**LECTURE NOTES**

For Nursing Students

# *Nursing Leadership and Management*



**Ethiopia Public Health Training Initiative**

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*This material is intended for educational use only by practicing health care workers or students and faculty in a health care field.*

# PREFACE

The rapid change in technology, knowledge explosion and the increased and complex health care demands challenge the nurse's knowledge, technical competence, interpersonal skills and commitment. Nurses work at each level of the health care system, have varied role, and are constantly in contact with people. Dealing with this dynamism and responsibility requires nurses to have knowledge and skills of management. It becomes apparent that the leadership needed to get work done through people is increasingly important for nurses to dispose their professional performance. Furthermore, proactive leaders who had a vision and could motivate associates to work toward common goals could help organization survive and even thrive during rapid change.

Although, this is the case teaching materials in this endeavor are scarce in Ethiopia. Therefore, this lecture note is written to narrow this gap. The target audiences for this teaching material are student nurses at BSc level and nurses working at each level of the health care system. This material is not intended to substitute other

teaching and reference materials. Its objective is to provide useful insights and information on management in general and nursing management in specific.

The lecture note is organized into fourteen chapters. Chapter one to five deals with introduction to management and nursing service administration; mission, philosophy and goals of an organization; organization and organizational structure; functions of management and decision making respectively. Theories of leadership, management of resources, evaluation of health care activity, and communication and group dynamics are the topics dealt in chapters 6, 7, 8, 9, and 10 respectively. In addition, conflict resolution; management of change, project management and quality assurance are discussed in chapter 11, 12, 13 and 14 in its order.

# ACKNOWLEDGMENTS

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# CHAPTER ONE

# INTRODUCTION TO NURSING

# SERVICE MANAGEMENT

## Objectives:

At the end of this chapter, the student should be able to:

- Define administration/management and nursing service administration
- Describe the managerial level, role and skills
- Explain the importance of good management in a health service organization

Management is as old as human kind and existed since man has been organized in to communities. Managers influence all phases of our modern organizations. Our society simply could not exist as we know it today or improve its present status without a steady stream of managers to guide its organizations. Peter Drucker makes this same point in stating that effective management is quickly becoming the main resource of developed countries and the most needed resource of developing ones (1).

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Essentially, the role of managers is to guide organizations toward goal accomplishment. All organizations exist for some purpose or objective, and mangers have the responsibility for combining and using organizational resources to ensure that the organizations achieve their purposes. Management moves organizations toward these purposes or goals by assigning activities that organization member perform. If these activities are designed effectively, the production of each individual worker represents a contribution to the attainment of organizational goals. Managers strive to encourage individual activity that will lead to reaching organizational goals and to discourage individual activity that hinders organizational goal accomplishment. Management has no meaning apart from its goals (2). Management must keep organizational goals clearly in mind at all times

## 1.2. Definition of management and nursing service administration

### 1.2.1. Definition of management

Different authorities define management differently but have strong unifying similarities in all the definitions. The term management can be used in several ways. For

instance, it can simply refer to the process that managers follow to accomplish organizational goals. The term can be used, however, to refer to a body of knowledge. In this context, management is a cumulative body of information that furnishes insight on how to manage.

Management is the art of getting things done through people. It is the process of reaching organizational goals by working with and through people and other organizational resources. It is the process of planning, organizing, leading and controlling the work of organization members and of using all available organizational resources to reach stated organizational goals. It is the process of directing, coordinating and influencing the operation of an organization to obtain desired result and enhance total performance.

### 1.2.2. Nursing service administration

Nursing service administration is a coordinated activity, which provides all of the facilities necessary for the rendering of nursing service to clients.

Nursing service administration is the system of activities directed toward the nursing care of clients, and includes

the establishment of over-all goals and policies within the aims of the health agency and provision of organization, personnel, and facilities to accomplish this goals in the most effective and economical manner through cooperative efforts of all members of the staff, coordinating the service with other departments of the institution

Nursing service administration is the marshaling of resources to accomplish a purpose.

It is both an art and a science. It is a science in the sense that one may systematically study and analyze the behavior of people as a collective endeavor and, even their individual behavior in relationship to their individual purposes and to draw generalizations from them that are valid guides to foresight and action. It is an art because it requires qualities of dynamic character to make them effective in application.

Nursing service administration is the process of planning, organizing, leading and controlling that encompasses human, material, financial and informational resources in an organizational environment to achieve the predetermined objectives.

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Nursing service is the process composed of the set of interrelated social and technical functional activities occurring within a formal organizational setting to accomplish predetermined objectives through utilization of human and other resources.

The primary objective of the role of nursing service administration is the provision for continuous individual, group and community service, including whatever is necessary. In addressing the factors, which determine health, and to bring them back to self-directive activity towards their own health. The subsidiary objectives of this role are the professional activities of administration, including human relations, communications, teaching, research, and personal development, designed to further the primary objective-the optimum nursing care of patients. In this lecture note management and administration are used interchangeably.

### 1.2.3. Types of managers, managerial skill and roles

Nursing service managers are people who appointed to positions of authority, which enable others to perform their work effectively, who have responsibility for resource utilization and who are accountable for work

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results and can be proud of their organizations and what they do.

## Types of managers

Traditionally classifications of managers are by level in the organizational hierarchy; common nomenclature is:

⇨ Top level–such as board of directors, Presidents and vice presidents

⇨ Middle level–such as directors of nursing, supervisory staffs and department heads

⇨ First line/front line/ or supervisory management– such as head nurses and staffs.

Regardless of level, managers have several common attributes; they are:

⇨ Formally appointed to positions of authority

⇨ Charged with directing and enabling others to do their work effectively

⇨ Responsible for utilizing resources

⇨ Accountable to superiors for results

The primary differences between levels of managers are the degree of authority and the scope of responsibility and organizational activity at each level. For example, top-level managers such as nursing administrators have authority over and responsibility for the entire

organization. Middle level managers such as department heads and heads of services have authority over and responsibility for a specific segment, in contrast to the organization as a whole and act as a liaison between top-level managers and first level managers. First line managers, who generally report to middle level managers have authority over and are responsible for overseeing specific work for a particular group of works.

## Managerial Skills

Managers can also be differentiated by the extent to which they use certain skills: conceptual, human relations and technical skills. All managers use human relation skills because they accomplish work through people. Human relations skills include motivation, leadership and communication skills. The degree to which each is used varies with the nature of the position, scope of responsibility, work activity, and number, types and skills of subordinates. Senior managers use disproportionately more conceptual skills in their jobs than do middle level or first line managers. These include recognizing and evaluating multiple complex issues and understanding their relationships, engaging

in planning and problem solving that profoundly affect the health service organization, and thinking globally about the organization and its environment. In contrast first line managers tend to use job related technical skills, or skills that involve specialized knowledge.

**Managerial roles**

All health service managers engage in planning, organizing, staffing, directing, controlling, and decision making to some degree. In addition, they perform other activities related to accomplishing work and organizational objectives that do not readily fall within the functional classification. These roles are defined as the behavior or activities associated with a management position because of its authority and status. Mintzberg's classification identifies:

⇨ Interpersonal
⇨ Informational and
⇨ Decisional roles

**Interpersonal role**

The three interpersonal roles are

❖ Figurehead: all managers, but especially senior managers, are figureheads because they engage

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in ceremonial and symbolic activities such as greeting visitors and making speeches at organizational events.

❖ Liaison: involves formal and informal internal and external contacts.

❖ Influencer: includes activities inherent in the directing function, the purpose of which is to motivate and lead.

**Informational role**

The three informational roles of a manager are

❖ Monitor

❖ Disseminator and

❖ Spokesperson

**Decisional Roles**

The four decisional roles of a manager are

❖ Entrepreneur

❖ Disturbance handler

❖ Resource allocator and

❖ Negotiator

## 1.3 Health care, health services and health service organizational models

**Health care:** is the total societal effort, organized or not, whether private or public, that attempts to guarantee, provide, and finance the promotion of health, prevention of diseases, and restoration of health and rehabilitation.

**Health service**: is the delivery of health care

**Health service organizations**: Deliveries of health services to clients occur in a variety of organizational settings. Health service organizations can be classified by ownership, profit motive, whether the client is admitted. Historically, hospitals and nursing facilities have been the most common and dominant health service organizations engaged in delivery of health services.

**Health Service Organizational Model**
**Model**

- ❖ Organizations are open systems
- ❖ Composed of inputs, throughput and output

## 1.4 The Benefit of good Management in Health Service organizations

- ❖ High lights priority areas

❖ Adopts the service to the needs of a changing situation

❖ Makes use of the most limited resources

❖ Improves the standard and quality of services

❖ Maintain high staff morale

**Learning activities**

1. Briefly discuss management and nursing service administration

2. List the three levels of management

3. Discus the four common attributes of managers regardless of their level

4. Describe the three management skills

5. Explain the role of managers in an organization

6. What is health care, health service and health service organization?

7. Discuss the components of the health service model

8. What is the benefit of good management for an organization?

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# CHAPTER TWO

# PHILOSOPHY OF NURSING

# SERVICE MANAGEMENT

## Objectives:

At the end of this chapter, the student should be able to:

- Define mission, philosophy and goals
- Explain the relationship of mission, philosophy and goals
- Discuss the importance of mission, philosophy and goals of an organization for nursing service administration

**Mission**

A mission statement is a broad general goal of an organization that describes its purpose in the community. The mission statement of a small community hospital may indicate that its purpose is to serve the health care needs of the immediate community and provide care for commonly occurring illnesses. A large university hospital may have a mission statement that encompasses research, teaching and care for complex problems. These two organizations will

establish different priorities for spending, choose different technologies as essential to their missions, and structure their staff in different ways. These mission statements provide the overall umbrella under which all functions of the organization take place.

In addition to or even in place of a mission statement a general statement of philosophy

may be used. When both are present, they should agree. The philosophy is typically longer and more detailed.

## Organizational Philosophy and philosophy of Nursing Service Administration

Organizational Philosophy is its explicit and implied view of itself and what it is. Generally it is expressed in mission statements. The philosophy is directly linked to and rooted in the organizations cultural beliefs and values. Philosophy depicts the desired nature of the relationships between health service organizations and its customers, employees and external constituents. It is a set of beliefs that determines how organizational purposes are achieved and that serves as the foundation for agency objectives, policies and procedures.

Nurses have the right to know the beliefs about nursing care, nursing practice and nursing management held by the collective group, which they are a part of the nursing department. A statement of philosophy is a valuable management tool. Nurses should be given a copy before they join the staff so that they can judge whether their personal philosophy is sufficiently in agreement with the organizational philosophy to enable them to become a contributing member of the department. Philosophy statements are relatively enduring documents because stated beliefs are usually expressions of firm commitment to the best that can be achieved and are derived from the broad goals of the agency.

 A useful philosophy has a timeless quality because basic premises change only under unusual conditions. Nevertheless, philosophy statements need to be reviewed periodically. If a review by all members of the department reveals that the statement still reflects the guiding beliefs of the collective group, there is no need to revise the document. If scrutiny indicates that the statement is not consistent with current agency goals or philosophy or is not effective in directing the actions of the department, then the statement should be rewritten

to assure that it meets the criteria of compatibility, attainability, intelligibility, acceptability, measurability and accountability. When developing or reevaluating a philosophy, the manager should consider theory, education, practice, research, and nursing's role in the total organization.

**Goals**

Goals are the broad statements of overall intent of an organization or individual. They are usually stated in general terms. The purpose of writing goals is to identify where you are going and to enable you to evaluate when you have arrived there. A meaningful stated goal is one that succeeds in communicating the intent of those generating the goal. It should be stated in such a way that it will be understood clearly by others. As a nurse in a health care institution, you need to be aware of the existence of several levels of goals: the institutional level, the nursing department level and the nursing unit level. The goal levels all need to relate to the health needs of the community, because these are the focus of health care.

**Institutional Goals**

Based on the community's health needs, the institution forms goals and objectives. An institution that focuses thinking on goals for the future and activities that will move the organization toward these goals is referred to as a proactive institution. The managers of such institutions spend a great deal of time, money and energy on identifying possible future events and on preparing the institution to deal with them. Institutions that do not have specific or future oriented goals are reactive institutions. They spend their time reacting to events, that is, "putting out fires" rather than "preventing them." A reactive facility would wait until such emergencies occurred and then would handle them as a crisis rather than as an anticipated event.

**Nursing Department Goals**

The goals of the institution definitely affect those of nursing service, which must support and complement institutional goals. In an institution with an overall goal of developing a mental health program, a nursing department goal may include developing nurses in psychiatry.

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The astute manager of a nursing department must also be proactive about the national issues facing nursing, community needs for nursing, and the needs within the institution itself. This manager would formulate goals to help the nursing department meet the challenges of care in the future, because the ultimate nursing department goal is quality client care.

**Nursing Unit Goals**

It is important that each employee understand the institutional and nursing department goals, because the group or unit goals develop from them. Each nurse should be able to contribute to the formation of unit goals in terms of philosophy of care, quality of care, and development of nursing expertise.

Helping to formulate the goals for your unit is important, because these goals can also represent your individual goals. Unit goals develop from the group as a whole and often include individual goals in the process.

Development and implementation of goals must be meaningful to the group if they are to be successful. The member of the group must feel that they are the originators of the unit goals and objectives.

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**Organizational Climate**

The climate of an organization refers to the prevailing feelings and values experienced by individuals. The feeling of thrust, belonging, esteem and loyalty are part of the climate. Values for competence and accomplishment are also part of the climate. The climate is bases on the official policies and procedures of the organization, and the feedback provided within the organization

**Learning Activities:**

1. What is the mission of a health service organization?
2. What is the importance of having a philosophy for an organization?
3. What is the relationship between organizational philosophy and the philosophy of nursing?
4. Describe the three types of goal
5. Discuss the similarities and difference of mission, philosophy and goals of an organization

# CHAPTER THREE
# ORGANIZATION AND
# ORGANIZATIONAL STRUCTURE

## Objectives:

At the end of this chapter, the student should be able to:

- Discuss systems theory and its components

- Describe formal and informal organizational structures

- Identify the four types of formal organizational structures

- Describe the differences between centralized and decentralized structures

- Discuss advantages and disadvantages of each of the following organizational structure: Pure line, line and staff, functionalized line and staff; and matrix

- Explain the relationship between responsibility and authority under ideal circumstances.

- Identify the major components required to deliver effective nursing care

- Discuss and compare each type of client care delivery system

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**Systems Theory**

Ludwig Von Bertalanffy introduced general system theory several decades age in an attempt to present concepts that would be applicable across disciplines and would be applicable to all systems. The theory was one of wholeness, proposing that the whole is more than the sum of parts; the system itself can be explained only as a totality. Holism is the opposite of elementarism, which views the total as the sum of its individual parts.

A system may be defined as "sets of elements standing in interrelation". All systems have elements in common. Societies, automobiles, human bodies and hospitals are system The theory of open system is part of a general system theory; An open system is defined as a "system in exchange of matter with its environment, presenting import and export, building up and breaking down of its material components. Open systems theory emphasizes the relationship between a system and its environment and the interrelationships of different levels of system (Katz & Kahn, 1996, p.3).

Systems are either closed or open. Closed systems are self-contained and usually can only be found in the physical sciences. This perspective has little relevance for the study of organizations. The open system

perspective recognizes the interaction of the system with its environment. Katz and Kahn outline 10 characteristics that are common to all open systems. Understanding these characteristics helps one to conceptually understand how organizations function.

The first characteristic is input, or importation of energy. Open systems import forms of energy from the external environment. As, the human cell receives oxygen and nourishment from the blood stream, and organization receives capital, human resources, material, or energy (e.g. electricity) from its environment.

The second characteristic is through put, in which open systems transform the energy and materials. Just as the human cell transforms nourishment into structure, an origination can create a new product, process materials, train people, or provide a service. The third characteristic is output. Open systems export some product a manufactured substance, an inquiring mind, or a well body into the environment. Fourth, an organizations throughput works as a system of cyclic events. Organizational activities occur over and over again in a self-closing cycle, as the material that is input is transformed by throughput and results in output.

System-boundaries-it follows that systems have boundaries, which separate them from their environments. The concept of boundaries helps us understand the distinction between open and closed systems. The relatively closed system has rigid, impenetrable boundaries; where as the open system has permeable boundaries between itself and a broader supra system. Boundaries are relatively easily defined in physical and biological systems, but are very difficult to delineate in social systems such as organizations.

The fifth open system characteristic is negative entropy. To survive, open systems must reverse the entropic process, they must acquire entropy. The entropic process is the universal law of nature in which all forms of organization move toward disorganization or death" (Katz & Kahn, 1966). In order to arrest entropy and be transformed into negative entropy, a process of transformation with continuous up dates or changes in the organization is necessary. The outside forces and governmental agencies (importing resources from its environment) supply major financial support to fuel the system's ongoing functions and continue operational processes.

The six characteristic of an open system is information input: the feedback and coding process. Every organization must take in information and feedback from the environment, code that information, and then store it so it can be used to predict the environment. Negative feedback is the type of input that allows the system to identify deviations in its functioning processes. Feedback enables the organization to maintain a steady state, the seventh characteristic of an open system.

Sometimes called homeostasis, a steady state refers to the ability and desire of an organization to maintain some constancy in energy exchange. Just as the human body stays in a steady state, with no significant variation in its size and mass over time, so an organization attempts to stay in a steady state. This is acquired through avoidance of entropy.

The eighth characteristic is differentiation, which occurs with growth of the organization.

This requires multiplication and changes in established roles with new knowledge and expansion of expertise. This activity must create a constant flow of energy exchange as each member also continuously adapts to new functional changes. As a result, integration and coordination are achieved. This process leads to the

establishment of a new organizational structure. The last characteristic of an open system is equi-finality: The principle that any final goal or end can be reached by a variety of means. As open systems move and develop within their environment, they may set different goals at different times and choose different methods to attain them, but the ultimate goal of any open system is survival. The adaptability of humans for survival represents equi-finality.

The total nursing management process and each management functions can be preserved as a system consisting of several inputs, one or more throughput processes, numerous outputs, and multiple feedback processes between outputs and throughput, output and inputs, and throughput and inputs. When management malfunctions, in the major system or a subsystem, analysis of the interrelationships among system elements will usually reveal imbalances, obstruction of some point in the system. Usually, when the cause for system malfunction is accurately diagnosed, the problem can be eliminated or relieved by appropriate managerial interventions.

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**Organizational Structure**

An organization is a group of people working together, under formal and informal rules of behavior, to achieve a common purpose. Organization also refers to the procedures, policies, and methods involved in achieving this common purpose. Thus, organization is both a structure and a process. Organizational structure refers to the lines of authority, communication, and delegation; can be formal or informal. Organizational process refers to the methods used to achieve organizational goals. An organization's formal structure is depicted in its organizational chart that provides a "blueprint," depicting formal relations, functions and activities.

The principal purpose for defining the organization diagram is to clarify chain of command, span of control, official communication channels, and linkage for all department personnel. It is customary to show formal organization structure in a diagrammatic form with a three dimensional model having depth, height and width. Boxes containing various position titles are positioned vertically to highlight differences in status and responsibility. Position boxes are connected with lines to demonstrate the flow of communication and authority

throughout the entire network. Different types of interconnecting lines signify different types of relation ships.

For example, a solid line between two positions, indicate direct authority or command giving relationship. A dashed line or broken or dotted line indicates a consulting relationship with no prescribed frequency of the structure to collaborate for planning or control purpose. Commands do not flow.

The primary significance of formal organization structure is the frequency of communication between particular staff members. Particular worker is expected to relate directly with certain individuals and not others. For instance, the Nursing director must give direction to and receive reports from vice-director or supervisors and not others. In this sense, the formal organization structure restrains worker behavior.

The organization chart does not show the degree of authority that a manager has over subordinates. A manager with authority of head nurse may lack authority to hire or fire the worker.

Every organization also has an informal structure, characterized by unspoken, often covert, lines of communication and authority relationships not depicted in the organizational chart. The informal structure develops to meet individuals' needs for friendship, a sense of belonging, and power. The lines of communication in the informal structure (commonly termed "the grapevine") are concerned mainly with social issues. Persons with access to vital information can become powerful in the informal structure. Some administrators try to hinder the effects of informal organization because they facilitate the passing of information. The information may be rumor, but the best way to combat rumor is by free flow of truthful information. The informal organization can help to serve the goals of the formal organization if it is not made the servant of administration. It should not be controlled. A major shortcoming in its use is that not all employees are part of the informal organization.

**Organizational characteristics**

**1. Span of control** - refers to the number of employees a manager can effectively oversee. Mostly top executive cannot manage as many employees' managers at lower

levels. Theoretically, A 1:3 supervisory ratio is common at the top of an organization; a 1:6 ratio is common at the middle; and a 1:20 or larger ratio is common at the base.

The effective span of control for each manager depends on work pace and pattern of workers skill and knowledge, the amount of work in interdependence. The top executive must supervise managers of different specialties; although mid level and first level managers supervise workers in the same specialty that performs similar tasks often in a common work area.

When span of control is too broad, the manager has insufficient time to observe and cannot evaluate performance or give feed back. On the other hand, too narrow span of control has time to supervise each one closely, and too close supervision discourages subordinates problem solving independent judgment and creative thinking. Research shows that worker productivity is higher when close supervision is impossible.

**Organizational Principles**

- The principle of unity of Command: An employee may interact with many individuals in the course of the work but should be responsible to only one supervisor.

- The principle of Requisite Authority: when responsibility for a particular task is delegated to a subordinate, subordinate must also be given authority over resources needed for task accomplishment.

- The Principle of Continuing Responsibility: When a manager delegates a function to a subordinate, the manager's responsibility for that function is in no way diminished.

- The Principle of Organizational Centrality: Workers who interact with the greatest number of other workers receive greatest amount of work related information and become most powerful in organizational structure.

**Organizational Concepts**

1. Responsibility- is the obligation to do, to the best of one's ability, the task that has been assigned, or delegated. In any organization, responsibility

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begins with the overall objective of the organization. For example, for nurses in a hospital, service or patient care is the responsibility.

2. Authority- the right of decision and commands. An individual with authority has the right to make decisions about his or her own responsibilities. Responsibility and authority are delegated down the scalar chain.

3. Delegation- is the process of assigning duties or responsibilities along with corresponding authority to another person. Authority must be delegated with the responsibility.

4. Accountability- is answering to someone for what has been done. It is related with responsibility.

**Centralization versus Decentralization**

In a highly centralized organization, the chief executive makes most decisions. Decentralization is the allocation of responsibility and authority for management decisions downward through the chain of command. In centralized, decisions made at the apex of the organization takes longer period of time than decisions made at the lower levels. Therefore, highly centralized

organizations are slow in adapting to major changes. Lower level workers become passive, unenthusiastic and mechanical.

The executive who will not permit supervisors to select staff, determine staff schedule, institute working improvements, evaluate goal achievement, and recommend policy change deprive middle managers of opportunities for professional growth.

Decentralization of responsibility leads to improved employee morale. When middle managers are given responsibility for decision-making, they in-turn make still further, empowering staffs to formulate unit level work plans, policies and procedures.

As job responsibility and autonomy increase, so does job satisfaction. It improves staff nurse moral and retention. The head nurse's tasks in a decentralized organization are similar to a nursing director task in a highly centralized organization. Therefore, expert staff specialist should support the head nurses.

**Types of Formal Organization Structures**

**Line Pattern/Relationship**:  This is the oldest and simplest type of formal organization chart. It is a straightforward, direct chain of command with superior

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subordinate relationships. The line pattern is more efficient than other structures, because it provides clear authority-responsibility relationships between workers and requires less information transmission between managers and workers.

The typical line pattern is divided laterally into segments representing different nursing specialties. The perspective of workers differs from the bottom to the top of the structure. Workers at the base of pyramids-Nursing assistants, Orderlies, staff nurses perform the basic work of nursing mission, i.e. direct patient care.

Employees in the middle of the structure- head nurses, patient care coordinators, supervisors are responsible for professional decision-making and direction of day to day operations. Personnel at the top of the structure-Vice president or director and assistant directors are responsible for non-programmed decision making, such as goal setting, program planning, and performance evaluation.

**Advantages of Line Pattern**

❖ It is easy to orient new employees, because of clearly defined interpersonal relations as well as responsibility and accountability;

❖ Easy to manage, because orders can be transmitted quickly;

❖ Well established division of labor;

❖ There is a clear-cut work specialization and role separation.

**Disadvantage**

❖ As a result of specialization, it makes employee's task narrow, repetitive performance and causes communication difficulties among specialists;

❖ Since it is rigid, workers tend to resist innovative changes and resist recommendations from outsiders;

❖ Line pattern causes passivity and dependence in staff members and autocratic behavior in managers. The strong chain of command and concentration of authority at the top of hierarchy cause lower level employees to refer difficult problems to their immediate superior. Managers talk more than to listen;

❖ It is characterized by weak integration of different divisions or departments. Interaction is only on the same division and there is no lateral communication. Head nurses will never seek

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advice from a more experienced head nurse in a different clinical division to resolve a patient care.

