COURSE MANUAL

Management Principle in Nursing/Organization of Health Care

NSG411

University of Ibadan Distance Learning Centre
Open and Distance Learning Course Series Development

General Editor: Prof. Bayo Okunade

University of Ibadan Distance Learning Centre
University of Ibadan,
Nigeria

Telex: 31128NG

Tel: +234 (80775935727)
E-mail: ssu@dlc.ui.edu.ng
Website: www.dlc.ui.edu.ng

Vice-Chancellor's Message

The Distance Learning Centre is building on a solid tradition of over two decades of service in the provision of External Studies Programme and now Distance Learning Education in Nigeria and beyond. The Distance Learning mode to which we are committed is providing access to many deserving Nigerians in having access to higher education especially those who by the nature of their engagement do not have the luxury of full time education. Recently, it is contributing in no small measure to providing places for teeming Nigerian youths who for one reason or the other could not get admission into the conventional universities.

These course materials have been written by writers specially trained in ODL course delivery. The writers have made great efforts to provide up to date information, knowledge and skills in the different disciplines and ensure that the materials are user-friendly.

In addition to provision of course materials in print and e-format, a lot of Information Technology input has also gone into the deployment of course materials. Most of them can be downloaded from the DLC website and are available in audio format which you can also download into your mobile phones, IPod, MP3 among other devices to allow you listen to the audio study sessions. Some of the study session materials have been scripted and are being broadcast on the university's Diamond Radio FM 101.1, while others have been delivered and captured in audio-visual format in a classroom environment for use by our students. Detailed information on availability and access is available on the website. We will continue in our efforts to provide and review course materials for our courses.

However, for you to take advantage of these formats, you will need to improve on your I.T. skills and develop requisite distance learning Culture. It is well known that, for efficient and effective provision of Distance learning education, availability of appropriate and relevant course materials is a *sine qua non*. So also, is the availability of multiple plat form for the convenience of our students. It is in fulfilment of this, that series of course materials are being written to enable our students study at their own pace and convenience.

It is our hope that you will put these course materials to the best use.

Prof. Abel Idowu Olayinka

Vice-Chancellor

Foreword

As part of its vision of providing education for "Liberty and Development" for Nigerians and the International Community, the University of Ibadan, Distance Learning Centre has recently embarked on a vigorous repositioning agenda which aimed at embracing a holistic and all encompassing approach to the delivery of its Open Distance Learning (ODL) programmes. Thus we are committed to global best practices in distance learning provision. Apart from providing an efficient administrative and academic support for our students, we are committed to providing educational resource materials for the use of our students. We are convinced that, without an up-to-date, learner-friendly and distance learning compliant course materials, there cannot be any basis to lay claim to being a provider of distance learning education. Indeed, availability of appropriate course materials in multiple formats is the hub of any distance learning provision worldwide.

In view of the above, we are vigorously pursuing as a matter of priority, the provision of credible, learner-friendly and interactive course materials for all our courses. We commissioned the authoring of, and review of course materials to teams of experts and their outputs were subjected to rigorous peer review to ensure standard. The approach not only emphasizes cognitive knowledge, but also skills and humane values which are at the core of education, even in an ICT age.

The development of the materials which is on-going also had input from experienced editors and illustrators who have ensured that they are accurate, current and learner-friendly. They are specially written with distance learners in mind. This is very important because, distance learning involves non-residential students who can often feel isolated from the community of learners.

It is important to note that, for a distance learner to excel there is the need to source and read relevant materials apart from this course material. Therefore, adequate supplementary reading materials as well as other information sources are suggested in the course materials.

Apart from the responsibility for you to read this course material with others, you are also advised to seek assistance from your course facilitators especially academic advisors during your study even before the interactive session which is by design for revision. Your academic advisors will assist you using convenient technology including Google Hang Out, You Tube, Talk Fusion, etc. but you have to take advantage of these. It is also going to be of immense advantage if you complete assignments as at when due so as to have necessary feedbacks as a guide.

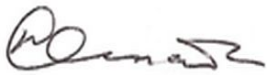
The implication of the above is that, a distance learner has a responsibility to develop requisite distance learning culture which includes diligent and disciplined self-study, seeking available administrative and academic support and acquisition of basic information technology skills. This is why you are encouraged to develop your

computer skills by availing yourself the opportunity of training that the Centre's provide and put these into use.

In conclusion, it is envisaged that the course materials would also be useful for the regular students of tertiary institutions in Nigeria who are faced with a dearth of high quality textbooks. We are therefore, delighted to present these titles to both our distance learning students and the university's regular students. We are confident that the materials will be an invaluable resource to all.

We would like to thank all our authors, reviewers and production staff for the high quality of work.

Best wishes.



Professor Bayo Okunade

Course Development Team

Content Authoring	Mrs Ifeoluwapo Kolawole
Content Editor	Prof. Remi Raji-Oyelade
Production Editor	Ogundele Olumuyiwa Caleb
Learning Design/Assessment Authoring	Folajimi Olambo Fakoya
Managing Editor	Ogunmefun Oladele Abiodun
General Editor	Prof. Bayo Okunade

Contents

About this course manual

Management Principle in Nursing/Organization of Health CareNSG411 has been produced by University of Ibadan Distance Learning Centre. All course manuals produced by University of Ibadan Distance Learning Centreare structured in the same way, as outlined below.

How this course manual is structured

The course overview

The course overview gives you a general introduction to the course. Information contained in the course overview will help you determine:

- If the course is suitable for you.
- What you will already need to know.
- What you can expect from the course.
- How much time you will need to invest to complete the course.

The overview also provides guidance on:

- Study skills.
- Where to get help.
- Course assignments and assessments.
- Margin icons.

We strongly recommend that you read the overview *carefully* before starting your study.

The course content

The course is broken down into Study Sessions. Each Study Session comprises:

- An introduction to the Study Session content.
- Study Session outcomes.
- Core content of the Study Session with a variety of learning activities.
- A Study Session summary.
- Assignments and/or assessments, as applicable.
- Bibliography

Your comments

After completing Management Principle in Nursing/Organization of Health Care we would appreciate it if you would take a few moments to give us your feedback on any aspect of this course. Your feedback might include comments on:

- Course content and structure.
- Course reading materials and resources.
- Course assignments.
- Course assessments.
- Course duration.
- Course support (assigned tutors, technical help, etc.)

Your constructive feedback will help us to improve and enhance this course.

Course Overview

Welcome to Management Principle in Nursing/Organization of Health Care NSG411

Pre-requisite(s): Completion of all 300level courses

Co-requisite(s): All registered courses for 400 level

Teaching Method(s): 100hr(s) others: (25hrs Lectures/Group Work/Tutorials/Seminars; 75hrs Self-directed Learning).

Module Co-ordinator: Mrs. Ifeoluwapo Kolawole

Lecturer: Mrs. Ifeoluwapo Kolawole

Module Objective: To explore with students the basic concepts related to management and working with groups of people providing health care. To assist students in developing their organisational management role in nursing practice.

Module Content: Management Theory; Leadership; Motivation, Managing change, Performance management, Strategy and planning, Human and Resource Management, Financial management. Evaluation and control in management.

Assessment: Total Marks 100: Class tests, Assignment/Term paper, Presentations, Class attendance: 30 marks and Formal Written Examination 70 marks (3 hour examination) at the end of each semester.

Compulsory Elements: Formal Written Examination. Attendance and participation at all timetabled teaching activities.

Penalties (for late submission of Course/Project Work/term paper etc.): The students involved will not be permitted to write the end of semester examination

Pass Standard and any Special Requirements for Passing Module: 50%.

Formal Written Examination: 1 x 3hours papers to be taken at the end of each semester.

Course outcomes

Outcomes

Upon completion of Management Principle in Nursing/Organization of Health Care NSG411, you will be able to:

- Utilize the knowledge of basic principles of management to participate in healthcare delivery system in all healthcare settings
- Identify the processes of management and their application to nursing practice.
- Explore leadership styles and their relevance to the development of the practice and profession of nursing.
- Discuss the challenges and difficulties of implementing different types of management (e.g. personnel, resource, financial).
- Discuss the process of change management in nursing with application to clinical practice.
- Demonstrate competence in the use of managerial skills for quality assurance in health care
- Explain the organization of health and nursing services at the various levels / institutions.
- Collaborate and co-ordinate with various agencies by using multi-sectoral approach.
- Discuss the planning, supervision and management of nursing workforce for various health care settings.
- Identify and analyze legal and ethical issues in nursing administration.
- Describe the process of quality assurance in nursing services.
- Demonstrate leadership in nursing at various levels.

Getting around this course manual

Margin icons

While working through this course manual you will notice the frequent use of margin icons. These icons serve to "signpost" a particular piece of text, a new task or change in activity; they have been included to help you to find your way around this course manual.

A complete icon set is shown below. We suggest that you familiarize yourself with the icons and their meaning before starting your study.

 Activity	 Assessment	 **Assignment**	 Case study
 **Discussion**	 **Group Activity**	 Help	 Outcomes
 Note	 **Reflection**	 Reading	 Study skills
 Summary	 Terminology	 Time	 Tip

Study Session 1

A Review of Principles of Management

Introduction

Management is seen as a social discipline that deals with the behaviour of people and human institutions. In this study session, we will define the term management. We will also distinguish between a manager and a leader. To conclude, we will state the functions of a manager and list the qualities of a leader

Learning Outcomes

Outcomes

When you have studied this session, you should be able to:

1.1 Define management

1.2 Differentiate between leadership and management

1.3 State the roles of management

1.4 List the qualities of leadership

Terminology

Management	the process of dealing with or controlling things or people

1.1 Definition of Management

Management, one of the responsibilities of leadership, is a five-step process that comprises planning, organizing, directing, coordinating, and controlling. Management takes place within a structured organizational setting with prescribed roles. It is directed towards the achievement of aims and objectives through influencing the efforts of others.

The essence of management is getting work done through others. The classic definition of management is Henri Fayol's 1916 list of managerial tasks: planning, organizing, commanding, coordinating, and controlling the work of a group of employees.

Management is seen as a social discipline that deals with the behavior of people and human institutions and a manager sets objectives organizes, motivates and communicates and develops people; the manager is the dynamic, life-giving element in every business. Without him the "resources of production" remain resources and never become production.

Tip

Management is getting people to work harmoniously together and to make efficient use of resources to achieve objectives

To sum it all up, management can be seen as a process of reaching the set objectives of an organization through usage of human, physical, and financial resources with the best possible means combination and making the appropriate decision while taking into consideration the external environment. The single most important purpose of management is to make effective and efficient use of institutional and organizational resources to achieve results outside the organization.

ITQ

What does management entails?

Feedback

Management entails all the identified elements planning, organizing, directing, coordinating, and controlling.

1.2 Differences between Leadership and Management

Leadership and management are related phenomena but they are not the same. It is important to realize that (a) not all individuals in management positions are necessarily leaders, and (b) leadership is not necessarily tied to a position of authority. While only those in management positions are expected to be managers, leadership can and needs to be exercised by each of us wherever we may be. In other words, even though an individual does not hold a management position, she can still be a leader on a clinical unit, in an institution, in her community, or in the profession as a whole. "Leaders and managers are very different kinds of people: they differ in their motivations, in their personal history, and in how they think and act; they differ in their orientation toward goals, work, human relations, and themselves; and they differ in their worldviews". For example, leaders are creative, innovative, and risk-takers; managers often are more concerned with maintaining the status quo and taking few risks. In addition, managers often have a short-range perspective and are concerned about the "bottom line," whereas leaders have a long-range, visionary perspective and are concerned about moving toward realization of that vision.

ITQ

What relationship exists between leadership and management?

Feedback

Leadership and management are related but they are not the same Their relationship is obvious in their responsibility towards achieving set goals, and in having an excellent relationship. It is also pertinent to note that leaders set long-term goals and take huge risks, while managers set short-term goals and take fewer risks.

In nursing practice, we must both do the right thing and do that thing right. For example, we apply standards of care to our practice that must be followed and acuity quotients that, in most cases, must be assessed in order to make decisions about staffing, admissions, and supports needed. Thus, we must do the thing right. But perhaps we also need to ensure that we are doing the right thing by e706aluating if the standards fit our patient population and if the acuity and staffing ratios are relevant to our needs. If they are not, leaders need to step forward to create standards that do fit and that are relevant.

All nurses need to lead and manage effectively in patient care settings in order to accomplish tasks and achieve maximum care quality

All need to share their visions of how patient care can be improved, and all need to learn from the leaders who have gone before them.

1.2.1 Concepts of Management And Leadership

- The manager administers; the leader innovates.
- The manager maintains; the leader develops.
- The manager focuses on systems and structure; the leader focuses on people.
- The manager relies on control; the leader inspires trust.
- The manager has a short-range view; the leader has a long-range perspective.
- The manager asks how and when; the leader asks what and why.
- The manager has his eye on the bottom line; the leader has his eye on the horizon.
- The manager imitates; the leader originates.
- The manager accepts the status quo; the leader challenges it.
- The manager is the classic good soldier; the leader is his own person.
- The manager does things right; the leader does the right thing.

The principles required to achieve the goals of organizations are continuing to evolve as our society and our knowledge of the principles of our universe expand. The current state of health- care delivery in the United States clearly calls for innovation and the development of original solutions that challenge the status quo. Complexity theory, recognizes that small changes "nudge" organizations in the right direction. As this transformation of the healthcare delivery system takes place, it remains vitally important that nurse leaders manage resources to foster the adaptation that must occur to sustain the current systems that support patient care.

ITQ

Which category of people are more concerned with maintaining the status quo and taking few risks?

Feedback

Managers often are more concerned with maintaining the status quo and taking few risks because they deal more with short-term goals and have to deliver results.

1.3 Review of Functions/Roles/Elements of Management

Management operates through various functions, often classified as planning, organizing, staffing, leading / directing, and controlling / monitoring i.e.

- **Planning**: Deciding what needs to happen in the future (today, next week, next month, next year, over the next 5 years, etc.) and generating plans for action.
- **Organizing**: (Implementation) making optimum use of the resources required to enable the successful carrying out of plans.
- **Staffing**: Job analyzing, recruitment, and hiring individuals for appropriate jobs.
- **Leading/Directing**: Determining what needs to be done in a situation and getting people to do it.
- **Controlling/Monitoring**: Checking progress against plans.
- **Motivation**: Motivation is also a kind of basic function of management, because without motivation, employees cannot work effectively. If motivation does not take place in an organization, then employees may not contribute to the other functions (which are usually set by top-level management).

ITQ

How do managers plan?

Feedback

Managers often plan by identifying the goals they desire to accomplish. Similarly, they need to identify the steps, resources and personnel that is required to achieve the set goals.

1.4 Qualities of An Effective Leader

If leadership is seen as the ability to influence, what qualities must the leader possess in order to be able to do that?

Some of the qualities of effective leaders in nursing

- Integrity,
- Courage,
- Attitude,
- Initiative,
- Energy,
- Optimism,
- Perseverance,
- Balance,
- Ability to handle stress,
- Emotional intelligence,
- Self-awareness are

Behaviors of an effective manager

- Leadership requires action.
- The effective leader chooses the action carefully
- Important leadership behaviors include setting specific goals, thinking critically, solving problems, respecting people, communicating skillfully, communicating a vision for the future, and developing oneself and others.

ITQ

What does leadership entails?

Feedback

Leadership often comes with diverse responsibilities. A leader is expected to take actions towards certain circumstances. The effective leader chooses his action carefully Important leadership behaviours include setting specific goals, thinking critically, and solving problems.

Study Session Summary

Summary

In this Study Session, we defined management as a social discipline that deals with the behaviour of people and human institutions. We distinguished distinctly between a manager and a leader. Conclusively, we stated the functions of a manager and listed the qualities of a leader

Assessment

Assessment

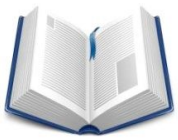
SAQ 1.1 (tests Learning Outcome 1.1)

Define Management? Differentiate between a manager and a Leader.

SAQ 1.2 (tests Learning Outcome 1.4)

Describe the Qualities of a good leader

Bibliography



Reading

https://en.wikiversity.org/wiki/Principles_of_Management
http://www.toolshero.com/management/14-principles-of-management/

Study Session 2

Management Theories and Applications

Introduction

In this study session, we will examine the various theories of management and their applications

Learning Outcomes

Outcomes

When you have studied this session, you should be able to:

2.1 explain the following management theories:

- Classical management theory
- Human relations theory
- Neo-human-relations theory
- System theories
- Contingency theory

Terminology

Human relations theory	a researched belief that people desire to be part of a supportive team that facilitates development and growth
System theory	the trans-disciplinary study of the abstract organization of phenomena, independent of their substance, type, or spatial or temporal scale of existence
Bureaucracy	a system of government where decisions are taken by officials not elected representatives
Hierarchy	a ranking according to status and authority

2.1 Classical Management Theory

Here we focus on three well-known early writers on management:

- **Henri Fayol**
- **F.W. Taylor**
- **Max Weber**

Definition of management: Management takes place within a structured organizational setting with prescribed roles. It is directed towards the achievement of aims and objectives through influencing the efforts of others.

Classical management theory

- Emphasis on structure
- descriptive about 'what is good for the firm'
- Practical manager (except Weber, sociologist)

Henri Fayol (1841 - 1925), France

1.Division of work	Reduces the span of attention or effort for any one person or group. Develops practice and familiarity
2. Authority	The right to give an order. Should not be considered without reference to *responsibility*
3. Discipline	Outward marks of respect in accordance with formal or informal agreements between firm and its employees
4. Unity of command	One man superior
5. Unity of direction	One head and one plan for a group of activities with the same objective
6. Subordination of individual interests to the general interest	The interests of one individual or one group should not prevail over the general good. This is a difficult area of management
7. Remuneration	Pay should be fair to both the employee and the firm
8. Centralization	Is always present to a greater or less extent, depending on the size of the company and quality of its managers
9. Scalar chain	The line of authority from top to bottom of the organization
10. Order	A place for everything and everything in its place; the right man in the right place
11. Equity	A combination of kindliness and justice towards the employees
12. Stability of tenure of personnel	Employees need to be given time to settle into their jobs, even though this may be a lengthy period in the case of the managers
13. Initiative	Within the limits of authority and discipline, all levels of staff should be encouraged to show initiative
14. Esprit de corps	Harmony is a great strength to an organization; teamwork should be encouraged

Advantages

- Fayol was the first person to actually give a definition of management which is generally familiar today namely 'forecast and plan, to organize, to command, to co-ordinate and to control'.
- Fayol also gave much of the basic terminology and concepts, which would be elaborated upon by future researchers, such as division of labour, scalar chain, unity of command and centralization.

Disadvantages

- Fayol was describing the structure of formal organizations.
- Absence of attention to issues such as individual versus general interest, remuneration and equity suggest that Fayol saw the employer as paternalistic and by definition working in the employee's interest.
- Fayol does mention the issues relating to the sensitivity of a patients' needs, such as initiative and 'esprit de corps', he saw them as issues in the context of rational organizational structure and not in terms of adapting structures and changing people's behaviour to achieve the best fit between the organization and its customers.
- Many of these principles have been absorbed into modern day organizations, but they were not designed to cope with conditions of rapid change and issues of employee participation in the decision making process of organizations, such as are current today in the early 21st century.
-

ITQ

How did the proponents of the Classical Management Theory view management?

Feedback

The proponents of the Classical Management Theory explained management as taking place within a structured organizational setting with prescribed roles. Here, there is a rigid adherence to structures and this is essential for an organisation.

F.W. Taylor (1856 - 1915), USA- The Scientific Management School

Taylorism involved breaking down the components of manual tasks in manufacturing environments, timing each movement ('time and motion' studies) so that there could be a proven best way to perform each task. Thus employees could be trained to be 'first class' within their job. This type of management was particularly relevant to performance drives e.g. 'Action On' projects.

This was a rigid system where every task became discrete and specialized. It is fair to suggest that this is unlikely to be of value to the

NHS with the modernization agenda suggesting that we should have a flexible workforce.

Key points about Taylor, who is credited with what we now call 'Taylorism':

- he was in the scientific management school
- his emphases were on efficiency and productivity
- but he ignored many of the human aspects of employment

For the **managers**, scientific management required them to:

- develop a science for each operation to replace opinion and rule of thumb
- determine accurately from the science the correct time and methods for each job (time and motion studies)
- set up a suitable organization to take all responsibility from the workers except that of the actual job performance
- select and train the workers (in the manner described above)
- accept that management itself be governed by the science deployed for each operation and surrender its arbitrary powers over the workers, i.e. cooperate with them.

For the **workers**, scientific management required them to:

- Stop worrying about the divisions of the fruits of production between wages and profits.
- Ensure that there is prosperity of the firm by working in the correct way and receiving wage increases.
- Give up their idea of time wasting and co-operate with the management in developing the science
- Accept that management would be responsible for determining what was done and how
- Agree to be trained in new methods where applicable

The **benefits** (mainly for the management) arising from scientific management can be summarized as follows:

- its rational approach to the organizational work enables tasks and procedures to be measured with a considerable degree of accuracy
- measurement of paths and processes provide useful information on which to base improvements in working methods, plant design, etc
- improving work methods brought enormous increases in productivity
- it enabled employees to be paid by results and to take advantage of incentive payments
- it stimulated management into adopting a more positive role in leadership at shop floor level.
- it contributed to major improvements in physical working conditions for employees
- it provided the formation for modern work studies

The **drawbacks** were mainly for the workers:

- it reduced the worker's role to that of a rigid adherence to methods and procedures over which he/she had no discretion
- it led to increased fragmentation of work due to its emphasis on divisional labour
- it generated an economically based approach to the motivation of employees by linking pay to geared outputs
- it put the planning and control of workplace activities exclusively in the hands of the managers
- it ruled out any realistic bargaining about wage rates since every job was measured and rated 'scientifically'

Therefore, in summary, while the scientific management technique has been employed to increase productivity and efficiency both in private and public services, it has also had the disadvantages of ignoring many of the human aspects of employment. This led to the creation of boring repetitive jobs with the introduction of systems for tight control and the alienation of shop floor employees from their managers.

