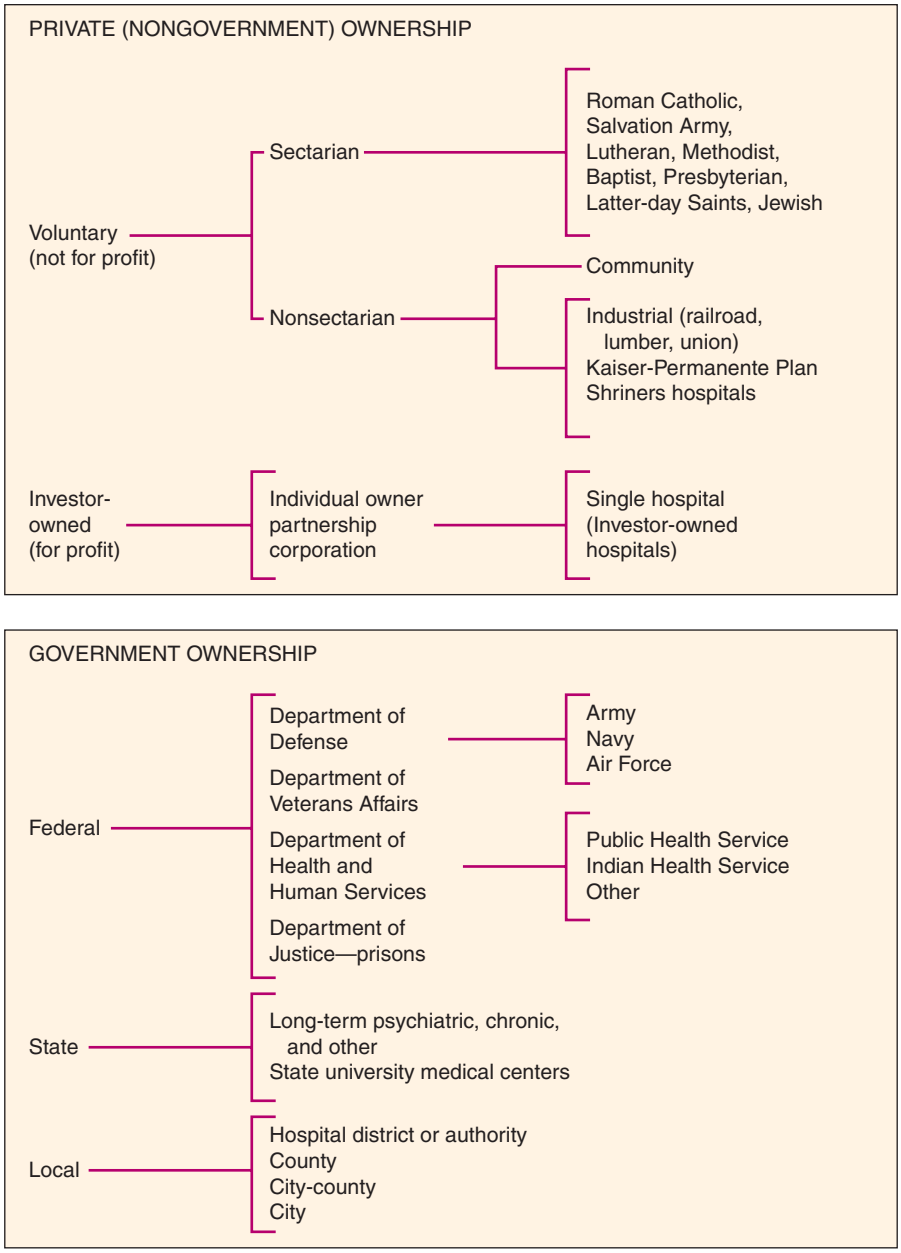

Figure 2-4 Types of ownership in healthcare organizations.

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.

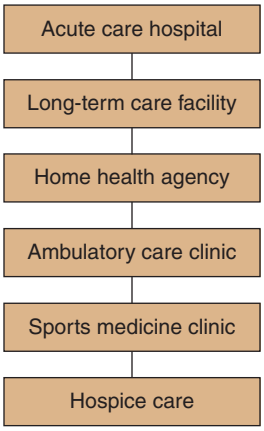

Figure 2-6 Vertical integration.

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).

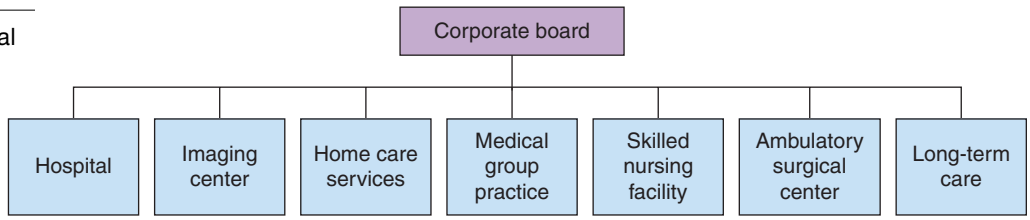

Figure 2-7 Corporate healthcare network.

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?

References

American Association of Critical-Care Nurses. (2011). *AACN standards for establishing and sustaining healthy work environments.* Retrieved May 5, 2011, from http://www.aacn.org/WD/HWE/Docs/HWEStandards.pdf

Ansel, T. C., & Miller, D. W. (2010). *Reviewing the landscape and defining the core competencies needed for a successful accountable care organization.* Louisville, KY: Healthcare Strategy Group.

Armstrong, K., Laschinger, H., &Wong, C. (2009). Workplace empowerment and Magnet hospital characteristics as predictors of patient safety climate. *Journal of Nursing Care Quality*, *24*(1), 55–62.