**Line and Staff Pattern/Relationship/in an Organization**

Line functions are those that direct responsibility for accomplishing the objectives of a nursing department. For the most, part they are filled with registered nurses licensed assistant nurses or other types of nurses. Staff functions are those that assist the line in accomplishing the primary objectives of nursing. They include clerical, personnel, budgeting, and finance, staff development, and research. The relationship between line and staff are a matter of authority. Line has authority for direct supervision of employees, while staff provides advice and counsel.

To make staff effective, top management ensures that line and staff authority relationships are clearly defined. Personnel of both should work to make their relationships effective; they attempt to minimize friction by increasing mutual trust and respect.

The advantage of a line and staff pattern is that key management functions that the chief executive has neither skill nor time to execute well are delegated to functional experts who can devote full time to the

assigned function without being distracted by responsibilities of day today management of personnel and material.

The disadvantage of line and staff pattern is that staff officers have less power than line officers, because the latter direct the basic operations. Furthermore, staff officers must stand quietly in the background, while line managers receive recognition for improvements. Staff positions are also located at the periphery of formal structure, which casts incumbents in the role of social isolates.

## Matrix Organizational Structure

This Pattern is a complex construct in which and employee may be responsible to two or more bosses for different aspects of work. In this pattern, a staff nurse stationed on a given patient unit is responsible to the head nurse of that unit but also to a case manager who oversees the clinical progress of her patients. It could also be through vertical and horizontal coordination.

Potential problems with a matrix type organization can easily be discerned. If, for example, the head nurse and the case manager give conflicting orders to the staff nurse, the job may be indefensible, or a manipulative

staff nurse may play his/her two bosses off against each other. When a matrix organization is used, there must be clear decision rules and, it is hoped, good interpersonal relationships. The employee must know which boss has the final word when they receive conflicting orders or conflicting demands concerning work priorities.

**Functional Line and Staff Pattern**

A third type of formal organization structure is the functionalized line and staff organization. In this structure, staff officers are no longer purely advisory but have some command authority over line employees. The director of in-service may have the authority to decide how much indoctrination training and what type of orientation each new nurse must receive and when orientation classes will be held. The director of quality improvement may have the authority to assign selected staff nurses to gather data on critical indicators of care quality, regularly submit quality monitoring reports, and remedy identified problems.

As a nursing organization increases in size, it may evolve from a pure line, to a line and staff, and finally, to a functional line and staff structure. The advantage of

functionalized line and staff organization is that the expert responsible for a specified management function, such as staffing, policies, quality improvement, or staff development, has authority to command line managers to implement needed actions that relate to the expert's specified function.

**Standards for evaluating the effectiveness of line and staff relationships in a hierarchical organization Standards**

1. Line authority relationships are clearly delineated and defined by the organizational and/or functional charts and policies;

2. Staff authority relationships are clearly delineated and defined by the organizational and /or functional charts and policies;

3. Functional authority relations are clearly delineated and defined by the organizational and /or functional charts and policies;

4. Staff personnel consult with, advise and provide counsel to line personnel;

5. Service personnel functions are clearly understood by line and staff personnel;

6. Line personnel seek and effectively use staff services;

7. Appropriate staff services are being provided by line nursing personnel and other organizational departments or services;

8. Services are not being duplicated because line and staff authority relationships.

**Systems of Nursing Service Delivery**

Effective management makes the organization function, and the nursing manager has a responsibility of nursing care delivery systems that demonstrate ways of organizing nursing's work. Within these systems there are advantages and disadvantages for quality of care, use of resources, and staff growth.

**Case Method**

The new method, traced back to Florence Nightingale, began in the early days of the nursing profession and was the convenient and appropriate way to manage care. Individuals are assigned to give total care to each patient, including the necessary medicine and treatments. The nurses report to their immediate superior, who is the head nurse. The disadvantages of

this system are that all personnel might not have been qualified to deliver all aspects of care, and depending on the structure, too many people were reporting to the head nurse (overextended span of control).

**Functional Method**

The functional method is the next step to deal with different levels of caregivers. Assignments of patient care are made by the level of task; in other words, each person performs one task or functions in keeping with the employees' educational experience. For example Nurse Aides /Health Assistants/ give baths, feed patients, and take vital signs to all patients. Professional nurses are responsible for medications, treatments, and procedures for all patients. The head nurse is responsible for overall direction, supervision, and education of the nursing staff.

**Advantages**

- Reduce personnel costs
- Supports cost control

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**Disadvantages**

- Fragments nursing care
- May decrease staff job satisfaction
- Decreases personal contacts with client
- Limits continuity of care

**Team Nursing**

A dramatic change occurred after World War II in the years between 1943 and 1945. The level and number of auxiliary personnel began increasing, and the professional nurse was assuming more and more of the management functions. Because of the changing configuration of the work group and the dramatic social upheaval, a study was commissioned to device a better way to provide nursing care. Dr. Eleanor Lambertson of Columbia University in New York and Francis Perkins of Massachusetts General Hospital were the authors of the system known as team nursing. Team nursing was developed to deal with the influx of post war workers and the head nurse's overextended span of control. This was accomplished by arranging the workers in teams.

The team consists of the senior professional nurse becoming the team leader; the members of the team are other registered nurses (RNs), licensed practical nurses

(LPNs) or vocational nurses, and nurses' aides. Each is being given a patient assignment in keeping with the employee's education and experience. The team leader make the assignments, delegated the work through the morning report, make rounds throughout the shift to make sure patients are being cared for properly, and conducts a team conference at the end of the shift to evaluate the patient care and plan an update nursing care plans.

Since 1950, team nursing is becoming a popular way to structure nursing care.

Team nursing is a pattern of patient care that involves changing the structural and organizational framework of the nursing unit. This method introduces the team concept for the stated aim of using all levels of personnel to their fullest capacity in giving the best possible nursing care to patients. The structural and organizational changes necessary for this method includes the introduction of the nursing team with the team leader assuming responsible for the management of the patient care. The head nurse decentralizes authority to the team leader to direct the activities of the team members. The head nurse is no longer the center of all communication on the division because the

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members communicate directly with the team leader. The team leader had the responsibility for synchronizing the abilities of her/his team members so that they are able to function effectively in a team relationship. Emphasis is placed on the ability of all participants of patient care to plan, administer, and evaluate patient care.

The team approach to patient care represents more than reorganization or restructuring of nursing service. Instead, it is a philosophy of nursing and a method of organizing patient care. The difficulty with this method concerns the nurse's absence at the bedside; the nurse is directing the care of others and thus not using nursing's specialized knowledge as the best provider of patient care. Problems with this system have become the stimulus for a new system.

**Advantages**

- Supports comprehensive care
- May increases job satisfaction
- Increases cost effectiveness

**Disadvantages**

- Decreases personal contact with client
- Limits continuity of care

**Primary Nursing**

Primary nursing as a system of care provided for a way to provide quality comprehensive patient care and a framework for the development of professional practice among the nursing staff. Primary nursing was a logical next step in nursing's historic evolution. By definition, primary nursing is a philosophy and structure that places responsibility and accountability for the planning, giving, communicating and evaluating of care for a group of patients in the hands of the primary nurse. Primary nursing was intended to return the nurse to the bedside, thus improving the quality of care and increasing the job satisfaction of the nursing staff.

The primary nurse is expected to give total care, to establish therapeutic relationship, to plan for 24 hours continuity in nursing are through a written nursing care plan, to communicate directly with other members of the health team, land to plan for discharge. The patient's participation is expected in the planning, implementing, land evaluating of his or her own care. Perhaps the best

aspect of primary nursing is the improved communication provided by the one-to-one relationship between nurse and patient.

Associate nurses are involved with this method by caring for the patients in the absence of primary nurse. Their responsibilities include continuing the care initiated by the primary nurse and making necessary modifications in the absence of primary nurse.

Primary nursing was adapted in organizations to fit the staffing patterns and general nursing philosophy. Because of the need for high percentage of professional nurses, other modifications of the system developed, such as modular nursing.

**Advantages**

- May increase job satisfaction
- Improves continuity of care
- Allows independent decision making
- Supports direct nurse-client communication
- Encourages discharge planning
- Improves quality of care

**Disadvantages**

- Increases personnel costs initially

- Requires properly trained nurses to carry out systems principles
- Restricts opportunity for evening and night shift nurses to participate

**Case Management**

More recently, a new method of nursing care delivery has evolved known as case management. The American Nurses Association (ANA) has defined case management to be a system of health assessment, planning, service procurement and delivery, coordination, and monitoring to meet the multiple service needs of clients. This is an all-inclusive and comprehensive model and is not restricted to the hospital setting.

When a patient deviated from the usual expected course of recovery or health, consultation ensures to quickly correct the problem. This requires a great deal of systematic knowledge about a patient's problems and putting that knowledge into a type of nursing care plan (case management plans) with time lines to demonstrate progress or deviations from the critical paths. In addition to the nursing and medical services that are required for

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patients, other services are included, such as physical therapy and respiratory therapy.

**Advantage**

- Improves nurse responsiveness to clients changing needs
- Improves continuity of care
- May increase nurse's job satisfaction

**Disadvantage**

- Increases personnel costs

**Learning Activities**

1. Describe the form of organizational structure of the nursing division on which you work as an employee. Discuss the changes that could be made to make it more functional.

2. Obtain the organizational chart of nursing from any department. Is it centralized or decentralized? Where does the nursing fit?

3. Discuss the functioning of the nursing delivery system (s) in your health care organization and does it make the nursing

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delivery system more efficient or effective? How do you improve it?

4. Using "standards for evaluating the effectiveness of line and staff relationships in an hierarchical organization," evaluate the nursing division or service in which you work as a student or as an employee.

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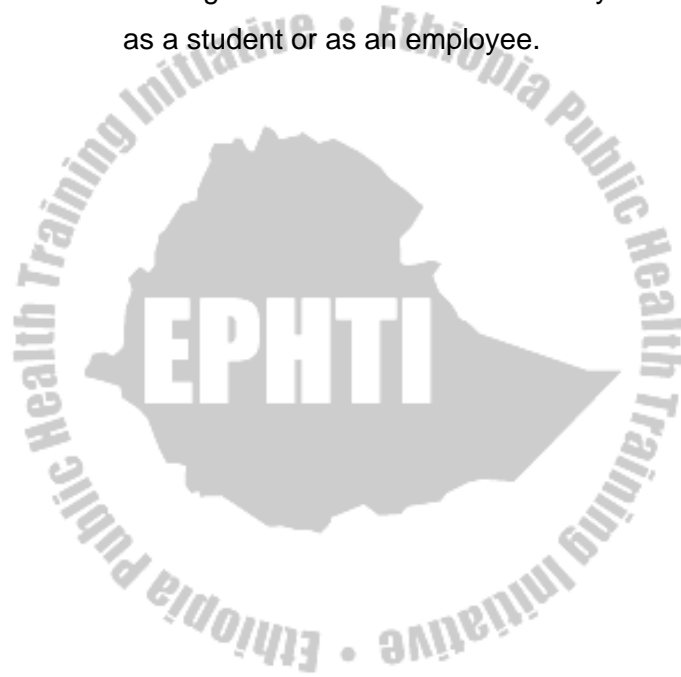
# CHAPTER FOUR

# FUNCTIONS OF MANAGEMENT

## Objectives:

At the end of this chapter, the student should be able to:

- Define the common terms used in the management process

- List down the expected functions of a nurse manager

- Discuss the concepts of each function using some examples

- Describe the effect of delegation on the manager's responsibility for the delegated functions.

**Definitions**

- **Planning –** determining the long-and short-term objectives (ends) of the institution or unit and the actions (means) that must be taken to achieve these objectives.

- **Staffing-** Selecting the personnel to carry out these actions and placing them in positions appropriate to their knowledge and skills

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- **Organizing-** Mobilizing human and material resources so institutional objectives can be achieved.

- **Directing-** Motivating and leading personnel to carry out the actions needed to achieve the institution's objectives.

- **Controlling-** Comparing results with predetermined standards of performance and taking corrective action when performance deviates from these standards.

- **Decision Making-** Identifying a problem, searching for solutions, and selecting the alternative that best achieves the decision maker's objectives.

**Management Functions of a Nurse Manager**

Success of management depends on learning and using the management functions. These functions include planning, organizing, staffing, directing, coordinating and controlling. These functions represent these activities expected of managers in all fields. Managers develop skill in the implementation of these functions as they gain experience in th role of managers. Nurse Managers

also use the same functions as they fulfill their responsibilities in the organization.

**Planning**

Planning is a technical managerial function that enables organizations to deal with the present and anticipate the future. It is the first and fundamental function of management because all other management functions are dependent on it. Planning is deciding what is to be done, when it is to be done, how it is to be done and who is to do it. It is an orderly process that gives organizational direction. Planning is the process of determining how the organization can get where it wants to go. Planning is the process of determining exactly what the organization will do to accomplish its objectives. In more formal terms, planning has been defined as 'the systematic development of action programmes aimed at reaching agreed objectives by the process of analyzing, evaluating and selecting among the opportunities which are foreseen.

*Purpose of planning*
   ❖ It gives direction to the organization.
   ❖ It improves efficiency.

❖ It eliminates duplication of efforts.

❖ It concentrates resources on important services.

❖ It reduces guess work.

It improves communication and coordination of activities

**The planning hierarchy**

Planning responsibilities are different for managers at each organizational level.

**Strategic planning**

Top-level managers, formulate long-term strategic planning to reinforce the firm's mission (the mission clarifies organizational purpose)

Strategic plans are specified for five years period or more; but circumstances dictate the planning horizon.

**Tactical planning**

Middle management is responsible for translating strategies into shorter-term tactics. Tactical plans are often specified in one-year increments. Eg. annual budget.

Translating strategic plans into measurable tactical objectives is important because most strategic objective is rather vague.

**Operational planning**

Operational planning is accomplished by fist-line managers. Operational planning is most concerned with budgets, quotas and schedules. These are refinements of tactical objectives in which work is defined and results are measured in small increments. Time horizon for operational planning is very short. Most plans at this level reflect operational cycles.

Operational objective are:

- ❖ Narrow in scope
- ❖ Short-lived
- ❖ Subject to sadden change.

In order to fulfill her/his own job responsibilities and to guide subordinates towards agency goals, the nurse manager must spend scarce materials and human resources wisely. Since the nursing service operation in even a small agency is immensely complicated, careful planning is needed to avoid waste, confusion and error.

### The formal planning process

Formal planning is a systematic process. It consists of five guidelines. These guidelines provide a general pattern of rational planning.

### Situation audit or environmental assessment

It analyzes the Past, current and future forces that affect the organization. Expectation of outside interests such as government officials, insurance companies and consumers are sought. Expectations of inside interests such as nurse, doctors, administrators and other staffs are collected. Environment, demographic, resources, legal, technological factors should also be considered.

### Establish Objectives

Every plan has the primary purpose of helping the organization succeed through effective management. Success is defined as achieving organizational objectives. These are performance targets, he end results that managers seek to achieve.

**Characteristics of objectives**

Well-defined objectives have several Characteristics. They are:

- *Specific*
- *Measurable*
- *Realistic and challenging*
- *Defined time period*

**Involve management and staff**

Involving a greater number of managers will result in better plans and more wide spread acceptance of objectives.

**Develop alternatives**

A successful planning process will generate several options for manages to consider. These options are alternative courses of action that can achieve the same result. The task of management is to decide among them. Managers usually consider many alternatives for a given situation, but a viable alternative suggests a proposed course of action that is:

- *Feasible*
- *Realistic*
- *Sufficient*

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**Communicate plans**

Planning requires clear and effective communication at all levels before performance begins to mirror expectations. Objectives are written and plans are documented to give employees direction. Managers communicate plans into two categories:

**A. Standing use plans**- are those that are used on a continuous basis to achieve consistently repeated objectives. Standing plans take the form of:

- *Policies*
- *Procedures*
- *Rules*

**Policies:** A standing plan that furnishes broad guidelines for channeling management thinking toward taking action consistent with reaching organizational objectives. It provides guidelines for behavior. Policies are also instruments of delegation that alert subordinates to their obligations. Effective policy statements are clear, understandable, stable overtime, and communicated to everyone involved.

**Procedures**: a standing plan that outlines a series of related actions that must be taken to accomplish a

particular task. It is an explicit set of actions, often sequential in nature, required to achieve a well defined result. Formal procedures provide specific and detailed instructions for the execution of plans. Good procedures provide a sequence of actions that once completed fulfill specific objectives, reinforce policies and help employees achieve results efficiently and safely.

**Rule:** is a standing plan that designates specific requires action. It indicates what an organization member should or should not do and allows as no room for interpretation. It is a statement that tends to restrict actions or prescribe specific activities with no discretion. Rules usually have a single purpose and are written to guarantee a particular way of behaving in a particular way.

**B. Single use plans**-are those that are used once to achieve unique objectives or objectives that are seldom repeated. They are communicated through:

- *Programs*
- *Budget*
- *Schedule*

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*Programs:* *is a single use plan designed to carry out a special project within an organization. It comprises multiple activities orchestrated to achieve one important objective.*

*Budget: is a single use financial plan that covers a specified length of time. It describes in numerical terms resources allocated to organizational activities. By budgeting, managers identify resources such as money, material and human resource. It also communicates performance expectations.*

*Schedule: is a commitment of resources and labor to tasks with specific time frames.*

**Approaches to planning**

There are three distinct approaches that describe who has the responsibility for formulating plans:

- *Centralized top down planning-* is the traditional approach to planning in which a centralized group of executives or staff assumes the primary planning responsibility.

- *Bottom-up planning-* is an approach that delegates planning authority to division and department managers, who are expected to

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formulate plans under the general strategic umbrella of organizational objectives.

- *Team planning*- is a participative approach to planning where by planning teams comprising managers and staff specialties initiate plans and formulate organizational objectives.

**Organizing**

Organizing may be defined as the arranging of component parts into functioning wholes. The purpose of organizing is to coordinate activities so that a goal can be achieved. The terms "planning" and "organizing" are often used synonymously. For example, organizing is considered step in the nursing process; however, planning is the second. In the managerial process (i.e., managerial theory of leadership, planning is considered the first step and organizing, the second.

In the managerial, planning is the determination of what is to be accomplished, and organizing is the determination of how it will be accomplished. However, most authors still describe the two processes with considerable overlap.

In the nursing process, planning includes writing objectives, setting priorities, and determining activities to meet the objectives. Thus, organizing may be considered part of the planning, even though it is not specifically identified. Planning, and thus organizing, may be viewed as being part of all processes, including the leadership process. Thus, planning and organizing may be said to answer the what, why, how, when, and where questions about specific activities.

There are six steps in the organizing process:

1. Establish overall objectives
2. Formulate supporting objectives, policies and plans
3. Identify and classify activities necessary to accomplish the objectives
4. Group the activities in light of the human and material resources available and the best way of using them under the circumstances
5. Delegate to the head of each group and the authorities necessary to perform the activities
6. Tie the groups together horizontally and vertically, through authority relationships, and information systems.

**Establishing Objectives**

The first step in the process of organizing is to establish overall objectives. Objectives are explicit, concise statements of what is to be accomplished. They provide directions for selecting materials and methods to achieve the desired goal. Behavioral objectives can be measured through observable performance. Overall objectives are usually broad and give a general idea of what is to be accomplished.

Five criteria for sound objectives in a management area have been established. First, the objective must be *acceptable* to both the leader and the group who will be involved in achieving it. They must agree that it is worthy of their efforts. All members of the group should see the objectives as related to the purpose of the group.

Second, the objective must be *attainable* within a reasonable period of time, that is, it must be realistic.

Third, the objective must be *motivational*, that is, it should be stated in such a way that it causes the group to want to strive toward reaching it. When the nurse-leader collaborates with group members in establishing objectives, members' ideas should be included, so that they will feel a part of the objective. When members

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have input into the objective, it becomes their own, and they are motivated to achieve it.

Fourth, the objective must be *simple*. It should be clearly describe only one behavior. A good objective is as brief as possible, yet it's meaning is clear.

Finally, the objective must be *communicated* to all persons who are concerned with its achievement. The leader, the group, and their superiors should all know, initially and throughout the process, the goals toward which they are working.

**Formulate Supporting Objectives**

Another part of the second step in the organizing process is the recognition of existing policies, procedures, and rules that affect the task and objectives. A policy is a guide to action that provides a standard decision for recurring problems and is made by top-level administrators. Policies aid in keeping activities in line with the overall objectives of the organization. For example, all critical patients on being discharge must go to the door in a wheelchair" is a policy to aid in meeting the overall goal, "patients will not fall in the hospital." If a policy states that a registered nurse must discharge all

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patients, an objective cannot provide for health assistants or volunteers to discharge patients.

**Identify and Classify Activities**

If the written objectives are very specific, the required activities will be obvious. The activities that a nurse will have to perform to provide care include giving medications, bathing patients, making beds…. The nurse leader must know when, what, how and why activities are done. Then prioritize activities based on biological and behavioral sciences.

**Group Activities**

The fourth step in the process of organizing is to group activities according to the human and material resources available. Once all the activities have been identified and given a priority, the nurse leader must analyze her resources, so that they can be used to best advantage in terms of time, talents, and economy. The nurse leader must assess both her group members and the material resources that she has at hand.

**Delegation**

Delegation is the process of assigning part or all of one person's responsibility to another person or persons. Delegating is an effective management competency by which nurse managers get the work done through the employees.

The purpose of delegation is efficiency; no one person can do all the work that must be done; therefore, some work must be passed on, or delegated to others. However, it must be remembered that, even when an activity is delegated to someone else, the ultimate responsibility for that activity still belongs to the nurse-leader (i.e. the person who delegated the activity.

Nurse managers need to be able to delegate some of their own duties, tasks, and responsibilities as a solution to overwork, which lead to stress, anger, and aggression. As nurse managers learn to accept the principle of delegation, they become more productive and come to enjoy relationships with the staff. The following list suggests ways for nurse managers to successfully delegate.

- Train and develop subordinates. It is an investment. Give them reasons for the task,

authority, details, opportunity for growth, and written instructions if needed.

- Control and coordinate the work of subordinates, but do not go over their shoulders. To prevent errors, develop ways of measuring the accomplishment of objectives with communication, standards, measurements, feedback and credit.

- Follow up by visiting subordinates frequently. Expect employees to make suggestions to improve work and use the feasible ones.

- Encourage employees to solve their own problems, and then give them the autonomy and freedom to do.

- Assess results. The nurse manager should accept the fact that employees will perform delegated tasks in their own style.

- Give appropriate rewards

- Do not take back delegated tasks.

**Barriers to Delegating**

**Barriers in the Delegator**

- Preference for operating by oneself

- Demand that everyone "know all the details"

- "I can do it better myself" fallacy
- Lack of experience in the job or in delegating
- Insecurity
- Fear of being disliked
- Refusal to allow mistakes
- Lack of confidence in subordinates
- Perfectionism, leading to excessive control
- Lack of organizational skill in balancing workloads
- Failure to delegate authority commensurate with responsibility
- Uncertainty over tasks and inability to explain
- Disinclination to develop subordinates
- Failure to establish effective controls and to follow up

**Barriers in the Delegatee**

- Lack of experience
- Lack of competence
- Avoidance of responsibility
- Over dependence on the boss
- Overload of work
- Immersion in trivia

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**Tie together**

The final step in the process of organizing is that of coordination. Group of group members must be placed horizontally and vertically into a framework of authority relationships and information systems in the organizational structure. The goal of organizing is the coordination of activities, and it is with this last step that the framework is fully established. It brings the whole process together. Even though all the five previous steps are satisfactorily completed, if the members' activities are not tied in, the process can still fail. Members need to know to whom they can go for help and relief.

- Open communication lines are and essential part of coordination
- Group members must also know to whom they can turn for assistance
- Group members, as well as the nurse leader, must be aware of who is fulfilling which tasks, so that they will be able to find one another when necessary.

**Staffing**

Staffing is the management activity that provides for appropriate and adequate personnel to fulfill the organization's objectives. The nurse manager decides how many and what type of personnel are required to provide care for patients. Usually the overall plan for staffing is determined by nursing administration and the nurse manager is in a position to monitor how successful the staffing pattern is as to provide input into needed change.

Staffing is a complex activity that involves ensuring that the ratio of nurse to patient provides quality care. The situation of a nursing shortage and the high activity levels of admitted patients to acute care areas complicate this process. Staffing depends directly on the workload or patient care needs. An ideal staffing plan would provide the appropriate ratio of caregivers for patients' individual needs based on data that predict the census.

**Directing**

Directing is a function of the manager that gets work done through others. Directing includes five specific

concepts; giving directions, supervising, leading, motivating, and communicating, as described below:

- Giving directions is the first activity and suggests that directions should be clear, concise and consistent and should confirm to the requirements of the situation. The manager should be aware of the tone of the directives. Different types of situations require different emphasis. For example, and emergency situation calls for different variation of voice than does a routine request.