Taylorism prevailed in the '30s through to the early '60s - and in many organizations considerably later than this. Peters and Waterman in the 70s/80 and Senge late '80s/early '90s led us towards what we now call 'systems thinking' where the rights and potential wider contributions of employees received considerably greater emphasis.

Max Weber (1864 - 1924), Germany

Bureaucracy in this context is the organizational form of certain dominant characteristics such as a hierarchy of authority and a system of rules.

Bureaucracy in a sense of red tape or officialdom should not be used as these meanings are value-ridden and only emphasize very negative aspects of the original Max Weber model.

Through analyses of organizations Weber identified three basic types of legitimate authority: Traditional, Charismatic, and Rational-Legal. Authority has to be distinguished from power in this discussion. Power is a unilateral thing - it enables a person to force another to behave in a certain way, whether by means of strength or by rewards. Authority, on the other hand, implies acceptance of the rules by those over whom it is to be exercised within limits agreeable to the subordinates that Weber refers to in discussing legitimate authority.

Weber presented three types of legitimate authority:
Traditional authority: where acceptance of those in authority arose from tradition and custom.

Charismatic authority: where acceptance arises from loyalty to, and confidence in, the personal qualities of the ruler.

Rational-legal authority: where acceptance arises out of the office, or position, of the person in authority as bounded by the rules and procedures of the organization.

It is the rational-legal authority form that exists in most organizations today and this is the form to which Weber ascribed the term 'bureaucracy'.

The main features of bureaucracy according to Weber were:

- a continuous organization or functions bounded by rules
- that individuals functioned within the limits of the specialization of the work, the degree of authority allocated and the rules governing the exercise of authority
- a *hierarchical* structure of offices
- appointment to offices made on the grounds of technical competence only
- the separation of officials from the ownership of the organization
- the authority was vested in the official positions and not in the personalities that held these posts. Rules, decisions and actions were formulated and recorded in writing.

It is not coincidence that Weber's writings were at a time of the major industrial revolutions and the growth of large complex organizations out of the cottage industries and/or entrepreneurial businesses.

The efficiency of this rational and logistical organization shares a considerable amount of common ground with the thinking of Fayol. In particular, features such as scalar chain, specialization, authority and the definition of jobs which were so essential to successful management as described by Fayol, are typical of bureaucracy. There is also little doubt that Weber's ideas concerning specific spheres of competence and employment based on technical competence would have considerable appeal for Taylor's scientific managers.

Advantages

- Appointment, promotion and authority were dependent on technical competence and reinforced by written rules and procedures of promoting those most able to manage rather than those favoured to manage. Anything else is regarded as nepotism and corruption.
- The adoption of bureaucratic type of management systems allow organizations to grow into large complex organized systems that are focused towards formalized explicit goals.
- It cannot be stated strongly enough that the Weber theory has the advantage of being used as a 'gold standard' on which to compare and develop other modern theories.

Disadvantages

Subsequent analysis by other researchers have identified many disadvantages:

- Tendency for organizations to become procedure dominated rather than goal dominated.
- Tendency for heavily formalized organizational roles to suppress initiative and flexibility of the job holders.

- Rigid behavior by senior managers can lead to standardized services that do not meet the needs of the client.
- Rigid procedures and rules are demotivating for the subordinates that work in the organizations.
- Exercise of control based on knowledge as advocated by Weber has led to the growth of 'experts' whose opinions and attitudes may frequently clash with those of the more generalized managers and supervisors.

ITQ

How did Max Weber explain the concepts of Power and Authority as separate entities?

Feedback

Max Weber explained Power as what enables a person to force another to behave in a certain way, whether by means of strength or by rewards, thus motivation to align comes from compulsion or by expectation of gains, for example, monetary. Authority means acceptance of the rules by those over whom it is to be used within limits agreed by both parties. From this standpoint, motivation comes from a laid out and agreed upon regulations.

2.2 Human Relations Theories

Elton Mayo: Hawthorns studies

Where Classical theorists were concerned with structure and mechanics of organizations, the theorists of human relations were, understandably, concerned with the *human* factors.

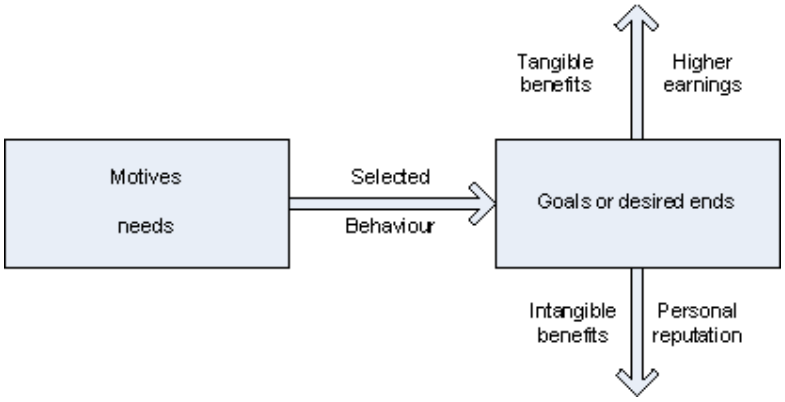
The foci of human relations theory is on motivation, group motivation and leadership

At the centre of these foci are assumptions about relationship between employer and employee. Best summarized by Schein (1965) or Elton Mayo

- they were academic, social scientists
- their emphasis was on human behavior within organizations
- they stated that people's needs are decisive factors in achieving an organization's effectiveness
- they were descriptive and attempted to be predictive of behavior in organizations

A 'motive' = a need or driving force within a person.

The process of motivation involves choosing between alternative forms of action in order to achieve some desired end or goal.



Alternative forms of action of motivation depend on a manager's assumptions about his/her subordinates:

	Prime Motivators	**Theory**
1. Rational-economic man	Self interest and maximization of gain	Basis of Classical, especially, Taylor/Scientific theory
2. Social man	Social need, being part of a group	Basis of Mayo
3. Self actualizing man	Self-fulfillment of individual	Maslow, Likert, McGregor, Argyris, Herzberg
4. Complex man	Depends on individual, group, task	'Systems approach'

ITQ

Mention the three types of Authority

Feedback

The three types of authority include the Traditional, Charismatic, and the Rational-Legal.

Elton Mayo: Hawthorne Studies

The ground-breaking Hawthorne studies carried out in the Hawthorne plant of the Western Electric Company (USA) 1927 - 32.

Stage 1: (1924 -27)

Study of the physical surroundings (lighting level) on productivity of workers. Control group and experimental group previously had similar productivity before study began

Control Group = constant lighting level
Experimental Group = varied lighting level

Result
Both groups productivity increased - even when experimental group was working in dim light

Product leader called Mayo and colleagues to explain

Stage 2: (1927 - 29) 'Relay assembly room stage'

Still analyzing effect of physical surroundings (rest, pauses, lunch break duration, length of working week) on output

Result
Output increased even when worsening conditions Hypothesis was now that it was the attitudes of subjects at work and not the physical conditions. This gave rise to the 'Hawthorne Effect' - employees were responding not so much to changes in the environment as to the fact they were the centre of attention - a special group.

Stage 3: (1928 - 30)

A Total of 20,000 interviews were collected with the workers on employee attitudes to working conditions, their supervision and their jobs.

Stage 4: (1932) 'Bank winning observation room'

This time the new subjects (14 men) put in separate room for six months

Result
Productivity restricted due to pressure from peers to adopt a slower rate to circumvent company wages incentive scheme to generally adopt own group rules and behaviour

Advantages

- first real attempt to undertake genuine social research in industrial setting
- individuals cannot be treated in isolation, but function with group members
- that individual motivation did not primarily lie in monetary or physical condition, but in need and status in a group
- the strength of informal (as opposed to formal) groups demonstrated a behaviour of workers (formal supervisors were powerless in Stage 4)
- it highlighted need for supervisors to be sensitive and cater for social needs of workers within the group

Disadvantages

- from 1930s -1950s some doubt was cast on the increased applicability of these theories to every day working life

ITQ

What were the gains of the Hawthorne studies?

Feedback

The Hawthorne studies provided the first real attempt to undertake genuine social research in industrial settings. Hawthorne was able to establish that individuals cannot be treated in isolation, but function with group members. Similarly, individual motivation did not primarily lie in monetary or physical condition, but in need and status in a group.

2.3 Neo-Human Relations Theory

These groups were social psychologists who developed more complex theories:

- Maslow
- McGregor (theory X and theory Y)
- Likert
  Argyris

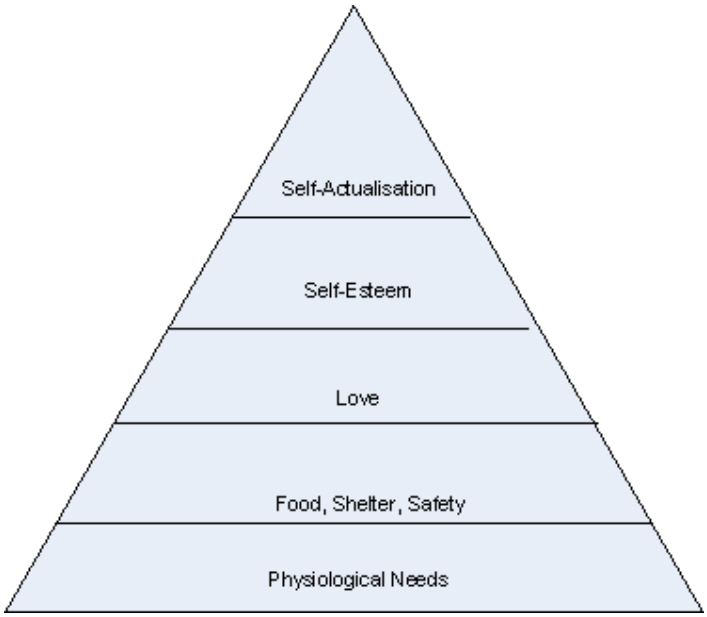
Maslow is still often-quoted today, having developed a seminal theory of the needs of human beings. Herzberg's and McGregor's neo-human relations theories both focus on motivation and leadership, but their theories are, as we shall see, very different.

In this group we find a particular focus on human motivation including:

- satisfaction
- incentive
- intrinsic

Maslow (1943)

1. This psychologist, from his studies, proposed a hierarchy of human needs building from basic needs at the base to higher needs at the top.



SOURCE:

2. Maslow made assumptions that people need to satisfy each level of need, before elevating their needs to the next higher level e.g. a hungry person's need is dominated by a need to eat (i.e. survival), but not to be loved, until he/she is no longer hungry.

3. Today the focus in most Western societies is on the elements towards the top of Maslow's hierarchy - in which work environments and 'jobs' (including 'having a job' and the satisfaction or otherwise such jobs provide - have become typical features. Notably the attainment of self-esteem and, at the very top of the hierarchy, what Maslow calls 'self-actualization' - fundamentally the synthesis of 'worth', 'contribution' and perceived 'value' of the individual in society.

Advantages

- Managers can/should consider the needs and aspirations of individual subordinates.

Disadvantages

- The broad assumptions in 2 above have been disproved by exceptions e.g. hungry, ill artist working in a garret.
- Empirical research over the years has not tended to support this theoretical model.
- Regarding monetary reward, sometimes beyond certain level of pays (e.g. consultant) other things become more important than another £1000 a year e.g. working conditions, boss, environment etc.

ITQ

What was the assumption of the Maslow's Hierarchy of needs?

Feedback

The Maslow Hierarchy of needs assumed that individuals must satisfy needs at lower level before higher needs are aspired to. That is, people need to satisfy each level of need, before elevating their needs to the next higher level. Therefore, Food, Shelter and Safety should be achieved before aspiring to Self Actualisation.

McGregor (Theory X and Theory Y)

Managers were perceived by McGregor, whose theories are still often quoted, to make two noticeably different sets of assumptions about their employees.

Theory X (essentially 'scientific' mgt)	**Theory Y**
Lazy	Like working
Avoid responsibility	Accept/seek responsibility
Therefore need control/coercion	Need space to develop imagination/ingenuity
Schein type: 'rational economic man'	Schein type: 'self-actualizing man'

Advantages

- Identifies two main types of individual for managers to consider and how to motivate.

Disadvantages

Only presents two extremes of managerial behaviour.

200 engineers and accountants were asked to recall the times/occasions when they experienced satisfactory and unsatisfactory feeling about their jobs. Later this also involves manual and clerical staff similar results claimed:

Herzberg showed two categories of findings:

Motivators - factors giving rise to satisfaction
Hygiene factors - factors giving rise to dissatisfaction

Important Motivators	Important Hygienes
Achievement	Company policy and recognition
Recognition	Supervision - the technical aspects
Work itself	Salary
Responsibility	Interpersonal relations – supervision
Advancement	Working conditions

Other features include:

Motivators	Hygiene Factors
related to content of work	related to context/environment of work
promote satisfaction	only prevent dissatisfaction
only neo-human school attempts to address these	Taylor (salary) + Mayo (interpersonal relations) look at these

Advantages

- Herzberg's work led to a practical way to improve motivation, which had, up to that point, been dominated by Taylorism (salary, wages). In particular ' job enrichment' programs

mushroomed. The aim of these was to design work and work structures to contain the optimum number of motivators.

- This approach counters the years of Taylorism, which sought to break down work into its simplest components and to remove responsibility from individuals for planning and control.

Disadvantages

- There remain doubts about Herzberg's factors applicability to non-professional groups, despite the fact that some of his later studies involved the clerical and manual groups. The numbers were in these categories though were small and many researchers still argue about the results in these groups.
- Social scientists argue about the validity of his definition of 'job satisfaction'

Likert

Described 'new patterns of management' based on the *behaviours* of managers

Four main patterns:

1. Exploitative - authoritative where power and direction come from the top downwards', where threats and punishment are employed, where communication is poor and teamwork non-existent. Productivity is typically mediocre	'Rational economic man'
2. Benevolent - authoritative is similar to the above but allows some upward opportunities for consultation and some delegation. Rewards may be available as well as threats. Productivity is typically fair to good but at cost of considerable absenteeism and turnover	Weaker version of 'rational - economic man'
3. Consultative where goals are set or orders issued after discussion with subordinates, where communication is upwards and downwards and where teamwork is encouraged, at least partially. Some involvement of employees as a motivator	'social man'
4. Participative - group is reckoned by many to be the ideal system. Under this system, the keynote is participation, leading to commitment to the organization's goals in a fully co-operative way. Communication is both upwards, downwards and lateral. Motivation is obtained by a variety of means. Productivity is excellent and absenteeism and turnover are low	Self - actualizing man (see also McGregor: theory Y)

Another useful way of looking at this is that (1) is a highly task-orientated management style, whereas (4) is a highly people-orientated management style.

Advantages

Essentially Likert's work gives more alternatives in the spectrum between Theory X and Theory Y of McGregor

Disadvantage

- Criticized for being based more on theory than empirical practice. Therefore not widely accepted by practicing managers.

Argyris

He studied the needs of people and the needs of organization. He felt that classical models of organization promoted 'immaturity'. He felt that it was important to understand the needs of people and integrate them with needs of organization. Only in this way, he said, can employees become co-operative rather than defensive or aggressive

Characteristics of Employee Immaturity	Maturity
Passivity ----------	Activity
Dependence----------	Relative independence
Behave in a few ways----------	Behave in many ways
Erratic, shallow interests----------	Deeper interests
Short time perspective----------	Long time perspective
Subordinate position----------	Equal or superior position
Lack of awareness of self----------	Awareness and self control

Advantages

- Argyris is moving here towards a 'contingency approach' i.e. remedy depends on diagnosing problems first
- He presents a spectrum rather than bipolar patterns of employees' behaviour could be expected from immaturity to maturity. Certain behaviours of employees may be preferred

Disadvantages

- Still too centered around 'self -actualizing man'. Viewed not to be applicable to production lines with manual workers, workers in sterile supplies, people manning phone help-lines etc whose needs are perceived to be typically lower in Maslow's hierarchy of needs

ITQ

How did Mc Gregor perceive managers?

Feedback

Managers were perceived by Mc Gregor based on two theories: Theory X and Y. According to Theory X, managers were viewed as being lazy, avoiding responsibility and therefore needed control/coercion to generate the required output. Theory Y viewed managers as those that liked to work, accepts/seeks responsibilities, and needed space to develop imagination/ingenuity.

2.4 System Theories

Attention began to focus on organizations as 'systems' with a number of inter-related sub-systems. The 'systems approach' attempted to synthesize the classical approaches ('organizations without people') with the later human relations approaches that focused on the psychological and social aspects, emphasized human needs - almost 'people without organizations'.

Systems theory focuses on *complexity* and interdependence of relationships. A system is composed of regularly interacting or interdependent groups of activities/parts that form the emergent whole.

Part of systems theory, *system dynamics* is a method for understanding the dynamic behaviour of complex systems. The basis of the method is the recognition that the structure of any system -- the many circular, interlocking, sometimes time-delayed relationships among its components -- is often just as important in determining its behaviour as the individual components themselves.
Early systems theorists aimed at finding a general systems theory that could explain all systems in all fields of science.

Systems theories took much more of an holistic view of organizations, focusing on the *total* work organization and the inter-relationships between structures and human behaviours producing a wide range of variables within organizations

They help us understand the interactions between individuals, groups, organizations, communities, larger social systems, & their environments and help us enhance our understanding of how human behaviour operates in a *context*.

A system is a *part*, and it is a *whole*, at the same time.

System Theory Key Terms:

Boundary - an imaginary line around system of focus. It regulates flow of energy (e.g. information, resources) into and out of the system.

Focal system - the system on which you are concentrating at any given time (e.g.: a manufacturing plant or a family).

Subsystem - a part of the focal system (e.g., in a family, it may be children or parents) , sometimes referred to as 'sibling subsystem' & 'parental subsystem').

Suprasystem - is external to focal system; it is its environment. It may include place of employment, school, neighbourhood, church, social service system.

Open system - Relatively open systems have a freer exchange of information and resources within the system and also allow relatively free passage of energy from and to the outside of the system.

Closed system - is more self-contained & isolated from their environment.

The business organization is an Open System: there is continual interaction with the broader external environment of which it forms a part. The systems approach considers the organization within its total environment and emphasizes the importance of 'multiple channels of interaction'. Thus the systems approach views organizations as a whole and involves the study of the organization in terms of the relationship between technical and social variables with the systems. Thus changes in one part, technical or social, will affect other parts and therefore the whole system.

It was Trist and others at the Tavistock Institute of Human relations who focused in on socio-technical systems arising from their study of the effects of changing technology in the coal-mining industries in the 1940s.

The following Timeline gives an interesting perspective to the development of Systems Theory:

- 1950 General Systems Theory (founded by Ludwig von Bertalanffy)
- 1960 cybernetics (W. Ross Ashby, Norbert Wiener) Mathematical theory of the communication and control of systems through regulatory feedback. Closely related: "*control theory*"
- 1970 catastrophe theory (René Thom, E.C. Zeeman) Branch of mathematics that deals with bifurcations in dynamical systems, classifies phenomena characterized by sudden shifts in behavior arising from small changes in circumstances.
- 1980 chaos theory (David Ruelle, Edward Lorenz, Mitchell Feigenbaum, Steve Smale, James A. Yorke) Mathematical theory of nonlinear dynamical systems that describes bifurcations, strange attractors, and chaotic motions.
- 1990 complex adaptive systems (CAS) (John H. Holland, Murray Gell-Mann, Harold Morowitz, W. Brian Arthur,). The "new" science of complexity which describes emergence, adaptation and self-organization, all of which are basic system principles, was established mainly by researchers of the Santa Fe Institute (SFI). It is based on agents and computer simulations and includes multi-agent systems (MAS) which have become an important tool to study social and complex systems. CAS are still an active field of research.

Tavistock Institute of Human Relations

- organization is an 'open system' with environment
- organizations are complex systems of people, task, technology
- technological environmental factors are just as important as social/psychological

ITQ

What is unique about System theories with respect to Classical Management and Human Relation theories in the management of organizations?

Feedback

System theories merged both Classical Management and Human Relation theories in the management of organizations. System theories tried to correct the deficiencies of both theories to evolve an efficient system. Systems theory focused on complexity and interdependence of relationships. A system is composed of regularly interacting or interdependent groups of activities/parts that form the emergent whole.

2.5 Contingency Theories

From the late 1950s, a new approach to organization theory was developed which became known as contingency theory. This theory argues that there is no 'one best way' to structure an organization. An organization will face a range of choices when determining how it should be structured, how it should be organized, how it should be managed. Successful organizations adopt structures that are an appropriate response to a number of variables, or contingencies, which influence both the needs of the organization and how it works.