Ballard, N. (2010). Factors associated with success and breakdown of shared governance. *Journal of Nursing Administration*, *40*(10), 411–416.

Bauer, J. C. (2010, April). Nurse practitioners as an underutilized resource for health reform: Evidence-based demonstrations of cost-effectiveness. *Journal of the American Academy of Nurse Practitioners*, *22*(4), 228–231.

Berenson, R. A., Hammons, T., Gans, D. H., Zuckerman, S., Merrell, K., Underwood, W. S., & Williams, A. F. (2008). A house is not a home: Keeping patients at the center of practice redesign. *Health Affairs*, *27*(5), 1219–1230.

Bleich, M., (2011). Providing nursing care in a complex health care environment. In A. Davidson, M. Ray, & M. Turkel (Eds.), *Nursing, caring, and complexity science.* New York: NY: Springer Publishing Company, LLC.

Conway-Morana, P. L. (2009). Nursing strategy: What's your plan? *Nursing Management*, *40*(3), 25–29.

Costello, D. (2008). Report from the field: A checkup for retail medicine. *Health Affairs*, *27*(5), 1299–1303.

Galbraith, J. R. (2009). *Designing matrix organizations that actually work*. San Francisco, CA: Jossey-Bass.

Gamble, K. H. (2009). Connecting the dots: Patient flow systems are being leveraged to increase throughput, improve communication, and provide a more complete view of care. *Healthcare Informatics*, *25*(13), 27–29.

Hafeman, P. (2015, October). What does it mean to be part of a system? The role of the chief nurse executive and shared governance. *Nurse Leader*, *13*(5), 69–72.

Handel, D. A., Hilton, J. A., Ward, M. J., Rabin, E., Zwemer, F. L., & Pines, J. M. (2010). Emergency department throughput, crowding, and financial outcomes for hospitals. *Academic Emergency Medicine*, *17*(8), 840–847.

Hersey, P. H. (2013). *Management of organizational behavior* (10th ed.). Upper Saddle River, NJ: Pearson.

Hill, K. S. (2009). Service line structures: Where does this leave nursing? *Journal of Nursing Administration*, *39*(4), 147–148.

Hravnak, M. (2014). The acute care nurse practitioner. In A. B. Hamric, C. M. Hanson, M. F. Tracy, & E. T. O'Grady (Eds.), *Advanced practice nursing: An integrative approach* (5th ed.). St. Louis, MO: Elsevier Saunders.

Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century*. Retrieved October 24, 2011, from http://www.iom.edu/Reports/2001/Crossing-the-Quality-Chasm-A-New-Health-System-for-the-21st-Century.aspx

Joosten, T., Bongers, I., & Janssen, R. (2009). Application of lean thinking to health care: Issues and observations. *International Journal of Quality in Health Care*, *21*(5), 341–347. Retrieved May 12, 2011, from http://www.jcrinc.com/E-dition-Home.

Kaplow, R., & Reed, K. D. (2008). The AACN synergy model for patient care: A nursing model as a force of magnetism. *Nursing Economics*, *26*(1), 17–25.

Kramer, M., Schmalenberg, C., & Maguire, P. (2010). Nine structures and leadership practices essential for a magnetic (healthy) work environment. *Nursing Administration Quarterly*, *34*(1), 4–17.

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

McDowell, J. B., Williams, R. L., Kautz, D. D., Madden, P., Heilig, A., & Thompson, A. (2010). Shared Governance: 10 years later. *Nursing Management*, *41*(7), 32–37.

Mensik, J. (2014). *Lead, drive & thrive in the system.* Silver Spring, MD: American Nurses Association.

Moore, S. C., & Wells, N. J. (2010). Staff nurses lead the way for improvement to shared governance structure. *Journal of Nursing Administration*, *40*(11), 477–482.

Norton, B., & Smith, C. (1997). *Understanding the virtual organization.* Hauppauge, NY: Barron's Educational Series, Inc.

Nugent, M., Nolan, K. C., Brown, F., & Rogers, S. (2008, May 1). Seamless service line management: Service line organization is as important as market strategy if providers are to optimize their limited capital investment pool. *Healthcare Financial Management*. Retrieved May 3, 2011, from http://www.hfma.org/Templates/InteriorMaster.aspx?id=1523

Page, L. (2010). Challenges facing 10 hospital service lines. Retrieved May 3, 2011, from www.beckershospitalreview.com/news-analysis/challenges-facing-10-hospital-service-lines.html

Ray, M. A., Turkel, M. C., & Cohn, J. (2011). Relational caring complexity: The study of caring and complexity in health care hospital organizations. In A. Davidson, M. Ray, & M. Turkel (Eds.), *Nursing, caring, and complexity science*. New York: NY: Springer Publishing Company, LLC.

Rohrer, J. E., Angstman, K. B., & Furst, J. W. (2009). Impact of retail walk-in care on early return visits by adult primary care patients: Evaluation via triangulation. *Quality Management in Health Care*, *18*(1), 19–24.

Soto, M. A. (2013). *Population health in the affordable care act era.* Retrieved February 29, 2016, from http://www.academyhealth.org/files/AH2013pophealth.pdf

Sullivan, E. J. (2013). *Becoming influential: A guide for nurses* (2nd ed.). Upper Saddle River, NJ: Pearson.

Zarubi, K. L., Reiley, P., & McCarter, B. (2008). Putting patients and families at the center of care. *Journal of Nursing Administration*, *38*(6), 275–281.

Chapter 3

Delivering Nursing Care

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

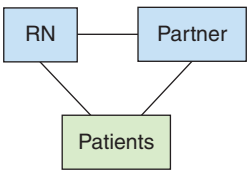

Figure 3-1 Practice partnerships.

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