- Supervising is concerned with the training and discipline of the work force. It also includes follow up to ensure the prompt execution of orders.

- Leading is the ability to inspire and to influence others t the attainment of objectives

- Motivating is the set of skills the manager uses to help the employee to identify his/her needs and finds ways within the organization to help satisfy them.

- Communicating: involves the what, how, by whom, and why of directives or effectively using the communication process.

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**Coordinating**

Coordinating is by definition the act of assembling and synchronizing people and activities so that they function harmoniously in the attainment of organizational objectives. Think about the situations in your own life when you have had to coordinate the multiple activities for an important event. An example in everyday life that demands coordination is a wedding. The music, flowers, ceremony and numerous other considerations must be coordinated so that each can contribute to make the wedding beautiful and joyful. The more assurance that all parties are cooperating and fulfilling their agreements, the more likely that the wedding will be a success with minimal complications.

**Controlling**

Is the regulation of activities in accordance with the plan. Controlling is a function of all managers at all levels. Its basic objective is to ensure that the task to be accomplished is appropriately executed. Control involves establishing standards of performance, determining the means to be used in measuring performance, evaluating performance, and providing feedback of performance data to the individual so

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behavior can be changed. Controlling is not manipulation, rigid, tight, and autocratic or oppression. Management by objectives (MBO) can be considered as a control mechanism. Based on MBO principle-determining objectives (standards) against which performance can be measured can be stated. Second, specific measures have to be established to determine whether these objectives are met. Third, the actual accomplishment of the objectives would be measured in relation to the standard and this information would be fed back to the individual. Then corrective action could be taken.

**Learning Activities**

1. Observe a manager using the functions of a management. Think about what it is the manager does while performing each of the following:

     1.1 Directing

     1.2 Coordinating

     1.3 Controlling

2. Divide the class into three groups. Have each group represent a different level of management. Give each group time to devise a plan that would reflect the type of planning expected at each level.

# CHAPTER FIVE

# DECISION MAKING

## Objectives:

At the end of this chapter, the student should be able to:

1. Describe the types of decisions
2. Explain the mechanisms of decision-making
3. Discuss the steps of logical decision-making
4. Identify the factors responsible for decision-making
5. Discuss the importance of decision making for nurse managers?
6. Recognize the decision-making tools
7. Explain the barriers for decision-making and mechanisms of overcoming it

### Decision Making

**Decision making**-is a choice made between two or more alternatives. It is choosing the best alternative to reach the predetermined objective. Thus decision-making is a process of identifying and selecting a course of action to solve specific problem.

**Types of decisions**

Decisions made in the nursing service can be categorized depending upon the following criteria

- How much time the manager spends in making decision

- What proportion of the organization must be involved in making decision

- The organization function/ the nursing/midwifery functions on which they focus

On the basis of these there are three classifications:

1. Ends -Means
2. Administrative-Operational
3. Programmed-Non-programmed

**1. Ends-Means**

**Ends:** deals with the determination of desired individual or organizational results to be achieved

**Means:** decisions deal with strategic or operational programmes, activities that will accomplish desired results. These usually occur during managerial planning processes, strategy and objective formulation processes

**2. Administrative-Operational**

Administrative: made by senior management, which have significant impact throughout the organization. Usually this type of decision is concerned with policy, resource allocation and utilization.

Operational: are generally made by mid level and first line managers and address day to day operational activities of a particular organizational

**3. Programmed-Non -programmed**

Programmed-these are repetitive and routine in nature. Since they can be programmed, procedures, rules and often manuals are formulated to cover those situations

None programmed: unique and non- routine

**Conditions that initiate decision making**

1. Opportunity/threat
2. Crisis
3. Deviation
4. Improvement

**Ways of Decision Making**

1. Relying on tradition: taking the same decisions that had been undertaken when similar problem arouse in the past
2. May appeal to authority and make decisions based on suggestions from an expert/a higher level management
3. Priori reasoning: based on assumption
4. Logical decision making: is a rational, intelligent and systematic approach to decision making

**Steps of logical Decision Making**

1. Investigating the situation
   - Define the problem
   - Identify the problem objective
   - Diagnose the cause
2. Develop alternatives
3. Evaluate alternatives
4. Implement and follow up

**Factors Influencing Decision Making**

1. **Decision makers attribute**
   - Knowledge, experience, and judgment
   - Perception and personality

- Values and philosophy

2. **The Situation**
   - Urgency of solution and time pressures
   - Magnitude and importance
   - Structure and uncertainty and risk
   - Cost benefit

3. **Environmental Constraints**
   - External
   - Internal

**Implications for Nurse Managers**

The activities of the problem solver, the nature of the situation and the environmental constraints influence how decision is done; resource spent in performing it, and the quality of the ultimate decision. However, these influences are not mutually exclusive. Managers should recognize these attributes and be sensitive to the factors that affect decision-making, change their method as appropriate, modify and mitigate detrimental influences when possible, and cope with those that cannot be changed. In this way, they will improve the quality of decision-making.

**Encouraging creativity**

- **Convergent thinking**-the problem is divided into smaller and smaller pieces to find a more manageable perspective.
- **Divergent thinking**: One's view of the problem is expanded. The problem is considered in different ways
- **Brain storming**: under favorable circumstances a group working together can identify more ideas than an individual or the group of individuals working separately. It is a technique managers can use to create a free flow of ideas

**Decision Making Tools**

There are many tools. The most common are:

1. **Probability theory**: is the likelihood that an event or outcome will actually occur and allow decision makers to calculate an expected value for each alternative.

   Expected Value (EV) = Income it would produce (I) x its probability of making that income (P).

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2.  **Decision tree**= are graphic decision making tools used to evaluate decisions containing a series of steps

**Deciding to decide**

1.  Is the problem easy to deal with

    Tip: avoid being bogged down in trivial details. Effective managers reserve decision-making techniques for problems that require them.

2.  Might the problem resolve itself

    Tip: prioritize and rank problems in order of importance

3.  Is it my decision

    Tip: the closer to the origin of the problem the decision is the better. Before deciding ask the following questions:

    - Does the issue affect other departments?

    - Will it have a major impact on the superior's area of responsibility?

    - Does it need further information from higher level?

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- Does it involve serious breach of my department's budget?
- Is this problem outside my area of responsibility or authority?

If the answer to any of these questions is 'YES' pass it to your superior.

**Barriers to Effect Decision-Making**

1. Easy recall: the more easily can recall the event, the more frequently they believe it occur
2. Easy search: not to put effort to seek information from the appropriate sources
3. Misconception of chance: Most people do not understand the nature of random events
4. Confirmation gap
5. Relaxed avoidance: the manager decides not to decide or act after noting that the consequences of inaction will not be serious
6. Defensive avoidance: Faced with a problem and unable to find a good solution based on past experience, this

manager seeks a way out. He/she may let someone else make decisions. This resigned posture may prevent consideration of more viable alternatives.

7. Panic: the manager feels pressurized not only by the problem but also time

**Overcoming barriers to individual problem solving**

1. Setting priority
2. Acquiring relevant information
3. Proceeding methodically and carefully
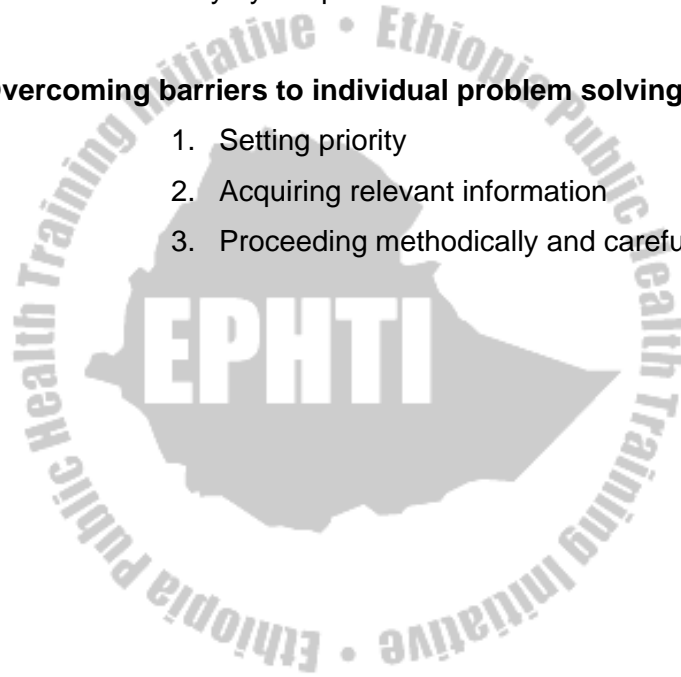
## Learning activities

1. Define decision-making
2. Define some of the common concepts in decision-making
3. What is a decision environment?
4. Explain the impact of gathering too much information
5. Explain the three types of decisions
6. How do nurse managers make decision?
7. What are the steps to be followed in logical decision-making?
8. What are the factors necessitating decision-making?
9. Why do you think the importance of decision making for nurse managers?
10. List the decision-making tools
11. What the barriers for decision-making? How can we overcome these problems?

# CHAPTER SIX
# THEORIES OF LEADERSHIP AND MANAGEMENT

## Objectives:

At the end of this chapter, the student should be able to:

- Trace the evolution of early leadership and management theories into the contemporary leader manger theories
- Compare and contrast the democratic style to the authoritarian and laissez faire styles; Theory X to Theories Y and Z
- Discuss the three elements of situational leadership theory (contingency model) and discuss it associated it with Path-Goal theory

**Leadership and Management Theories**

**What is the Difference between Management and Leadership?**

Mangers come from the "headship" (power from position) category. They hold appointive or directive posts in formal organizations. They can be appointed for both technical and leadership competencies, usually

needing both to be accepted. Managers are delegated authority, including the power to reward or punish. A manager is expected to perform functions such as planning, organizing, directing (leading) and controlling (evaluating).

Informal leaders, by contrast, are not always managers performing those functions required by the organization. Leaders often are not even part of the organization. Florence Nightingale, after leaving the Crimea, was not connected with an organization but was still a leader.

Managers focus on results, analysis of failure, and tasks, management characteristics that are desirable for nurse managers. Effective managers also need to be good leaders. Manager-leaders ask for information, provide positive feedback, and understand the power of groups. Mistakes are tolerated by manager-leaders who challenge constituents to realize their potential.

**Similarities between Leadership and management**

Gardner asserts that first class managers are usually first class leaders. Leaders and leader-managers distinguish themselves beyond general run-of-the-mill managers in six respects:

- They think longer term-beyond the day's crises, beyond the quarterly report, beyond the horizon.
- They look beyond the unit they are heading and grasp its relationship to larger realities-the larger organization, of which they are a part, conditions external to the organization, global trends.
- They reach and influence constituents beyond their jurisdiction, beyond boundaries. Thomas Jefferson influenced people all over Europe. Gandhi Influenced people all over the world.
- They put heavy emphasis on the intangibles of vision, values, and motivation and understand intuitively the non-rational and unconscious elements in the leader constituent interaction.
- They have the political skill to cope with the conflicting requirements of multiple constituencies.
- They think in terms of renewal. The routine manager tends to accept the structure and processes, as they exist. The leader or leader/manager seeks the revisions of process and structure required by ever changing reality.

Good leaders, like good managers, provide visionary inspiration, motivation, and direction. Good managers,

like good leaders, attract and inspire. They want to pursue goals and values they consider worthwhile. Therefore, they want leaders who respect the dignity, autonomy, and self-esteem of constituents.

**Early Leadership Theories**

A. **Trait Theories** – If you have ever heard the statement that "leaders are born, not made", then you have heard someone expressing the fundamental belief underlying a trait theory of leadership. Trait theories assume that a person must have a certain innate abilities, personality traits, or other characteristics in order to be a leader. If true, it would mean that some people are naturally better than others.

B. **Great Man Theory** – According to the "Great man" theory of leadership tremendous influence of some well known people has actually determined or changed the course of history. Some believe that these people possessed characteristics that made them great leaders. Such important historical figures, such as Caesar, Alexander the great, Hitler, and Gandhi

have been studied to find the characteristics that made these men leaders of their time**.**

C. **Individual Characteristics**- Many studies have focused on ascertaining which individual physical or personality traits are associated with leadership. Despite the fact that no single trait has been discovered in all leaders, some popular beliefs remain and influence selection of individuals' positions, because they seem stronger and more dominating. A tall person can be physically imposing and can literally "look down" on other people.

There are also certain traits and behaviors commonly associated with leadership abilities. For example, the most outspoken person in a group is often assumed to be a leader even when other evidence does not support this assumption. The most intelligent or skilled person in a group is often designated the leader because other group members admire this person.

Charismatic Leaders- Charisma is the quality that sets one person apart from others: supernatural, superhuman, endowed with exceptional qualities or powers. Charismatic leadership can be good or evil. Charismatic leaders emerge in troubled times and in

relation to the state of mind of constituents. They eventually run out of miracles even though the leaders are magnetic; persuasive and fascinating.

## Behavioral Theories

The behavioral theories, sometimes called the functional theories of leadership, still focus on the leader. The primary difference between the trait and behavioral theories is that the behavioral theories are concerned with what a leader does rather than who the leader is. They are still limited primarily to the leader element in a leadership situation, but they are far more action oriented and do consider the co-actors.

## Authoritarian-Democratic-and Laissez-Faire styles

The classic research done by Lewin, Lippitt, and White **(White, Lippitt, 1960)** on the interaction between leaders and group members indicated that the behavior of the leader could substantially influence the climate and outcomes of the group. The leaders' behaviors were divided into three distinct patterns called leadership styles: authoritarian, democratic, and laissez-faire. These styles can be thought of as a continuum from a

highly controlling and directive type of leadership to a very passive, inactive style as illustrated in fig.   .

The authoritarian leader maintains strong control over people in the group. This control may be benevolent and considerate (Paternalistic leadership) or it may be dictatorial, with the complete disregard for the needs and feelings of group members. Authoritarian leaders give orders and expect group members to obey these orders. Directions are given as commands, not suggestions. Criticism is more common from the authoritarian leader than from the other types, although not necessarily a constant occurrence. Mostly authoritarian leaders are also quite punitive.

The leader alone, not by the group, does decision-making. Some will try to make decisions congruent with the group's goals. The less benevolent leaders will make decisions that are directly opposed to the group's needs or goals. The authoritarian leader clearly dominates the group, making the status of the leader separate from, and higher than, the status of group members. This reduces the degree of trust and openness between leader and group members, particularly if the leader tends to be punitive as well.

Authoritarian leadership is particularly suitable in an emergency situation when clear directions are the highest priority. It is also appropriate when the entire focus is on getting the job done or in large group when it is difficult to share decision making for some reason. It is often referred to today as a directive or controlling style of leadership.

In contrast, democratic leadership is based on the following principles:

1. Every group member should participate in decision-making.

2. Freedom of belief and action is allowed within reasonable bounds that are set by society and by the group.

3. Each individual is responsible for him self or her self and for the welfare of he group.

4. There should be concern and consideration for each group member as a unique individual.

Democratic leadership is much more participative and far less controlling than authoritarian leadership. It is not passive, however. The democratic leader actively stimulates and guides the group toward fulfillment of the principles listed and toward achievement of the group's goals.

Rather than issuing commands, democratic leader offer information, ask stimulating questions, and make suggestions to guide the work of the group. They are catalysts rather than controllers, more likely to say "we" rather than" I" and "you" when talking about the group. They set limits, enforce rules, and encourage productivity. Criticism is constructive rather than punitive.

Control is shared with group members who are expected to participate to the best of their abilities and experience. The democratic style demands a strong faith in the ability of group members to solve problems and to ultimately make wise choices when setting group goals and deciding how to accomplish these goals.

Most studies indicate that democratic leadership is not as efficient as authoritarian leadership. While the work done by a democratic group is more creative and the group is more self-motivated, the democratic style is also more burdensome. First, it takes more time to ensure that everyone in the group has participated in making decision, and this can be very frustrating to people who want to get a job done as fast as possible. Second, disagreements are more likely to arise and must be resolved, which can also require much effort.

Democratic leadership is particularly appropriate for groups of people who will work together for an extended time, when interpersonal relationships can substantially affect the work of the group. It is often called supportive or participative leadership today. There are variations in the degree to which decision-making is shared with the group, with styles midway between democratic and autocratic. For example, a leader may encourage in put from group members and consider their views but make the final decision.

The laissez faire leader is generally inactive, passive, and non-directive. The laissez- faire leader leave virtually all of the control and decision making to the group and provides little or no direction, guidance, or encouragement. Laissez faire leaders offer very little to the group: few commands, questions, suggestions, or criticism. They are very permissive, set almost no limits, and allow almost any behavior.

Some laissez faire leaders are quite supportive of individual group members and will provide information or suggestions when asked. The more extreme laissez faire leader, however, will turn such a request back to the group. When the laissez faire style becomes extreme, no leadership exists at all.

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In a laissez faire group, members act independently of each other, disinterest will set up, activity becomes chaotic and the frustration level rises. The goals are unclear and procedures are confusing or absent altogether. In most situations, however, laissez faire leadership is unproductive, inefficient, and unsatisfactory. Laissez-faire leadership is often called permissive or non -directive leadership today.
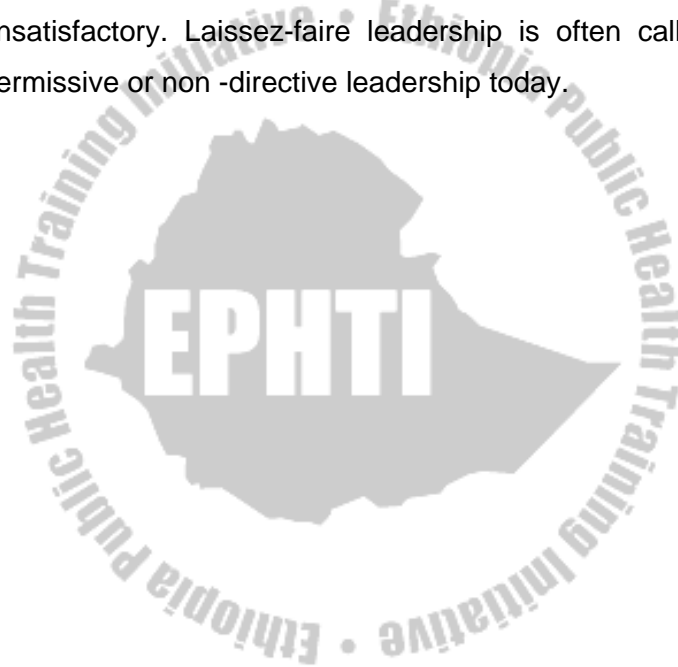
|  | **Authoritarian** | **Democratic** | **Laissez faire** |
|---|---|---|---|
| Degree of freedom | Little freedom | Moderate freedom | Much freedom |
| Degree of control | High control | Moderate control | No control |
| Decision making | By the leader | Leader and group together | By the group or by no one |
| Leader activity level | High | High | Minimal |
| Assumption of responsibility | Primarily the leader | Shared | Relinquish |
| Output of the group | High quantity, good quality | Creative, high quality | Variable may be poor quality |
| Efficiency | Very efficient | Less efficient than authoritarian | Inefficient |

Fig- 6.1 comparison of authoritarian, democratic, and Laissez-faire leadership styles

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**Management Theories**

**Likert's Management System**

**Authoritative**                                    **Democratic**

| System 1 Exploitative Authoritative | System 2 Benevolent Authoritative | System 3 Consultative Democratic | System 4 Participative Democratic |
|---|---|---|---|
| Top management Makes all decisions | Top management makes most decisions | Some delegated decisions made at lower levels | Decision making dispersed throughout organization |
| Motivation by coercion | Motivation by economic and ego motives | Motivation by economic, ego, and other motives such | Motivation by economic rewards established by |

| | | as desire for new experiences | group participation |
|---|---|---|---|
| Communication downward | Communication mostly downward | Communication down and up | Communication down, up, and with peers |
| Review and control functions Concentrated in top management | Review and control functions primarily at top | Review and control functions primarily at the top but ideas are solicited from lower levels | Review and control functions shared by superiors and subordinates |

## Situational Theories

### 1. Contingency Theory (Fred Fiedler) -

In the contingency model, three situational variables are used to predict the favorability of a situation for the leader: the leader's interpersonal relations with group members, the leaders' legitimate power, and the task structure.

**Variables affecting Leadership Effectiveness**

1. Leader-member relations- the personal relationships between the leader and the members of the group. (The better the relationships, the more favorable the situation).

2. Degree of task structure- how specifically the job can be defined so that everyone knows exactly what to do. (The more structured the task, the more favorable the situation).

3. Position Power- the leaders place within the organization and the amount of authority and power given to the leader. Position power may be strong or weak; it does not reflect the strength of the individual leader's personality; rather it measures the leader's status in the organization.

(The greater the position power, the more favorable the situation).

According to the contingency model, a nurse manager should modify situations based on group relations, personal power, and task structure to improve staff productivity. A nurse manager who uses the contingency model must have a thorough understanding of her/his relationship with staff members, her/his power and status within the organization, and the nature of the group task.

## 2. Path -Goal Theory (Robert House)

Robert House's Path Theory, introduced in 1971, is concerned with motivation and productivity. According to this theory, the motivational function of management is to help employees see the relationship between personal and organizational goals, clarify the "paths" to accomplishing these goals, remove obstacles to goal achievement, and reward employees for the work accomplished.

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### 3. Contemporary Leader-Manager Theories

**Theories X and Y (Douglas McGregor)**

In his 1960 book, the Human side of Enterprise, McGregor (1960) compared two different sets of beliefs about human nature, describing how these led to two very different approaches to leadership and management. The first, more conventional approach, he called Theory X, and the second, more humanistic, approach was termed as Theory Y.

Theory X is based on a common view of human nature: the ordinary Person is lazy, unmotivated, irresponsible, and not too intelligent and prefers to be directed rather than act independently. Most people do not really like to work and do not care about such things as meeting the organization's goals. They will work only as hard as they must to keep their jobs, and they avoid taking on additional responsibility. Without specific rules and the threat of punishment, most workers would come in late and produce careless work.

Based on this view of people, leaders must direct and control people in order to ensure that the work is done properly. Detailed rules and regulations need to be developed and strictly enforced. People need to be told exactly what to do, and how to do it. Close observations

is necessary to catch mistakes, to make sure people keep working, and to be sure that rules, such as taking only 30 minutes for lunch, are obeyed.

Motivation is supplied by a system of rewards and punishments. Those who do not obey the rules are reprimanded, fined or fired. Those who do obey the rules are rewarded with continued employment, time off and pay rises.

According to theory Y, the behavior described in theory X is not inherent in human nature but a result of management emphasis on control, direction, reward, and punishment. The passivity, lack of motivation, and avoidance of responsibility are symptoms of poor leadership and indicate that people's needs for belonging, recognition, and self-actualization have not been met.

Theory Y proposes that the work itself can be motivating and rewarding. People can become enthusiastic about their work and will support the team or organization's goals when these goals also meet their need. They can be trusted to put forth adequate effort and to complete their work without constant supervision if they are committed to these goals. Under the right conditions, the ordinary person can be imaginative,

creative, and productive. Theory Y leaders need to remove obstacles, provide guidance and encourage growth. The extensive external controls of theory X are not necessary because people can exert self-control and self-direction under theory Y leadership.

### 4. Theory Z (Ouchi) /participative approach to management/

Ouchi (1981) expanded and enlarged on theory Y and the democratic approach to leadership to create what he calls theory Z. Like theory Y, Theory Z has a humanistic viewpoint and focuses on developing better ways to motivate people, assuming that this will lead to increased satisfaction and productivity.

Theory Z was developed in part from a study of successful Japanese organizations. It was adapted to the American culture, which is different in some ways but similar in its productivity goals and advanced technology. Elements of theory Z include collective decision-making, long-term employment, slower but more predictable promotions, indirect supervision, and a holistic concern for employees.

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**Collect Decision-making** - This is democratic, participative mode of decision making which is extensive and involving everyone who is affected by the decision. Everyday problems are also dealt with in a participative manner through problem solving groups called quality circles; in which all members of a team or deportment are encouraged to identify and resolve problems faced by group or organizations.

**Long-Term Employment**- Employees move around with in the organization, taking on different functions and working in different departments. People who do this become less specialized but more valuable to the Z organizations, which is consequently more willing to invest in training its employees and encouraging their growth. In turn, they are better able to understand how a department works and its problems and capabilities.

**Slower promotions** - Rapid promotions can be misleading; if everyone is promoted rapidly, your relative position in the organization does not really change. It also means that close working relationships with in groups do not have times to develop, nor is there any incentive to develop them. Slower but more predictable promotions allow sufficient time to make a thorough

evaluation of the individual's long-term contribution to the organization.

**Indirect supervision**- Workers become a part of the culture of the organization and are intimately familiar with its working philosophy, values, and goals. Decisions are made not only on the basis of what will work but also on the basis of what fits the culture of the organization. A person who is well acquainted with these characteristics of the organization does not need to be told what to do or what decision to make as often as a new, unassimilated employee is.