- these theories take a comprehensive view of people in organizations
- they recommend a diagnosis of people/ task/ technology/environment - then suggest the development of appropriate solutions

1. Pugh (UK)
2. Burns and Stalker (UK)
3. Lawrence / Lorsch (USA)

Contingency theorists have found that three contingencies are particularly important in influencing an organization's structure. These are:

- its size
- the technology it uses
- its operating environment.

There are two significant implications of contingency theory:

- if there is no 'one best way', then even apparently quite similar organizations, for example, two nearby colleges, may choose significantly different structures and still survive, be reasonably successful in achieving their missions, and so on
- if different parts of the same organization are influenced in different ways by the contingencies bearing upon them, then it may be appropriate for them to be structured differently, for

example, one university department may have a functional structure, whilst another may have a matrix structure

Tip

Management theories are implemented to help increase organizational productivity and service quality

Not many managers use a singular theory or concept when implementing strategies in the workplace: They commonly use a combination of a number of theories, depending on the workplace, purpose and workforce. Contingency theory, chaos theory and systems theory are popular management theories. Theory X and Y, which addresses management strategies for workforce motivation, is also implemented to help increase worker productivity.

Contingency Theory

- This theory asserts that managers make decisions based on the situation at hand rather than a "one size fits all" method. A manager takes appropriate action based on aspects most important to the current situation. Managers in a university may want to utilize a leadership approach that includes participation from workers, while a leader in the army may want to use an autocratic approach.

Systems Theory

- Managers who understand systems theory recognize how different systems affect a worker and how a worker affects the systems around them. A system is made up of a variety of parts that work together to achieve a goal. Systems theory is a broad perspective that allows managers to examine patterns and events in the workplace. This helps managers to coordinate programs to work as a collective whole for the overall goal or mission of the organization rather than for isolated departments.

Chaos Theory

- Change is constant. Although certain events and circumstances in an organization can be controlled, others can't. Chaos theory recognizes that change is inevitable and is rarely controlled. While organizations grow, complexity and the possibility for susceptible events increase. Organizations increase energy to maintain the new level of

complexity, and as organizations spend more energy, more structure is needed for stability. The system continues to evolve and change.

Theory X and Theory Y

- The management theory an individual chooses to utilize is strongly influenced by beliefs about worker attitudes. Managers who believe workers naturally lack ambition and need incentives to increase productivity lean toward the Theory X management style. Theory Y believes that workers are naturally driven and take responsibility. While managers who believe in Theory X values often use an authoritarian style of leadership, Theory Y leaders encourage participation from workers.

Frederick Taylor - Scientific Management

Description

Frederick Taylor, with his theories of Scientific Management, started the era of modern management. In the late nineteenth and early twentieth century's, Frederick Taylor was decrying the "awkward, inefficient, or ill-directed movements of men" as a national loss. He advocated a change from the old system of personal management to a new system of scientific management. Under personal management, a captain of industry was expected to be personally brilliant. Taylor claimed that a group of ordinary men, following a scientific method would out-perform the older "personally brilliant" captains of industry.

Taylor consistently sought to overthrow management "by rule of thumb" and replace it with actual timed observations leading to "the one best" practice. Following this philosophy he also advocated the systematic training of workers in "the one best practice" rather than allowing them personal discretion in their tasks. He believed that "a spirit of hearty cooperation" would develop between workers and management and that cooperation would ensure that the workers would follow the "one best practice." Under these philosophies Taylor further believed that the workload would be evenly shared between the workers and management with management performing the science and instruction and the workers performing the labor, each group doing "the work for which it was best suited."

Taylor's strongest positive legacy was the concept of breaking a complex task down in to a number of small subtasks, and optimizing the performance of the subtasks. This positive legacy leads to the stop-watch measured time trials which in turn lead to Taylor's strongest negative legacy. Many critics, both historical and contemporary have pointed out that Taylor's theories tend to "dehumanize" the workers. To modern readers, he stands convicted by his own words:

> "… in almost all of the mechanic arts, the science which underlies each act of each workman is so great and

> amounts to so much that the workman who is best suited to actually doing the work is incapable of fully understanding this science, without the guidance and help of those who are working with him or over him, either through lack of education or through insufficient mental capacity."

And:

> "To work according to scientific laws, the management must takeover and perform much of the work which is now left to the men; almost every act of the workman should be preceded by one or more preparatory acts of the management which enable him to do his work better and quicker than he otherwise could."

The Principles of Scientific Management

Environment

Taylor's work was strongly influenced by his social/historical period. His lifetime (1856-1915) was during the Industrial Revolution. The overall industrial environment of this period is well documented by the Dicken's classic Hard Times or Sinclar's The Jungle. Autocratic management was the norm. The manufacturing community had the idea of interchangeable parts for almost a century. The sciences of physics and chemistry were bringing forth new miracles on a monthly basis. One can see Taylor turning to "science" as a solution to the inefficiencies and injustices of the period. His idea of breaking a complex task into a sequence of simple subtasks closely mirrors the interchangeable parts ideas pioneered by Eli Whitney earlier in the century. Furthermore, the concepts of training the workers and developing "a hearty cooperation" represented a significant improvement over the feudal human relations of the time.

Successes

Scientific management met with significant success. Taylor's personal work included papers on the science of cutting metal, coal shovel design, worker incentive schemes and a piece rate system for shop management. Scientific management's organizational influences can be seen in the development of the fields of industrial engineering, personnel, and quality control.

From an economic standpoint, Taylorism was an extreme success. Application of his methods yielded significant improvements in productivity. Improvements such as Taylor's shovel work at Bethlehem Steel Works (reducing the workers needed to shovel from 500 to 140) were typical

Frederick Taylor and Scientific Management

Frederick Winslow Taylor (1856-1915) was an American inventor and engineer that applied his engineering and scientific knowledge to management and developed a theory called scientific management theory. His two most important books on his theory

are *Shop Management* (1903) and *The Principles of Scientific Management* (1911).

Frederick Taylor's scientific management theory can be seen in nearly all modern manufacturing firms and many other types of businesses. His imprint can be found in production planning, production control, process design, quality control, cost accounting, and even ergonomics. If you understand the principles of scientific management, you will be able to understand how manufacturers produce their goods and manage their employees. You will also understand the importance of **quantitative analysis**, or the analysis of data and numbers to improve production effectiveness and efficiency.

Principles of Scientific Management Theory

In broad terms, **scientific management theory** is the application of industrial engineering principles to create a system where waste is avoided, the process and method of production is improved, and goods are fairly distributed. These improvements serve the interests of employers, employees, and society in general. Taylor's theory can be broken down into four general principles for management:

1. Actively gathering, analyzing, and converting information to laws, rules, or even mathematical formulas for completing tasks.
2. Utilizing a scientific approach in the selection and training of workers.
3. Bringing together the science and the worker so that the workers apply the scientifically developed techniques for the task.
4. Applying the work equally between workers and managers where management applies scientific techniques to planning and the workers perform the tasks pursuant to the plans.

Frederick Taylor approached the study of management quantitatively through the collection and analysis of data. For example, he and his followers performed **motion studies** to improve efficiency. He analyzed the motions required to complete a task, devised a way to break the task down into component motions, and found the most efficient and effective manner to do the work.

An example of a motion study is observing the number of distinct motions required to shovel coal into a furnace. The task is then broken down into its distinct components, such as picking up the shovel, walking to the coal, bending over, manipulating the shovel to scoop the coal, bending back up, walking to the furnace, and manipulating the shovel to deposit the coal. The most efficient way

to perform the task was developed and workers were instructed on how to apply the method.

Human Relations Movement - Hawthorne Works Experiments

Description

If Taylor believed that science dictated that the highest productivity was found in "the one best way" and that way could be obtained by controlled experiment, Elton Mayo's experiences in the Hawthorne Works Experiments disproved those beliefs to the same extent that Michelson's experiments in 1926 disproved the existence of "ether."

The Hawthorne Studies started in the early 1920's as an attempt to determine the effects of lighting on worker productivity. When those experiments showed no clear correlation between light level and productivity the experiments then started looking at other factors. Working with a group of women, the experimenters made a number of changes, rest breaks, no rest breaks, free meals, no free meals, more hours in the work-day / work-week, fewer hours in the work-day / work-week. Their productivity went up at each change. Finally the women were put back to their original hours and conditions, and they set a productivity record.

This strongly disproved Taylor's beliefs in three ways. First, the experimenters determined that the women had become a team and that the social dynamics of the team were a stronger force on productivity than doing things "the one best way." Second, the women would vary their work methods to avoid boredom without harming overall productivity. Finally the group was not strongly supervised by management, but instead had a great deal of freedom.

These results made it clear that the group dynamics and social makeup of an organization were an extremely important force either for or against higher productivity. This caused the call for greater participation for the workers, greater trust and openness in the working environment and a greater attention to teams and groups in the work place.

Environment

The human relations movement that stemmed from Mayo's Hawthorne Works Experiments was borne in a time of significant change. The Newtonian science that supported "the one best way" of doing things was being strongly challenged by the "new physics" results of Michalson, Rutherford and Einstein. Suddenly, even in the realm of "hard science" uncertainty and variation had found a place. In the work place there were strong pressures for shorter hours and employee stock ownership. As the effects of the 1929 stock market crash and following depression were felt, employee unions started to form.

Successes

While Taylor's impacts were the establishment of the industrial engineering, quality control and personnel departments, the human relations movement's greatest impact came in what the organization's leadership and personnel department were doing. The seemingly new

concepts of "group dynamics", "teamwork" and organizational "social systems" all stem from Mayo's work in the mid-1920.

Max Weber - Bureaucracy

Description

At roughly the same time, Max Weber was attempting to do for sociology what Taylor had done for industrial operations. Weber postulated that western civilization was shifting from "wertrational" (or value oriented) thinking, affective action (action derived from emotions), and traditional action (action derived from past precedent to "zweckational" (or technocratic) thinking. He believed that civilization was changing to seek technically optimal results at the expense of emotional or humanistic content.

Viewing the growth of large-scale organizations of all types during the late nineteenth and early twentieth centuries, Weber developed a set of principles for an "ideal" bureaucracy. These principles included: fixed and official jurisdictional areas, a firmly ordered hierarchy of super and subordination, management based on written records, thorough and expert training, official activity taking priority over other activities and that management of a given organization follows stable, knowable rules. The bureaucracy was envisioned as a large machine for attaining its goals in the most efficient manner possible.

Weber did not advocate bureaucracy; indeed, his writings show a strong caution for its excesses:

> "…the more fully realized, the more bureaucracy "depersonalizes" itself, i.e., the more completely it succeeds in achieving the exclusion of love, hatred, and every purely personal, especially irrational and incalculable, feeling from the execution of official tasks"

Or:

> "By it the performance of each individual worker is mathematically measured, each man becomes a little cog in the machine and aware of this, his one preoccupation is whether he can become a bigger cog."

Environment

Weber, as an economist and social historian, saw his environment transitioning from older emotion and tradition driven values to technological ones. It is unclear if he saw the tremendous growth in government, military and industrial size and complexity as a result of the efficiencies of bureaucracy, or their growth driving those organizations to bureaucracy.

Successes

While Weber was fundamentally an observer rather than a designer, it is clear that his predictions have come true. His principles of an ideal bureaucracy still ring true today and many of the evils of today's bureaucracies come from their deviating from those ideal principles.

Unfortunately, Weber was also successful in predicting that bureaucracies would have extreme difficulties dealing with individual cases.

It would have been fascinating to see how Weber would have integrated Mayo's results into his theories. It is probable that he would have seen the "group dynamics" as "noise" in the system, limiting the bureaucracy's potential for both efficiency and inhumanity.

Henri Fayol - Administration

Description: With two exceptions, Henri Fayol's theories of administration dovetail nicely into the bureaucratic superstructure described by Weber. Henri Fayol focuses on the personal duties of management at a much more granular level than Weber did. While Weber laid out principles for an ideal bureaucratic organization Fayol's work is more directed at the management layer.

Fayol believed that management had five principle roles: to forecast and plan, to organize, to command, to co-ordinate and to control. Forecasting and planning was the act of anticipating the future and acting accordingly. Organization was the development of the institution's resources, both material and human. Commanding was keeping the institution's actions and processes running. Co-ordination was the alignment and harmonization of the groups' efforts. Finally, control meant that the above activities were performed in accordance with appropriate rules and procedures.

Fayol developed fourteen principles of administration to go along with management's five primary roles. These principles are enumerated below:

- **Division of Work** – When employees are specialized, output can increase because they become increasingly skilled and efficient.
- **Authority** – Managers must have the authority to give orders, but they must also keep in mind that with authority comes responsibility.
- **Discipline** – Discipline must be upheld in organizations, but methods for doing so can vary.
- **Unity of Command** – Employees should have only one direct supervisor.
- **Unity of Direction** – Teams with the same objective should be working under the direction of one manager, using one plan. This will ensure that action is properly coordinated.
- **Subordination of Individual Interests to the General Interest** – The interests of one employee should not be allowed to become more important than those of the group. This includes managers.
- **Remuneration** – Employee satisfaction depends on fair remuneration for everyone. This includes financial and non-financial compensation.
- **Centralization** – This principle refers to how close employees are to the decision-making process. It is important to aim for an appropriate balance.

- **Scalar Chain** – Employees should be aware of where they stand in the organization's hierarchy, or chain of command.
- **Order** – The workplace facilities must be clean, tidy and safe for employees. Everything should have its place.
- **Equity** – Managers should be fair to staff at all times, both maintaining discipline as necessary and acting with kindness where appropriate.
- **Stability of Tenure of Personne**l – Managers should strive to minimize employee turnover. Personnel planning should be a priority.
- **Initiative** – Employees should be given the necessary level of freedom to create and carry out plans.
- **Esprit de Corps** – Organizations should strive to promote team spirit and unity.

The final two principles, initiative and esprit de corps, show a difference between Fayol's concept of an ideal organization and Weber's. Weber predicted a completely impersonal organization with little human level interaction between its members. Fayol clearly believed personal effort and team dynamics were part of an "ideal" organization.

Environment: Fayol was a successful mining engineer and senior executive prior to publishing his principles of "administrative science." It is not clear from the literature reviewed if Fayol's work was precipitated or influenced by Taylor's. From the timing, 1911 publication of Taylor's "The Principles of Scientific Management" to Fayol's work in 1916, it is possible. Fayol was not primarily a theorist, but rather a successful senior manager who sought to bring order to his personal experiences.

Successes: Fayol's five principle roles of management are still actively practiced today. The author has found "Plan, Organize, Command, Co-ordinate and Control" written on one than one manager's whiteboard during his career. The concept of giving appropriate authority with responsibility is also widely commented on (if not well practiced.) Unfortunately his principles of "unity of command" and "unity of direction" are consistently violated in "matrix management" the structure of choice for many of today's companies.

Conclusion

It is clear that modern organizations are strongly influenced by the theories of Taylor, Mayo, Weber and Fayol. Their precepts have become such a strong part of modern management that it is difficult to believe that these concepts were original and new at some point in history. The modern idea that these concepts are "common sense" is strong tribute to these founders.

Fayol's Six Functions of Management

Fayol's six primary functions of management, which go hand in hand with the Principles, are as follows:

1. Forecasting.
2. Planning.

3. Organizing.
4. Commanding.
5. Coordinating.
6. Controlling

ITQ

What was Fayol's perspective about management?

Feedback

Fayol believed that management had five principle roles which is to forecast, plan, organize, command, coordinate, and to control.

Study Session Summary

Summary

In this Study Session, we examined the various theories of management and their applications. We highlighted these theories to include contingency theory, system theory, classical management theories, human relations and neo-human relations theories.

Assessment

Assessment

SAQ 2.1 (tests Learning Outcome 2.1)
Describe Management according to the Henry Fayol's Classical Management Theory

SAQ 2.2 (tests Learning Outcome 2.2)
List the components of the Fayol's theory

SAQ 2.3 (tests Learning Outcome 2.3)
Discuss briefly the intentions of the Maslow's Hierarchy of Needs and how it affects management

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Study Session 3

Functions/Component of Management 1: Planning

Introduction

In this study session, we will discuss the concept of planning. We will also examine the purposes of planning as well as its characteristics. Again, we will list the three major types of organizational planning as well as the various phases involved. We will also analyze the classifications and elements of planning. To conclude, we will highlight and explain problems facing effective planning as well as the policies and procedures of planning.

Learning Outcomes

Outcomes

When you have studied this session, you should be able to:

3.1 examine the following:

- purpose and characteristics of planning
- types and phases of planning
- classification and elements of planning
- problems facing effective planning
- policies and procedure of planning

Terminology

Policy	a course or principle of action adopted or proposed by a government, party, business, or individual

3.1 Defining Planning

Planning is the first function of management. All other management functions – organizing, staffing, directing, and controlling- depend on planning. The nurse manager needs to be familiar with the decision–making process and tools so that she can identify the purpose of the institution, state the philosophy, define goals and objectives, prepare budget to implement her plans, and effectively manage her time and that of the organization.

Definitions

- Planning, a basic function of management, it is a principal duty of all managers within the division of nursing.
- It is a systematic process and requires knowledgeable activity based on sound managerial theory.
- Koontz and Weihrich defined planning as selecting missions and objectives and the actions to achieve them; it requires decision making i.e., choosing future courses of action from among alternatives.

ITQ

What is planning?

Feedback

Planning is a systematic process that involves selecting missions, objectives, and the actions to achieve them. Managers often have to identify goals to work toward, and also the steps, resources and personnel to achieve the set goals. It is the most important aspect of the management process.

3.2 Purpose of Planning

Generally, the missions, or purpose or reasons for planning include;

- To succeed in achieving goals and objectives
- To gives meaning to work
- Provides for effective utilization of available personnel and facilities
- Helps in coping with crisis situations
- It is cost effective
- It is needed for effective control
- It is based on past and future ,thus helping to reduce the element of change
- It can be used to discover the need for change
- Satisfactory outcome of decisions

- Assurance of economy of time , space and materials
- Highest use of personnel

ITQ

What determines how managers plan?

Feedback

Planning is based on the future and the past. Consideration of the past helps to eliminate past mistakes and the future to reduce effect of change.

3.3 Characteristics of Planning

- It is an interdependent process
- It is future-oriented
- Forecasting integral
- Continuous process
- Intellectual process
- Integrating process
- Planning and control are inseparable
- Choice among alternative courses of action.
- Flexible process.

3.4 Types of Planning

The major types of Organizational plan include;

- Long range or strategic planning
- Medium range or tactical planning has a span of 6-12 months duration.
- Short range or operational planning

ITQ

What is the duration of tactical planning?

Feedback

The duration of Tactical planning usually takes 6 to 12 months.

3.5 Phases/Steps Involved In Planning

PHASE 1: Assessment of the internal and external environment- The economic, demographic, technological, social, educational, and political factors are assessed in terms of their impact on opportunities and threats within the environment.

PHASE 2: Review of Mission Statement, Philosophy, Goals, and Objectives- A mission statement reflects the purpose and direction of the healthcare agency or the department within it. A statement of philosophy provides direction for the agency and/or department within it. Goals assist nurse administrators and other members of the healthcare team to focus attention on what is relevant and important and to develop strategies and actions to achieve the goals. The ability to write clear and concise objectives is an important aspect of nursing administration.

ITQ

How else can we describe Medium Range Planning?

Feedback

Medium Range Planning is also referred to as Tactical Planning.

PHASE 3: Identification of Strategies- This phase involves identifying major issues, establishing goals, and developing strategies to meet the goals. Strategy ‘’determines how the organization will go about attaining their vision. All departmental managers are involve in this process and are responsible for preparing a detailed plan of action which may involve the following:

- development of short- and long-term objectives,
- formulation of annual department objectives,
- resource allocation, and
- preparation of the budget

PHASE 4: Implementation- The specific plans for action are implemented in order of priority in this phase. This entails open communication with staff in regards to the priority for the next year and subsequent periods, formulation of revised policies and procedures in regard to changes and formulation of area and individual objectives related to the plans.

PHASE 5: At set periods the strategic plan is reviewed at all levels to determine if the goals, objectives, and activities are on target.

ITQ

What does implementation entail?

Feedback

Implementation involves formulation of policies and procedures in regards to planned changes**.** Actions that are critical to the actualization

of set goals are quickly taken to ensure results. Communication with members of the team is also essential.

3.6 Classification of Planning

The various methods upon which planning has been classified and adopted by most early management writers include;

- Time horizon
- Comprehensiveness
- The level
- Element

3.7 Elements of Planning

- Written statement of mission or purpose
- Philosophy
- Objectives or goals
- Detailed management or operational plans
- Policies
- Procedures
- Standards
- Protocols
- Characteristic
- Activities

ITQ

What are the elements of Planning?

Feedback

The elements of planning includes procedures, standards, protocols, and activities.

3.8 Influencing Planning

- Timing
- Cost/money
- Manpower
- Adequate communication
- Commitment of members in the organization

ITQ

What does the third phase of planning entails?

Feedback

The third phase of planning involves Strategy Identification. It includes, but not limited to development of short and long-term objectives, formulation of annual department objectives, resource allocation, and preparation of the budget.

3.9 Problems Facing Effective Planning

- No commitment
- No clear objectives
- Poor communication; when it is one man decision that people are not carried along.
- Lack of resources; man, material and money.
- Unrealistic in term of cost, time and resources or when cost is not enough. So he who fails to plan, plans to fail.
- The time lag between setting of objectives and implementing the plan.