**Holistic Concern**- Trust, fair treatment, commitment, and loyalty are all characteristics of the Theory Z organization. These characteristics are part of the over all consideration for each employee as a whole, including concern for the employee's health and well being, as well as his/her performance as a worker.

**Motivating Staff**

**Why do you motivate people?**

Motivation is unquestionable important in health care institutions because, like in any other organization, people are required to function effectively if they are to provide adequate patient care. This implies that a health

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care institution must motivate qualified personal to seek employment in the institution and then motivate them to remain on the job. Continual turnover means continual recruiting and training costs, inconvenience, and disruption of staff functions.

A leadership function is to arouse, excite, or influence another person to behave in some role or perform some action the person would not ordinarily do.

**Motivation Theories**

Need hierarchy Theory (Maslow)

Maslow (1943; 1954) stated that a lower level need is prerequisite, or controls behavior until it is satisfied, and then the next higher need energizes and directs behavior. The hierarchy, from the lowest to the highest level, is as follows: (a) physiological needs (e.g. hunger, thirst), (b) safety needs (i.e., bodily safety), (c) need for love and sense of belongings (e.g. friendship) affection, (love), and (d) need for self-esteem (e.g. recognition, appreciation, self respect) and (e) self actualization (e.g. developing one's whole potential).

Maslow's need theory is frequently used in nursing to provide an explanation of human behavior. A patient's

needs are viewed in this hierarchical order, with nursing care directed toward meeting the lower level needs before addressing higher needs.

**Two Factor theories- Hertzberg (Theory of Job satisfaction)**

Hertzberg enlarged on the theory Y approach by dividing the needs that affect a person's motivation to work into two sets of factors: those that affect dissatisfaction and those that affect satisfaction. The first set, called hygiene factors are those factors that meet a person's need to avoid pain, insecurity, and discomfort. If not met, the employee is dissatisfied. The second set, called motivation factors are those that meet needs to grow psychologically, when met, the employee feels satisfied. These are distinct and independent factors according to Hertzberg. Meeting hygiene needs will not increase satisfaction, and meeting motivation needs will not reduce dissatisfaction.

Engineers and accountants were asked to describe incidents at work that made them feel especially good or bad. The hygiene factors include:

- Adequate salary
- Appropriate supervision

- Good interpersonal relationships
- Safe and tolerable working conditions (including reasonable policies and procedures)

  The motivation factors include:
- Satisfying, meaningful work
- Opportunities for advancement and achievement
- Appropriate responsibility
- Adequate recognition

The leader manager's function is to ensure that both sets of needs are met, some directly and others by providing opportunities to meet them in a conducive work environment.

**Achievement Need Theory (McClelland)**

McClelland claimed that human needs are socially acquired and that humans feel basic needs for achievement, affiliation, and power. Need for achievement is the drive to exceed one's former accomplishments, to perform an activity more skillfully or effectively than before. A person with high achievement need to spend much time thinking about how to improve personal performance, how to overcome obstacles to improvement, and what feelings will result from success and failure. McClelland claims that a person with high

achievement need to set moderate, realistic goals, enjoy problem-solving activities, and desires concrete feedback on performance.

The need for affiliation consists of a desire for friendship, love, and belonging that causes a person to spend much time and planning how to establish friendly personal relations. Persons' with high affiliation need are sensitive to others' feelings, support others' ideas, and prefer jobs involving conversational give and take.

Need for power is the desire to control the means of influencing others and resisting control by others. Persons with high power need to spend much time thinking about how to gain authority, dominate decisions, and change others' behavior. Such persons are likely to be articulate, demanding, and manipulative in dealing with peers and subordinates.

## Equity Theory (Adams)

Adams's (1965) equity theory of motivation suggests that an employee continuously compare her or his work inputs (skill, effort, time) and outcomes (status, pay, privileges) with those of other employees. The employee perceives inequity whenever her/his rewards are

disproportionate to those received by other employees for the same amount of input. Feelings of inequity motivate an employee to resolve the inequity by reducing input, attempting to increase outcomes, selecting a different comparison worker, or resigning. Equity does not in any way imply equality; rather, it suggests that those employees who bring more to the Job deserve greater rewards.

### Expectancy Theory (Victor Vroom)

Victor Vroom's expectancy theory of human motivation indicates that a person's attitudes and behavior are shaped by the degree to which they facilitate the attainment of valued outcomes. According to Vroom's theory, the amount of an employee's job effort depends on her or his perception of the relationship between good performance and specific outcomes.

### Transformational Leadership

A transformational leader is one who "commits people to action, who converts followers into leaders, and who may convert leaders into agents of change". Transformational leaders do not use power to control and repress constituents. These leaders instead

empower constituents to have a vision about the organization and trust the leaders so they work for goals that benefit the organization and themselves.

Leadership is thus not so much the exercise of power itself as it is t he empowerment of others. The goal is change in which the purpose of the leader and that of the constituent become enmeshed, creating a collective purpose. Empowered staffs become critical thinkers and are active in their roles within the organization. A creative and committed staff is the most important asset that an administrator can develop. People are empowered when they share in decision-making and when they are rewarded for quality and excellence rather than punished and manipulated. When the environment is humanized and people are empowered, they feel part of the team and believe they are contributing to the success of the organization. In nursing, empowerment can result in improved patient care, fewer staff sick days, and decreased attrition. Nurses who are transformational leaders have staff with higher job satisfaction and who stay in the organization for longer periods.

**Nurses Role- as- a Leader**

Leaders make things happen! As a leader, your first priority is to get the Job done. In order to do this, you must:

1. Know your objectives and have a plan for reaching them

   If you are unclear about your goals, clarify them with your manager.

   On planning, list everything you have to do both short & long-term goals.

   Set priorities. Decide which t asks are the most important in achieving your objectives.

   Decide how much time you will need to complete each task.

   Check to see that resources needed to complete the task are available.

Use wall calendars, desk calendars daily to do lists and other aids to help you develop a plan for getting jobs done.

2. Build a team committed to achieving those objectives

3. Help each team member to give his or her best effort.

**Achieving goals depends on teamwork**

You simply cannot do everything on your own. As a leader, it is your Job to build a team that values what it does and knows that it is valued.

**Set clear standards**

Let your team know exactly what you expect in terms of quality and quality of work, time keeping, and following safety rules. Strive to maintain high but realistic standards.

**Explain the "Why" as well as the "What"**

It is important for team members to understand why a task is necessary and why it must be done in a certain way and how it will be achieved.

**Encourage Involvement**

Whenever the situation allows, ask for team member's ideas and opinions. Team members who are involved in the decision making process are more likely to feel they have a stake in achieving goals. However, be sure your team understands that you are responsible for making the final decision.

**Build positive working relationships**

4. Strive to be fair with all employees at all times.

5. Be understanding. Keep in mind that everyone makes mistakes occasionally. When you must criticize, be constructive and tactful.

6. Build an atmosphere of respect among team members.

7. Put the team first. Make it clear that you are more interested in the group's achievements than in the personal gain.

**Keep your team informed**

Provide as much information as you can as soon as you can. The news you have to convey may not always be pleasant. However, your team will appreciate hearing it directly from you instead of through the grapevine.

**Leader use different styles**

In general, your leadership style will depend on your personality, when you feel comfortable with, the abilities of your team members and the situation at hand. For example, you may use a:

8. Participative style, when it is appropriate to involve members of your team in making decisions

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9. Directive style, when a situation requires you to give specific instructions, such as when training new employees. Flexibility and good judgment are essential to successful leadership.

**Leaders tend to share some important qualities**

While no two leaders are exactly alike, in general, leaders are:

10. Positive- they believe in themselves and others, and the contributions they can make

11. Enthusiastic - they're willing to tackle tasks that others may dismiss as possible

12. Committed to excellence - they're always looking for new and better ways to do things

13. Self confident- they're willing to make decisions even when these are unpopular

14. Sincere - when they make a promise, they do all they can to keep it

15. Open to new ideas - they realize they do not have all the answers.

**What Makes a Leader?**

The 20 most important qualities of a leader, as cited by 3,032 Latinos in a recent nation-wide survey. Some

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traits appear similar because they were named in response to and open-ended question, not chosen from a prepared list

1. Honest/Trustworthy/Integrity       50.4%        10. Just/impartial/Fair       2.3%

2. Intelligent/Educated/Experienced    7.5%        11. Strong leader/Assertive 1.7%

3. Respectful/Respects the people      4.6%        12. Skilled communicator   1.2%

4. Serve/Help the community            4.3%        13. Patriot/Loves country   1.2%

5. Loving/compassionate/kind           4.1%        14. Hard working/ethical   0.8%

6. Strong moral values/Ethical person  2.9%        15. Good listener/Accessible 0.6%

7. Good person/Responsible             2.8%        16. Dedicated/Committed  0.6%

8. Courageous/Tenacious                2.7%        17. Charismatic/Visionary   0.5%

9. Humble/Sincere                      2.6%        18. Goal oriented/Efficient   0.3%

**Obtaining and Using Power**

Power is the ability and willingness to influence another's behavior for the sake of producing intended effects. When power is not linked to a worthwhile goal, it is used as a personal possession, and becomes evil. The essence of power is the ability to cope with life's demands; to impress one's will on external events, to achieve significance in the total schemes of things.

**Bases of Power**

In order to acquire power, maintain it, and use it effectively, a manager must recognize power sources and know the types of power needed to effect change. There are six bases of social power common in organizations.

- **Reward power** is based upon the incentives the leader can provide for group members to influence behavior by granting rewards. For example, a nurse manager may have considerable influence in determining a vacation time of a staff nurse and give incentives or recommendations.

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- **Punishment, or coercive power,** is based in influencing behavior through the negative things a leader might do to individual group members or the group as a whole by withholding rewards or applying sanctions. Example, Giving undesirable job assignment or salary cut.

- **Information Power-** is based upon "who knows what" in an organization and the degree to which they can control access to that information by other individuals. The nurse manager, for instance, is has private ground to information obtained at meetings with the nursing director or through other informal channels of communication that either are not available to or are unknown to members of staff nurses.

- **Legitimate Power-** stems from the group members' perception that the nurse manager has a legitimate right to make a request; this power is based on the authority delegated to the nurse manager by virtue of his her/his job and position within kith management hierarchy.

- **Expert Power-** is based upon particular knowledge and skill not possessed by staff members. Nurse managers, by virtue of their

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experience and, possibly, advanced education, frequently qualify as the persons who know best of what to do in a given situation. For example, newly graduated nurses might look to the nurse manager for advice regarding particular procedures or for help in using equipment on the unit.

- **Referent Power-** is based upon admiration and respect for an individual as a person. For example, a new graduate might ask the advice of the nurse manager regarding career planning.

**Application to Nursing**

- All nurse managers possess some degree of legitimate power-authority to carry out organizational decisions and goals.
- This authority is supplemented by the nurse managers' power to reward of coerces
- Nurse Managers become leaders through the development of referent and expert power bases that inspire others' obedience and loyalty.

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- By developing referent and expert power, a nurse leader need not rely on legitimate power
- A nurse manager and nurse leader can use various sources of power to effect change at the unit, organizational, and professional level (Sullivan, 1990).

**Reasons for Acquiring Power**

A nurse manager should seek power for both selfish and unselfish reasons. A nurse manager will need considerable power to survive in the dog eat dog world of institutional politics. Without strength to move others, he or she cannot complete with the managerial elite for scarce funds, scarce personnel and scarce materials. He or she should also seek power to benefit patients and subordinates.

Individuals and groups in heath agency may seek power in order to manipulate others. Power holders at the top of the hierarchy look for persons with similar values to be their successors and to ensure the preservation of cherished values.

**Skills Used in Acquisition**

Basic skills for exerting power over others include: peer skills, leadership skills, information processing skills, conflict resolution skills and skills in unstructured decision making.

- Peer skills are communication and interaction skills by which a person builds a network of supporters from whom to obtain help in a crisis.
- Leadership skills are communication and motivation skills with which one resolves problems arising from power, authority, and dependency phenomena.
- Information processing skills are skills of receiving, encoding, grouping, storing, retrieving, translating, and sending information by which one interprets the world and transmits interpretation to others.
- Conflict resolution skills are skills by which a person finds agreement between candidates and persuades disputants to collaborate in the interest of mutual gain.
- Skills in the unstructured decision making is the ability to analyze problems for the cause and effect relationships, generate possible solutions,

select the most effective course of action, and assign responsibility for plan implementation.

**Learning Activities**

1. Discuss basic points that you consider for an outstanding nurse leader

2. Kurt Lewin suggests that there are three leadership styles-Autocratic, Democratic, and Laissez-faire;

    2.1 Which leadership style does your supervisor exhibit?

    2.2 List three of his or her activities as decisions that illustrate the style.

    2.3 How does your supervisors' leadership style affect your work and attitudes?

3. From the theory of leadership described in this chapter, describe and discuss actual examples of leadership demonstrated by persons. Consider:

    3.1 A charismatic leader

    3.2 A transforming leader

    3.3 McGregor's theory X and theory Y

    3.4 Likert's authoritative and democratic systems

    3.5 Leadership style.

4. Choose a theory of leadership and describe how you would implement it in your ideal nursing setting.

# CHAPTER SEVEN
# MANAGING RESOURCES

## Objectives:

At the end of this chapter, the student should be able to:

- Explain the mechanisms of acquiring and retaining human resource.
- Describe the process of budgeting
- Discuss the points to be taken in controlling and maintaining equipment.
- How do managers maximize their time?

**Human Resource Management**

Human resource management is the process of acquiring and retaining the organization's human resource.

**Acquisition of human resource** includes human resource planning, recruitment, selection and orientation

**Retention activities** include performance appraisal, placement, training and development, discipline and corrective counseling, compensation and benefit administration, safety, and health.

## A.  Acquiring Human Resource

## 1. Human resources planning

Human resource planning precedes the other acquiring activities. Health service organizations determine staffing needs through human resources planning. Because organizations are dynamic, these needs change. The work force must be considered in the context of a changing environment: present staff must be retained and new employees recruited to meet changing needs. Staff needs in Health Service Organizations are driven by

1. **Organizational growth:** occurs through increased demand for services, higher occupancy, facility expansion and the addition of new services or intensifying services.
2. **Employee turnover**: through resignation, discharge and retirement

**Human resource planning involves five steps**

1. Profiling-to profile the personnel need of the organization at some future point
2. Estimating-Projecting the type and number of personnel needed

3. Inventorying-human resource audit of present employees

4. Forecasting-anticipating changes in the present work force in terms of entries and exits

5. Planning-Assumptions made by following steps 1-4 to ensure the right number of personnel with appropriate prerequisite knowledge and skill

**Human resource Sources**

1. Internal Sources-filling vacancies by transferring or promoting from within. Advantage

   - It is cost effective, reduces recruiting and relocation costs
   - Usually quicker, and
   - Enhances employee morale

   Disadvantage

   Seniority rules policy rather than best qualification

2. External sources -new employees may be recruited from outside through advertising vacancies, visits to colleges and universities, contacts with public and private employment agencies and participation in professional organizations

Advantage

## 2. Recruitment

Recruitment is the process of attracting qualified people to apply for a job. It involves searching for and attracting prospective employees either from within the organization or outside the organization. It is the process of making applicants available for selection. You can select only from those people who apply for a job, the odds of finding a strong candidate are less than if you have many applicants to choose them.

## 3. Selection

Selection is the process of choosing for employment. It is to choose among the applicants using job qualification as a guide. The essence of selection is to determine whether an applicant is suited for the job in terms of training, experience and abilities

## Sources of information for selection

1. Application forms and
2. pre employment interviews
3. Testing

**Selection Model**

**Step 1**. Analysis of the vacant job(s)-Using job analysis procedures the vacant job(s) are studied to find the knowledge skills and abilities needed for job success. Many problems in personnel selection stem from the fact that there is often inadequate understanding of the job and its requirements. The best person is best only insofar as he/she optimally meets these requirements

**Step2**: Selection of criterion and predictor: this step involves two procedures. First, based on the job analysis, a criterion of job success is chosen. As always, the criterion must be a sensitive indicator of work quality. Secondly, a predictor must be chosen

**Step 3:** Measuring performance-After the criterion and predictor have been chosen, the worker's performance is measured on both variables.

**Step 4:** Assessing the predictor's Validity-determine if differences in predictor scores correspond with differences in criterion scores, that is, does the predictor have validity?

**Step 5**: Determining the predictor's Utility-is to determine how useful it will be in improving the quality of the work force

**Step 6**: Reanalysis-Any personnel selection program should be periodically reevaluated to see if changing employment conditions have altered the predictor-criterion relationship

**The Classic Selection Model**
**3. Orientation**
After selection, induction and orientation occur. Orientation programmes include information about the organization, organizational structure, philosophy and objectives of the organization, rules and regulations, universal precautions enrolling new employees in benefit plans, issuing an identification badge are typically carried.
**Advantage**

- Builds employees sense of identification with the health service organization
- Helps the gain acceptance by fellow workers
- Give them a clear understanding **of the many things???** they need to know

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- Enables the new employee to become familiar with the entire organization as well as their own work area and department

## B. Retaining Employees

The Retaining activities include, performance appraisal, training and development, discipline and compensation administration.

## Personnel Training

A personnel training is the formal procedure which an organization utilizes to facilitate learning so that the resultant behavior contributes to the attainment of organization's goals and objectives

Personnel training should contribute to the goals of both the organization and the individual. Training is a management tool designed to enhance organization's efficiency. However, in the process of attaining organizational goals, many individual goals can also be attained.

## Assessing training needs

Assessing training needs usually involves a three-step process

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1. Organizational analysis- is the study of an entire organization-its objectives, its resources and the way in which it allocates resources to attain its goals. Organizational analysis can take several forms. One form is that of a personnel audit for manpower planning. A personnel audit is an inventory of the personnel assets of an organization and a projection of the kinds and numbers of employees who will be required in the future. A second approach to organization analysis involves indicators of organizational effectiveness. These are examined to see if training could improve the organization's performance

2. Operational analysis-is the orderly and systematic collection of data about an existing or potential task or a cluster of tasks that define a job. It examines the task or job requirements regardless of the person holding the job. It determines what an employee must do to perform the job properly. Operational analysis is most directly concerned with what training should cover

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3. Personnel analysis-is directed toward learning, whether the individual employee needs training and what training he/she needs. It is concerned with ascertaining how well a specific employee is carrying out his/her tasks and with determining what skills must be developed, what knowledge acquired, and what attitudes cultivated if the employee is to improve his/her job performance. A large portion of person analysis involves diagnosis. We want to know not only how well people are performing but also why they are performing at that level. Personnel analysis involves appraising an employee's performance, objective records and diagnostic achievement tests.

## Methods and Techniques of Training

After determining an organization's training needs and translating them into objectives, the next step is to design a training program to meet these objectives. This is not an easy task, because each training method has its strengths, weaknesses, and costs. Ideally, we seek to choose the one that meets our objectives in a cost

efficient manner. There are many training methods available.

**Performance Appraisal**

Performance appraisal is a systemic review of an individual employee's performance on the job, which is used to evaluate the effectiveness of his/her work

**Purpose:**

- Provide information upon which to base management decisions regarding such matters as salary raises, promotions, transfers, or discharges
- Helps to assist employees in their personal development
- Performance appraisal information will help to assess the effectiveness of hiring and recruiting practices
- Supply information to the organization that will help to identify training and development needs of the employees
- Helps in the establishment of standards of job performance often used as a criterion to

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assess the validity of personnel selection and training procedures

Employee's work should continually be assessed in a formal or informal basis. A formal appraisal is more accurate, fair and useful to all concerned

**Common Problems in Performance Appraisal**

- Performance appraisal may be viewed as demanding too much from supervisors. Especially in large number of span of control. It is difficult for a first line supervisor to know what each of 20, 30 or more subordinating is doing

- Standards and rates tend to vary widely, with some raters being tough and others more lenient. **Leniency Errors-**some raters are hard graders and others easy graders. So raters can be characterized by the leniency of their appraisals. Harsh raters give evaluations that are lower than the true level of ability. This is called severity of negative leniency. The easy rater gives evaluations that are higher than the true level called positive leniency. These errors usually occur because the rater has applied personal standards derived from his/her own personality or pervious experience

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- An appraiser may replace organizational standards with personal values and bias. **Halo errors**-are evaluations based on the rater's general feelings about an employee. Thus, the rater generally has a favorable or unfavorable attitude toward the employee that permeates all evaluations of the person. Typically, the rater has strong feelings about at least one important aspect of the employee's performance. This is then generalized to other performance factors, and the employee is judged (across many factors) as uniformly good or bad. Raters who commit halo errors do not distinguish among the many dimensions of employee performance
- Because of lack of information, standards by which employees think they are being judged are sometimes different from those superiors actually use
- The validity of ratings may be reduced by the supervisor's resistance to making the ratings, because of the discomfort they feel when having to confront the employee with negative ratings and negative feedback. Example, central tendency errors: refers to the rater's unwillingness to assign

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extreme -high or low -ratings. Everyone is average, and only the middle part of the scale is used

## Characteristics of an Effective Performance Appraisal

- Relate performance appraisal to the job description
- Understanding the criteria for evaluation

## Tools of performance appraisal

- Rating scales-the tool consists of a behavior or characteristics to be rated and of some type of scale that will indicate the degree to which the person being evaluated demonstrates that behavior
- The checklist- it describes the standard of performance and the rater indicates by placing a checkmark in a column if the employee demonstrates the behavior
- Management by objective- it focuses on the evaluator's observations of the employee's performance as measured against very specific predetermined goals that have been jointly agreed upon by the employee and the evaluator.

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**Appraisal methods designed to avoid rater bias**

   a. The field review method- this method allows the ratings of several supervisors to be compared for the same employee

   b. The forced choice rating method-the evaluator choose from among a group statements those that best describe the individual being evaluated and those that least describe this person

The critical incident technique-the supervisor observes, collect, and record instances of the employee carrying out responsibilities critical to the job. These are used to prepare the evaluation or serve as the evaluation itself to be viewed with the employee during the feedback interview. These written accounts of behavior tend to focus on performance rather than personality traits

**II. Budgeting**

   • Is a plan for the allocation of resources and a control for ensuring that results comply with the plans

**1. Prerequisite for budgeting**

   • Sound organizational structure
   • Job descriptions
   • Goals and objectives

- Formal budgeting policies and procedures

**The budgeting process should provide for**

1. Plans of anticipated activity
2. A mechanism for measurement of work effort on timely basis
3. Accountability by someone for variances from budget
4. An awareness of costs by all participants in the budgeting program

## 2. Major types of budgets

- **Operating/recurrent-** estimates of operating expenses, estimates of operating revenues and estimates of activity

**Example**: personnel salaries, supplies, light water, drugs, repairs and maintenance

- **Plant/Capital-**estimates of expenditure for adding, replacing or improving buildings or equipment for the budget period

**Example**: buildings, major equipment

## 3. Other types of budget

## Cash Budgets

Cash budgets are planned to make adequate funds available as needed and to use any extra funds

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profitably.  They ensure that the agency has enough, but not too much, cash on hand during the budgetary period.  This is necessary because income does not always coincide with expenditures.

## Labor or Personnel Budgets

Personnel budgets estimate the cost of direct labor necessary to meet the organization's objectives. It includes recruitment, hiring, assignment, lay off, and discharge of personnel.  The nurse manager decides on the type of nursing care necessary to meet the nursing needs of the estimated patient  population.   How many nurses are needed during what shifts, what months, and in what areas? The current staffing patterns, number of unfilled positions and last year's reports can provide a base for examination and proposals.  Patient occupancy and the general-complexity of cases affect staffing patterns.    Personnel budgets also are affected by personnel policies, such as salary related to position and number of days allowed for educational and personal leave.  Overtime costs should be compared with the cost of new positions.  Employee turnover, recruitment, and orientation cost must be considered.

**Flexible Budgets**

Some costs are fixed and do not change with the volume of business. Other costs vary proportionately with changes in volume. Some variable expenses are unpredictable and can be determined only after change has begun: thus the need for flexible budgets, to show the effects of changes in volume of business on expense items. Periodic budget reviews help managers compensate for changes. Relationships between the volume of business and variable costs may be predicted by a historical analysis of costs and development of standard costs.

**Strategic Planning Budgets**

Long-range budgets for long-range planning are often called the organization's strategic plan and are usually projected for 3 to 5 years. Program budgets are part of the strategic plan that focuses on all the benefits and costs associated with a particular program.

Business plans are detailed plans for proposed services, projects, or programs. The contain information to assess the financial feasibility of the plan. The business plan states the objectives of the project and links them to the organization's strategic plan.

**STANDARD COST**

Standard cost may be developed to predict what labor and supplies should cost.

Multiplying the standard cost by the volume predicts the variable cost. Supervising community health nurses can predict the standard number of clinic visits and the number of birth control pills that will be required by each family planning client who has chosen birth control pills as a method of contraception. Multiplying the number of pills needed by each client by the number of clients using birth control pills, nurse mangers can predict the inventory needed and the cost. They also can predict the number of clinic visits needed and plan staffing.