3.10 Policies and Procedures

A policy is a statement of a mandatory course or method established by Saskatchewan Health that regional health authorities and health care organizations must comply with in their operations and decision-making.

Policies can be to:

- interpret or clarify legislative provisions (where further clarification or a description of process is necessary); or
- define those matters which are supplementary to specific legislation and are part of the ministry's mandate

Tip

Policies define as a required course of action.

It is important to differentiate policy from those items which can be categorized as procedures, guidelines, or general information. Planning must reflect the policies of an organization. Policy is typically described as a principle or rule to guide decisions and achieve rational outcome (s). It contains the 'what 'and the 'why'. Policies are generally adopted by the Board of or senior governance body within an organization. A policies can be considered as a ''statement of intent'' or a ''commitment. For that reason at least, we can be held accountable for our ''Policy''.

ITQ

What is the difference between Policy and Procedure?

Feedback

Policy is described as a principle or rule to guide decisions and achieve rational outcome while Procedures describes individual steps taken which may or may not be a part of the said Policy.

The term policy may apply to government, private sector organizations and groups and individuals. Policy differs from rules or law. While law can compel or prohibit behaviours, policy merely guides actions toward those that are most likely to achieve a desired outcome. Policy may also refer to the process of making important organizational decisions, including the alternatives such as programs or spending priorities, and choosing among them on the basis of impact they will have. It provides the framework within which decision-makers are expected to operate while making organizational decisions. They are the basic guides to be consistent in decision-making.

A procedure is a series of steps to be followed or particular action(s) to implement to perform a function and may comply with policy or guidelines.

A guideline is a statement or other explanation by which to set standards or determine a course of action. The guidelines may or may not be required to be followed in order to comply with policy

ITQ

What should be done to a policy to yield optimal results?

Feedback

A policy must be accepted and approved by team members for optimum results. This is essential because the team members must be aware of and must direct all efforts to achieve the items of the policy statement.

A **policy** is a formal statement of a principle or rule that members of an organization must follow. Each policy addresses an issue important to the organization's mission or operations.

A **procedure** tells members of the organization how to carry out or implement a policy. Policy is the "what" and the procedure is the "how to". Policies are written as statements or rules. Procedures are written as instructions, in logical steps.

Steps in Policy Development

Typically, policy development will follow the following steps:

Step 1: Establish need for a policy

Step 2: Develop policy content

Step 3: Draft the policy

Step 4: Write the procedure

Step 5: Review of the policy by key parties

Step 6: Approve the policy

Step 7: Implement the policy

Step 8: Policy review and update

Step 9: Communication of changes to the policy

Policy sections

- Purpose
- Scope
- Statement
- Responsibilities
- Definitions
- Questions
- References
- Effective Date
- Review Date
- Approval

ITQ

What is peculiar about a policy statement?

Feedback

A policy statement shows the formal statement of purpose and guidelines that organisation members must follow while procedures state how the purpose is achieved.

3.11 Decision Making

This can be regarded as the cognitive process resulting in the selection of a belief or a course of action among several alternative possibilities. Every decision-making process produces a final choice that may or may not prompt action. Decision-making is the study of identifying and choosing alternatives based on the values and preferences of the decision maker. Decision-making is one of the central activities of management and is a huge part of any process of implementation.

For effective decision-making

- Objectives must first be established
- Objectives must be classified and placed in order of importance
- Alternative actions must be developed
- The alternative must be evaluated against all the objectives
- The alternative that is able to achieve all the objectives is the tentative decision
- The tentative decision is evaluated for more possible consequences
- The decisive actions are taken, and additional actions are taken to prevent any adverse consequences from becoming problems and starting both systems (problem analysis and decision-making) all over again

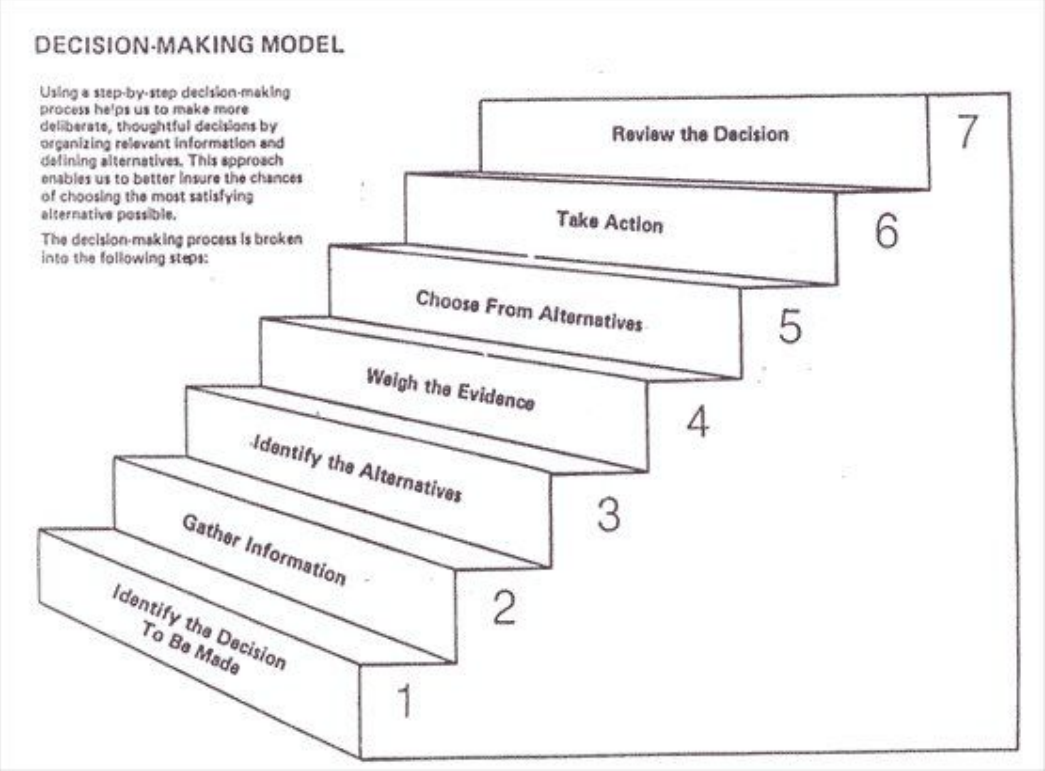
There are steps that are generally followed that result in a decision model that can be used to determine an optimal production plan.

In a situation featuring conflict, role-playing may be helpful for predicting decisions to be made by involved parties.

Decision-making steps

Each step in the decision-making process may include social, cognitive and cultural obstacles to successfully negotiating dilemmas. It has been suggested that becoming more aware of these obstacles allows one to better anticipate and overcome them. The Arkansas program presents eight stages of moral decision-making based on the work of James Rest:

1. Establishing community: creating and nurturing the relationships, norms, and procedures that will influence how problems are understood and communicated. This stage takes place prior to and during a moral dilemma.
2. Perception: recognizing that a problem exists.
3. Interpretation: identifying competing explanations for the problem, and evaluating the drivers behind those interpretations.
4. Judgment: sifting through various possible actions or responses and determining which is more justifiable.
5. Motivation: examining the competing commitments which may distract from a more moral course of action and then prioritizing and committing to moral values over other personal, institutional or social values.
6. Action: following through with action that supports the more justified decision. Integrity is supported by the ability to overcome distractions and obstacles, developing implementing skills, and ego strength.
7. Reflection in action.
8. Reflection on action.



There are seven steps in effective decision making.

Step 1: Identify the decision to be made. You realize that a decision must be made. You then go through an internal process of trying to define clearly the nature of the decision you must make. This first step is a very important one.

ITQ

What is required for effective decision-making?

Feedback

For effective decision-making, it is essential that objectives must first be established. Objectives must be classified and placed in order of importance. In addition, alternative actions must be developed, and the alternative must be evaluated against all the objectives. Similarly, the alternative that is able to achieve all the objectives should be the tentative decision.

Step 2: Gather relevant information. Most decisions require collecting pertinent information. The real trick in this step is to know what information is needed, the best sources of this information, and how to go about getting it. Some information must

be sought from within you through a process of self-assessment; other information must be sought from outside yourself-from books, people, and a variety of other sources. This step, therefore, involves both internal and external "work".

Step 3: Identify alternatives. Through the process of collecting information you will probably identify several possible paths of action, or alternatives. You may also use your imagination and information to construct new alternatives. In this step of the decision-making process, you will list all possible and desirable alternatives.

Step 4: Weigh evidence. In this step, you draw on your information and emotions to imagine what it would be like if you carried out each of the alternatives to the end. You must evaluate whether the need identified in Step 1 would be helped or solved through the use of each alternative. In going through this difficult internal process, you begin to favor certain alternatives which appear to have higher potential for reaching your goal. Eventually you are able to place the alternatives in priority order, based upon your own value system.

Step 5: Choose among alternatives. Once you have weighed all the evidence, you are ready to select the alternative which seems to be best suited to you. You may even choose a combination of alternatives. Your choice in Step 5 may very likely be the same or similar to the alternative you placed at the top of your list at the end of Step 4.

Step 6: Take action. You now take some positive action which begins to implement the alternative you chose in Step 5.

Step 7: Review decision and consequences. In the last step you experience the results of your decision and evaluate whether or not it has "solved" the need you identified in Step 1. If it has, you may stay with this decision for some period of time. If the decision has not resolved the identified need, you may repeat certain steps of the process in order to make a new decision. You may, for example, gather more detailed or somewhat different information or discover additional alternatives on which to base your decision.

Kinds of Decisions

There are several basic kinds of decisions.

1. **Decisions whether:** This is the yes/no, either/or decision that must be made before we proceed with the selection of an alternative. Should I buy a new TV? Should I travel this summer? Decisions whether are made by weighing reasons

pro and con. A simple worksheet with two columns (one for Pro--reasons for, and one with Con--reasons against) can be useful for this kind of decision.

It is important to be aware of having made a decision whether, since too often we assume that decision making begins with the identification of alternatives, assuming that the decision to choose one has already been made.

2. **Decisions which:** These decisions involve a choice of one or more alternatives from among a set of possibilities, the choice being based on how well each alternative measures up to a set of predefined criteria.
3. **Contingent decisions:** These are decisions that have been made but put on hold until some condition is met. Most people carry around a set of already made, contingent decisions, just waiting for the right conditions or opportunity to arise. Time, energy, price, availability, opportunity, encouragement--all these factors can figure into the necessary conditions that need to be met before we can act on our decision. Some contingent decisions are unstated or even exist below the awareness of the decision maker. These are the types that occur when we seize opportunity. The best contingent and opportunistic decisions are made by the prepared mind--one that has thought about criteria and alternatives in the past.
4. **Contingent alternatives:** Similar to contingent decisions, contingent alternatives involve two or more choices of action, one of which will be taken when the appropriate trigger occurs. Often this trigger is an event or more information.
5.

ITQ

What are Contingent decisions?

Feedback

Contingent decisions are decisions that have been made but put on hold until some conditions are met. It may involve just waiting for the right conditions or opportunity to arise. Time, energy, price, availability, opportunity, encouragement are put in consideration to make contingent decisions.

3.12 Concept of Power in Organization

There are times when one's attempts to influence others are overwhelmed by other forces or individuals. Where does this power come from? Who has it? Who does not? In the earlier section on hierarchy, it was noted that, although people at the top of the hierarchy have most of the *authority* in the organization, they do not have all of the *power*. In fact, the people at the bottom of the hierarchy also have some sources of power. This section explains how this can be true. First, power is defined, and then the sources of power available to people on the lower rungs of the ladder are considered.

Tip

Power is the ability to influence other people despite their resistance

Using power, one person or group can impose its will on another person or group. The use of power can be positive, as when the nurse manager gives a staff member an extra day off in exchange for working during the weekend, or negative, as when a nurse administrator transfers a "bothersome" staff nurse to another unit after the staff nurse pointed out a physician error.

Sources of power

There are numerous sources of power. Many of them are readily available to nurses, but some of them are not. The following include sources of power:

1. **Authority:** The power granted to an individual or a group by virtue of position (within the organizational hierarchy, for example)
2. **Reward:** The promise of money, goods, services, recognition, or other benefits
3. **Expertise:** The special knowledge an individual is believed to possess; as Sir Francis Bacon said, "Knowledge is power".

ITQ

How is power distributed in the hierarchy of organisations?

Feedback

It is true that the people at the top of hierarchy of organisations have most of the power in an organisation. However, the people at the bottom of the hierarchy also have some sources of power. They are usually tasked with the operational activities in an organization and they often exercise their power in this respect.

Study Session Summary

Summary

In this Study Session, we discussed the concept of planning. We also examined the purposes of planning as well as its characteristics. Again, we listed the three major types of organizational planning as well as the various phases involved. We also analyzed the classifications and elements of planning. Conclusively, we highlighted and explained problems facing effective planning as well as the policies and procedures of planning

Assessment

Assessment

SAQ 3.1 (tests Learning Outcome 3.1)

What is Planning?

SAQ 3.2 (tests Learning Outcome 3.2)

What are the types of planning and how is planning classified?

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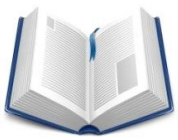

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Study Session 4

Functions/Component of Management 2: Organizing

Introduction

In this study session, we will consider types of health-care organization and explore through organizational culture and structure. We will also discuss the organizational change, its types and resistance and/or receptivity to change.

Learning Outcomes

Outcomes

When you have studied this session, you should be able to:

4.1 List and explain types of health care organization

4.2 Examine the concept of organizational culture and structure

4.3 Discuss micro and macro change

Terminology

Organizational structure	a definition of how activities such as task allocation, coordination and supervision are directed toward the achievement of organizational aims and/or the viewing glass or perspective through which individuals see their organization and its environment.
Organizational culture	a system of shared assumptions, values, and beliefs, which governs how people behave in organizations

4.1 Types of Health-Care Organizations

Although some nurses work as independent practitioners, as consultants, or in the corporate world, most nurses are employed by health-care organizations. These organizations can be classified into three types on the basis of their sponsorship and financing:

1. Private not-for-profit. Many health-care organizations were founded by civic, charitable, or religious groups. Some have been in existence for generations. Many hospitals, long-term care facilities, home-care services, and community agencies began this way. Although they need money to pay their staff and expenses, they do not have to generate a profit.

2. Publicly supported. Government-operated service organizations range from county public health departments to complex medical centers, such as those operated by the Veterans Administration, a federal agency.

3. Private for-profit. Increasing numbers of healthcare organizations are operated for profit like any other business. These include large hospital and nursing home chains, health maintenance organizations, and many freestanding centers that provide special services, such as surgical and diagnostic centers.

ITQ

Describe the ownership of Health Maintenance Organisations

Feedback

Health Maintenance Organisations are not publicly supported**.** However, they are privately owned but operated to generate profit.

4.2 Organizational Culture

People seek stability, consistency, and meaning in their work. To achieve this, some type of culture will develop within an organization

Tip

. An organizational culture is an enduring set of shared values, beliefs, and assumptions

It is taught (often indirectly or unconsciously) to new employees as the "right way" or "our way" to assess patient needs, provide care, and relate to fellow caregivers. As with the cultures of societies and communities, it is easy to observe the superficial aspects of an organization's culture, but much of it remains hidden from the casual observer. Edgar Schein, a well-known scholar of organizational culture, divided the various aspects of organizational culture into three levels:

1. **Artifact level:** visible characteristics such as patient room layout, patient record forms, etc.
2. **Espoused beliefs:** stated, often written, goals; philosophy of the organization

3. **Underlying assumptions:** unconscious but powerful beliefs and feelings, such as a commitment to cure every patient, no matter the cost. Organizational cultures differ a great deal. Some are very traditional, preserving their customary ways of doing things even when these processes no longer work well. Others, in an attempt to be progressive, chase the newest management fad or buy the latest high-technology equipment. Some are warm, friendly, and open to new people and new ideas. Others are cold, defensive, and indifferent or even hostile to the outside world. These very different organizational cultures have a powerful effect on the employees and the people served by the organization. Organizational culture shapes people's behavior, especially their responses to each other, which is a particularly important factor in health care.

Culture of Safety

The way in which a health-care organization's operation affects patient safety has been a subject of much discussion. The shared values, attitudes, and behaviors that are directed to preventing or minimizing patient harm have been called the culture of safety. The following are important aspects of an organization's culture of safety:

■ Willingness to acknowledge mistakes

■ Vigilance in detecting and eliminating error prone situations

■ Openness to questioning existing systems and to changing them to prevent errors

ITQ

What is regarded as the culture of safety?

Feedback

The shared values, attitudes, and behaviours that are directed to preventing or minimizing patient harm have been termed the culture of safety.

4.3 Organisational Structure

Almost all health-care organizations have a hierarchical structure of some kind. In a traditional hierarchical structure, employees are ranked from the top to the bottom, as if they were on the steps of a ladder. The number of people on the bottom rungs of the ladder is almost always much greater than the number at the top. The president or CEO is usually at the top of this ladder; the housekeeping and maintenance crews are usually at the bottom.

Nurses fall somewhere in the middle of most health-care organizations, higher than the cleaning people, aides, and technicians, but lower than physicians and administrators

Bureaucracy in Organisation

Although it seems as if everyone complains about "the bureaucracy," not everyone is clear about what a bureaucracy really is. Max Weber defined a bureaucratic organization as having the following characteristics:

- **Division of labor:** Specific parts of the job to be done are assigned to different individuals or groups. For example, nurses, physicians, therapists, dietitians, and social workers all provide portions of the health care needed by an individual.
- **Hierarchy:** All employees are organized and ranked according to their level of authority within the organization. For example, administrators and directors are at the top of most hospital hierarchies, whereas aides and maintenance workers are at the bottom.
- **Rules and regulations:** Acceptable and unacceptable behavior and the proper way to carry out various tasks are defined, often in writing. For example, procedure books, policy manuals, bylaws, statements, and memos prescribe many types of behavior, from acceptable isolation techniques to vacation policies.
- **Emphasis on technical competence:** People with certain skills and knowledge are hired to carry out specific parts of the total work of the organization. For example, a community mental health center has psychiatrists, social workers, and nurses to provide different kinds of therapies and clerical staff to do the typing and filing. Some bureaucracy is characteristic of the formal operation of every organization, even the most deliberately informal, because it promotes smooth operations within a large and complex group of people.

ITQ

What is pertinent to note about an organization's culture? is an enduring set of shared values, beliefs, and assumptions.

Feedback

An organization's culture is an enduring set of shared values, beliefs, and assumptions. It is taught to new employees as the "right way" or "our way" to assess patient needs, provide care, and relate to fellow caregivers.

4.4 Organizational Change

Change is a part of everyone's lives. Every day, people have new experiences, meet new people, and learn something new. People grow up, leave home, graduate from college, begin a career, and perhaps start a family. Some of these changes are milestones, ones for which people have prepared and have anticipated for some time. Many are exciting, leading to new opportunities and challenges. Some are entirely unexpected, sometimes welcome and sometimes not. When change occurs too rapidly or demands too much, it can make people uncomfortable, even anxious or stressed.

Macro and Micro Change

The "ever-whirling wheel of change" in health care seems to spin faster every year. By itself, managed care profoundly changed the way health care is provided in the United States. Medicare and Medicaid cuts, increasing numbers of people who are uninsured or underinsured, restructuring, downsizing, and staff shortages are major concerns. Such changes sweep through the health-care system, affecting patients and caregivers alike. They are the *macro-level* (large-scale) changes that affect virtually every health-care facility.

Change anywhere in a system creates "ripples throughout the system". Every change that occurs at this macro level filters down to the *micro level* (small-scale change), to teams and to individuals. Nurses, colleagues in other disciplines, and patients are participants in these changes.

Resistance to Change

People resist change for a variety of reasons that vary from person to person and situation to situation.

You might find that one patient-care technician is delighted with an increase in responsibility, whereas another is upset about it. Some people are eager to risk change; others prefer the status quo. Managers may find that one change in routine provokes a storm of protest and that another is hardly noticed.

Resistance to change comes from three major sources: technical concerns, psychosocial needs, and threats to a person's position and power.

Active	**Passive**
Attacking the idea	Avoiding discussion
Refusing to change	Ignoring the change
Arguing against the change	Refusing to commit to the change
Organizing resistance	Agreeing but not acting of other people

Receptivity to Change

Recognizing Different Information Processing Styles

An interesting research study suggests that nurse managers are more receptive to change than their staff members. Nurse managers were found to be more innovative and decisive, whereas staff nurses preferred proven approaches, thus being resistant to change. Nursing assistants, unit secretaries, and licensed practical nurses were also unreceptive to change, adding layers of people who formed a "solid wall of resistance" to change. Helping teams recognize their preference for certainty (as opposed to change) will increase their receptivity to necessary changes in the workplace.

Speaking to People's Feelings

Although both thinking and feeling responses to change are important, the heart of change lies in the emotions surrounding it. The following are some examples of appeals to feelings.

- Instead of presenting statistics about the number of people who are re-admitted due to poor discharge preparation, providing a story is more persuasive: an older man collapsed at home the evening after discharge because he had not been able to control his diabetes post surgery. Trying to break his fall, he fractured both wrists and is now unable to return home or take care of himself.
- Even better, videotape an interview with this man, letting him tell his story and describe the repercussions of poor preparation for discharge.
- Drama may also be achieved through visual display. A culture plate of pathogens grown from swabs of ventilator equipment and patient room furniture is more attention-getting than an infection control report. A display of disposables with price tags attached used for just one surgical patient is more memorable than an accounting sheet listing the costs.

Phases of planned change

- Designing the Change
- Plan implementation
- Implement the change
- Integrate the change

Myths about Changing Behaviour

- Crisis is a powerful impetus for change: Ninety percent of patients who have had coronary bypasses do not sustain changes in the unhealthy lifestyles, which worsens their severe heart disease and greatly threatens their lives.
- Change is motivated by fear: It is too easy for people to go into denial of the bad things that might happen to them.

Compelling positive visions of the future are a much stronger inspiration for change.

- The facts will set us free: Our thinking is guided by narratives, not facts. When a fact does not fit people's conceptual "frames"—the metaphors used to make sense of the world—people reject the fact. Also, change is best inspired by emotional appeals rather than factual statements.
- Small, gradual changes are always easier to sustain: Radical, sweeping changes are often easier because they yield benefits make and quickly.
- People cannot change because the brain becomes "hardwired" early in life: Brains have extraordinary "plasticity," meaning that people can continue learning complex new things throughout life—assuming they remain truly active and engaged.

ITQ

What are the phases of planned change?

Feedback

The Phases of planned change include designing the change, planning implementation, and implementing the change.

Study Session Summary

Summary

In this Study Session, we considered types of health-care organization and explored through organizational culture and structure. We also discussed the organizational change, its types and resistance and/or receptivity to change.

Assessment

Assessment

SAQ 4.1 (tests Learning Outcome 4.1)
How does Organizing affect Nursing

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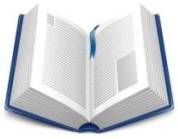

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Study Session 5

Functions/Components of Management 3: Staffing

Introduction

In this study session, we will define staffing and scheduling. We will state the functions of staffing as well as the objectives and steps of staffing. Lastly, we will discuss performance evaluation and explain delegation of responsibility in staffing.

Learning Outcomes

Outcomes

When you have studied this session, you should be able to:

5.1 Define staffing

5.2 Highlight some of the functions of staffing

5.3 List the steps, and state the objectives of staffing

5.4 Discuss the concept of performance evaluation and delegation of responsibility

Terminology

Staffing	the process of hiring, positioning and overseeing employees in an organization
Performance evaluation	a constructive process to acknowledge the performance of a non-probationary career employee

5.1 Staffing and Scheduling

Staffing is the process of selecting and training individuals for specific job functions, and charging them with the associated responsibilities. It can also be described as the number of employed personnel in an organization or program

Staffing is filling and keeping filled with qualified people all positions in the business. Recruiting, hiring, training, evaluating and compensating are the specific activities included in the function. In the family business, staffing includes all paid and unpaid positions held by family members including the owner/operators.

ITQ

What does staffing entails?

Feedback

Staffing is filling and keeping filled with qualified people all positions in the business. Recruiting, hiring, training, evaluating and compensating are the specific activities included in the function.

5.2 Functions in Staffing

There are various divisions and functions in staffing that would be further explained in staffing process. These functions are:

- Identifying the type and amount of service needed by agency client i.e. the "who"
- (Picturing the ideal candidate) and "which" position is vacant.
- Determining the personnel categories that have the knowledge and skill to perform needed service measures i.e. the qualifications possessed by each candidate.
- Predicting the number of personnel in each job category that will be needed to meet anticipated service demands.
- Obtaining, budgeted positions for the number in each job category needed to service for the expected types and number of clients.
- Recruiting personnel to fill available positions.
- Selecting and appointing personnel from suitable applicants i.e. making a final decision on whom to hire.
- Combining personnel into desired configurations by unit and shift.

- Orienting personnel to fulfill assigned responsibilities.
- Assigning responsibilities for client services to available personnel.

ITQ

What are some of the functions executed in staffing?

Feedback

Some of the functions carried out in staffing includes determining the personnel categories that have the knowledge and skill to perform needed service measures (i.e. the qualifications possessed by each candidate). It also predicts the number of personnel in each job category that will be needed to meet anticipated service demands.

5.3 Steps and Objectives of Staffing

The following are the steps of staffing:

- Determine the number and types of personnel needed to fulfill the philosophy, meet fiscal planning responsibilities, and carryout the chosen patient care management organization.
- Recruit, interview, select, and assign personnel based on established job description performance standards.
- Use organizational resources for induction and orientation.
- Ascertain that each employee is adequately socialized to organizational values and unit norms.
- Use creative and flexible scheduling based on patient care needs to increase productivity and retention.
- Develop a program of staff education that will assist employees meeting the goals of the organization.

Objectives of Staffing in Nursing

The following are the main objectives of staffing in Nursing:

- Provide an all professional nurse staff in critical care units, operating rooms, labour and emergency room
- Provide sufficient staff to permit a 1:1 nurse- patient ratio for each shift in every critical care unit
- Staff the general medical, surgical, obstetrics and gynaecology, paediatric and psychiatric units to achieve a 2:1 professional-practical nurse ratio.
- Provide sufficient nursing staff in general, medical, surgical, obstetrics and gynaecology, paediatric and psychiatric units to permit a 1:5 nurse patient ratio on a day and afternoon shifts and 1:10 nurse- patient ratio on night shift.
- Involve the heads of the nursing staffs and all nursing personnel in designing the department's overall staffing program.

- Design a staffing plan that specifies how many nursing personnel in each classification will be assigned to each nursing unit for each shift and how vacation and holiday time will be requested and scheduled.
- Hold each head nurse responsible for translating the department's master staffing plan to sequential eight weeks time schedules for personnel assigned to her/ his unit.
- Post time schedules for all personnel at least eight weeks in advance.
- Empower the head nurse to adjust work schedules for unit nursing personnel to remedy any staff excess or deficiency caused by census fluctuation or employee absence.
- Inform each nursing employee that requests for specific vacation or holiday time will be honoured within the limits imposed by patient care and labour contract requirements.
- Reward employees for long term service by granting individuals special time requests on the basis of seniority.(culled from American Nurses Association principles of Nursing Staffing).

ITQ

What are some of the objectives of staffing in nursing?

Feedback

The objectives of staffing in nursing entails providing an all-professional nurse staff in critical care units, operating rooms, labour and emergency room. It also involves providing sufficient staff to permit a 1:1 nurse-patient ratio for each shift in every critical care unit. Similarly, there is a need to staff the general medical, surgical, obstetrics and gynaecology, paediatric and psychiatric units to achieve a 2:1 professional- practical nurse ratio.

The nine principles are:

I. Patient Care Unit Related

a) Appropriate staffing levels for a patient care unit reflect analysis of individual and aggregate patient needs.

b) There is a critical need to either retire or seriously question the usefulness of the concept of nursing hours per patient day (HPPD).

c) Unit functions necessary to support delivery of quality patient care must also be considered in determining staffing levels.

II. Staff Related

a) The specific needs of various patient populations should determine the appropriate clinical competencies required of the nurse practicing in that area.

b) Registered nurses must have nursing management support and representation at both the operational level and the executive level.
c) Clinical support from experienced RNs should be readily available to those RNs with less proficiency.

III. Institution/Organization Related

a) Organizational policy should reflect an organizational climate that values registered nurses and other employees as strategic assets and exhibit a true commitment to filling budgeted positions in a timely manner.
b) All institutions should have documented competencies for nursing staff, including agency or supplemental and travelling RNs, for those activities that they have been authorized to perform.
c) Organizational policies should recognize the myriad needs of both patients and nursing staff.

Norms of Staffing **(S I U- staff inspection unit)**

Norms- are standards that guide, control, and regulate individuals and communities. For planning nursing manpower we have to follow some norms.

Steps Involved In Staffing Process

1. Manpower requirements
2. Recruitment
3. Selection
4. Orientation and Placement
5. Training and Development
6. Remuneration
7. Performance Evaluation

Types of Recruitment

Internal Recruitment

Internal sources are primarily 3:

i. Transfers
ii. Promotions (through Internal Job Postings) and
iii. Re-employment of ex-employees

External Recruitment

Difference between Recruitment and Selection

Basis	Recruitment	Selection

Meaning	It is an activity of establishing contact between employers and applicants	It is a process of picking up more competent and suitable employees
Objective	It encourages large number of candidates for a job	It attempts at rejecting unsuitable candidates
Process	It is a simple process	It is a complicated process
Hurdles	The candidates have not to cross over many hurdles	Many hurdles have to be crossed
Approach	It is a positive approach	It is a negative approach
Sequence	It precedes selection	It follows recruitment
Economy	It is an economical method	It is an expensive method
Time Consuming	Less time is required	More time is required

ITQ

What constitute the Internal Recruitment Process?

Feedback

The internal recruitment process includes Transfers, Promotion and Re-employment of ex-employees.

5.4 Performance Evaluation

This is necessary in order to keep a track or record of the behaviour, attitudes as well as opinions of the workers towards their jobs. For this, regular assessment is done to evaluate and supervise different work units in a concern. It is basically concerned to know the development cycle and growth patterns of the employees in a concern. This evaluation helps the employer to appraise the employee if there is a great development.

A performance appraisal, employee appraisal, performance review, or (career) development discussion is a method by which the job performance of an employee is evaluated (generally in terms of quality, quantity, cost, and time) typically by the corresponding manager or supervisor

A performance appraisal is a part of guiding and managing career development. It is the process of obtaining, analyzing, and recording information about the relative worth of an employee to the organization.

Performance appraisal is an analysis of an employee's recent successes and failures, personal strengths and weaknesses, and suitability for promotion or further training. It is also the judgement of an employee's performance in a job based on considerations other than productivity alone.

Aims of Performance Appraisal

Generally, the aims of a performance appraisal are to:

- Give employees feedback on performance
- Identify employee training needs
- Document criteria used to allocate organizational rewards
- Form a basis for personnel decisions: salary increases, promotions, disciplinary actions, bonuses, etc.
- Provide the opportunity for organizational diagnosis and development
- Facilitate communication between employee and administration
- Validate selection techniques and human resource policies to meet federal Equal Employment Opportunity requirements.
- To improve performance through counseling, coaching and development.

Methods used in Performance appraisal

A common approach to assessing performance is to use a numerical or scalar rating system whereby managers are asked to score an individual against a number of objectives/attributes. In some companies, employees receive assessments from their manager, peers, subordinates, and customers, while also performing a self assessment. This is known as a 360-degree appraisal and forms good communication patterns.

The most popular methods used in the performance appraisal process include the following:

- Management by objectives
- 360-degree appraisal
- Behavioral observation scale
- Behaviorally anchored rating scales

Trait-based systems, which rely on factors such as integrity and conscientiousness, are also commonly used by businesses. The scientific literature on the subject provides evidence that assessing employees on factors such as these should be avoided. The reasons for this are twofold:

1. Because trait-based systems are by definition based on personality traits, they make it difficult for a manager to provide feedback that can cause positive change in employee performance. This is caused by the fact that personality dimensions are for the most part static, and while an employee can change a specific behavior they

cannot change their personality. For example, a person who lacks integrity may stop lying to a manager because they have been caught, but they still have low integrity and are likely to lie again when the threat of being caught is gone.

2. Because they are vague, are more easily influenced by office politics, causing them to be less reliable as a source of information on an employee's true performance. The vagueness of these instruments allows managers to fill them out based on who they want to/feel should get a raise, rather than basing scores on specific behaviors employees should/should not be engaging in. These systems are also more likely to leave a company open to discrimination claims because a manager can make biased decisions without having to back them up with specific behavioral information.

ITQ

What is the common approach to assessing performance in performance evaluation?

Feedback

A common approach to assessing performance is to use a numerical or scalar rating system whereby managers are asked to score an individual against a number of objectives/attributes.

5.5 Delegation of Responsibility

Delegation is the assignment of responsibility or authority to another person (normally from a manager to a subordinate) to carry out specific activities. It is one of the core concepts of management leadership. However, the person who delegated the work remains accountable for the outcome of the delegated work. Delegation empowers a subordinate to make decisions, i.e. it is a shift of decision-making authority from one organizational level to a lower one. Delegation, if properly done, is not abdication. The opposite of effective delegation is micromanagement, where a manager provides too much input, direction, and review of delegated work. In general, delegation is good and can save money and time, help in building skills, and motivate people. Poor delegation, on the other hand, might cause frustration and confusion to all the involved parties. Some agents however do not favour a delegation and consider the power of making a decision rather stressful.

Delegation is one of the most important management skills. These logical rules and techniques will help you to delegate well (and will help you to help your manager when you are being delegated a task or new responsibility - delegation is a two-way process!). Good delegation saves you time, develops your people, grooms a successor, and motivates. Poor

delegation will cause you frustration, demotivates and confuses the other person, and fails to achieve the task or purpose itself. So it's a management skill that's worth improving. Here are the simple steps to follow if you want to get delegation right, with different levels of delegation freedom that you can offer.

Delegation is a very helpful aid for succession planning, personal development - and seeking and encouraging promotion. It is how we grow in the job - delegation enables us to gain experience to take on higher responsibilities. Delegation is vital for **effective leadership**

Delegation and SMART, or SMARTER

A simple delegation rule is the SMART acronym, or better still, SMARTER. It's a quick checklist for proper delegation. Delegated tasks must be:

- Specific
- Measurable
- Agreed
- Realistic
- Timebound
- Ethical
- Recorded

Traditional interpretations of the SMARTER acronym use 'Exciting' or 'Enjoyable', however, although a high level of motivation often results when a person achieves and is given recognition for a particular delegated task, which in itself can be exciting and enjoyable In truth, let's be honest, it is not always possible to ensure that all delegated work is truly 'exciting' or 'enjoyable' for the recipient. More importantly, the 'Ethical' aspect is fundamental to everything that we do, assuming you subscribe to such philosophy.

The Steps of Successful Delegation

1. Define the task
2. Select the individual or team
3. Assess ability and training needs
4. Explain the reasons
5. State required results
6. Consider resources required
7. Agree deadlines
8. Support and communicate
9. Feedback on results

Levels of Delegation - Examples

These examples of different delegation levels progressively offer, encourage and enable more delegated freedom. Level 1 is the lowest level

of delegated freedom (basically none). Level 10 is the highest level typically (and rarely) found in organizations.

a. "Wait to be told." or "Do exactly what I say." or "Follow these instructions precisely."
b. "Look into this and tell me the situation. I'll decide."
c. "Look into this and tell me the situation. We'll decide together."
d. "Tell me the situation and what help you need from me in assessing and handling it.
e. "Give me your analysis of the situation (reasons, options, pros and cons) and recommendation.
f. "Decide and let me know your decision, and wait for my go-ahead before proceeding."
g. "Decide and let me know your decision, then go ahead unless I say not to."
h. "Decide and take action"
i. "Decide and take action."
j. "Decide where action needs to be taken and manage the situation accordingly."

What to Delegate

There is always the question of what to delegate and what to do yourself, and you must take a long term view on this: you want to delegate as much as possible to develop you staff to be as good as you are now.

The starting point is to consider the activities you used to do before you were promoted. You used to do them when you were more junior, so someone junior can do them now. Tasks in which you have experience are the easiest for you to explain to others and so to train them to take over. You thus use your experience to ensure that the task is done well, rather than to actually perform the task yourself. In this way you gain time for your other duties and someone else becomes as good as your once were (increasing the strength of the group). Tasks in which your staffs have more experience must be delegated to them. This does not mean that you relinquish responsibility because they are expert, but it does mean that the default decision should be theirs. To be a good manager though, you should ensure that they spend some time in explaining these decisions to you so that you learn their criteria.

Decisions are a normal managerial function: these too should be delegated - especially if they are important to the staff. In practice, you will need to establish the boundaries of these decisions so that you can live with the outcome, but this will only take you a little time while the delegation of the remainder of the task will save you much more.

Delegation may be direct or indirect. *Direct delegation* is usually “verbal direction by the RN delegator regarding an activity or task in a specific nursing care situation”. In this case, the RN decides which staff member is capable of performing the specific task or activity. *Indirect delegation is* “an approved listing of activities or tasks that have been established in policies and procedures of the health care institution or facility”

The Five Rights of Delegation

1. Right task
2. Right circumstances
3. Right person
4. Right direction/communication
5. Right supervision/evaluation

Supervision

Supervision is more direct and requires directly overseeing the work or performance of others. Supervision includes checking with individuals throughout the day to see what activities have been completed and what may still need to be finished.

Factors for Determining if Client Care Activity should be Delegated

- Potential for harm to the patient
- Complexity of the nursing activity
- Extent of problem solving and innovation required
- Predictability of outcome
- Extent of interaction

Barriers to Delegation

Many nurses, particularly new ones, have difficulty delegating. The reasons for this include experience issues, licensure issues, and quality-of-care issues.

ITQ

What steps makes a successful delegation?

Feedback

The following steps makes a successful delegation. These include defining the task, Select the individual or team, Assess ability and training needs, Explain the reasons, State required results, Consider resources required, Agree deadlines, Support and communicate, and Feedback on results.

Study Session Summary

In this Study Session, We stated the functions of staffing as well as the objectives and steps of staffing. Lastly, we discussed performance evaluation and explained the concept of delegation of responsibility

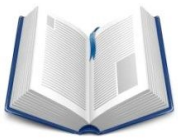
Summary

Assessment

Assessment

SAQ 5.1 (tests Learning Outcome 5.1)
What is Delegation? How does it improve Nursing Care

Bibliography



Reading

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Study Session 6

Functions and Components of Management Motivation

Introduction

Motivation is the general desire or willingness of someone to do something. In this study session, we will examine the concept of motivation. We will also discuss the process of motivation and list its type. To conclude, we will examine forms and various strategies for motivation.

Learning Outcomes

Outcomes

When you have studied this session, you should be able to:

6.1 Define motivation

6.2 Discuss the process of motivation

6.3 List the types of motivation

6.4 Examine forms and various strategies for motivation

Terminology

Motivation	The reason or reasons one has for acting or behaving in a particular way
Reinforcement	The process of encouraging or establishing a belief or pattern of behaviour, especially by encouragement or reward

6.1 Concept of Motivation

Nearly all the conscious behaviour of human being is motivated. The internal needs and drives lead to tensions, which in turn result into actions. The need for food results into hunger and hence a person is motivated to eat.

A manager is required to create and maintain an environment in which individuals work together in groups towards the accomplishment of common objectives. A manager cannot do a job without knowing what motivates people. The building of motivating factors into organizational

roles, the staffing of these roles and the entire process of leading people must be built on knowledge of motivation. It is necessary to remember that level of motivation varies both between individuals and within individuals at different times. Today in the increasingly competitive environment maintaining a highly motivated workforce is the most challenging task. The art of motivation starts by learning how to influence the behaviour of the individual. This understanding helps to achieve both, the individual as well as organizational objectives. Motivation is a powerful tool in the hands of leaders. It can persuade convince and propel people to act.

It is a general tendency to believe that motivation is a personal trait. Some people have it and others don't. In practice, some are labelled to be lazy because they do not display an outward sign of motivation. However, individuals differ in their basic motivational drives. It also depends upon their areas of interest. The concept of motivation is situational and its level varies between different individuals and at different times. If you understand what motivates people, you have at your command the most powerful tool for dealing with them.

Tip

Motivation is to inspire people to work, individually or in groups in the ways such as to produce best results

It is the will to act. It is the willingness to exert high levels of effort towards organizational goals, conditioned by the efforts and ability to satisfy some individual need.

Motivation is getting somebody to do something because they want to do it. It was once assumed that motivation had to be injected from outside, but it is now understood that everyone is motivated by several differing forces.

Motivation is the driving force or 'our get up and go' factor which stimulates human senses into the achievement of goals that have been set out for them. Motivation can also be associated from having enthusiasm to do or be something. Enthusiasm means the inspiration within humans.

Motivation is a general term applied to the entire class of drives, desires, needs, wishes and similar forces. To say that managers motivate their subordinates is to say that they do those things which they hope will satisfy these drives and desires and induce the subordinates to act in a desired manner.

To motivate others is the most important of management tasks. It comprises the abilities to communicate, to set an example, to challenge, to encourage, to obtain feedback, to involve, to delegate, to develop and train, to inform, to brief and to provide a just reward.

ITQ

How does motivation begin?

Feedback

The art of motivation starts by learning how to influence the behaviour of the individual. This understanding helps to achieve both, the individual as well as organizational objectives. Motivation is a powerful tool in the hands of leaders. It can persuade convince and propel people to act.

6.2 Process of Motivation

In the initiation a person starts feeling lacknesses. There is an arousal of need so urgent, that the bearer has to venture in search to satisfy it. This leads to creation of tension, which urges the person to forget everything else and cater to the aroused need first. This tension also creates drives and attitudes regarding the type of satisfaction that is desired. This leads a person to venture into the search of information. This ultimately leads to evaluation of alternatives where the best alternative is chosen. After choosing the alternative, an action is taken. Because of the performance of the activity satisfaction is achieved which than relieves the tension in the individual.

6.3 Types of Motivation

1) **Achievement Motivation:** It is the drive to pursue and attain goals. An individual with achievement motivation wishes to achieve objectives and advance up on the ladder of success. Here, accomplishment is important for its own sake and not for the rewards that accompany it. It is similar to 'Kaizen' approach of Japanese Management.
2) **Affiliation Motivation:** It is a drive to relate to people on a social basis. Persons with affiliation motivation perform work better when they are complimented for their favorable attitudes and co-operation.
3) **Competence Motivation**: It is the drive to be good at something, allowing the individual to perform high quality work. Competence motivated people seek job mastery, take pride in developing and using their problem-solving skills and strive to be creative when confronted with obstacles. They learn from their experience.
4) **Power Motivation:** It is the drive to influence people and change situations. Power motivated people wish to create an impact on their organization and are willing to take risks to do so.
5) **Attitude Motivation:** Attitude motivation is how people think and feel. It is their self confidence, their belief in themselves, their attitude to life. It is how they feel about the future and how they react to the past.