**ZERO-BASED BUDGETING**

Many budgeting procedures allocate funds to departments based on their previous year's expenditures. Then the department managers decide how the funds will be used. This procedure usually allows for enrichment and enlargement of programs but seldom for decreases or deletion of programs. Obsolescence is seldom examined, and this leads to increased costs.

With zero-based budgeting, no program is taken for granted. Each program or service must be justified each time funds are requested. Managers decide what will be done, what will not be done, and how much of an activity will be implemented. A decision package is prepared. The package includes a list of the activities that make up a program, the total cost, a description of what level of service can be performed at various levels of funding, and the ramifications of including them in or excluding them from the budget. The manager may identify the activity, state the purpose, list related activities, outline alternative ways of performing activities, and give the cost of the resources needed.

After decision packages are developed, they are ranked in order of decreasing benefits to the agency. They can be divided into high, medium, and low-priority categories and reviewed in order of rank for funding. Resources are allocated based on the priority of the decision package. The cost of each package is added to the cost of approved packages until the agreed-on spending level is reached. Lower ranked packages are then excluded.

A major advantage to zero-based budgeting is that it forces managers to set priorities and justify resources.

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**SUPPLEMENTARY BUDGETS**

Some budgetary flexibility may be obtained through a supplemental monthly budget.  A basic or minimal budget is planned, usually for a year's time, to outline the framework for the agency's plans, establish department objectives, and coordinate departments. Then a monthly supplementary budget is prepared based on volume of business forecast for the month.

**Moving Budgets**

The moving budget may be used when forecasting is difficult.  The moving budget plans for a certain length of time, such as a year.  At the end of each month, another month is added to replace the one just completed. Thus, the budgetary period remains constant.  The projections progress a month at a time but always for a fixed period such as one year.  It is an annual budget revised monthly.  As Sene is completed, Sene budget for the forthcoming year is added to the moving budget.

**4. The budget period**

Most health care agencies budget on a monthly basis for a 1-year period. The budget year often begins July 1 and ends June 30.

## 5. Advantages of Budgeting

Budgets plan for detailed program activities.

- They help fix accountability assignment of responsibility and authority.

- They state goals for all units, offer standard of performance, and stress the continuous nature of planning and control process.

- Budgets encourage managers to make a careful analysis of operations and base decisions on careful consideration.

- Consequently, hasty judgments are minimized. Weaknesses in the organization can be reveled and corrective measures taken.

- Staffing, equipment, and supply needs can be projected and waste minimized.

- Financial matters can be handled in an orderly fashion, and agency activities can coordinated and balance.

## 6. Budgeting Process

Financial planning responsibilities need to be identified before budget preparation begins.

**Steps**

1. The first step in the budget process is the establishment of operational goals and policies for the entire organization.

2. The top management should approve a long-range plan of 3 to 5 years that reflects the community's future health needs and other community health care providers' activities. Because the situation changes over time, flexibility is built into the plan.

3. Then operational goals must be translated into quantifiable management objectives for the organizational units.

4. The department heads use the organizational goals as a framework for the development of department goals.

5. A formal plan for budget preparation and review including assignment of responsibilities and timetables must be prepared.

6. Historical, financial, and statistical data must be collected monthly so that seasonal fluctuation can be observed.

7. Departmental budgets need to be prepared and coordinated. During this phase, units of service,

staffing patterns, salary and non-salary expenses, and revenues are forecasted so that preliminary rate setting can be done.

8. Next, departmental budgets are revised, and the master budget is prepared. At this point, operating, payroll, non salary, capital, and cash budgets can be incorporated into the master budget.

9. Then the financial feasibility of the master budget is tested, and the final documents is approved and distributed to all parties involved.

10. During the budget period, there should be periodic performance reporting by responsibility centers.

## 7. Cost Implication to Budgeting

### Cost Containment

The goal of cost containment is to keep costs within acceptable limits for volume, inflation, and other acceptable parameters. It involves cost awareness, monitoring, management, and incentives to prevent, reduce, and control costs.

**Cost Awareness**

Cost awareness focuses the employee's attention on costs. It increases organization awareness of what costs are, the process available for containing them, how they can be managed, and by whom. Delegating budget planning and control to the unit level increases awareness. Managers should be provided a course about budgeting and be oriented to the agency budgeting process before being assigned the responsibility. They should have a budget manual that contains budget forms, budget calendar, and budget periods.

**Cost Monitoring**

Cost monitoring focuses on how much will be spent where, when, and why. Identifies, reports, and monitors costs. Staffing costs should be identified recruitment, turnover, absenteeism, and sick time are analyzed, and inventories are controlled. A central supply exchanger chart prevents hoarding of supplies and allows identification of lost items.

**8. Costing Out Nursing Services**

There are several benefits to costing out nursing services.

- Charging our nursing services makes it possible for the customer to pay for what he or she gets. The patient pays for the care rendered.

- Customers start to realize that direct care has a price value. This helps them comprehend costs of health care and, ideally, to value it

- Hospitals can receive compensation for what they provide, to help maximize profits.

- Nursing can be viewed as a revenue-generating center rather than a cost.

- Charging a fee for services helps enhance the professionalism of nursing through the traditional pattern of reimbursement for services.

- Costing out nursing services stimulates productivity by visualizing productivity measures to enhance the use of human resources, contain costs, and maintain quality.

- Using a cost accounting system to assess and change the nursing department helps establish a reputation for innovation and leadership. Quick

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responsiveness to changes will help agencies survive in a rapidly changing environment

The most commonly used methods for determining nursing service costs are per diem, or cost per day, of service; costs per diagnosis; costs per relative intensity measures (RUMs); and patient classification systems (costs per nursing workload measures).

**Per Diem**

Per Diem methods are the oldest methods used for both rate setting and reimbursement. Average nursing care cost per patient day is calculated by dividing the total nursing costs by the number of patient days for a specific period. Nursing costs are usually considered as salary and fringe benefits for staff and administrative nursing personnel. These costs can be calculated for individual cost centers, subdivisions, or the entire nursing service. Per Diem relates nursing costs directly to length o stay but does not identify patient needs, acknowledge differences in diagnosis, specify nursing services

needed, justify care given, or provide information for management decisions.

## Costs per Diagnosis

Information about the patient mix is often used to reduce the variability in nursing care requirements. The medical diagnosis is frequently used to identify groupings.   DRGs use this method.   Some people recommend using nursing diagnosis or nursing care standards for grouping patients according to their nursing care needs.   It seems logical that nursing diagnosis could better predict nursing care needs than DRGs based on medical diagnosis.

## Costs per RIMS

RIMs were developed in New Jersey to allocate nursing resources in such a way as to address the complaints that DRGS inadequately represent variability of nursing care requirements.  A RIM is 1 minute of nursing resource use.  RIMS are coasted and allocated to DRG case-mix categories through three steps: (1) The cost of a RIM is calculated by dividing the total nursing costs for a hospital by the total minutes of care estimated or nursing resources

used to provide care to all patients. (2) The number of minutes used by the total hospital population, including adjustments for downtime, such as sick leave and vacation time, is calculated. (3) The cost of care for each patient is determined by multiplying the RIM by the minutes of care required by the patient as estimated by an equation. The RIMs development studies used data from New Jersey Hospitals to measure the time used by nursing personnel performing nursing and non-nursing activities during the entire hospitalization.

**Costs per Nursing Workload Measures**

Patient classification systems were developed to allocate nursing staffing before DRG-based reimbursement. Some to calculate the cost of the nursing component of room rate has used nursing workload data. Cost accounting methods allow calculations for whole patient care units and for individual patients; consequently, t is possible to generate a separate charge for nursing services for individual patients. These methods are also used to allocate nursing costs to DRGs or cost centers. Unfortunately, there is limited irretrievability of data,

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because few hospitals record patient classification data for individual patients in the patient record or on a database, data collection and analysis are expensive, and practice may not adhere standards.

### III. Material management

- Material management is the integrated function of purchasing and allied activities to achieve the maximum coordination and optimum expenditure in the area of materials.
- One of the objectives of materials management is to have the right materials at the right place at the right time. This depends on effective policies of forecasting, inventory, and materials distribution.

### Materials/equipment can be divided into:

1. Expendable/consumable/recurrent-are those materials/items that should be regularly kept in stock for production purposes or maintenance of the plant and are used within a short time.

2. Non-expendable/capital/non-recurrent: are those materials/items that are

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required only for specific purposes or jobs and which are not to be automatically recouped, lasts for several years, and needs care and maintenance.

**Managing equipment**

**Ordering**-obtaining equipment from stores of shops

**Storing**- recording, labeling and holding equipment in a stock or store room

**Issuing**- giving, labeling and holding equipment in a stock or store room

**Controlling**- monitoring expendable equipment, maintaining and repairing non-expendable equipment.

**Important points in controlling and maintaining equipment:**

- Convincing staff that equipment must be cleaned, inspected and kept in good order. Defects must be reported immediately. Equipment must always be returned to its correct place after use.

- Use inspection check list and inspection schedule
- Detecting discrepancies and explaining them

**Good management takes care of equipment by:**

- Motivating staff to feel responsible for the equipment they use
- Ordering supplies when needed
- Storing supplies safely
- Controlling the use of supply

Accurate records save time and contribute to the economy, efficiency and smooth functioning of the health service

In most of the government sectors in Ethiopia, receiving and issuing of

Materials/equipment/items are carried out using the following models

- Model 19- model confirming delivery of items/drugs
- Model 20- Model for requesting items/drugs

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- Model 21- Model for approving item delivery by person in authority
- Model 22- Model for issuing items/drugs

## IV. Managing Time

Time is a non-renewable resource.

Maximize Managerial Time

1. Set goals- determines the short, medium and long-range goals. Which goals must be completed before others? Which will take the longest to achieve? Setting priorities helps resolve goal conflict.
2. Once you have determined and ranked your goals plan strategies to achieve them
3. Plan schedule
4. Improve reading
5. Improve memory

Planning time arrangements

- Events are arranged in daily, weekly, monthly or yearly time periods.
- The periodicity depends on the frequency or regularity of particular events.
- Time plans are written in various common forms known as :

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**Timetable:** daily or weekly regularly recurring events.

**Schedule**: intermittent or irregular or variable events, and where they take place.

**Roster**: duties planned for different staff members, for different times in turn.

Preparing a health unit time table

- List all activities that happen regularly each week.
- Then arrange them in an appropriate timetable grid.

Preparing health unit schedule

- A schedule is required when a different activities or the same activity in a different place is spaced at intervals over time.
- To make a schedule, each different activity or each different place is listed and passed through the dates in turn, the whole cycle is repeated.

**Preparing duty roster**

- A duty roster is a time plan for distributing work among staff members
- Duty rosters are needed for three purposes:

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1.  To distribute work fairly and evenly outside normal working hours, e.g. night duty, weekend duty, holiday duty
2.  To distribute uninteresting or difficult work, and interesting or varied work.
3.  To divide extra duties among the whole staff.

**Learning activities**

1.  What are the mechanisms of acquiring and retaining human resource in nursing?
2.  What are the procedures and process to be followed in forecasting the budget of the nursing department?
3.  How do we maximize the best use of nursing equipment in an organization?
4.  What are the principles of effective time management?

# CHAPTER EIGHT

# EVALUATING HEALTH ACTIVITIES

## Objectives:

At the end of this chapter, the student should be able to:

- Define evaluation
- Describe the roles of evaluation
- Explain the types and levels of evaluation
- Discuss the steps of evaluation

**Evaluation**

- Is the process of finding out the value of something
- Determining the value or worth of objects of interest against standard of acceptability
- In evaluation we have to ask two broad questions:
    - Are the results those that were intended?
    - Are they of value?

**Roles of Evaluation**

1. As a step ensuring the delivery of high quality health care

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2. An important tool for controlling health care expenditures and ensuring accountability

**Levels of Evaluation**

- Effort-to assess the resources or capacities
- Performance-to assess the output or outcome of the program
- Adequacy of performance-the extent to which performance meets the program objectives
- Effectiveness-the amount of the intended objectives that have been attained
- Efficiency-the degree to which the program achieved its result at the lowest possible cost

**Steps of evaluation**

1. Decide what is to be evaluated?
2. Collect the information needed to provide the evidence
3. Compare the results with the targets or objectives
4. Judge to what extent the targets and objectives have been meet

5. Decide whether to continue the programme unchanged, to change it or to stop it

**How to evaluate work progress?**

Work progress is evaluated in order to measure the efficiency of the nursing/ midwives team, i.e. to find out whether the team completed the work which was assigned to it in order to reach its targets, the work was of expected quality, was carried out in time and its budget was not overspent?

**Types of evaluation**

- **Process evaluation**- measurements obtained during the implementation of program activities to control or assure or improve the quality of performance or delivery.
- **Impact evaluation**- focuses on the immediate observable effects of a program leading to the intended outcomes of a program
- **Formative evaluation**- measurements and judgments made on the process of the program

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- **Summative evaluation**

**Learning activity**

1. What is evaluation?

2. Explain the roles and levels of evaluation

3. How can we evaluate work progress?

# CHAPTER NINE
# COMMUNICATION

## Objectives:

At the end of this chapter, the student should be able to:

- Define verbal communication and non verbal communication
- List down the components of communication process using a diagram direction
- Discuss the ten basics for good communication
- Use an assertive style of communication using the nurses Bill of Rights as identified by Hermann and differentiate between aggressive and passive style of communication
- List down common blocks to communication and discuss on how to improve them
- Use through examples the common patterns of communication networks.

### Communication

Communication by definition is the transfer of information and understanding from one person to another. To be a leader, the student must have a basic

understanding of the communication process, which consists of a sender, a message and a receiver, all of which are influenced by an environment. Each of the components of the communication process is capable of enhancing or inhibiting the understanding of the message.

**The Message**

The message is that which is being conveyed. The leader must remember that the meaning of words resides not in the message but in the person receiving the message. Words mean different things to different people. Individuals assign their own meaning to what has been suggested, and their meaning may be different from what was intended by the leader. The message is composed of what it is you are trying to convey through verbal and nonverbal symbols. Since words are more symbols with meaning residing in people, it is possible for everyone to hear the same thing and interpret the message differently. The second aspect of a message is nonverbal behavior. Nonverbal behavior consists of facial expressions, pauses, gestures, posture, and tone of voice that reinforces or contradicts what is being said in the primary message. The message through both

verbal and non-verbal means is conveyed by means of the communication process.

The message

1. Verbal

   What you talk about

2. Non -verbal

   How it is communicated - facial expression, pauses, gestures, posture, tone of voice (accepting or rejecting) - body language

   3. Communication climate

Positive-enhances the message or Negative-detracts from understanding the message.

Fig.9.1 The essential elements of communication components: the message and communication in which the message is delivered.


**The Communication process**

In technical terms, the communication process consists of six steps: ideation, encoding, transmission, receiving, decoding, and response (Fig. 9.2). Ideation refers to the message, the idea or thought to be conveyed to an individual or a group. Encoding is the manner in which the message is conveyed and may be other than verbal, such as a written message or a visual or audible cue.

Encoding also takes into account the nonverbal behaviors that accompany the message, such as a gesture or an expression. Transmission is the actual expression of the message. For the listener or reader to receive the message, he or she must have appropriate listening or other abilities. Decoding refers to the receiver's under standing or interpretation of the message. The response, or feedback, should convey to the leader the degree of understanding held by the individual or the group. The communication process is now reversed so that the leader has the task to understand the new message using the same process.

The nurse leader or manager uses communication skills in all aspects of organizational life. Different skills are required to communicate effectively with groups of professional workers. The professional person is an educated individual with a very specific contribution to the work place. Therefore, appropriate manner of communication process is essential.
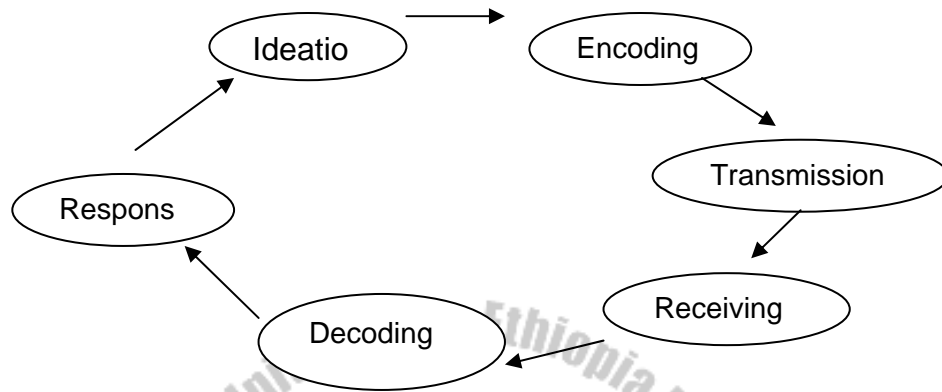
Fig.9.2. The conceptual components of the communication process. The circle is used to denote the dynamic and reciprocal properties of the communication process.

**Ten Basics for Good communication**

1. Clarify your ideas before communicating to others. Before speaking to an individual or a group, plan and organize what it is you are going to say. Analyze your thoughts carefully, and keep in mind the objective you wish to meet as well as the uniqueness of the individual or the group. Provide an opportunity for questions and answers to enhance the clarity of the message.

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2. Consider the setting, both physical and psychological. The physical setting can be conducive or can be serious block to communication. Take for instance the backdrop of a busy emergency department currently understaffed. This would not be a place to discuss an employee's performance appraisal, but it might be the perfect setting in which to discuss the shortage of nurses with the administrator.

The psychological environment is also important. This is referred to as the communication, or social, climate. If you as a leader have less difficulty, communicating with your staff than you would with in a defensive and hostile (negative) environment.

Positive climate behavioral characteristics

Listening

Empathy

Acceptance

Shared problem solving attitude

Openness

Evaluating

Advice giving

Superiority

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Fig.9.3. The characteristics of both a negative and positive communication climate.

The leader or the followers or both exhibit these behaviors.

A psychological and emotional relationship results between and among the work group and the manager and may be either supportive or defensive. A supportive communication climate means that communication patterns are characterized by a leader who listens; is empathetic; offers acceptance of individuals; exhibits a shared, problem-solving attitude; is open; and values equality in the work place. The members of the group exhibit the same attitudes and behavior. A defensive climate, on the other hand, is characterized by a leader's communication pattern that may be controlling, punishing, evaluating, advice giving, and reinforced by leader behavior that says, "I am superior and always right". The followers, on the other hand, are submissive or aggressive, and communication is usually non-productive and unpleasant.

The value of a positive communication climate is that it fosters behaviors among the leader and followers that lead to trustful and cooperative working relationships. It is a kind of climate that will

foster innovations in the work place, making change a possibility.

3. Consult with others when necessary to be exact and objective. The worst mistake a leader can make is to communicate incorrect information to the members of the group. If misinformation is given to an individual or to the group, the leader should acknowledge the error and correct the situation. This demonstrates to the staff and to superiors that the leader deals with mistakes in a direct, honest and forthright manner.

4. Be mindful of the overtones as well as the message itself. Non-verbal cues may be saying something opposite from the words nature. It may give mixed messages, making it very difficult for the listeners to know what you are trying to convey. Non-verbal behavior should support your message, not detract from it.

5. Take the opportunity to convey something to help, value, or praise to the receiver. People need to know that their contributions are useful and respected. This is not just limited to subordinates; you also might wish to acknowledge the helpful contributions of superiors.

6. Follow up your communication. You must get feed back to make sure that the message is understood as you intend it to be understood. Ask questions and encourage the receiver to express his or her reaction by follow up contacts.

7. Be sure your actions support your communication. In other words, "What I say. I do". If action and attitudes are in conflict, there will e confusion, and people will tend to deny what has been said. For example, if you tell your staff that, they must be on time for work and then you are late on a regular basis; your message will not be taken seriously.

8. Be an active listener. Practice what you preach. Listen to what the person has said as well as the way in which it was said. Probably one of the least developed skills in the communication process is active listening. Listening takes effort and often time to develop because it demands discipline. It is difficult to listen to non-stop talkers or to people who use other communication patterns that get on your nerves. A true leader must develop the self-mastery to be silent when someone else is speaking. To do that you must consider the other person's ideas to be more important than your own.

Active listening, however, does not imply agreement on your part, nor does it imply that you do not have the right to interrupt the conversation. It does mean that you must learn the other's point of view by hearing and trying to understand the message. It only through understands what the differences are that the potential for positive solutions exist.

9. Give credit for the contributions of others when genuinely deserved. It is amazing how powerful praise can be in establishing positive feelings in other people. Everyone needs to know when he or she have done something especially well

10. Be an assertive when expressing your view. Communication patterns exist on a continuum from passive to aggressive. Assertiveness is the desirable style for the nurse leader and manager. Assertive communication and behavior maintains a balance between aggressive and passive styles. The assertive style considers the rights of all persons involved in the communication process.

The nurse's Bill of Rights, identified by Herman, states very clearly what these rights are :( Hermann)

• The right to be treated with respect

• The right to be listened to

- The right to have and to express thoughts, feelings, and opinions
- The right to ask questions and to challenge
- The right to understand job expectations as well as have them written
- The right to say "no" and not feel guilty
- The right to be treated as an equal member of the health team
- The right to ask for change in the system
- The right to have a reasonable workload
- The right to make a mistake
- The right to make decisions regarding health and nursing care
- The right to initiate health teaching
- The right to make decisions regarding health and nursing care
- The right to initiate health teaching
- The right to be a patient advocate or to help a patient speak for himself or herself
- The right to change one's mind

The assertive style is demonstrated by communication that says directly and clearly, what is on y our mind. It is also demonstrated by listening to what others say. The leader uses objective words, uses "I" messages, and

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makes honest statements about the leader's ideas and feelings. Part of assertive style is the use of direct eye contact, spontaneous verbal expressions, and appropriate gestures and facial expressions while speaking in a well-modulated voice. Assertiveness is also a process that comes with maturing in role gaining self-confidence in one's own knowledge and experience. An assertive style is appropriate and is based on self-respect and consideration for other people.

Aggressiveness, on the other hand, is concerned only with the rights of one position and may be loud, inappropriate, confronting, or hostile. This style uses subjective words, makes accusations, and sends "you" messages that blame others. A confronting, sarcastic, verbal approach with an air of superiority and rudeness may be usual. This individual often belittles others while seeming to take charge of the situation. There is absolutely nothing to be gained by this style. The individual may win the battle but will surely lose the war. The rights of all individuals have not been considered.

A Passive Communication style is one that does not consider any rights. It may be viewed as being

uninvolved or unable to share thoughts. This style may be withdrawn and shy or purposefully withholding. Women in particular may tend to be quiet in-group situations, and beginning leaders may have to overcome some hesitation about speaking to groups. Some suggestions that can help include recognizing your value and rights in a situation. Try to make one contribution in each group situation. Gradually you will feel more comfortable speaking in groups.

Communication among professionals is an essential hallmark of health care. Keep in mind that the leader and followers have a basic right to give and to receive information in a professional manner. Communication skills grow and develop over time and are the means by which leadership is exercised. It is important to remember that communication does not necessarily mean agreement or harmony over every issue but is rather an attempt to achieve understanding of the message between leader and followers.

Case Study

Dr. Hailu is a well-known and experienced surgeon. At the very least, he is known to be a "difficult individual".

He has gained this reputation because he shouts before he thinks, blames before he knows the facts, and generally has a short fuse.

Alemnesh Sium, RN, did not know Dr. Hailu's and unintentionally walked into the unit to transfer a patient. In typical fashion, Dr. Hailu could not find the laboratory work on the chart and began a temper tantrum aimed at Alemnesh Sium. Alemnesh looked him in the eye, told him to stop shouting, and, when he could be reasonable, to restate his request. The spectators to this event were speechless.

Difficult individual's impositions of relative power can be problematic for a staff. However, appropriate behavior and the rights of all individuals have to be considered if good working relationships are to exist.

What kind of communication technique did Alemnesh Use?

What would you have done?

**Blocks to Communication**

Blocks to communication refer to obstacles that somehow prevent the message from being delivered or understood. Some common reasons for blocks to communication are poor listening habits, Psychological

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blocks, Environmental distractions, and semantic barriers (Davis). Blocks to communication are the reason why people leave meetings with half messages and incomplete or inaccurate information.

**Listening Skills**-To improve your listening skills, certain behaviors must be learned and practiced as you interact with people. Active listening begins as you give full attention to the person speaking. This means that you listen carefully with your mind as well s with your gestures and facial expressions. Look directly at the person to whom you are speaking. Direct eye contact conveys your undivided attention to the speaker. It is a good idea to indicate your desire for understanding by asking for clarification, paraphrasing, or summarizing or by requesting information as necessary. Probably the most important aspect of active listening and the most difficult are keeping silent, which is a means of showing respect for the other person. Active listening will enhance the understanding of messages by facilitating communication through appropriate feedback.

Feedback allows the leader to judge the listener's understanding and can be gained by asking the right questions. This means phrasing questions within a

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frame or reference and requesting that questions asked of you be also placed in a frame or reference. As always, acknowledge the message and affirm that both you and the speaker have the same understanding. If it is appropriate, thank the other person for the honesty and true expression of feelings. Listening is a skill for which you as a leader will be rewarded because it will lead to effective behavior.

**Psychological Blocks**-Consider the following situation. An individual hears something that produces a profound emotional reaction. An intense response to a communicated message very likely will produce a temporary block to the rest of the message. It is highly unlikely that constructive communication can continue until feelings have been defused. The individual stops listening, focuses on part of the message, and may close his/her mind to other ideas. Emotions are powerful forces that may interfere with reason and must be recognized and respected before constructive communication may continue.

**Environmental Distractions** - The problem of environment is considered to be a block to

communication when it interferes with the communication process. People may be trying to have a serious conversation when a sudden, distracting noise occurs that directs attention away from the message and toward the environmental stimuli. For example, the head nurse is telling one of her staff nurse about his performance of the last four months and the phone rings or there is a knock at the head nurse's door. This is distracting, and both parties will have to compensate for the interruption before they are ready to continue their conversation.

**Semantic Barriers-** Semantics is the study of words. Since words are symbolic, their meaning is subject to multiple interpretations. The leader should try to be aware of the choice of words or phrases used in conveying a message to avoid misinterpretation or sending the wrong message to the group. In addition, the leader should consider the context of words or their relationship to a particular idea. Using messages in the proper context will reduce misinterpretation. For example, a head nurse wishes to convey to the staff that they have been especially competent and productive during an extremely hectic period and that she is

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pleased with their performance. The words the head nurse chooses to use are, "You are guilty of doing and unbelievable job!" Unfortunately, it is really not clear what the head nurse is trying to say or for what period of time or particular activity. In this case there is a great deal of room for misunderstanding the message.

**Communication Networks**

Communication patterns, or networks, allow information to be circulated among the group. These same networks also affect the ways groups solve the problem. The actual pattern of the communication network may be as varied as the number of groups in existence. Common patterns include downward, upward and downward, circular, or multi-chaneled. Fig. 9.4 illustrates the communication networks. In essence, the leader either talks in downward pattern to the group or there is sharing both up and down with the participants of the group as well as communications that are shared among the participants. The real issue is not whether every participant shares a two-way communication channel with every other member but whether the communication is adequate as measured through the appropriate performance of the group. Attempts at open

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communication are preferable to restricted communication patterns.
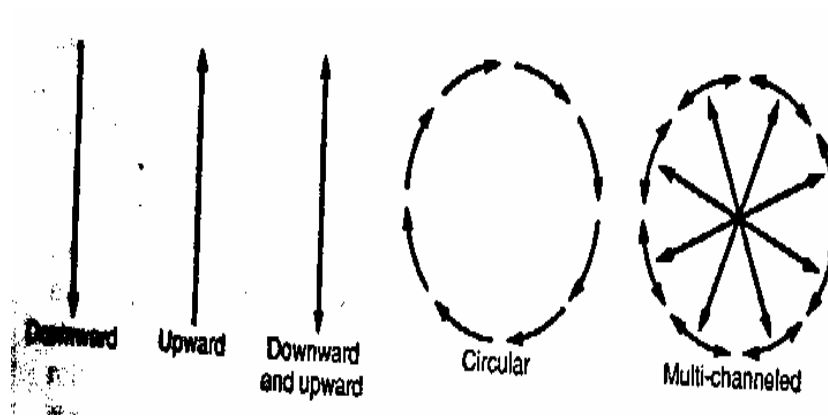


Fig. 9.4 some of the ways communication networks can form

**Learning Activities**

1. Ho you personally prepare for small group interactions?

2. Select a recent situation in which you interacted with several people in a formal group structure. How do you communicate verbally and non-verbally?

# CHAPTER TEN
# GROUP DYNAMICS

## Objectives:

At the end of this chapter, the student should be able to:

- Differentiate among primary and secondary groups in a group dynamics
- Analyze the functions and roles of a group
- Discuss nonfunctional and unhelpful roles in the group dynamics
- Demonstrate in class the five phases of small groups using a role play
- Develop a skill of decision making in small groups using brainstorming and nominal group technique exercises in a classroom.
- Explain the major guideline to increase team cohesiveness
- Describe the guideline for making a committee effective

### Group Dynamics

Communication skills are only one aspect of leadership development, the other is knowledge of Group

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dynamics. Group dynamics include the study of how people form and function within a group structure. The group becomes a unit when it shares a common goal and acts in union to either achieve or thwart the accomplishment of the goal.

**Primary and Secondary Groups -** A group may be defined as a collection of individuals who interact with each other on a regular basis, who are psychologically aware of each other, and who see themselves as a group. Groups are categorized as primary or secondary. **Primary groups** are composed of individuals who interact on a "face to face" basis, and the relationships are personal. In addition, there are no written, formal rules or regulations because they are unnecessary. Examples of primary groups are families or groups of friends. In the workplace, primary groups also exist in the form of those who affiliate because of something held in common. Similarity distinguishes this group. For instance, the group members may be all women in the administrative field or all graduates from the same institution, or they may all be of the same ethnic background.

**Secondary groups** are larger and more impersonal. These groups are organized around formal rules, procedures, policies and other regulations. The work place is composed of secondary groups that are found in departments or at levels and that form the work group.

The leader deals with the secondary group in the work place. Secondary groups may also be categorized as formal or informal groups. Formal groups are the official or legitimate work group, while informal groups form for different reasons. The leader must be able to influence both groups and thus move the work group toward meeting its objectives.

An effective work group is characterized by the ability to meet its goals through a high degree of appropriate communication and understanding among its members. This type of group makes good decisions based on respect for all members' "points of view". Another characteristic is the ability to arrive at a balance between group productivity and satisfying individual needs. The leader does not dominate a group like this; instead there is flexibility between the leader and members to use different and individual talents appropriately. This group is cohesive and can

objectively review its own work and face its problems in a way that balances emotional and rational behavior for a productive group effort. The leader who enhances cohesion and cooperation will be moving the group toward completion of its goals.

**Characteristics of a Group-** One of the characteristics of the group is **a value structure** that is created in groups that comes about because of the influencing process among and between its memberships. For example, some groups value their expertise, they value friendship, or they value higher wages. Another characteristic of a group is the sharing of norm**.** Norms refer to the expected behavior within a group. If the individual violates these norms, he/she will take the risk of being an outcast. Norms of a group are powerful enforcers for human behavior. Compliance to the norms means a group membership.

**Task Behaviors of a Group**

Some of the available behaviors that participants in the group may exhibit are broadly grouped as task or maintenance behaviors. Task behaviors serve to facilitate and to coordinate group effort in the selection

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and definition of a common problem and in the solution of that problem. Behaviors that fall in this category are:

- Initiating-suggests new ideas, or a different way of looking at an old problem, or proposing new activities

- Information seeking- asks for relevant facts and feelings about the situation at hand

- Information giving- provides the necessary and relevant information

- Clarifying- probes for meaning and understanding in whatever the group is considering

- Elaborating- builds on previous comments and thoughts and thus enlarge the concept under consideration

- Coordinating- clarifies the relationships among the various ideas and attempts to pull things together

- Orienting- defines the progress of the discussion in terms of goals to keep the discussion in the right direction

- Testing- checks periodically to see if the group is ready to make a decision or to recommend some action

- Summarizing- reviews the content of past discussion

Maintenance functions are carried out through behavior that maintains or changes the way in which the group is working together. These behaviors seek to allow the group to develop loyalty to one another and to the group as a whole. These behaviors include;

- Encouraging- the giving of friendly advice and help. Praising and agreeing with others also define this behavior.

- Mediating or harmonizing- helps others to compromise or to resolve differences in a positive way.

- Gate keeping- allows the fair and equal participation of all members of the group by such comments as." We haven't heard from Seifu."

- Standard Setting- the action that determines the yardstick the group will use in choosing its subject matter, procedures, rules of conduct, and , most important its values.

- Following- Going along with the group passively or actively either during a discussion or in response to the group's decision.

- Relieving tension- diverts attention from unpleasant to pleasant matters. Often this behavior smoothes the way for constructive communication.

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The third and last category of group roles is the one, which is nonfunctional and unhelpful to the group. Group members to satisfy their own particular needs use individual roles. These roles do not help the group to accomplish its task or to facilitate good member relationships. The roles in this group category are listed below:

- Aggressor: Attacks or disapproves of others' suggestions, feelings, or values.

- Blocker: Resists, without good reason, or becomes extremely negative to others suggestions.

- Recognition seeker: Calls attention repeatedly to own accomplishments and diverts the group's attention.

- Self-confessor: Uses the group's time to express personal, non-group oriented feelings or comments.

- Play boy-Playgirl: Plays around and displays other behavior that indicates he/she is not involved in the group process.

- Dominator: Tries repeatedly to assert own authority and often interrupts other group members.
- Help seeker: Tries to elicit sympathy from other group members.

**Phases of Small Groups**

**Orientation Phase:** The beginning period in the small group process is called the orientation phase. During this phase, individuals spend time assessing their purpose for joining the group and figuring out where they fit in the group. Orientation phase is also called the forming phase. Members engage in testing the other members and the leader to determine what is appropriate and acceptable behavior within the group. Members spend time at this point trying to identify the nature of the task and the ground rules.

**Conflict Phase:** During this phase, members become less interested in orientation issue, such as how they are fitting into the group, land more interested in control issues, such as how they are influencing the group. Each member wants to be perceived by others as a competent group member with something to offer others. In addition, frequent discussions typically occur

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about what task needs to be completed, which rules of procedure will be followed, and how decisions will be made in the group. Here leaders can assist group members to satisfy their needs for control or influence within the group during the conflict phase.

**Cohesion Phase (Norming Phase):** This phase is the developmental phase and members of a task group may become aware of time pressures and realize that they need to start moving toward consensus in order to meet their objectives. Members of a therapy group may become more understanding of one another differences and more able to accept these differences in the group. Still others may observe the splits and factions of the previous stages and feel the need to move closer rather than farther away from others. Essentially, members want to develop more unity during this phase. During this phase, there is greater expression of the ideas, opinions, and observations on task issues.

Leadership during this phase poses fewer problems than during other phases because of the positive feelings and the unified sense of directions in the group at this time. The leader can put the group on "automatic pilot" during this phase as members work in harmony on group objectives. The leader provides guidance and

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direction only as needed during this phase and essentially assumes a non-dominant role.

**Working Phase (Performing phase):** This phase is similar to the cohesion phase but it involves more time, greater depth, and increased disclosure among group members. At this point members feel secure to express both positive and negative emotions in task groups, yet communication usually remains positive, even to the point of members joking and praising each other. The group spirit and the feeling of unity among members are often high during the working phase.

**Termination Phase:** This phase usually occurs when the goals of a group have been fulfilled or when the allotted time has run out and the members begin to consider the implications of lending the group. During the termination phase, leaders need to summarize the work of the group, emphasize goal achievement, and help group members find a sense of closure as they confront their feelings about the approaching end of the group and the members' relationships.

| Orientation | Conflict | Cohesion | Working | Termination |
|---|---|---|---|---|
| Sale topics | Disagreements and debates Discussions | Supportive comments | Positive comments Consensus | Summary of discussions |
| Goblet issues | about rules and procedures "Top or bottom" | Greater self disclosure | statements | Expression of feelings |
| Little self disclosure "In or Out" discussions | discussions | Suppression of negative feelings "Close or far" discussions | Problem solving comments In-depth self disclosure | Closure statements. |

Table 10.1. Typical kinds of communication in different Phases of Groups

**Techniques for Decision Making in Small Groups**

There are three useful procedures for a small group of people that helps them to arrive at a decision for a problem. These include Brainstorming, the nominal group technique and the Delphi method. Each procedure provides a different but practical approach to group decision-making.

**Brainstorming**

Brainstorm is a discussion technique developed by Osborn (1957) to stimulate the production and generation of creative ideas in groups. Brainstorming enhances by allowing them to express their ideas freely without being inhibited by the fear of criticism. The assumption that underlies brainstorming is that if group members feel uninhibited about expressing their ideas, more ideas and better ideas will emerge from the group. The brainstorming technique is relatively easy to use in small group discussions.

The rules for brainstorming technique include:
1. Generate numerous ideas about an issue
2. Welcome free thinking and facilitate open expression of ideas
3. Withhold any evaluation or criticism of the ideas that are expressed
4. Build and improve on ideas already expressed

For brainstorming to work effectively; group members must not judge or criticize the ideas expressed by others. This nonjudgmental approach is often difficult to master because most people are conditioned to evaluate the pros and cons of a new idea as soon as it

is introduced in a group. Criticism, is however counterproductive of the overall goal of brainstorming because members who fear criticism will most likely express conventional solutions and withhold wild or innovative ideas.

**Nominal Group Technique**

This technique is designed to promote the expression of many high quality ideas from members who initially work independently and then share their ideas with the group. Unlike the free willing expression of ideas in brainstorming, this technique uses a more systematic procedure that ensures that each member will have the opportunity to present an idea to the group for consideration. The overall goal of the nominal group technique is to arrive at a group decision that represents a pooled judgment that is based on the independent ideas of all group members.

The steps for nominal group technique include:

1. Group members, without any discussion, independently write down their ideas about a problem or task

2. Each group member presents an idea to the group without discussion. This process continues

around the table until all ideas have been expressed. The ideas are summarized and listed on either a chart or a chalkboard

3. Members discuss each of the recorded ideas for the purpose of clarification and evaluation

4. Members independently give their own priority ranking of ideas. These independent rankings are added together and averaged. The final group decision emerges from the pooled outcome of the independent rankings.

The format utilizes both the independent thinking of members (example, writing down ideas) and group interaction, (example, discussing the ideas) in order to arrive at a joint decision. The nominal group technique is used when individuals can be brought together at one location and when the problem requires a relatively quick solution. In health care, this method can be used for determining program priorities or for identifying needed program content in areas such as staff development.

As a decision-making procedure, the nominal group technique has several advantages. First, when members are given opportunity to write down their own ideas independently, their ideas tend to be more

problem centered and of higher quality. Second, the technique allows all members an equal opportunity to express their views and also an equal opportunity to vote on the group decision. This technique prevents a group discussion from being dominated by a few influential members. On the negative side this technique can be time consuming and somewhat difficult to implement in all situations.

## Delphi Method

The Delphi method of decision-making was initially developed by Dalkey and his associates (1963, 1969) who used this method to gather data from groups of experts for the purpose of making forecasts about future events. More recently, in health care, the Delphi method has been employed to determine priorities in such areas as nursing research and cancer nursing. In this method, participants are usually in different geographical locations and they do not meet for face-to-face interaction as they typically do in the brainstorming and nominal group technique procedures. The Delphi method structures the group communication process so that a large group of individuals can work together as a whole and solve a complex problem.

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Steps in the Delphi Method of Group Decision Making include:

1. Group members are sent a questionnaire which asks them to identify important questions or issues on a specific topic

2. Members responses are compiled and a second questionnaire is administered which asks members to assess and prioritize the list of responses derived from the first round

3. Step 2 is repeated in subsequent rounds. Each time the priorities of members are summarized and narrowed down to those, which are the most important. The results are returned to each group member for further ranking and evaluation.

4. In the last phase, a final summary and ranking is provided to each member of the group. This represents a synthesis of the series of sequential rankings completed in all prior rounds.

The major disadvantage of the Delphi method are that it does not allow for the development of emotions and feelings in the group, and it does not allow for face to face feedback and clarification. Overall, however, the Delphi method is a very useful, though time consuming, decision-making technique.

**Team Work**

A team is defined as two or more people who interact and influence each other toward a common purpose

**Types of teams**

**1. Formal Team:** is a team deliberately created by managers to carry out specific activities, which help the organization to achieve its objectives.

Formal team can be classified as

      a. Command team: is a team composed of a manager and employees that report to the manager.

      b. Committee: a formal organizational team usually relatively long lived, created to carry out specific organizational tasks

      c. Task force or project team: A temporary team to address a specific problem

**2. Informal team: e**merge whenever people come together and interact regularly. This group has a function of:

      a. to hold in common the norms and values of their members

       b.  give to their members status, security and social, satisfaction

       c.  help their members communicate

       d.  help solve problems

       e.  act as a reference groups

3. **Super teams:** a group of workers drawn from different departments of the organization to solve problems that workers deal with their daily performance

4. **Self managed team**: are super teams who manage themselves without any formal supervision

**Characteristics of a team**

Awareness of the characteristics of a team helps to manage effectively the group.

Effective teams are built on:

- Communication
- Trust
- Shared decision-making
- Positive reinforcement
- Cooperation
- Flexibility
- Focus on common goals
- Synergy

Teams that are effective can achieve more together than they would as individuals all working alone

## Stages of team development

Teams move through five stages to develop

**a. Forming**: during the initial stage the team forms and learns the behaviour acceptable by the group

**b. Storming:** as the group becomes more comfortable with one another they begin to assert their individual personalities

**c. Norming:** the conflicts that arose in the previous stages are addressed and hopefully resolved. Group unity emerges as members establish common goals, norms and ground rules.

**d. Performing:** it is a stage by which a group begins to operate as a unit

**e. Adjourning:** it is a time for a temporary group to wrap up activities

## Team cohesiveness

Team cohesiveness is the degree of solidarity and positive feelings held by individuals towards their group. The more cohesive the group the more strongly members feel about belonging to it. Highly cohesive

teams have less tension and hostility and fewer misunderstandings than less cohesive groups do. Studies have found that cohesive teams tend to produce more uniform output than less cohesive groups.

**Ways to improve team cohesiveness**
1. Introduce competition
2. Increase interpersonal attraction
3. Increase interaction
4. Create common goals

**Guidelines for effective committee functioning**
1. Goals should be clearly defined, preferably in writing
2. Specify committees authority
3. Determine the size of the committee
4. Select a chairperson on the basis of the ability to run the meeting efficiently
5. Distribute the agenda and all supporting materials before the meeting
6. Start and end meeting on time

**Conflict within teams**

Conflict may arise within teams when they go along in their activities. Some of the conflicts are essential for effective functioning of the team. Some of the common conflicts in teamwork are:

1.  The paradox of identity-the feeling of people in a team that the group diminishes their identity
2.  The paradox of disclosure: disclose only what they think acceptable to others because of fear of rejection
3.  The paradox of thrust:  for a trust to develop in a group members must trust the group
4.  The paradox of individuality: feeling of members that their individuality is threatened by the group
5.  Paradox of authority: diminishing individual power by putting it at groups disposal
6.  The paradox of regression: : the groups pressure on individual progress may lead to regression
7.  Paradox of creativity: treat to the groups creative potential

**Determinants of work group effectiveness**

1. Task independence: the extent to which a group's work requires its member s to interact with one another

2. Sense of potency: collective belief of a group that can be effective

3. Outcome independence: the degree to which the work of a group has consequences felt by all its members

**Checklist for Evaluating Meeting Effectiveness**

**Standards**

- The meeting started on time
- A quorum existed
- The meeting agenda is on a schedule
- The chair acts as and equal member of the group, taking no special considerations.
- The chair follows the agenda

    Dull items are scheduled early, star items last

    Important items have a starting time

    The agenda avoids "any other business"

    Meetings are scheduled for one hour before lunch or one hour before end of workday

    The chair is well prepared for the meeting

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    The chair referees, paces, summarizes and clarifies discussion

    The meeting concludes with definitive decisions and a commitment to them

    Useful information is circulated with the minutes

- The chair allows adequate time for discussion
- The chair facilitates participation by all members
- Items requiring further study are referred to smaller groups as projects. Timetables for results are established.

Technical assistance is provided to facilitate meeting success.

**Learning Activities**

1. Observe the group dynamics in one of your classes or groups. What do you see in terms of roles played by the different participants? What is your role?

2. Compare from your own individual experiences positive and negative

communication climates. Discuss the characteristics in each.

3. Try to find people in your experience that fit the various roles played by group members. Do they consistently use the same behaviors, or do they alter, as the situation requires? Share with the class your observations, and discuss the relative effectiveness of the different behaviors in influencing the group.

4. What are the major types of teams?

5. How can managers increase team cohesiveness?

6. How can committees be made more effective?

7. How can managers deal with conflicts within their team?

8. What are the determinant factors of team effectiveness?

# CHAPTER ELEVEN
# CONFLICT RESOLUTION

## Objectives:

At the end of this chapter, the student should be able to:

- Identify aspects of your professional role that predisposes to conflict with nurse administrators or physicians

- Analyze an ongoing conflict in your organization and identify the manifest conflict, the felt conflict, antecedent conditions and internal and external factors influencing the conflict;

- Differentiate the three common methods of conflict resolution

- Elaborate the different ways of conflict management and identify the most preferred of conflict management;

**Conflict Resolution**

Conflict is inevitable in human organizations. In health care organizations the potential for conflict is heightened because within these settings individuals must address life and death issues; they have to function both

independently and interdependently within a system containing considerable role ambiguity and complex lines of authority. Health care workers also need to be highly skilled both in technical areas and in human relationships. Other organizations may demand similar qualities from individuals, but seldom to the same extent that they are required of professional in health care. These demands on health professionals make conflict unavoidable.

## What is Conflict?

Conflict is an expressed struggle between at least two interdependent parties, who perceive incompatible goals, scarce rewards, and interference from the other party in achieving their goals. They are in a position of opposition in conjunction with cooperation. Conflict produces a feeling of tension, and people wish to do something to relieve the discomfort that results from tension.

Five characteristics of a conflict situation may be identified: (1) at least two parties are involved in some form of interaction; (2) difference in goals and/or values either exists or is perceived to exist by the parties involved; (3) the interaction involves behavior that will

defeat, reduce, or suppress the opponent, or gain a victory; (4) the parties come together with opposing actions and counteractions; and (5) each party attempts to create in imbalance, or favored power position (Filley, 1975).

## Types of Conflict
### Interpersonal Conflicts

Interpersonal conflicts are those that arise between two individuals, and these are the most frequent type, because people are constantly interacting and therefore differing. Two staff nurses who disagree about the approach to use with a depressed patient are involved in a conflict, as are two children who want to play with the same toy.

### Inter-group conflicts

Inter-group conflicts can occur between two small groups, two large groups, or between a large group and a small group. A small group may be a family or a group of 10 or fewer persons, or it may be a group that is a small in relation to another group.

Regardless of a size of the groups involved, inter-group conflict has certain predictable consequences. Within

each group cohesiveness increases, but members become more task oriented and less concerned with the needs of individual members. Group leadership tends to become more autocratic, but members nevertheless accept it. The groups become highly structured, so that a unified front will be presented to the opposition. If the groups are required to meet, they will see and hear only those aspects of the other group that support their opinions.

These consequences of conflict are both positive and negative. The increased cohesion and structure will probably increase production, but the stereotyping and hostile behaviors toward the other group are likely to be destructive to the persons involved. Conflict management strategies should therefore be used to ensure that the conflict will have a healthy outcome.

**Personal Group Conflicts**

Conflicts between an individual and a small group or between an individual and a large group are called personal –group conflicts. In this type of conflict an individual is at odds with a group. The nurse who does not finish giving her patient's bath before she goes to lunch will be in conflict with the rest of the staff if they

believe that all baths should be completed by noon. This type of conflict is very difficult for the individual because he or she typically feels overwhelmed and powerless in the situation. The odds are all against the individual.

**Intrapersonal Conflicts**

Conflict may also be intrapersonal (i.e., within a person). The individual feels tension because of a disagreement within him-or herself. Intrapersonal conflict may result from having to make a choice between two things of generally equal value (positive or negative), from ambivalence about doing or not doing something, or from problems related to decision making between two or more of the individual's roles. A nurse leader who is a mother may experience intrapersonal role conflict when she must choose between going to apparent teacher conference about her child or going to a professional nursing meeting.

Management of intrapersonal conflict must come from the individual involved. Several options are available, but the individual must first decide what is most important, and then work to change the environment or his or her attitudes, or else use a systematic decision making process to identify a solution.

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**Conflict Resolution Theory**

Filley (1975), Proposed a model of conflict resolution represented in Fig. 11.1, which provides a framework that helps explain how and why conflict, occurs and, ultimately, how one can minimize conflict or resolve it with the least amount of negative aftermath? Filley argues that the conflict resolution process moves through six steps: (1) antecedent conditions, (2) perceived conflict, (3) felt conflict, (4) manifest behavior, (5) conflict resolution or suppression, and (6) resolution aftermath.

**Antecedent Conditions (Preexisting) -** certain conditions exist which can lead to conflict, though they do not always do so.

Conflict may develop from a number of antecedent sources, including:

- Incompatible goals
- Distribution of scarce resources when individuals have high expectations of rewards
- Regulations, when an individual's need for autonomy conflicts with another's need for regulating mechanisms
- Personality traits, attitudes, and behaviors

- Interest in outcomes
- Values
- Roles, when two individuals have equal responsibilities but actual boundaries are unclear, or when they are required to simultaneously fill two or more roles that present inconsistent or contradictory expectations.
- Tasks, when outputs of one individual or group become inputs for another individual or group, or outputs are shared by several individuals or groups..