6) **Incentive Motivation**: It is where a person or a team reaps a reward from an activity. It is "You do this and you get that", attitude. It is the types of awards and prizes that drive people to work a little harder.
7) **Fear Motivation:** Fear motivation coerces a person to act against will. It is instantaneous and gets the job done quickly. It is helpful in the short run.

ITQ

What is peculiar about competence motivation?

Feedback

Competence Motivation is the drive to be good at something, allowing the individual to perform high quality work. Competence motivated people seek job mastery, take pride in developing and using their problem-solving skills and strive to be creative when confronted with obstacles. They learn from their experience.

6.4 Forms of Motivation

Motivation as earlier identified can be intrinsic or extrinsic.

Intrinsic Motivation: This refers to motivation that is driven by an interest or enjoyment in the task itself, and exists within the individual rather than relying on any external pressure. Research has found that it is usually associated with high achievement and enjoyment. Intrinsic motivation is a form of self determination.

Extrinsic Motivation: This is a form of motivation that is derived from outside of the individual. The common extrinsic forms of motivation are;

- Rewards like money and grades
- Coercion and threat of punishment
- Competition.

6.5 Strategies for Motivation

The following are the strategies for motivation;

1. Positive reinforcement
2. Effective discipline and punishment
3. Treating people fairly
4. Satisfying employees' needs
5. Setting work related goal that are realistic
6. Restructuring jobs
7. Base reward on job performance

Motivation is a means to reduce and manipulate the gap between an individual's actual state and some desired state

The motivational system must be tailored to the situation and the organization.

In a study conducted in Minneapolis Gas Company, it was found that;

- Security was the highest rated factor for motivation. The other factors are
- Advancement
- Type of work
- Company- which they are proud to work for

Surprisingly, factors such as pay, benefits and working condition were given a low rating. So the contrary to common belief, money is not the prime motivator.

Motivation Theorist Their Theories

The factors that motivate an individual keep changing as one climbs the ladder of age and maturity. And also, achievement of one goal sets the ball rolling for another one to be achieved. Thus, to be motivated is a constant need. There are times when one faces a period of de-motivation and everything seems bleak. It is then that they need to find what would motivate them back into action.

Thus, there are different factors that can serve as motivators to different individual, so different theorist identified various theories with respect to their beliefs.

Theories of motivation have been classified into content theories and process theories.

Content Theories

Theory Z or Maslow's Hierarchy of Needs Theory

This theory was developed by a psychologist, Abraham Maslow, He holds that all the good qualities are inherent in people, at least, at birth, although later they are gradually lost.

A man's personality is the sum total of his works and that only the man's work survives him at death and this work is perhaps the essence of Maslow's hierarchy of needs theory, as it is more commonly known.

The basic human needs according to Maslow are:

- ***Physiological needs:*** The body needs water, food, oxygen, elimination, rest, exercise, sex, shelter and protection from the environment. People have a strong drive for self preservation and whenever their basic physiological needs are threatened, the needs become prepotent. In an affluent society, these needs are probably not motivators. Thus

personnel should not be overworked, meal and rest breaks should be provided and pay should be adequate for food, shelter, health care and recreation.

- ***Safety needs:*** everyone needs physical, emotional and financial safety. People do not want to worry about inadequate income because of loss of job, accident, or old age. Therefore, arbitrary management actions, favoritism toward or discrimination against employees, and unpredictable administration of policy are dangerous to safety needs and should be avoided.
- ***Love needs:*** this includes recognition as an accepted member of a group, being an integral part of the operation, giving and receiving in friendship, affectionate relations with others. A cohesive work group is likely to be more effective than an equal number of people working separately.
- ***Esteem needs:*** this needs includes, achievement, competence, status recognition, appreciation, reputation and respect contribute to one's self confidence and self esteem. Thus, management can help meet the need by offering praises, titles to compensate good work. A person whose self-esteem is satisfied has feelings of self-confidence, worth, strength, capability, adequacy, usefulness, and being needed in the society.
- ***Self-actualization:*** which is the highest of all the needs and it includes feelings of accomplishment, responsibility, challenge, advancement, all of which contribute to self-fulfilment.

In contrast to Taylor's monistic theory as the primary motivator, Maslow maintained that people are motivated by a desire to satisfy a hierarchy of needs. He hypothesized that satisfaction of the basic physiological needs triggers the emergence of more abstract needs and the satisfied needs is no more a motivator.

Man behaviour is seen as dominated by his unsatisfied needs and he is a perpetually wandering animal; for when one need is satisfied he aspires for the next higher one. This is therefore seen as an on-going activity, in which the man is totally absorbed in order to attain perfection through self- development.

The highest state of self-actualization is characterized by integrity, responsibility, magnanimity, simplicity and naturalness.

Certain conditions are prerequisites for basic need satisfaction. When basic needs are thwarted, the individual is threatened. These conditions include:

- Freedom to speak, that is, communication.
- Freedom to do what one wishes to do without harming others
- Freedom to express oneself- creativity
- Freedom to investigate and seek for information
- Freedom to defend oneself; justice, fairness, honesty and orderliness in the group.

A long- satisfied need may become unvalued; having never been deprived, a person does not regard such a need as being important. If two needs emerge, a person will probably want the more basic one satisfied first.

Clayton Alderfer's Modified Need Theory

He reduced Maslow's hierarchy of needs theory from five to three levels which are

- Existence
- Relatedness
- Growth

The theory stipulates that energy can be redirected to a lower level need when higher level needs are frustrated, that is, people will regress to satisfaction of lower needs.

Comparing Alderfer scheme with Maslow's, existence needs will equate to physiological and safety needs; relatedness needs would equate to belongingness, social and love needs; and growth needs would equate to self-esteem and self actualization.

Frederick Herzberg- Hygiene/Motivation Theory

Frederick believed that people work first and foremost in their own self enlightened interest, for they are truly happy and mentally healthy through work accomplishment. He stated that people's needs are of two types namely;

1. Animal needs (Hygiene factors): This includes supervision, interpersonal relations, working conditions and salary. Herzberg argued that pay is at best a hygiene factor; poor pay reduces motivation, but good pay does not of itself create enthusiasm.
2. Human needs (motivators): this includes recognition, work, responsibility and advancement.

Unsatisfactory hygiene factors can act as de-motivators or dissatisfiers, but if satisfactory, their emotional effect is limited. According to him, motivation is complex and he has identified several myths about motivators such as:

- Shorter working weeks
- increasing wages
- Fringe benefits

- sensitivity/human relations training,
- Communication.

Hygiene factors satisfy animal needs but not human needs.

McClelland's Basic Needs Theory

David McClelland identified three basic needs that all people have in varying degrees:

1. The need for achievement: this involves a desire to make contribution, excel or succeed. People with this need are eager for responsibility and take calculated risks.
2. The need for power: this involves a desire to be in control. People with this need want to be in control and desires to influence others.
3. The need for affiliation: people with this need desire working in human environment and seek out meaningful friendships. They want to be respected and avoid decisions or actions that oppose group norms. They are interested in morale than productivity.

This theory emphasizes that management should match personnel with assignments. A project with well defined objectives should be handled by a person with high achievement. Work involving unpleasant task should be handled by a person with high need for power rather than a person with high affiliation need who is sympathetic.

Process theories

The four process theories of motivation are: Reinforcement theory, expectancy theory, equity theory and goal setting. Most behavior within organizations is learned behavior such as the perceptions, attitudes, goals, emotional reactions and skills. Practice that occurs during the learning process results in a relatively enduring change in behavior.

Skinner's Positive Reinforcement Theory

This theory, otherwise known as operant conditioning or behavior modification theory, stipulates that learning occurs as a consequence of behavior. Behavior is strengthened or weakened by what follows.

Behaviors are the operants and are controlled by altering the consequences with reinforcers or punishments. Reinforcers motivates, increasing the strength of a response or inducing its repetition. Continuous reinforcement speeds up early performance. Thus positive or desired behaviors should be rewarded or reinforced. Negative reinforcement occurs when desired behaviors occurs to avoid negative consequences of punishment. Behaviorist believes that people will repeat behavior when consequences are positive.

Application of behavior modification is occurring in large companies and nursing as a profession is not left out. The benefits of behavior modification are; improved attendance, productivity, efficiency and cost savings. Reinforcers focus on praise, recognition and feedback.

Victor Vroom- Expectancy Theory

This theory states that motivation is dependent on how much someone wants something and her estimate of the probability of getting it.

Tip

Motivation is the sum of valence and expectancy

Valence is the strength of one's preference for something which may be positive or negative. To be positive means something is wanted while to be negative means the thing is not wanted. Zero (0) valence means to be indifferent about something.

Expectancy is the probability of getting something through specific actions. Expectancy of one (1) means the person believes that the action will result in an outcome. Expectancy of zero (0) indicates that the person has no expectancy. Expectancy varies from one situation to another. Vroom believes that high valence and high expectation will lead to high motivation while a low valence and expectation will lead to low motivation. With either of the two low and the other high, a moderate motivation would be reached.

He went ahead to give a formula as follows:

M=EP x PO x V. Where M is motivation

EP is belief that effort will lead to desired performance,

PO is the anticipation that performance will lead to a particular outcome,

V is value of reward.

To be motivated, a person must find an outcome attractive, certain actions will lead to the desired outcome and so the person uses the outcome to determine if the action is worthwhile. An individual should be rewarded with what he or she perceives as important rather than what the manager perceives, for example, an individual may value a salary whereas another may value promotion.

Equity Theory

This theory was developed by Jo Stacy Adams and others. They assert that people asses fairness by considering their input and the psychological, social and financial rewards in comparison with those of others. Perceived inequality causes tension which is proportional to the magnitude of the perceived inequality. With inequality the person tends to decrease his or her productivity and performance. Thus, the manager should be attentive to the perceived equity of the reward system. Equity can be achieved or restored in the work place by changing outputs, attitudes, the reference person, or the situation. Research on equity theory has focused on pay.

Goal Setting Theory of Locke

This is the fourth process theory of motivation. This theory is based on the goals as the determinants of behavior. The more specific the goals, the better the results produced. Goals are powerful forces that must be achievable. Goal clarity and accurate feedback increases security.

Other theories of motivation are:

Douglas McGregor's Theory X

In this theory, which has been proven counter-effective in most modern practice, management assumes employees are inherently lazy and will avoid work if they can and that they inherently dislike work. Theory X assumes also that workers have no ambition, take no initiative and avoid taking any responsibility; all they want is security, and to get them do any work, they must be rewarded, coerced intimidated and punished. As a result of this, management believes that workers need to be closely supervised and comprehensive systems of controls developed. According to this theory, employees will show little ambition without an enticing incentive program and will avoid responsibility whenever they can.

If the organizational goals are to be met, theory X managers rely heavily on threat and coercion to gain their employee's compliance. Beliefs of this theory lead to mistrust, highly restrictive supervision, and a punitive atmosphere. He or she thinks all prospective employees are only out for themselves. Usually these managers feel the sole purpose of the employee's interest in the job is money. A Theory X manager believes that his or her employees do not really want to work, that they would rather avoid responsibility and that it is the manager's job to structure the work and energize the employee.

Summary of the theory include:

1. Management is responsible for organizing the elements of productive enterprise such as money, materials, equipment, and people in the interest of economic ends.
2. With respect to people, this theory is a process of directing their efforts, motivating them, controlling their actions, modifying their behavior to fit the needs of the organization.
3. Without this active intervention by management, people would be passive, even resistant to organizational needs, they must therefore be persuaded, rewarded, punished, controlled and their activities must be directed. This is management's task in managing subordinate managers or workers.

Theory Y

This theory was propounded by Douglas McGregor. On contrast to theory 'X', McGregor believed that people want to learn and that work is their natural activity to the extent that they develop self-discipline and self development. They see their reward not so much in cash payments as in freedom to do difficult and challenging work by themselves.

The managers' work is to 'dovetail' the human wish for self development into the organizations need for maximum productive efficiency. The basic objective of both manager and managed are therefore met and with imagination and sincerity, the enormous potential can be tapped.

The concepts of theory Y are:

1. Management is responsible for organizing the elements of productive enterprise such as, money, materials, equipment and people in the interest of economic ends.
2. People are not by nature passive or resistant to organizational needs. They have become so as a result of experience in organizations.
3. The motivation, the potential for development, the capacity for assuming responsibility, the readiness to direct behavior toward organizational goal are all present in people. Management does not put them there. It is the responsibility of the management to make it possible for people to recognize and develop these human characteristics for themselves.
4. The essential task of management is to arrange organizational conditions and methods of operation so that people can achieve their own goals best by directing their own efforts toward organizational objectives.

Chris Argyris- Psychological Energy Theory

This theorist asserts that people will exert more energy to meet their own needs than those of the organization. Disparity between the individual and organizational goals will make the person dissatisfied, tensed, conflict and apathy.

Thus management should match personnel and jobs by taking in to consideration their talents and interests, so that their job will be interesting and challenging and self actualization can be reached.

Frederick Taylor's Monistic Theory

The monistic theory is derived from the principles of scientific management. Taylor believes that if an energetic person with high productivity learns that she earned no more than a lazy worker who did as little as possible, she would lose interest in giving optimal performance. Thus an incentive was needed to prevent this loss. It should be possible to more by producing more, so that pay would depend on productivity. Incentives such as merit increases, bonus systems, profit sharing are examples of monistic methods.

Application of Employee Motivation Theory to the Work Place

Although there are many theories and much has been written about motivation, there is no easy way to motivate employees. Human motivation is diverse, subtle and complex. To use the available information on motivation effectively, the manager will have to read and

select and use those elements that appear to be practical and workable. Knowledge of motivation theories is essential to improving job performance of employees. Individual employees have different needs and goals. So, managers will learn and use motivation theories selectively.

The manager's main task is to develop a productive work place, with and through those he or she is in-charge of. The manager should motivate his or her team, both individually and collectively, so that a productive work place is developed and maintained and at the same time employees derive satisfaction from other jobs.

The main tools for motivating the team are:

- Approval, praise and recognition
- Trust, respect and high expectation
- Removing organizational barriers that stand in the way of individuals and group performance
- Job enrichment
- Good communications
- Financial incentives

The manager must not coerce but rather persuade, because persuasion is far more powerful than coercion and they have much chance of success if they use persuasion. Persuasion builds morale, initiative and morale.

Below is a list of tips the manager can use to motivate individuals. The manager tell the follower to

- Achieve their dreams. They should consume themselves with the motivation to achieve tremendous results from everything they attempt
- Believe in themselves, and in what they can do.
- Consider things on every angle and aspect.
- Don't give up and don't give in.
- Enjoy work as if they don't need money.
- Give more than what is enough.
- Hang on to their dreams.
- Just be themselves.
- Keep trying no matter how hard life may seem.
- Make things happen.
- Stop procrastinating.
- Take control of their life.
- Understand others.
- Zero in on their dreams and go for it.

Requisites to Motivate

* We have to be Motivated to Motivate

* Motivation requires a goal

* Motivation once established, does not last if not repeated

* Motivation requires Recognition
* Participation has motivating effect
* Seeing ourselves progressing Motivates us
* Challenge only motivates if you can win
* Everybody has a motivational fuse i.e. everybody can be motivated
* Group belonging motivates

Motivating Different People in Different Ways

Motivation is not only in a single direction i.e. downwards. In the present scenario, where the workforce is more informed, more aware, more educated and more goal oriented, the role of motivation has left the boundaries of the hierarchy of management. Apart from superior motivating a subordinate, encouragement and support to colleague as well as helpful suggestions on the right time, even to the superior, brings about a rapport at various work levels. Besides, where workforce is self motivated, just the acknowledgement of the same makes people feel important and wanted.

Difference between Motivation, Satisfaction, Inspiration and Manipulation

Motivation refers to the drive and efforts to satisfy a want or goal, whereas satisfaction refers to the contentment experienced when a want is satisfied. In contrast, inspiration is bringing about a change in the thinking pattern. On the other hand Manipulation is getting the things done from others in a predetermined manner.

Hence, manipulation or external stimulus as well as inspiration or internal stimulus acts as carriers of either demotivation or motivation which in turn either results into dissatisfaction or satisfaction depending upon.

Being a Motivating Manager

a. Treat staff well: Subordinates have to be treated with diligence. The manager has to stay friendly as well as maintain a level of distance with his staff. It's a tricky ground to tread. The staff looks up on the manager as their leader. They expect maturity, rationality and understanding from their superiors. Simple things like calling people by their first name, chatting about their families for a while or even a general inquiry about their well-being, brings in a feeling of belongingness. Small gestures of this type help in building up of a cordial relationship.
b. Think like a winner: A manager has to handle two situations, "The Winning" and "The loosing". The crux is to think like a winner even when all the odds seem against you. It is necessary to equip yourself with all the tools of a winner. Always remember that winning and loosing rotate in a cycle. If you have been loosing from a long time you are very near the winning edge.
c. Recognize the differences: All the employees in the organization vibrate to a different pace. A treatment that motivates one may

demotivation the other. Understanding the difference in temperament in between the individuals is important.

d. 4) Set realistic goals: Set moderate goals. Setting too high a task creates a feeling of non-achievement, right from the beginning itself. The goals set should be such which seem feasible to the employees to be achieved. A slightly higher target than expected provides a challenge.
e. Prevent Demotivation: A job of the manager is to motivate people. His task requires him to punish and penalize people. This might create resentment in the mind of the staff members, which may affect the productivity of the workforce. Henceforth, care should be taken, that punishment and penalties are used as a controlling technique and that they do not demotivation.
f. Job-financial enrichment and small job changes are handy: To make job more effective and to break the monotonous routine, small task additions and minor changes are always welcome. Even small suggestions of the manager seem valuable to the employees. A few challenges in the same job can enrich it.
g. Non-financial rewards: Monetary rewards have always had a high motivational capacity. But non-monetary rewards are equally helpful. A thank you note, a letter of appreciation or even few words of praise can help smoothen the creases between the different levels of management.

ITQ

Establish the difference between Motivation, Satisfaction, Inspiration and Manipulation.

Feedback

Motivation refers to the drive and efforts to satisfy a want or goal, whereas satisfaction refers to the contentment experienced when a want is satisfied. In contrast, inspiration is bringing about a change in the thinking pattern. On the other hand, Manipulation is getting the things done from others in a predetermined manner. Hence, manipulation or external stimulus as well as inspiration or internal stimulus acts as carriers of either demotivation or motivation, which in turn results into either dissatisfaction or satisfaction depending upon.

Study Session Summary

In this Study Session, we defined motivation as the general desire or willingness of someone to do something. We also examined the concept of motivation and discussed the process of motivation. Finally, we listed types of motivation and examined forms and various strategies for

Summary

motivation.

Assessment

Assessment

SAQ 6.1 (tests Learning Outcome 6.1)
Define Motivation

SAQ 6.2 (tests Learning Outcome 6.2)

Discuss the process of motivation

SAQ 6.3 (tests Learning Outcome 6.3

List the types of motivation

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Study Session 7

Functions and Components of Management Communication

Introduction

In this study session, we will define the term communication and examine the organizational communication. We will also list and explain the types of communication and discuss the problems of communication in the nursing practice setting and/or the impact of poor communication generally. Lastly, we will explore through the concept of controlling as well as financial management.

Learning Outcomes

Outcomes

When you have studied this session, you should be able to:

7.1 *define* communication and *examine* the concept of organizational communication

7.2 *explain* the concept of controlling

7.3 *describe* the term financial management

Terminology

Communication	the imparting or exchanging of information or news and/or the means of connection between people or places, in particular, the means of sending or receiving information, such as telephone lines or computers

7.1 Defining Communication

Communication is vital in every sphere of human activity. It may even be described as the life wire of the society. Through communication, politicians sell their manifestoes to voters, business enterprise sell their products and services to buyers, preachers propagate their religious messages, teachers impart knowledge to students, sicknesses and diseases diagnosed by

doctors, relationships, whether personal or official are activated, affected, maintained and sustained by it.

The way we communicate may manifest in verbal or in non-verbal form, and it involves two parties one communicating the other receiving. Good communication is essential to any groups or organizations effectiveness

Communication skills are needed to be an effective leader. Furthermore, in the complex client care environment, effective communication is a key factor in promoting efficiency and patient safety. Understanding the communication process can assist in preventing misunderstandings and improve the sending of important messages. Based on a theoretical model, communication is an interactive process between two or more persons and consists of several elements. The sender encodes a message using verbal and nonverbal behaviors, the message is sent, and the receiver must then decode the message. The receiver becomes the sender and must encode and send a response back to the sender who now becomes the receiver. In order to assure successful communication, a message must be verified by some type of feedback. Knowing that a message was communicated accurately is very important, especially in a critical patient-centered situation.