**Perceived Conflict** - two or more individuals logically and objectively recognize that their aims are incompatible.

**Felt Conflict**- Individuals experience feelings of threat, hostility, fear or mistrust.

**Manifest behavior**- overt action or behavior takes place - oppression, competition, debate, or problem solving.

**Conflict Resolution or Suppression**- the conflict is resolved or suppressed either by all parties' agreement or else by the defeat of one party.

**Resolution Aftermath**- Individuals experience or live with the consequences of the Resolution
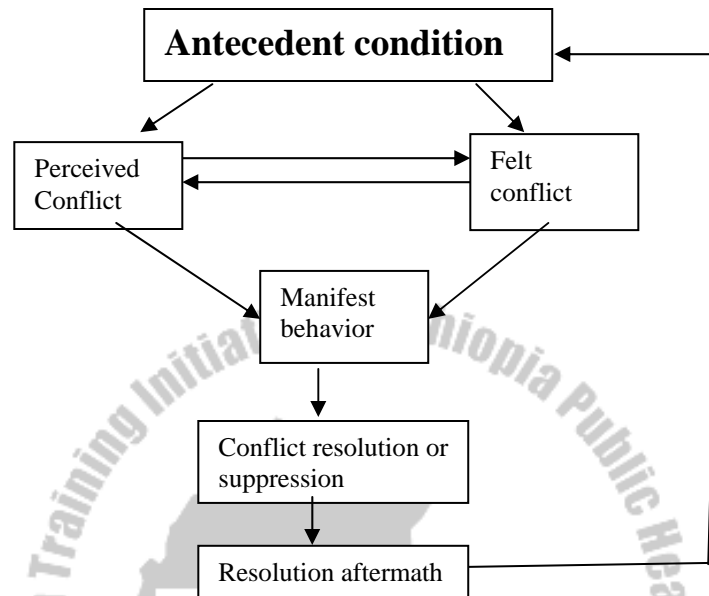
Fig.11.1     The conflict process

**Manifest behavior**

Manifest behavior refers to the behavior and action of individuals in response to conflict. These are the signs of conflict that are observable to bystanders. Individuals manifest primarily two kinds of behaviors in response to perceived and felt conflict: (1) Conflictive behaviors (negative) and (2) Problem solving behaviors (Positive). Conflictive behavior is characterized by the conscious attempts of one person to compete, dominate, and win over a second behavior. For example, conflictive

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behavior would be manifested by a health professional in an interdisciplinary meeting who consciously tries to block the innovative program suggested by another health professional. The dominating professional may try tactics such as discrediting the proposed program or diverting the discussion to a completely different topic in order to prevent program adoption. Problem solving behaviors, on the other hand, are conscious attempts to find mutually acceptable alternatives- to find approaches to problems that have positive outcome for both parties.

**Conflict Resolution or Suppression**

In conflict situations, individuals can either suppress conflict or engage in activity, which will lead to its resolution. Behavior directed toward the resolution of conflict can be characterized by three different communication strategies: (1) **Win- Lose**, (2) **Lose- Lose, or (3) Win -Win.**

**Win -Lose Strategies**- The win- lose strategy of conflict resolution is quite common, and most of us have used it at one time or another. It is not the optimal way of resolving conflict because one of the participants loses. This strategy is characterized by attempts of one individual to control or dominate another so as to obtain

his/her own goal(s) even at the expense of another's goal(s).

**Lose – Lose Strategies-** the lose –lose approach to conflict is obviously one we would all like to avoid when possible. Most people do not intentionally select a lose-lose strategy, but they end up with this outcome when other strategies, such as when a win-lose strategy, fail. In lose-lose conflicts both parties try to win over the other but both end up losing to each other. Neither person's goals are achieved and the relationship is weakened. Attempts by individuals to dominate over each other result in mutually destructive communication between the participants and negative outcomes.

## Case Study

A school of nursing was seeking a new director. Administrators at the college strongly desired to have an "in-house" person assume the position, since that person would already be familiar with the program and would have faculty support. Two faculty members said that they would like the position and both tried to line up faculty support. In their attempt to gather faculty support, strong disagreements developed between the two candidates and two distinct factions developed within

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the faculty. Both factions of faculty members threatened to quit if the person of their choice was not selected. In the end, neither in-house candidate was appointed as director of the program; instead a person from the outside who was less qualified had to be hired for the position. The tension and conflict that were generated within the two quality groups produced what could be called a lose-lose, destructive outcome.

**Win- Win Strategies**

Individuals who employ win-win strategies approach conflict in ways that are significantly different from the strategies used by individuals who take win-lose or lose-lose approaches toward conflict. The win-win strategy is an approach that allows both individuals to feel they have accomplished all or part of their goals. This strategy tries to satisfy mutual needs, to solve problems creatively, and to develop relationships. There is no attempt by one party to win over or control another party in this approach.

Finding win-win conflict solutions mean suppressing but not sacrificing our own needs in order to listen for the needs of others. Whether it is a conflict over a policy or procedure or conflict for control or esteem, win-win

strategies mean both parties communicate in ways that allow each of them to satisfy at least some of their needs. Win-Win solutions strengthen relationships. They make individual feel better about how they are related to others. Overtime, the strengthening of relationships has the advantage of helping individuals in future conflict resolution.

**Example: -**

Development of a joint appointment program in which staff could spend part of their time working for governmental school of nursing and part of their time working for the private school. This type of programs where there is scarcity of instructors would benefit both institutions as well as the individual staff members.

**Resolution Aftermath**

The final aspect of conflict in the Filley conflict model is resolution aftermath. During this phase, participants experience feelings directly related to the outcomes of the resolution process. If the conflict is resolved in a positive fashion, the participants will have good feelings about themselves, about each other and the situations. This was the case in win-win strategies. On the other

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hand if the conflict is resolved in an unproductive style, participants will have negative feelings about themselves, each other, and the relationship. This is common in win-lose or lose-lose situations, where participants may feel less cooperative, more distrustful and very prone to further conflicts (Filley, 1975). Obviously, the preferred goal of conflict resolution is to arrive at solutions that result in positive feelings, productive interactions, and cooperative relationships among the participants.

## Conflict Management /Styles of Approaching Conflict/

We have discussed the nature of conflict, different kinds of conflict, and theoretical perspectives on conflict and strategies for resolving conflict. Now we would like to address the questions, do individuals have different ways of handling conflict? In addition, how do the styles employed by individuals affect the outcomes of the conflicts?

Researchers have found that individuals approach interpersonal conflict utilizing five styles: (1) avoidance, (2) Competition, (3) accommodation (4) compromise, and (5) collaboration. This five-category scheme for

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classifying conflict was developed by Kilmann and Thomas (1976) and is based on the work of Blake and Mouton (1964). In the next section, each of the five conflict styles will be discussed in more detail. As you read the descriptions of these styles, perhaps you can identify which style of the conflict management you must commonly use in your communication with others. Is that style productive or counter productive? Of all the styles described, is there one or more that you could develop to enhance your conflict handling skills?

**Avoidance**

Avoidance is a style characteristic of individuals who are passive and who do not want to recognize conflict. These persons generally prefer to ignore conflict situations rather than confront them directly. In conflict producing circumstances, these individuals are not assertive about pursuing their own interests nor are they cooperative in assisting others to pursue their concerns.

In health care settings, avoidance is not and uncommon conflict style. In fact, there times when avoidance may almost be necessary. For example, on department in a hospital may frequently be in conflict with another department that is always slow in responding to

requests. If the request is directly related to the survival of a patient, the interdepartmental conflict becomes less important than just getting the service immediately- and avoiding conflict may be the best way. Health care practitioners are frequently dealing with life and death decisions for patients; consequently they often need to suppress their own concerns or conflicts with other staff members' in order to perform the necessary services. In these critical situations, avoidance of conflict may facilitate the health care delivery process.

In general, however, avoidance is not a constructive style of confronting conflict. Health professionals who are continually required to avoid conflict experience a great deal of stress. They bottle up their feelings of irritation, frustration, or anger, inside themselves, creating more anxiety, instead of expressing them or resolving the situation. Furthermore, avoidance is essentially a static approach to conflict: It does nothing to solve problems or to make changes that could prevent conflicts. In health, care organizations, the problems that exist will seldom be alleviated or resolved of avoidance is employed in conflict situations**.**

**Competition**

Competition is a conflict style characteristic of individuals who are highly assertive about pursuing their own goals but uncooperative in assisting others to reach their goals. These individuals attempt to resolve a struggle by controlling or persuading others in order to achieve their own ends. A competitive style is based on a win-lose conflict strategy.

Competition is spreading in our culture and can produce solutions to conflicts that are more effective and more creative than if competition were not present. For example, in a community in which school of nursing are competing to provide specific training, the quality of trainings will be higher, and the costs to the public will eventually be lower than if there were no competition. In the area of cost containment, a competitive approach to conflict can generate innovative cost solving solutions to complex problems. Similarly, on the interpersonal level, when two professionals compete to provide quality care, the

Outcomes can be very positive for clients. In effect, competitive approaches to conflict can challenge participants to make their best efforts, and this can have positive results.

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Generally, though, competitive approaches to conflict are not the most advantageous approach to conflict because they are more often counterproductive than productive. In failing to take other's concerns into account, we do others damage. When we attempt to solve conflict with dominance and control, communication can easily become hostile and destructive. Too much competition among health professionals can direct energy away from patient care objectives toward unnecessary inter-professional struggles. Too much competition between health care facilities can lead to a duplication of services within communities (example, two CAT scans, two dialysis units, etc.) and duplication increases healthcare costs. Competitive approaches to conflict create unstable situations as one party is constantly striving to attain or maintain dominance over the other party. Finally, competition creates discomfort; and competition individuals fail to recognize the concerns and needs of others.

## Accommodation

Accommodation is a conflict style that is unassertive but cooperative. An accommodating individual attends very

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closely to the needs of others and ignores her or his own needs. Using this style, individuals confront problems by deferring to others.

Accommodation is one way for individuals to move away from the uncomfortable feelings of struggle that conflict inevitably produces. By yielding to others, individuals can lessen the frustrations that conflict creates. By yielding to others, individuals can lessen the frustrations that conflict creates. In accommodating, an individual essentially communicates to another, "You are right, I agree; let's forget about it."

The problem with accommodation is that it is in effect a lose-win strategy. Individuals who accommodate may lose because they fail to take the opportunity to express their own opinions and feelings. Their contributions are not fully considered because they are not actively expressed or forcefully advocated. This style is primarily a submissive style, which allows others to take charge. To illustrate accommodation, consider the following conflict between a nurse and a physician regarding the use of pain medication with a terminally ill cancer patient. The physician believes that pain medication should be given no sooner than every four hours. In contrast, the nurse believes that the patient should be

allowed to request pain medications as necessary and should not have to adhere to a rigid four-hour schedule. After only brief discussion of their differences, the nurse decides to give in-to accept the physician's approach to the situation. The nurse in this situation suppresses his/her values regarding pain management in order to maintain a friendly nurse –physician relationship and in order to prevent further conflict.

From a positive perspective, accommodation can be useful I situations in which preserving harmony is necessary. For ex. If two professionals differ on an issue but one professional is deeply interested in the particular issue while his/her colleague is less involved in the issue, then it can be useful for the professional who finds the issue less important to go along with the concerned professional in order to maintain good personnel relations. In general, accommodation can at times be an effective means of eliminating conflict. As a rule, however, accommodation is not a preferred conflict style.

**Compromise**



Cooperativeness

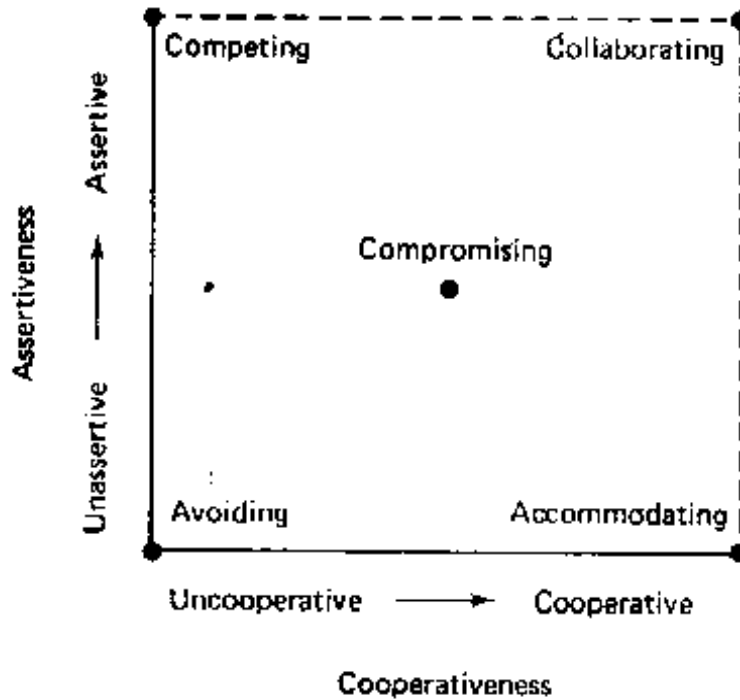Fig. 11.2 A diagrams depicting the relationship between assertiveness, cooperativeness, and styles of approaching interpersonal conflict.

As. Fig.11.2 Indicates, compromise occurs halfway between competition and accommodation, which means it, includes both a degree of assertiveness and a degree of cooperativeness. In using compromise to approach conflict, an individual attends to the concerns of others

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as well as to her or his own concerns. On the diagonal axis of fig. 11.2, Compromise occurs midway between avoidance and collaboration. This means that persons using this approach do not completely ignore confrontations but neither do they struggle with problems to the fullest degree. This conflict style is often chosen because it is measure and provides a quick means to find a middle ground. It partially satisfies the concerns of both parties.

Compromise is a positive conflict style because it requires that individuals attend to others' goals as well as their own. Compromise reminds us of the golden rule: "Do unto others as you would have them do unto you." The problem with compromise is that it does not go far enough in resolving conflict. As two persons give in to one another's demands, both individuals also pull back from fully expressing their own demands. Both individuals suppress personal thoughts and feelings in order to reach solutions that are not completely satisfactory for either side.

In health care, the compromise strategy may sometime be seen in the communication among health

professionals in interdisciplinary team meetings. One person may quickly agree with another person in order to resolve a problem so that each of them can get back to other responsibilities. Although this may be efficient and conserve time, innovative solutions are sacrificed in favor of quick solutions**.**

**Collaboration**

Collaboration, the most preferred of the conflict styles, requires both assertiveness and cooperation. It involves attending fully to others' concerns while not sacrificing or suppressing one's own concerns. Although collaboration is the most preferred style, it is the hardest to achieve. Collaboration requires energy and work among participants. To resolve incompatible differences through collaboration, individuals need to take enough time to work together to find mutually satisfying solutions.

The results of collaboration are positive because both individuals win, communication is satisfying, relationships, are strengthened, and future conflicts can be resolved more easily. An effective style such as collaboration and productive strategy such as win-win

approach both require that participants attend closely to one another's opinions and proposals and interact in ways that result in solutions acceptable to all parties. Effective communication is the pivotal element that prevents difference among individuals from escalating and facilitates constructive resolution to conflict situations**.**

**Learning Activities**

1.  Observe the interaction, which a conflict occurs. Determine the type of conflict and the strategies used to manage the conflict. Propose alternative approaches to resolve the conflict.

2.  **Case Study:** You are called to a ward to resolve a conflict between an RN and assistant nurse. As you approach them you hear the following dialogue:

RN: I asked you to get Mr. Nuru ready to go to X-ray, and you ignored me. The technician was here and left because you have not prepared the patient.

Ass. nurse: I was busy with Wro. Hanna and could not leave her. Why didn't you get Mr. Nuru ready? You actually knew about it.

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RN: It was your job. I assigned Mr. Nuru to you.

Ass.N. I do my own work and part of yours. You are the RN. You are supposed to be the leader on this ward.

RN: Do not get sarcastic with me. I do not have to put up with it. I am going to call the supervisor and report you for your rudeness.

Ass.N. My rudeness! Go ahead and report me! I will tell the supervisor what a lazy nurse you are!

Outline a plan to deal with this conflict. You may use the following format.

2.1. What is (are) the cause (s) of the conflict?

2.2. Decide on aims, strategies, and specific skills for resolving the conflict and list them.

    **3.** Describe a recent instance of a conflict in which you are involved. Was it resolved satisfactorily? Can the group help in finding a better solution? Discuss.

# CHAPTER TWELVE
# MANAGEMENT OF CHANGE

**OBJECTIVES:**

At the end of this chapter, the student should be able to:

- Describe the importance of change and appreciate its nature
- Explain key factors in management of change
- Discuss the source of resistance to change and the ways this resistance can be overcome
- Play a leading role in initiating and managing change in your organization of work environment
- Discuss Lewin's 3-step model of change management.

**Management of Change**

Change is defined as "the process of alteration or transformation of individuals, groups, and organization undergo in response to internal factors."

**Purpose of change**

- To meet changing clients needs
- To meet changing market conditions

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- To respond to internal pressures
- To take advantage of new opportunities
- To respond to competitive pressure

**Factors that cause change**

A number of internal and external forces, often interacting to reinforce one another, stimulate changes in organization. Pressure for change may arise from a number of sources within the organization, particularly from new strategies, technologies, and employee attitudes and behavior. For example, a top manager's decision to seek a higher rate of long term growth will affect the goals of many departments of the organization. Unexpected opportunities may arise that permit the innovators inside the organization to develop new ways of doing things. This can stimulate organizational change.

An enormous variety of external forces, from technological advances to competitive actions can pressure organizations to modify their structure, goals, and methods of operation. Outside pressures come from changes in the organizations technological settings,

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economic, political, legal, social, and competitive environments.

**Managing Change in an Organization**

Change can be planned or unplanned. The latter just happens in the natural course of events. Planned change, on the other hand, is the result of consciously designed preparation to reach a desired goal or organizational state. An effective management of change involves change agents, performances gaps, levels and targets of change, systems approach, and content and process.

**a. Change Agent** - In every situation in which a change is desired, some person or group must be designated as the catalyst for change. That person or group is called the change agent. The change agent is the individual who is responsible for taking a leadership role in managing the process of change. The individual, group, or organization that is the target of the change attempt is called the client systems. Managers or staff at various levels in organizations can serve as change agents. Consultants brought in from outside can also be change agents. Their role is to recognize the need for altering

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the status quo and to plan as well as to manage the implementation of the desired changes.

 **b. Performance Gaps** - It is the difference between the status quo and the desired new standard of performance or desired organizational state. The change agents think in terms of performance gaps.

**c. Levels and Targets of change** - Change agents must identify the level at which their efforts will be directed. Effects can be made to change individuals, groups, and entire organizations. Each represents a different level, or unit of change. Besides, change agents' focus on targets to alter in attempting to close performance gaps and reach desired objectives. These targets of change include people, technology, Jobs and workflow, organizational structure and processes, culture, and management. The following examples illustrate how managers can change some of these targets.

| Target | Example |
|--------|---------|
| Individual | • Fire a person and replace him/her with some one else.<br>• Change knowledge, skill, attitude, or behavior |
| Technology | • Replace existing technology with a more modern machine or way of doing work |
| Structure | • Change from functional structure to a product division structure<br>• Add a new department or division, or consolidate the existing ones |
| Processes | • Change the pay system from hourly wages to salaries |
| Culture | • Implement a program to encourage valuing quality and service |
| Management | • Encourage participation in the diagnosis and solution of problems by people at lower levels to replace a top-down approach |

**d. Systems Approach**- since various elements of an organization are all part of an inter- dependent system,

a change in any single target often leads to changes in the others. For example, when intensive care unit introduces ECG machines to improve diagnosis of patients, a series of changes followed. First, nurses have to learn on how to monitor the ECG and all have to learn the concepts and its interpretation.

**E. Content and process**: - Two key concepts in managing change are content and process. Content is the what aspect of change, and process is the how dimension of change. For example, assume a manager is concerned about decreasing productivity among the clerical staff. She thinks the cause might be excessive talking among staff members. In order to discourage talking among the clerical staff, she may decide to move their desks farther apart or place partitions between them. This is a content change.

How this manager introduces and implements the change is the process. For example, she may decide to announce the change by memo or in a staff meeting, or she might have the desks moved during the night so that the clerks find out about the change when they come to work the next day.

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**Programming Change**

The realization of organizational change requires effective planning or programming. A change program should incorporate the following processes.

1. **Recognizing the need for change** – The need for change is sometimes obvious, as when results are not inline with expectations, things clearly are not working well, or dissatisfaction is apparent.

2. **Setting Goals** – Defining the future state or organizational conditions desired after change.

3. Diagnosing the present conditions in relation to the stated goals.

4. Defining the transition state activities and commitments required on meeting the future state.

5. Developing strategies and action plans.

**Lewin's 3 Step model of the change Management**

Sociologist Kurt Lewin (1951) envisioned that any potential change is interplay of multiple opposing forces. These forces are broadly categorized under two major fields: **the driving forces and restraining forces**. The driving forces are the factors that encourage or facilitate

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the change, while the restraining forces are the factors that obstruct change. If these opposing forces are approximately equal, there will be no movement away from status quo. For change to occur the driving forces must be increased and/or the restraining forces must be reduced. This requires thorough understanding and analysis of the forces likely to resist change as well as those creating the need for change. Lewin called this process "**force field analysis**". He noted that force field analysis is an important diagnostic and problem solving technique. It involves:

1. Analyzing the restringing forces or driving forces, which will affect the transition to the future state. These restraining forces will include the reactions of those who see change as unnecessary or constituting a threat.
2. Assessing which of the driving or restraining forces are critical
3. Taking steps both to increase the critical driving forces and to decrease the critical restraining forces.

Kurt Lewins further studied the process of bringing about effective change. He noted that individuals

experience two major obstacles to change. First, they are unwilling (or unable) to alter long-established attitudes and behavior. Second, their change of behavior frequently last only a short time. After a brief period of trying to do things differently, individuals often return to their traditional behavior.

To overcome obstacles of this sort, Lewin developed a three – step sequential model of the change process. The model involves "**unfreezing**" the present behavior pattern, "**Changing**" or developing a new behavior pattern, and then "**refreezing**" or reinforcing the new behavior.

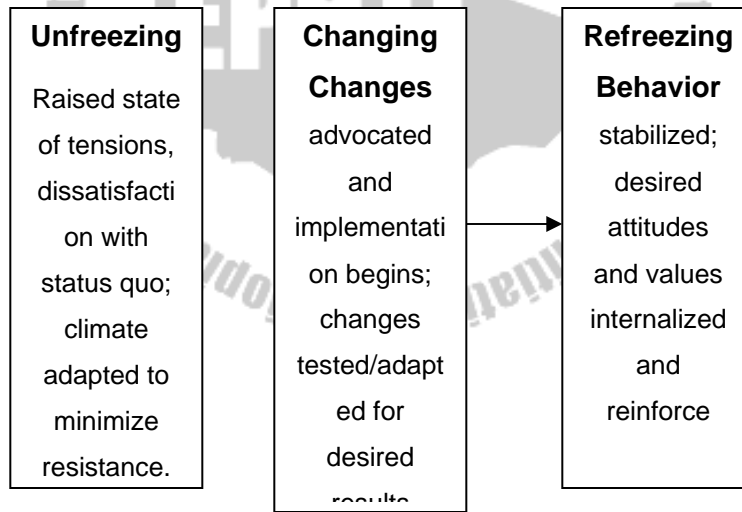| **Unfreezing** | **Changing** | **Refreezing** |
|---|---|---|
| Raised state of tensions, dissatisfaction with status quo; climate adapted to minimize resistance. | **Changes** advocated and implementation begins; changes tested/adapted for desired results | **Behavior** stabilized; desired attitudes and values internalized and reinforce |

Fig. 12.1, the three step of change process

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1. **Unfreezing**- it involves making the need for change so obvious that the individual, group, or organization can readily see and accept it. It is the process of creating a climate ready for change. In this stage, the management realizes that the current strategy is no longer appropriate and the organization must breakout of (unfreeze) its present mold. As such, it tries to make other people (employees) realize that some of the past ways of thinking, feeling, and doing things are obsolete. It convinces individuals and groups that present conditions or behavior are inappropriate.

2. **Changing**- once the members have been prepared to accept change, their behavioral patterns have to be redefined. There are three methods of reassigning individuals' new patterns of behavior. These are:

   a. **Compliance** – It is achieved by strictly enforcing the reward and punishment strategy for good or bad behavior. The fear of punishment or actual reward seems to change the behavior for the better.

b. **Identification** – Identification occurs when the members are psychologically impressed upon to identify themselves with some given role of models, whose behavior they would like to adopt and try to become like them.

c. **Internalization** – Internalization involves some internal changing of the individual's thought processes in order to adjust to a new environment. Members are left alone and given the freedom to learn and adopt new behavior in order to succeed in the new set of circumstances.

As a whole, in this stage, new behavior is developed and change is effected through a conscious process as individuals seek to resolve the anxieties that surfaced during unfreezing stage.

3. **Refreezing** – It means locking the new behavior pattern into place by means of supporting or reinforcing mechanisms, so that it becomes the new norm. It is the process of institutionalizing the new state of behavior or work by rewards (praise, etc).

**Making the change process Effective**

The important aspects of Kanter's Ten Commandments have been summarized as follows (Lovell, 1994).

1. **Analyze the organization and its need for change**- any change process should start with a meticulous understanding of how the organization works; what are its strength and weakness, what are its relationships with the environment and what are its needs to change.

2. **Create a shared vision and common Direction**- One of the key first steps is to unite the organization around a vision of the future.

3. **Separate from the past-** This is a similar idea to Lewin's (1947) unfreezing process. This is an absolute detachment from the past. The organization must identify what aspects of its operations are no longer relevant.

**4. Create a sense of urgency**

A sense of urgency seems to be important for the organization to unfreeze and develop support for the changes. Sense of urgency is accelerated as a result of crisis. But preferably organizations should be productive in their change strategies and change before crises occur.

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**5. Support a strong leader (transformational leader)**

Several studies demonstrated that a strong leader is a factor to vision creation, motivating the organization behind the vision and rewarding who strive towards its realization.

**6. Line up political support**

Although leader ship is a very important prerequisite for propelling change, it is not enough in its own. Successful change needs a broad-base support from all the stakeholders, including those who will lose, as well as those who will profit from change.

**7. Craft an implementation plan**

While visions are of paramount importance in effecting changes, the organization needs clear information about what will be done to achieve it. A road map has to be prepared, giving clear direction and a route to take.

**8. Developing enabling structures**

The old structures and methods of working are unlikely to be satisfactory to support and sustain the change process on their own. Enabling structures are systems and structures, which support the transformation process during the transition from the old to the new state. They include new institutional names, new logos and uniforms and office relocations and renewal.

**9. Communicate, involve people and be honest**

Wherever or whenever possible, there should be open communications and the involvement and trust of people in the organization.

**10. Reinforce and institutionalize the change**

Managers need constantly to demonstrate their commitment to the change. They should reward the new desired behaviors and ensure they become part of normal day to day operations.

**Resistance to change and gaining support**

**1. Reasons for resistance**

Change is neither always accepted nor always rejected. Some people desire change and welcome new experiences as a break from monotony, on the other hand, there are a good number of people who resist change for various reasons than one. Management may recognize the need for change, but most employees may resist the process.

No matter what the resistance might arise, the change must occur continually in order to adjust to dynamic forces that are continuously at play. The society will become stagnant if no changes took place. The reasons

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for resistance to change must be studied carefully, but four main reasons are common.

1. **Parochial self interest**

    - Threat to core skills and competence

    - Threat to status

    - Threat to power base

2. **Misunderstanding and lack of trust**

    - Lack of information

    - Misinformation

    - Historical factors (poor timing)

    - Low trust of organizational climate

    - Poor relationships (quarrelsome)

3. **Contradictory Assessments**

    - No perceived benefits

    - An assessment that the proposed change is wrong/ill thought out

    - Strong peer-group norms, which may shape such contradictory assessments

4. **Low tolerance of change**

    - Fear of unknown

    - Fear of failure

    - Customer bound (inertia-unwillingness to disturb status quo)

    - Reluctance to let go

A variety of reasons thus exist for resistance to change. The change itself or the methods of implementation may be opposed. But if managed correctly, the opposition can be minimized or completely eliminated.

**Managing resistances to change**

If the change is to be implemented successfully, it needs full acceptance and cooperation from employees. More specifically, Kotter and Schlesinger (1979:110) have put forward six valuable ways of overcoming resistance to change. The techniques include:

1. **Education and communication** - Management should educate employees about upcoming changes before they occur. It should communicate not only the nature of the change but its logic. The process include one-on-one discussions, presentations to groups (variety of conferences), brochures, or reports and memos.

2. **Participation and Involvement** - If management involves those who might resist change with the design and implementation of the change, resistance may be prevented.

    Considerable research has demonstrated that, in general, when employees participate in the

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decision to change, they are committed to implementing it. Therefore, employees should also be involved in the change's design and implementation.

3. **Facilitation and support** - Management should make the change as easy as possible for employees and be supportive of their efforts. This could be achieved through providing training new skills, or giving employees' time off after a demanding period of change, or simply listening and providing emotional support.

4. **Negotiation and Agreement** - When necessary, management can offer concrete incentives for cooperation with the change. Rewards such as bonuses, wages and salaries, recognition, Job assignments and perhaps restructured to reinforce the direction of change.

5. **Manipulation and co-optation** - This process involves making covert-attempts to influence others. One common form of manipulation is co-optation. Co-optation involves giving an informal leader (a resisting individual) a desirable role in the design or implementation of a potential change. For instance, management might invite a union

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leader to be a member of an executive committee or ask a key member of an outside organization to join the company's board of directors. As a person involved in the change, he or she may become less resistant to the actions of the co-opting group or organization.

6. **Explicit and Implicit coercion** - Some managers apply punishment to those who resist change. With this approach, managers use force to make people comply with their wishes. For instance, a boss may force employees to go along with a change by threatening them with dismissed, with being passed over for promotion, with unattractive Job assignment, or through other negative suggestions.

**Learning Activities**

1. Analyze a change that has occurred. Was the change planned or unplanned? Who was the change agent? What strategies did the change agent used?

2. Interview a nurse leader about changes that have occurred in the past month. How was the

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nurse leader and her group involved in the change process?

3. Propose a plan for change. Describe the anticipated resistance and methods to manage the resistance.

4. Identify a needed change in your health care setting. What are the driving and restraining forces that will enable or prevent that change?
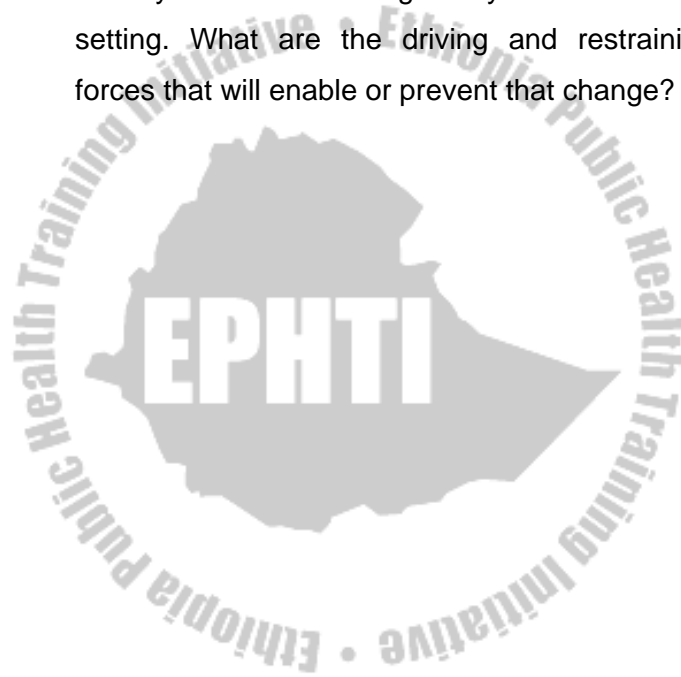
# CHAPTER FORTEEN
# PROJECT PLAN MANAGEMENT

## Objectives:

At the end of this chapter, the student should be able to:

- Develop a complete project plan of its interest using all the steps of project planning.

**Project Plan Management**

Studies have consistently shown that planning and goal setting can improve program performance. A total plan provides the structure for implementing the program, serves as a guide for effectively using human, material and financial resources, and creates a common understanding of program goals and objectives among staff.

**Organizing and Developing a Written Plan**

A good plan should describe the type of project that you intend to implement, the expected results, the plan of activities for setting up and implementing the project, the way that progress will be tracked, the reporting system,

and the cost of carrying out the project. The plan should contain distinct sections that clearly describe:

- The existing problem or need that the project will address and the proposed project;
- The goals and objectives of the project, and the time frame for achieving the objectives;
- A general activity plan for the term of the project, including how the activities will be carried out, who will be responsible for each activity, and when each major activity will be completed;
- A plan for monitoring progress and evaluating the results of the project;
- A reporting plan and schedule, including how the project will manage its finances;
- A projected budget for at least the first year of the project, land a summary budget for the life of the project.

**Explaining the Purpose of your Initiative**

Each new initiative or project should be created to respond to documented needs or problems in the community or region your program serves. Thus, the first part of the plan should justify the need for the project. This part of the plan can be divided into two

sub-sections; the problem statement and your proposed solutions.

**The Problem Statement**

This is a statement of the specific problem or need to be addressed by the project. It should include some basic data (baseline data) that help to explain the problem, including the following information:

- A description of the extent, scope, or severity of the problem, so that the proposed results can be put in the perspective;

- A description of the geographic area and demographic characteristics of the population in the area in which the problem exists;

- An analysis of the causes of the problem;

- The results of the previous efforts, by your program or other programs, to solve the problem.

**An example of Problem Statement:**

Within the region of Somalia there is a large per-urban population of 250,000 that at the present time does not have any access to family planning services. Ten government clinics are located within and near this area

but they offer only some other services on maternal and child health services. At 52 births per 1,000 populations, the birth rate in this peri-urban area is roughly two times than in other areas within the state.

**The Proposed Solution-** in this section of the plan you should explain the design of your project, emphasizing those aspects of your approach that you think best address the problem you have described. The description of the project design should answer the following questions:

- What approach will you use, and why have you chosen this approach over other possibilities?
- What other local programs are addressing this problem and how does your proposed approach complement their activities?
- What changes do you expect will result from this project?
- How does this project fit in your organization's overall strategic plan?
- What sources of support are likely to be available to you for continuing the project in the future?
- In what ways is the project designed so that it can be replicated in other areas?

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**An example of a Proposed Solution:**

Within the Peri-urban area of Somalia region there are 10 MCH clinics staffed by government nurses. This initiative, "Project Expand: Somalia", would use existing government clinics to introduce family planning services to these peri-urban areas. A family planning trained physicians and nurses in each of the existing clinics would provide Family Planning services. In addition, a network of local promoters (TTBA and extension health workers) would be formed to disseminate family planning information, distribute contraceptives, and refer clients to clinics for clinical methods. By building on the accessibility of the existing government clinics and linking community outreach activities with clinic services, this project is expected to significantly decrease the birth rate in the peri-urban area of Somalia region. It is expected that this model will be replicable in other urban areas in Ethiopia.

**Being Specific about what the New Initiative will Accomplish**

A well-designed project should have both **overall goals** and **specific objectives.** The goals and objectives set forth the intended results to be achieved by the project

and the degree to which the problem described will be resolved. Once the objectives have been determined, a set of activities that describe how each objective will be achieved should be specified in the activity plan that follows.

**Goals**: The overall goals should describe, in a broad way, the long-term changes that will result from your project's work on the problem outlined in the problem statement. Normally one or two general statements describing the proposed long-range benefits to the target population are sufficient to describe the overall project goals.

**Example of an overall goal**: To reduce the birth rate in the peri-urban community of Somalia-region, by providing clinic-and community-based family planning services.

**Objectives**: for each overall goal that you develop, there should be several specific, measurable objectives. These objectives relate to the problem statement and describe anticipated results that represent changes in knowledge, attitudes, or behavior of the project clients or participants. Your objectives should be **SMART.**

**S**pecific - to avoid differing interpretations

**M**easurable - measurable, observable, or otherwise documentable. It allows for monitoring and evaluation.

**A**ppropriate - to the problems, goals and strategies

**R**ealistic - achievable, challenging, and meaningful

**T**ime bound - with a specific time period for achieving them

**Examples of specific objectives**:

- To select, recruit, and train a network of 60 family planning promoters by the end of the first year of the object.

- To attract 4,000 new family planning acceptors during the first year of operation of the project, and an additional 9,500 during the second year of the project.

To be serving 20,000 family planning clients by the end of the third year of the project.

**Developing Detailed project Activities**

The plan of activities constitutes the core of your plan and should describe the major activities needed to accomplish each project objectives. To fully develop the plan, you should list the key activities that must be

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carried out in order to achieve each objective. One or more individuals should be assigned to each activity and these people will be responsible for overseeing or carrying out the activity. The plan of activities can be divided into two sub-sections: a detailed description of project activities and a project activity timeline.

**Sample-project Activity Timeline**

| Project Activity | Year-1<br>1 2 3 4 | Year-2<br>1 2 3 4 | Year-3<br>1 2 3 4 | Person(s)<br>Responsible |
|---|---|---|---|---|
| Select and recruit project personnel<br>    5 nurses<br>    3 outreach supervisors<br>    20 promoters | <br><br>X X<br>X X<br>X X X | | | <br>Head    Nurse/<br>Metron |
| Order contraceptive supplies and IEC materials | X X X | X X X | X X X | Project Coordinator |
| Develop    monitoring    and    reporting forms | X X | | | " |
| Evaluate project progress and impact | | X X | X X | Head    Nurse/<br>Metron |

**Tracking the progress toward Meeting Objectives**

Plans for monitoring and evaluating your project should be included in the initial project design.

**Monitoring** - is the process by which project activities and the budget are regularly reviewed. Monitoring helps to ensure that the activities planned in the work plan are being completed and that the costs are in line with the budget. The monitoring plan should include at least the following information:

- A list of the project personnel who will be involved in monitoring the project, and their specific monitoring responsibilities
- How and when project managers will monitor activities
- A plan for the development of criteria that will be use to monitor project activities, including measures of service quality
- A plan for the development of forms that will be used for monitoring activities

**An example of a monitoring plan**

The project coordinator assigned to the project will monitor the progress of activities and the costs incurred in carrying out these project activities. On a quarterly

basis, the project coordinator will compare the completed activities and the expenditures against planned activities and the budget, by making site visits to clinics and outreach worker sites. Clinic heads will be responsible for monitoring the activities of the promoters on a quarterly basis by making visits to selected outreach worker sites with the supervisors assigned to each area. The medical director will monitor the quality of care provided by the nurses on a quarterly basis by making site visits to the clinics and by conducting random exit interviews with clients. Early in the first quarter of the project, the project coordinator and the medical director will develop specific monitoring criteria for the project and will revise existing government monitoring and reporting forms for use in the project. The forms will be designed to collect basic family planning data, to track potential discontinuers so that the outreach workers can provide timely and effective follow up visits, and to assess client satisfaction with clinical and outreach services.

**Evaluation** - The evaluation of the project should analyze the implementation process (that is whether the planned activities were carried out and completed) as well as the impact (or long-term effect) that the project

has had on the target population. By developing this section of the plan, you will define and let other project personnel know in advance what aspects of the project will be evaluated, and how and when the evaluation(s) will be conducted.

Your evaluation plan should specify the following:

- How the evaluation criteria will be developed
- Who will perform the evaluation and when the evaluation(s) will occur
- How evaluation data will be collected and submitted, including how qualitative data, such as information on user satisfaction, will be collected
- How and when evaluation data will be analyzed and reported
- How the evaluation findings will be used

To establish the evaluation criteria, base the criteria on specific project objectives. Because these objectives are SMART, they are measurable and observable, and can be easily converted into evaluation criteria.

Example:

| Evaluation criteria | Target (yr 1.) | Actual No. % | Target (yr 2) | Actual No. % |
|---|---|---|---|---|
| **.** Number of family planning acceptors served by the clinics | 2,000 | | 7,000 | |
| **.** Number of family planning promoters oriented and trained | 60 | | 60 | |

### Reporting Your Achievements

You should have forms for reporting on both programmatic achievements and financial activities. If you do not already have reporting forms, you will need to develop new forms, or modify existing forms used by your program or other similar programs.

**Programmatic reporting** provides detailed information on the activities under taken in the project. **The narrative reports** should refer to the stated objectives,

activity plan, and evaluation criteria to be used in analyzing project progress.

**Financial Reporting** - shows how much money has been expended during a specific reporting period and for what purpose, and whether the money that was spent was in line with the budget.

## Sample project proposal outline

I. **Project summary**

II. **Why this new Initiative?**

    A. Problem statement

    B. Proposed solution

III. **Organizational Qualifications**

    A. Organizational Experience

    B. Key personnel

IV. **Goals and objectives**

    A. Goals

    B. Objectives

V. **Detailed Activities**

    A. Project Activities

    B. Project Activity timeline

VI. **Project Sustainability**

VII. **Tracking Progress**

    A. Monitoring

   B. Evaluation

VIII**. Reporting**

   A. Financial

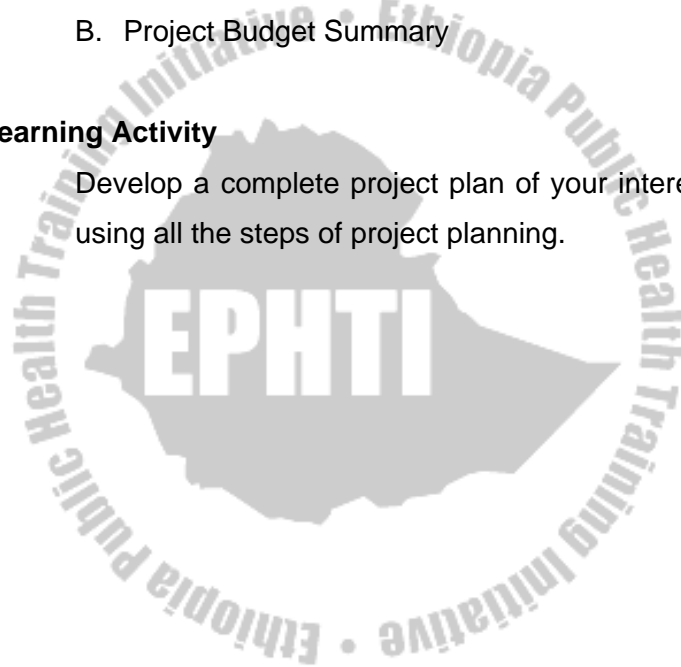   B. Programmatic

IX**. Budget**

   A. Detailed project Budget (year I)

   B. Project Budget Summary

**Learning Activity**

   Develop a complete project plan of your interest
using all the steps of project planning.

# CHAPTER FIFTEEN

# QUALITY

# ASSURANCE/IMPROVEMENT

## Objectives

At the end of this chapter, the student should be able to:

- Define, and elaborate down the quality assurance process
- Discuss the methods used in monitoring the nursing care for the quality assurance
- Identify clinical indicators of quality care
- Discuss on the concepts of total quality management.

**History of Quality Assurance**

The process of systematic evaluation of heath care is not new; quality assurance activities date back to Florence Nightingale. She urged that all nursing care being rendered be evaluated. During the Crimean War, Nightingale reported statistics on the mortality of British soldiers in comparison to civilians before and after some of her innovative nursing practices. She reported that the patient outcome mortality rate decreases by 2

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percent in a six-month period at one military hospital (Nutting and Dock, 1907). She communicated her findings and received public support. The government interest in health care accountability resulted in the regular evaluation of hospital care; these efforts eventually contributed to similar health care being delivered to soldiers and civilians.

In the late 1940s and early 1950s, the general public became more aware of organizing, planning, and evaluating methods of health care services. In 1952, the Joint Commission on Accreditation of Hospitals was founded. It provides standards for accreditation. The American Nurses Association (ANA) in 1959 published its *Functions, standards and Qualifications for Practice*, and the National League for Nursing published *What people can Expect of a Modern Nursing Service.* All of these efforts helped to form professional and public expectations about adequate care.

### Definitions

In order to understand the quality assurance/ improvement guidelines that are distributed by legislative, voluntary, and professional bodies, the nurse

manager should be familiar with the following definitions (Gillies, 1994).

**Accountability** is the obligation to provide an estimate for one's actions to the persons who delegated authority for that action. The conscious nurse exhibits accountability toward her/his employer, the patient, and government agency that pays for the patient health care.

**A nursing care Outcome** is the end result of a nursing intervention, a measurable change in the state of a patient's health that is as a circumstance by nursing action.

**A criterion** is the value free name of a variable that is known to be a reliable indicator of quality. Example, nurses educational preparation affect the quality of patient care decisions.

**A standard** is the desired quantity, quality, or level of performance that is established as a criterion against which worker performance will be measured. A nursing department might establish a standard that requires 100 percent of nurse managers to earn a bachelor's by a target date.

**A norm** is current level of performance of a selected work group with reference to a given criterion. Example,

a norm for writing nursing diagnosis in the ward for each patient within 12 hours of admission is 50 percent.

**An Objective** is a goal toward which effort is directed. To be effective, an objective should be expressed in observable, measurable terms and should include target date for fulfillment. For example, "By January, 1995, all head nurses will be certified trainers of cardiopulmonary resuscitation."

**A Critical clinical indicator** is a quantitative measure that can be used as a guide to monitor and evaluate the quality of important patient care activities.

The effectiveness of a particular nursing intervention is the extent to which desired outcomes are attained through the use of the intervention. The efficiency of a particular nursing intervention is determined by computing the intervention's cost benefit ratio, or the relationship between monetary value of resources expended and monetary value of results achieved.

**Quality Assurance** describes all activities related to establishing; maintaining and assuring high quality care for patients.

**Quality Assurance Process**

Quality assurance process is the systematic process of evaluating the quality of care given in a particular unit or institution. It involves setting standards, determining criteria to meet those standards, data collection, evaluating how well the criteria have been met, making plans for change based on the evaluation, and following up on implementation for change.

**Setting Standards**- The nursing profession should have to design standards of nursing practice that are specific to the patient population served (for example, the American Nurses Association has set up a Standards of Nursing Practice based on nursing process).  These standards could serve as the foundation upon which all other measures of quality assurance are based. An example of a standard is: Every patient will have a written care plan.

**Determining Criteria**- After standards of performance are established, criteria must be determined that will indicate if the standards are being met and to what degree they are met. Just as with standards of care, criteria must be general as well as specific to the individual unit. One criterion to demonstrate that the standards regarding care plans for every patient are

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being met would be: A nursing care plan is developed and written by a nurse within 12 hours of admission. This criterion, then, provides a measurable indicator to evaluate performance.

**Data Collection-** The actual collection of data is the third step in quality assurance. Sufficient observations and random samples are necessary for producing reliable and valid information. A useful rule is that 10 percent of the institutional patient population per month should be sampled. The devised tool to collect data should leave as little room for interpretation by the data collector as possible. Data collectors need to be taught the purpose of quality assurance along with the principles of data collection.

Data collection methods include patient observations and interviews, nurse observations and interviews, and review of charts. Flow sheets and Kardexes are also resources from which to assemble information about past and present conditions.

A policy should outline guidelines of the reporting of quality assurance data so it is clear who in the organization needs to receive quality assurance information. The policy should also state at what level in the organization the analysis of the different criteria is to

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take place, to whom these analyses and recommendations are to be reported, who is responsible for implementing the recommendations, and who is responsible for follow up. Unless definite policies are established, the system may fail and changes in nursing practice are not likely to occur (Sullivan, 1992).

**Evaluating Performance**

Several methods can be used to evaluate performance. These include reviewing documented records, observing activities as they take place, examining patients, and interviewing patients, families, and staff. Records are the most commonly used source for evaluation because of the relative ease of their use, but they are not as reliable as direct observations. It is quite possible to write in the patient's chart activities that were not done or not to record those things that were done. Further, the chart only indicates that care was provided; it does not demonstrate the quality of that care. For example, care plan could be checked nursing diagnosis, interventions planned, and discharge planning.

**Monitoring Nursing Care**

In addition to the individual patient care activities described, another component of quality assurance is the ongoing monitoring of nursing care. Several methods are used to monitor nursing care. These include the nursing audit, peer review, utilization review, and patient satisfaction.

**Nursing Audit** can be retrospective or concurrent. A retrospective audit is conducted after a patient's discharge and involves examining records of a large number of cases. The patients' entire course of care is evaluated and comparisons made across cases. Recommendations for change can be made from the perspective of many patients with similar care problems and with the spectrum of care considered.

A concurrent audit is conducted during the patient's course of care; it examines the care being given to achieve a desirable outcome in the patient's health and evaluates the nursing care activities bearing provided. Changes can be made if they are indicated by patient outcomes.

**Peer Review-** occurs when practicing nurses determine the standards and criteria that indicate quality care and then assess performance against these. In this case,

nurses are the "experts" at knowing what the indicators of quality care and when such care has been provided.

**Patient Satisfaction**. It is using a questionnaire and asking the patient to fill out before leaving the institution. Such questionnaire includes care given in a timely fashion and other variables in the environment that contribute to recovery rather than standards of professional care.

**Critical Indicators (Rate based) Surgical Unit**

- Postoperative pneumonia
- Paralytic ileus
- Wound infection
- Haemorrhage
- Urinary tract infection
- Phlebitis
- Fever

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