This basic process of communication between sender and receiver is intended to both convey information and exchange thoughts or feelings

Both the internal and external climate of communication also have considerable influence over the message being sent, and impact how the message might be received. The internal climate is composed of the sender's and receiver's feelings, biases, values, basic temperament, and the stress level. The temperature, personal space needs, timing and the general surroundings where the communication occurs characterize the external environment. In addition, there are other external influences that can be potential barriers to effective communication, such as a person's status; power and authority issues; and gender, especially when communication occurs between a predominantly male medical profession and a predominantly female nursing professional. Despite these considerations that influence the ability to communicate effectively, it is important to remember that communication is first and foremost an interactive process and that

the message being sent is never more important than the people engaged in the process.

In addition to being aware of the communication process, there are also certain skill sets that relate to effective communication. These interpersonal communication skills can be grouped into the following five key categories:

- *Listening Skills*–active or conscious skills required to truly listen and understand, plus effectively respond to what a person is saying.
- *Assertion Skills*–verbal and nonverbal behaviors that allow a person to maintain respect, satisfy needs, and defend rights without dominating, abusing, or controlling others.
- *Conflict Resolution Skills*– abilities that allow a person to deal with conflict, while preserving or promoting closer relationships when the conflict is resolved.
- *Collaborative Problem-Solving Skills*–a means of resolving conflicts and solving problems effectively. *Skill Selection*–guidelines that enable a person to choose what communication skills to use situation, including the use of appropriate humor. in any given

ITQ

What is important to remember regarding communication?

Feedback

As pertaining to communication, it is important to remember that communication is primarily an interactive process and that the message being sent is never more important than the people engaged in the process.

7.1.1 Organizational Communication

Lines of authority

In all organizations, there are 2 established systems which include:

- The formal communication system
- The informal communication system

Formal communication system: This could be vertical, horizontal or semi-vertical depending on the direction of information flow.

- **Vertical communication**: This is from the most senior officers to the most junior workers or from bottom to top (it could be upward or downward)
  - **Downward**: Plans, policies, strategies instructions are communicated through this means
  - **Upward:** Feedback, responses, clarifications, suggestions, opinions and comments are passed through this means.
- **Horizontal communication**: This is the exchange of messages or ideas between colleagues on the same level about the tasks which they perform within the organization
- **Semi-vertical communication**: This is through the trade unions recognized by law as the official mouth-piece of the workers.

Informal communication system: This is an unofficial channel in processing official information

Channels for informal communication include: Rumour and grapevine

- **Rumour**: This unofficial or unconfirmed information sent through interpersonal channels. It is inaccurate and often malicious. It is bad for people and for organizations. It is a sign that there is a gap in communication between management and employees. It should be prevented by the management.
- **The grapevine** is the positive side of rumour in an informal communication system. It is related to some aspects of the life of the organization. Sources of grapevine include; new information, excitement, loyalty, informal conversation, insecurity etc.

Teamwork and Communication

Teamwork is another key concept related to communication and ultimately the provision of safe patient care. Teamwork is the interaction or relationship of two or more health professionals who work interdependently to provide care for patients; teamwork means that the members of the team:

- Are mutually dependent;
- See themselves as working collaboratively for patient-centered care;
- Benefit from working collaboratively to provide patient care;
- Share information that may lead to shared decision-making; and
- Know when teamwork should be used to optimize patient-centered care.

With teamwork as a desired outcome, a culture of effective communication is imperative; many medical errors have been attributed to interpersonal interactions, with the lack of or failed communication being cited as the most common cause. In order to achieve a collaborative, high-performance team that achieves optimal patient outcomes as the end in mind, one must have an understanding of how and where communication breakdowns occur among team members.

7.1.2 Types of communication

This could be verbal or non-verbal

Verbal communication: can be oral or written

- **Oral (spoken):** Include face-to-face discussion, interviews, telephone, addressing a meeting, talking in groups. It is used in intrapersonal communication (within and individual), interpersonal communication, or in group communication.
- **Written (alphabet symbols):** In form of memos, notes, letters, notices, statement orders, invoices etc. It is the translation of oral messages to alphabetic symbols for personal business letters, queries, reporting, circulars, memos, essays, data collection instruments, telex and telegrams.

Non-verbal communication: This is a means of showing feelings through bode movement, gestures and postures.

- Body language: Including gestures, body shape, facial expression
- Paralanguage: That is, tone of voice or countenance
- Distance that is, gap between people.

ITQ

How can effective communication amongst members of a team help to avert medical error?

Feedback

With teamwork as a desired outcome, a culture of effective communication is imperative. Many medical errors have been attributed to interpersonal interactions, with the lack of or failed communication being cited as the most common cause. Therefore, to achieve a collaborative, high-performance team that achieves

optimal patient outcomes as the end in mind, one must have an understanding of how and where communication breakdowns occur among team members.

7.1.3 Problems with Communication in the Nursing Practice Setting/ Barriers to Communication

In the nursing practice environment, there are several complicated communication relationships including nurse-nurse, nurse-physician, and nurse-patient. This communication is critical to the patient and to the operations within a surgical environment. Because clinical communication is so complex, there are several ways in which it could fail, such as:

- *System Failure*–where the process is not in place to support effective communication;
- *Message Failure*–when the information is not transmitted even though the system exists;
- *Reception Failure*–in which the information that was transmitted accurately and using the proper tools was misinterpreted or it arrived too late.

In other words, barriers to effective communication include:

- Structural constraints: that is, location and architectural design of structures
- Human constraints: resulting from disparity in the level of language usage between different categories of workers
- Technological constraints or departmental barriers, which may include the use of professional jargons etc.

It is important to remember that the failure to communicate in an accurate and timely manner, that is, communication failure, is a significant contributor to medical errors.

ITQ

What are the identified problems responsible for poor communication between nurses and other members of the health care team?

Feedback

The problems that have identified includes System Failure–where the process is not in place to support effective communication; Message Failure–when the information is not transmitted even though the system

exists; and Reception Failure–in which the information that was transmitted accurately and using the proper tools was misinterpreted or it arrived too late.

7.1.4 The Impact of Poor Communication

There are various consequences that may occur when health-care professionals do not communicate well. For example, information can be overlooked or forgotten, not conveyed, or misdirected; instructions can also be delayed or misinterpreted. Other effects of poor communication include:

- Inappropriate orders may be implemented–an example of this may include administering the wrong dose of medication or administering medication at the wrong time.
- Ambiguous telephone orders may be given and accepted–because the names of several medications sound alike, as well as the issues of poor connections, language accents, or background noise, telephone orders are often opportunities for either misinterpretation or confusion. If an ambiguous order is taken and not verified, errors related to wrong treatments or medications could occur.
- A change in status may be overlooked or go undocumented–such changes include the onset of depression, a rise in body temperature, or an increase in heart rate. If unaware of such changes, the care delivered by a health-care provider could potentially cause harm.
- Critical details may be overlooked or go undocumented–examples here include patient allergies, blood type, or correct surgical site. Again, if unaware of these details, a health-care provider could potentially cause a patient harm.

Assertiveness

There is one skill that can help you effectively stand up to the bossy co-worker, an overbearing manager or a difficult team. It can also help your self-esteem and positively impact both personal happiness and workplace achievement. It is assertiveness.

There are four ways that you can respond to a challenging person or situation:

- submissiveness/passivity
- passive aggression
- aggression
- assertiveness

Submissive people avoid conflict and often fail to address issues at all. They keep the perception of peace but allow issues to fester as elephants remain in the room.

Passive-aggressive people express negative feelings indirectly through actions instead of words. This may include giving a partial effort or showing up late for work.

Aggressive people respond to circumstances by alienating others in a rude, obnoxious or hostile manner. Being aggressive allows your viewpoint to be heard but results in enemy creation and the inability to get things done.

Appropriately **assertive** individuals thrive, especially in ambiguous situations. Assertive people stand up for themselves in a respectful manner that does not purposely or intentionally escalate situations. They foster honest and clear communication and generate results by positively controlling their environment. Assertiveness is a sign of confidence, pride and enables people to feel higher levels of self-esteem.

Assertiveness is necessary to manage workplace relationships, assignments and ideas. However, being assertive is not easy and it is important to prepare for specific or general situations to make sure you handle them well.

Here are some tips to help to be appropriately assertive in the workplace:

Believe in your worth: It is easy to be assertive when you believe in the value you are adding to an organization. Consider yourself at least as important as anyone else and do not let others take advantage of you by being easily intimidated, silent or passive. Exhibit professional confidence and express yourself and your opinions.

Control your emotions: Frustration, anger and disappointment can lead to emotional reactions that limit your effectiveness. Lack of emotional self-control is a sign of weakness in the workplace and crying is a game changer and usually not a good one. If you feel your emotions getting the better of you, go for a walk and calm down. Never speak or react emotionally.

Set clear boundaries: Setting boundaries let's co-workers know how to behave around you. No one is a mind reader. Let people know your expectations, likes and dislikes. Boundaries add clarity to relationships and limit unwelcomed behavior and interactions.

Pick the right battles: It is not necessary to be assertive in all situations. Instead, know when to be assertive and when to hold your tongue. Many things can pass without the necessity of addressing them.

Rehearse: As with every new skill you should prepare in advance of a meeting or conversation. Plan out how you will open the conversation, transition to your main point and prepare to handle any specific objections and questions you might receive. Preparation will give you the confidence to execute.

Use positive body language: How you say things is as important as what you say. Display open body language, standing up straight and making good eye contact.

Directly and clearly address issues: If there is a problem with another person it is important to address it directly. Don't gossip or speak behind another's back; instead talk to the person cogently. Lack of clarity will be viewed as aggressive, confused or misdirected. Take the time to frame

your position with specificity, being conversational, unambiguous and direct.

Speak in the first person: Let the other person know that you are expressing your feelings, opinions and beliefs. Use the word "I" to make it clear that you are speaking. It will add sincerity and impact to your words.

Some examples of assertive statements include:

- "No, I cannot do that."
- "Thanks for the advice. I will consider that option."
- "This is not a priority for me. I will reach out to you when I have time."
- "I need to get back to you about that."
- "I appreciate your perspective but I do not agree."

Ask for what you want: Have you been passed over for a raise or promotion over the last couple of years? Now is the time to get it. Structure the discussion in light of the objective reasons you deserve the additional recognition. Be prepared for the boss to say no. If she does, it is important that you stay focused and positive and ask for a review in three to six months. You are not being pushy; instead you are being assertive.

Learn to say no: If you do not need to do something, you do not have to always accede to others. Saying "no" is a great way to take control of your workplace and relationships.

Here are some other tips to help one learn to be more assertive.

Make the decision to positively assert yourself: Commit to being assertive rather than passive or aggressive and start practising today.

Aim for open and honest communication: Remember to respect other people when you are sharing your feelings, wants, needs, beliefs or opinions.

Listen actively: Try to understand the other person's point of view and don't interrupt when they are explaining it to you.

Agree to disagree: Remember that having a different point of view doesn't mean you are right and the other person is wrong.

Avoid guilt trips: Be honest and tell others how you feel or what you want without making accusations or making them feel guilty.

Stay calm: Breathe normally, look the person in the eye, keep your face relaxed and speak in a normal voice.

Take a problem-solving approach to conflict: Try to see the other person as your friend not your enemy.

Practice assertiveness: Talk in an assertive way in front of a mirror or with a friend. Pay attention to your body language as well as to the words you say.

Use 'I': Stick with statements that include 'I' in them such as 'I think' or 'I feel'. Don't use aggressive language such as 'you always' or 'you never'.

Be patient: Being assertive is a skill that needs practice. Remember that you will sometimes do better at it than at other times, but you can always learn from your mistakes.

ITQ

How can a health-care provider cause harm to a patient as a result of poor communication?

Feedback

Critical details pertaining to the health of the patient may be overlooked or go undocumented. Examples include patient allergies, blood type, or correct surgical site. Again, if unaware of these details, a health-care provider could potentially cause a patient harm.

7.2 Controlling

Controlling in management involves comparing actual performance with planned performance and taking corrective action when and where necessary to ensure that the objectives of the organization are accomplished. The primary purpose of controlling is to ensure that everything occurs in line with the set standards. An effective system of control helps to predict deviations before they actually occur.

Three phases of controlling are described and include:

- Anticipating the things that could go wrong and taking preventive measures to see that they do not.
- Measuring actual performance in order to compare what is supposed to be happening
- Correcting performance problems that occur. This is referred to as the therapeutic aspect of control.

Need for control

- Adapting to environmental change
- Limiting the accumulation of errors
- Coping with organizational complexity
- Increasing productivity
- Reinforcing other management functions

Areas of control

- Physical resources
- Human resources
- Information resources
- Financial resources

Steps in control process

- Establish standard
- Measure performance
- Compare performance against standards
- Consider corrective actions

Requirements for effective control

- Integration with planning
- Flexibility
- Accuracy
- Timeliness
- Objectivity

Levels and types of control

Control is practiced at various levels in the organization and could be structural, operational of financial.

Types of operations control

- Preliminary control
- Screening control
- Post-action or feedback control

Resistance to control

- Over control
- Inappropriate focus
- Rewards for inefficiency
- Too much accountability

Overcoming resistance to control

- Encouraging employee participation
- Developing verification procedures

Time management

This is a conscious effort in doing what we plan to do and completing them in good time, putting first thing first. It is result-oriented and must therefore be goal-oriented. Success in time management reflects not only in the quality of work in the workplace but in one's personal life as well.

Principles of time management

- Develop a personal sense of time
- Identify long-term goals
- Make middle-term plans
- Weekly and daily planning
- Make the best use of your best time-Pareto principle
- Organize office work
- Manage meetings
- Delegate effectively
- Make use of committed time
- Managing one's health

Human resource management in nursing practice

Personnel management involves the effective use of the skills of people, be they health workers, teachers, factory workers or traders. Personnel

management is the planning, organizing, directing, and controlling of the procurement, development, compensation, integration and maintenance of people for the purpose of contributing to organizational, individual and social goals.

Functions

- *Manpower planning*
- *Entry*
- *Workforce*
- *Exit*

Steps in manpower planning

- *Analysis of current manpower inventory*
- *Manpower forecast*
- *Job analysis*

Steps in job analysis

- *Identification of how information will be used*
- *Review of background information*
- *Selecting representative positions for analysis*
- *Data collection and analysis*
- *Review of information collected with incumbents*
- *Development of job description/job specification*

Discipline

Discipline is a process designed to encourage an employee's compliance with defined standards by utilization of clearly outlined and progressive framework. Staff discipline is very important for the success of any organization.

The following are necessary for discipline at the workplace

- Positive attitude to work
- Focus on outcome as well as inputs
- Prompt and careful investigation of acts of misconducts
- Protection of privacy
- Even when enforcing discipline, all to understand that is the act was not acceptable and not the employee.
- Enforce rules consistently
- Appreciate growth and support others

Steps of constructive discipline

- Oral warning
- Written warning
- Suspension

Other disciplinary measures include:

- Fine for carelessness

- Transfer to less desirable unit or situation
- Suspension from work
- Demotion of rank
- Deferment of promotion
- Dismissal
- Retirement

ITQ

What does controlling in management entails?

Feedback

Controlling in management involves comparing actual performance with planned performance and taking corrective action when and where necessary to ensure that the objectives of the organization are accomplished. The primary purpose of controlling is to ensure that everything occurs in line with the set standards.

7.3 Financial Management/Budgeting

Health care is undergoing a transformation that embraces business values while trying to hold onto the professional concept of caring. Health care is a business with limited financial resources.

Tip

Financial management refers to the efficient and effective management of money (funds) in such a manner as to accomplish the objectives of the organization

Nurses are finding themselves providing care in an environment where the economics of health care are highly competitive and the costs of health care are closely monitored and frequently contemplated. “Nurses are entering into a new reality of practice that is controlled by costs”. Nurses need to keep in mind that money spent in any area must be budgeted. If unbudgeted money is spent, if the category is over budget or over the projected budget, then that money must be subtracted from another area. There is not an infinite supply of money that can be spent, no matter what the reason.

Take for example a personal budget. If you overspend, you try to accommodate this by spending less in another area. Or you go into debt. In contrast, if you spend less than the budgeted amount and are under your budget, you may have money saved for another area or to compensate for overspending. We do, however, have more control over

our personal spending than the spending of our organizations. Our organizations are subject to many variables that influence both revenue and expenses. Just think for a minute about the many events that increase labor costs. Sick calls, leave of absence, and an increase in census or acuity are just a few of the incidents that increase the dollars budgeted for staff.

Objectives of budget process

■ To provide a written expression, in quantitative terms, of the plans of the organization.

■ To provide a basis to evaluate financial performance in relation to the plans of the organization.

■ To provide a tool to measure fiscal and outcome compliance with the stated plan.

■ To create a sensitivity and heightened awareness of costs relative to resources used.

Creating a budget

Nurses have been expertly educated to use the nursing process. The same type of process is the most widely used approach to preparing a budget:

- Assessment
- Planning
- Implementation
- Evaluation

Types of budgets

■ Accrual: An accounting method that records expenses as they happen and revenue as it is earned. In nursing, vacation time is accrued as the employee earns it. This is usually recorded directly on an employee's pay stub in the pay period or month earned.

■ Bottom line: An expression that discusses the income of an organization that is the result of revenue (money earned) minus expenses: revenue - expenses _ income (bottom line)

■ Direct cost: Items that can be directly attributed to a cost center and related to the service delivered. For example, salaries of personnel and clerical supplies for a particular patient care unit are direct costs.

■ Expense: This is the amount of money an organization spends to produce its services or products. For example, wages are an expense to produce patient care.

■ Fiscal year: A business accounting period. It is usually 12 months and is used to report fiscal activity of an organization. This accounting period can start at any month of the year and end 12 months later. For example, it may begin November 1 and end the following October 31, 20XX (the next year).

■ For-profit: An organization established with the intention of making a profit to share with owners or stockholders.

■ Full-time equivalent (FTE): An FTE is the equivalent of the cost of one full-time employee working for 1 year. In general practice, this is calculated as 40 hours per week for 52 weeks per year, or a total of 2080 paid hours per year. The 2080 hours include productive (actually worked) and nonproductive time (vacation, sick, holiday, education). More than one employee may work to reach 2080 hours to make up the FTE.

■ Indirect costs: These costs may not be directly related to the cost center but are for the good of the organization as a whole. For example, costs for an advertisement for nursing positions and for housekeeping of public areas are indirect costs.

■ Nonproductive: Time not worked but for which the employee receives remuneration, e.g., pay for vacation and sick days.

■ Not-for-profit: An organization that does not have shareholders and reinvests its profits into the business.

■ Position control: A monitoring tool to compare actual numbers of FTE employees with the number of FTEs budgeted for the cost center.

■ Productive: Time actually worked by an employee.

■ Revenue: The amount of money the organization receives for its services or product.

ITQ

What are the phases of the budgeting process?

Feedback

The phases of the budgeting process include assessment, planning, implementation, and evaluation.

Rules of budgeting

■ Manager accountable for budget, must prepare budget

■ Expenses charged to cost center that spent the money

■ Expenses under control of manager

■ Unspent budgeted funds do not carry over to next fiscal year

■ Funds do not transfer between salary, supplies, or capital equipment money

■ Variance explanation also requires a corrective plan of action

ITQ

What is peculiar about the preparation of the budget?

Feedback

The Managing Nurse must be aware that preparation of the budget is not a delegated duty under any circumstance. Therefore, the managing nurse must always prepare the budget.

Study Session Summary

Summary

In this Study Session, we defined the term communication and examined the organizational communication. We also listed and explained the types of communication and discussed the problems of communication in the nursing practice setting and/or the impact of poor communication. We concluded by exploring through the concept of controlling as well as financial management

Assessment

Assessment

SAQ 7.1 (tests Learning Outcome 7.1)

Define communication

SAQ 7.2 (tests Learning Outcome 7.3)

Describe the term financial management

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Study Session 8

Application of Management to Nursing Practice

Introduction

In this study session, we will consider the roles of a nurse manager in the management of nursing unit and highlight those responsibilities to be fulfilled by a nurse manager.

Learning Outcomes

Outcomes

When you have studied this session, you should be able to:

8.1 Highlight the roles of a nurse manager

Terminology

Nurse manager	a supervisor of all of the performances of staff and patient care

8.1 The Role of the Rurse Manager in the Management of Nursing Unit

Nurse managers' can greatly influence the success of health care organizations because of their management role, especially at the unit level. During the past two decades, the nurse manager role has rapidly evolved into a position with greater authority and responsibility. "The role of the nurse manager is critical in the provision of effective and high quality care in any patient care delivery setting. This individual is actually the Chief Executive Officer (CEO) of that clinical area. She or he is accountable and responsible for patient safety and quality. This includes all of the nurse sensitive indicators recognized by regulatory and accrediting bodies, patient satisfaction, and financial performance. In addition, the nurse manger represents the direct caregiver voice at nursing leadership decision-making tables. This person has to advocate up to management for nurses and other staff, but also interpret and manage organizational decisions that come down to the unit. Because nurse

managers have such an immediate impact and such a far reach, they can influence everything from doctor satisfaction and patient length of stay to staff nurse turnover. As the demands of the job grow, many hospital leaders are making a subtle, yet important, change in the nurse manager's status by elevating the job title to "director.

With everything that is expected of nurse managers in this role, many hospitals are dedicating many resources to help them succeed, going well beyond traditional manager orientation. Some organizations provide special on-site training; some send nurses to programs offered by universities or professional groups; and some link nurses with mentors and support groups. These efforts emphasize the complex role of the nurse manager and the importance of organizations developing strong leaders for middle management. Another way that organizations are developing managers includes using fellowships and institutes to further develop the knowledge, skills and abilities essential for nurse manager's success. These provide networking opportunities and often foster working in teams on capstone projects in order to develop, not only essential skill sets, but confidence in project management. Socialization and emotional intelligence development are also a focus of these groups and aim at providing novice managers negotiation and cultural awareness skills.

Excellent nurse leadership is vital to surviving and thriving in the nurse manager role because an excellent nurse leader must possess administrative confidence, appropriate educational preparation, skills to manage business deals, broad clinical expertise and a thorough understanding of leadership principles.

In particular, nurse managers hold a pivotal role in linking the vision of the administration to actual clinical practice at the bedside. The nurse manager role is currently seen as one of the hardest, most complex roles in healthcare. The nurse manager is responsible for translating strategic goals and objectives formulate at the operational level into practice; thus, the position of nurse manager requires an ability to interpret general concepts and integrate them into specific clinical and management performance, while simultaneously determining and monitoring outcomes.

This nurse manager role is important because it is the direct link between the administrative mission and vision, and the direct care provider. In addition, the nurse manager role provides not only administrative and clinical leadership, but also has 24- hour accountability for all patient care activities on the unit. The role of the nurse manager in the acute care nursing area is pivotal in the development and retention of staff, as well as overall unit productivity. In total, the nurse manager has the responsibility to assure that the mission of the organization is translated into everyday practice, while assuring the quality and efficiency of the daily operations of their unit.

Remarkably, the nurse manager role has become increasingly complex due to the shifting environment of health care delivery, largely due to the evolution of care that has occurred at the nursing unit-level. Tremendous transformation over the past decade includes management of increased

complexity in clinical nursing practice, shorter hospitalizations for more acutely ill patients and pressures from compliance and regulatory agencies. Changes in healthcare economics, advances in technology, and structural operations in delivery systems have caused organizational transformation in healthcare institutions impacting nurse managers. Nurse managers are instrumental in role modeling and setting expectations for staff nurses regarding the importance of high quality, transparent and patient-focused care. Additionally, they are the conduit of communication between upper management and the bedside staff, providing key messages and setting the culture for their units and organization. The importance of this role cannot be underestimated in successful healthcare organizations today.

Categories of evolving role of the nurse manager include:

- Management of clinical nursing practice and patient care delivery;
- Management of human, fiscal, and other resources;

Development of personnel;

- Compliance with regulatory and professional standards;
- Strategic planning; and
- Fostering interdisciplinary, collaborative relationships within a unit(s) or area(s) of responsibility and the institution as a whole

Further breakdown of the management of clinical excellence included maintaining a safe, caring environment for patients, developing methods to assess patient's and family's response to nursing care, validating consistent medical regimes, and evaluating the effectiveness of the unit-based clinical programs. Managing resources was further defined as ensuring the effective and appropriate utilization of human and fiscal resources. Human resource development includes participation in the development and support of multi-skilled workers utilized in delivering patient care. Standards compliance includes accountability for local, state, and national professional organizations, regulatory agencies, and government. The nurse manager role and strategic planning includes translating the unit's strategic plan to staff, ensuring support of the plan, and modifying the plan in response to changing internal and external factors. At the unit-level, the nurse manager plays a pivotal role in promoting collegial relationships based on mutual respect and support. These collaborative relationships focus on patient care issues at the unit-level.

ITQ

What is the role of a Nurse Manager in the management of a nursing unit?

Feedback

The roles of a nurse manager includes all of the nurse sensitive indicators recognized by regulatory and accrediting bodies, patient satisfaction, and financial performance. In addition, the nurse manger represents the direct caregiver voice at nursing leadership decision-making tables. This person has to advocate up to management for nurses and other staff, and also interpret and manage organizational decisions that come down to the unit.

8.1.1 Nurse Manager Role

Nurse managers are accountable to upper-level administration for implementation of the philosophy, goals, and standards of the hospital organization at the unit-level. These pivotal individuals are responsible for overseeing units of people handling the daily operations of a unit or service line. These nurse administrators may be assigned titles such as nurse manager, clinical coordinator, nursing supervisor, or patient care director. They serve as the conduits between nurses and executive management, representing and advocating for their staff. Other responsibilities vary depending on the size and function of the organization. They may or may not be accountable to a nurse administrator at the organizational level.

Tip

Nurse managers are responsible to a nurse executive and manage one or more defined areas of nursing services

Nurse managers advocate for and allocate available resources to promote efficient, effective, safe, and compassionate nursing care based on current standards of practice. They promote shared decision-making and professional autonomy by providing input – their own and that of their staff – into executive-level decisions, and by keeping staff informed of executive-level activities and vice versa. Other responsibilities vary depending on the size and function of the organization.

Nurse managers also coordinate activities between defined areas of the organization, and provide clinical and administrative leadership and expertise. They facilitate an atmosphere of interactive management and the development of collegial relationships among nursing personnel and others. They serve as a link between nursing personnel and other healthcare disciplines and workers throughout the organization and within the healthcare community. Nurse managers have major responsibility for the implementation of the vision, mission, philosophy, core values, evidence-based practice, standards of the organization, and nursing services within their defined areas of responsibility.

Nurse managers are accountable for the environment in which clinical nursing is practiced. The nurse manager must create a learning environment that is open and respectful, and facilitate the sharing of expertise to promote quality care. The ability of nurse managers to enhance the practice environment is critical to the recruitment and

retention of registered nurses with diverse backgrounds and appropriate education and experience. Nurse managers contribute to the strategic planning process, day-to-day operations, standards of care, and attainment of goals of the organization. Nurse managers collaborate with the nurse executive and others in organizational planning, innovation, and evaluation.

The Scope and Standards from the ANA (2009) for Nurse Administration states that to fulfill the responsibilities, the nurse manager, in collaboration with nursing personnel and members of other disciplines, performs the following:

a. Ensure that care is delivered with respect for individuals' rights and preferences.
b. Participate in nursing organizational policy formulation and decision-making involving staff.
c. Accept organizational accountability for services provided to recipients.
d. Evaluate the quality and appropriateness of health care.
e. Coordinate nursing care with other healthcare disciplines, and assist in integrating services across the continuum of health care.
f. Participate in the recruitment, selection, and retention of personnel, including staff representative of the population diversity.

• Assess the impact of, and plan strategies to address such issues as:
  - Ethnic, cultural and diversity changes in the population.
  - Political and social influences.
  - Financial and economic issues.
  - The aging of society and demographic trends.
  - Ethical issues related to health care.
  - Assume responsibility for staffing and scheduling personnel. Assignments reflect appropriate utilization of personnel, considering scope of practice, competencies, patient/client/resident needs, and complexity of care.
  - Ensure appropriate orientation, education, credentialing, and continuing professional development for personnel.
  - Provide guidance for and supervision of personnel accountable to the nurse manager.
  - Evaluate performance of personnel.
  - Develop, implement, monitor, and be accountable for the budget for the defined area(s) of responsibility.
  - Ensure evidence-based practice by participating in and involving the nursing staff in evaluative research activities.
  - Provide or facilitate educational experiences for nursing and other students.
  - Ensure shared accountability for professional practice.
  - Advocate for a work environment that minimizes work-related illness and injury.

- Organizations may refer to nurse administrators at the manager-level by other titles, such as District Supervisor, Head Nurse, Department Head, Shift Manager, Clinical Coordinator, Project Manager, or Division Officer.

Models of Care Delivery

Functional nursing, team nursing, total client care, and primary nursing are models of care delivery that developed in an attempt to balance the needs of the client with the availability and skills of nurses. Both delegation and communication skills are essential to successfully follow through with any given model of care delivery.

Functional Nursing

Functional nursing or task nursing evolved during the mid-1940s due to the loss of RNs who left home to serve in the armed forces during the Second World War. Prior to the war, RNs comprised the majority of hospital staffing. Because of the lack of nurses to provide care at home, hospitals used more LPNs or licensed vocational nurses and UAP to care for clients.

When implementing functional nursing, the focus is on the task and not necessarily holistic client care. The needs of the clients are categorized by task, and then the tasks are assigned to the "best person for the job." This method takes into consideration the skill set and licensure scope of practice of each caregiver. For example, the RN would perform and document all assessments and administer all IV medications; the LPN or LVN would administer treatments and perform dressing changes. UAP would be responsible for meeting hygiene needs of clients, obtaining and recording vital signs, and assisting in feeding clients. This method is efficient and effective; however, when implemented, continuity in client care is lost. Many times, re evaluation of client status and follow-up do not occur, and a breakdown in communication among staff occurs.

Team Nursing

Team nursing grew out of functional nursing; nursing units often resort to this model when appropriate staffing is unavailable. A group of nursing personnel or a team provides care for a cluster of clients. The manner in which clients are divided varies and depends on several issues: the layout of the unit, the types of clients on the unit, and the number of clients on the unit. The organization of the team is based on the number of available staff and the skill mix within the group.

An RN assumes the role of the team leader. The team may consist of another RN, an LPN, and UAP. The team leader directs and supervises the team, which provides client care. The team knows the condition and needs of all the clients on the team.

The team leader acts as a liason between the clients and the health-care provider/physician. Responsibilities include formulating a client plan of care, transcribing and communicating orders and treatment changes to team members, and solving problems of clients and/or team members. The nurse manager confers with the team leaders, supervises the client care teams and, in some institutions, conducts rounds with the health-care

providers. For this method to be effective, the team leader needs strong delegation and communication skills. Communication among team members and the nurse manager avoids duplication of efforts and decreases competition for control of assignments that may not be equal based on client acuity and the skills sets of team members.

Total Client Care

During the 1920s total client care was the original model of nursing care delivery. Much nursing was in the form of private duty nursing, in which nurses cared for clients in homes and in hospitals. Schools of nursing located in hospitals provided students who staffed the nursing units and delivered care under the watchful eyes of nursing supervisors and directors. In this model, one RN assumes the responsibility of caring for one client. This includes acting as a direct liason among the client, family, health-care provider, and other members of the health-care team. Today, this model is seen in high acuity areas such as critical care units, postanesthesia recovery units, and in labor and delivery units. This model requires RNs to engage in non-nursing tasks that might be assumed by individuals without the educational level of an RN.

Primary Nursing

In the 1960s nursing care delivery models started to move away from team nursing and placed the RN in the role of giving direct client care. The central principle of this model is to distribute nursing decision making to the nurses caring for the client. As the primary nurse, the RN devises, implements, and is responsible for the nursing care of the client during the time the client remains on the nursing unit. The primary nurse along with associate nurses gives direct care to the client. In its ideal form, primary nursing requires an all-RN staff. Although this model provides continuity of care and nursing accountability, staffing is difficult and expensive. Some view it as ineffective as many tasks that consume the time of the RN could be carried out by other personnel.

ITQ

What is important about the responsibilities of the Nurse manager?

Feedback

Nurse managers advocate for and allocate available resources to promote efficient, effective, safe, and compassionate nursing care based on current standards of practice. They promote shared decision-making and professional autonomy by providing input – their own and that of their staff – into executive-level decisions, and by keeping staff informed of executive-level activities and vice versa.

Study Session Summary

Summary

In this Study Session, we considered the roles of a nurse manager in the management of nursing unit and highlighted those responsibilities to be fulfilled by a nurse manager

Assessment

Assessment

SAQ 8.1 (tests Learning Outcome 8.1)
Highlight the roles of a nurse manager

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Study Session 9

Quality Assurance and Risk Management

Introduction

In this study session, we will consider the discussion of quality improvement. We will also examine the aspects of health care that need to be evaluated. Finally, we will explore through the concept of risk management

Learning Outcomes

Outcomes

When you have studied this session, you should be able to:

9.1 *discuss* the concept of quality improvement

9.2 *explain* the aspects of health care for evaluation

9.3 *examine* the concept of risk management

Terminology

Quality improvement	a formal approach to the analysis of performance and systematic efforts to improve it
Risk management	the identification, analysis, assessment, control, and avoidance, minimization, or elimination of unacceptable risks

9.1 Quality Improvement

QI activities have been part of nursing care since Florence Nightingale evaluated the care of soldiers during the Crimean War. To achieve quality health care, QI activities use evidence-based methods for gathering data and achieving desired results. QI usually involves common characteristics:

- A link to key elements of the organization's strategic plan
- A quality council consisting of the institution's top leadership
- Training programs for all levels of personnel

- Mechanisms for selecting improvement opportunities
- Formation of process improvement teams
- Staff support for process analysis and redesign
- Personnel policies that motivate and support staff participation in process improvement

QI is called by many names: quality assurance, FADE, PDSA, total quality management (TQM), Six Sigma, and CQI.

ITQ

How does Quality Improvement help to achieve Quality Health care?

Feedback

To achieve quality health care, Quality Improvement activities use evidence-based methods for gathering data and achieving desired results.

Tip

QI is a structured organizational process for involving personnel in planning and executing a continuous flow of improvements to provide quality health care that meets or exceeds expectations

9.1.1 Using CQI to Monitor and Evaluate Quality of Care

Continuous quality improvement (CQI) is a process of identifying areas of concern (indicators), continuously collecting data on these indicators, analyzing and evaluating the data, and implementing needed changes. When one indicator is no longer a concern, another indicator is selected. Common indicators include, for example, number of falls, medication errors, and infection rates. Indicators can be identified by the accrediting agency or by the facility itself. The purpose of CQI is to improve the capability continuously of everyone involved in providing care, including the organization itself. CQI aims to avoid a blaming environment and attempts to provide a means to improve the entire system. CQI relies on collecting information and analyzing it. The time frame used in a CQI program can be retrospective (evaluating past performance, often called *quality assurance*), concurrent (evaluating current performance), or prospective (future-oriented, collecting data as they come in). The procedures used to collect data depend on the purpose of the program. Data may be obtained by observation, performance appraisals, patient satisfaction surveys, statistical analyses of length-of-stay and costs, surveys, peer reviews, and chart audits. In the CQI framework, data collection is everyone's responsibility. Collecting comprehensive, accurate, and representative data is the first step in the CQI process. You may be asked to brainstorm your ideas with other nurses or members of the interdisciplinary team, complete surveys or checklists, or keep a log of your daily activities. How do you administer medications to groups of patients? What steps are involved? Are the medications always available at the right time and in the right dose, or do

you have to wait for the pharmacy to bring them to the floor? Is the pharmacy technician delayed by emergency orders that must be processed? Looking at the entire process and mapping it out on paper in the form of a flowchart may be part of the CQI process for your organization.

9.1.2 QI at the Organizational and Unit Levels

Strategic Planning

Leaders and managers are so often preoccupied with immediate issues that they lose sight of their ultimate objectives. Quality cannot be found at the unit level if the organization is not focusing on quality issues. To stay on track, an organization needs a strategic plan. A **strategic plan** is a short, visionary, conceptual document that:

- Serves as a framework for decisions or for securing support/approval
- Provides a basis for more detailed planning
- Explains the business to others in order to inform, motivate, and involve assists benchmarking and performance monitoring
- Stimulates change and becomes the building block for the next plan.

During the strategic planning process, the organization develops or reviews its vision, mission statement, and corporate values. A group develops business objectives and key strategies to meet these objectives. In order to do this, a SWOT analysis is done—a review of the organization's Strengths, Weaknesses, Opportunities, and Threats. Key strategies are identified, and action plans are developed.

The organization's mission, goals, and strategic plan ultimately drive the outcomes and QI plan for that organization. Be proactive, and participate in the process. Ask your nurse manager if there are opportunities for the staff to participate in the planning process.

Issues related to QI may come out of strategic planning process. Quality issues are not often apparent to senior managers

Staff members at the unit level can often identify quality issues because they are the ones who can feel the impact when quality is lacking. Once a process that needs improvement is identified, an interdisciplinary team is organized whose members have knowledge of the identified process. The team members meet to identify and analyze problems, discuss solutions, and evaluate changes. The team clarifies the current knowledge of the process; it identifies causes for variations in the process and works to unify the process.

Structured Care Methodologies

Most agencies have tools for tracking outcomes. These tools are called *structured care methodologies* (SCMs). SCMs are interdisciplinary tools

to "identify best practices, facilitate standardization of care, and provide a mechanism for variance tracking, quality enhancement, outcomes measurement, and outcomes research". SCMs include guidelines, protocols, algorithms, standards of care, critical pathways, and order sets.

- **Guidelines.** Guidelines first appeared in the 1980s as statements to assist health-care providers and patients in making appropriate health-care decisions. Guidelines are based on current research strategies and are often developed by experts in the field. The use of guidelines is seen as a way to decrease variations in practice.
- **Protocols.** Protocols are specific, formal documents that outline how a procedure or intervention should be conducted. Protocols have been used for many years in research and specialty areas but have been introduced into general health care as a way to standardize approaches to achieve desired outcomes. An example in many facilities is a chest pain protocol.
- **Algorithms.** Algorithms are systematic procedures that follow a logical progression based on additional information or patient responses to treatment. They were originally developed in mathematics and are frequently seen in emergency medical services. Advanced cardiac life support algorithms are now widely used in health-care agencies.
- **Standards of care.** Standards of care are often discipline-related and help to operationalize patient care processes and provide a baseline for quality care. Lawyers often refer to a discipline's standards of care in evaluating whether a patient has received appropriate services.
- **Critical (or clinical) pathways.** A critical pathway outlines the expected course of treatment for patients with similar diagnoses. The critical pathway should orient the nurse easily to the patient outcomes for the day. In some institutions, nursing diagnoses with specific time frames are incorporated into the critical pathway, which describes the course of events that lead to successful patient outcome within the diagnosis-related group (DRG)–defined time frame. For the patient with an uncomplicated myocardial infarction (MI), a proposed course of events leading to a successful patient outcome within the 4-day

DRG-defined time frame might be as follows:

a. Patient states that chest pain is relieved;
b. ST- and T-wave changes resolve and pulse oximeter reading is greater than 90%; patient has clear breath sounds;
c. Patient ambulates in hall without experiencing extreme fatigue or chest pain;
d. Patient verbalizes feelings about having an MI and future fears;
e. Patient identifies effective coping strategies;
f. Ventricular dysfunction, dysrhythmia, or crackles resolved

Critical Pathways

Critical pathways are clinical protocols involving all disciplines. They are designed for tracking a planned clinical course for patients based on average and expected lengths of stay. Financial outcomes can be

evaluated from critical pathways by assessing any variances from the proposed length of stay. The health-care agency can then focus on problems within the system that extend the length of stay or drive up costs because of overutilization or repetition of services Critical pathways provide a framework for communication and documentation of care. They are also excellent teaching tools for staff members from various disciplines. Institutions can use critical pathways to evaluate the cost of care for different patient populations.

Most institutions have adopted a chronological, diagrammatic format for presenting a critical pathway. Time frames may range from daily (day 1,day 2, day 3) to hourly, depending on patient needs. Key elements of the critical pathway include discharge planning, patient education, consultations, activities, nutrition, medications, diagnostic tests, and treatment.

Although originally developed for use in acute care institutions, critical pathways can be developed for home care and long-term care. The patient's nurse is usually responsible for monitoring and recording any deviations from the critical pathway. When deviations occur, the reasons are discussed with all members of the health-care team, and the appropriate changes in care are made. The nurse must identify general trends in patient outcomes and develop plans to improve the quality of care to reduce the number of deviations. Through this close monitoring, the health-care team can avoid last-minute surprises that may delay patient discharge and can predict lengths of stay more effectively.

Questions the Team Needs to Ask

1. Who are our customers, stakeholders, markets?

2. What do they expect from us?

3. What are we trying to accomplish?

4. What changes do we think will make an improvement?

5. How and when will we pilot-test our predicted improvement?

6. What do we expect to learn from the pilot test?

7. What will we do with negative results? Positive results?

8. How will we implement the change?

9. How will we measure success?

10. What did we learn as a team from this experience?

11. What changes would we make for the future?

ITQ

With respect to an organization, what does the strategic planning process entails?

Feedback

During the strategic planning process, the organization develops or reviews its vision, mission statement, and corporate values. A group develops business objectives and key strategies to meet these objectives.

In order to do this, a SWOT analysis is done. A SWOT analysis is a review of the organization's Strengths, Weaknesses, Opportunities, and Threats. Key strategies are identified, and action plans are developed. This is important because the organization's mission, goals, and strategic plan ultimately drive the outcomes and QI plan for that organization.

9.2 Aspects of Health Care to Evaluate

A CQI program can evaluate three aspects of health care: the structure within which the care is given, the process of giving care, and the outcome of that care. A comprehensive evaluation should include all three aspects. When evaluation focuses on nursing care, the independent, dependent, and interdependent functions of nurses may be added to the model.

Structure

Structure refers to the setting in which the care is given and to the resources (human, financial, and material) that are available. The following structural aspects of a health-care organization can be evaluated:

a. ***Facilities***. Comfort, convenience of layout, accessibility of support services, and safety
b. ***Equipment***. Adequate supplies, state-of-the-art equipment, and staff ability to use equipment
c. ***Staff***. Credentials, experience, absenteeism, turnover rate, staff-patient ratios
d. ***Finances***. Salaries, adequacy, sources

Although none of these structural factors alone can guarantee quality care, they make good care more likely. A higher level of nurses each shift and a higher proportion of Registered Nurses are associated with shorter lengths of stay; higher proportions of RNs are also related to fewer adverse patient outcomes.

Process

Process refers to the activities carried out by the health-care providers and all the decisions made while a patient is interacting with the organization. Examples include:

a. Setting an appointment
b. Conducting a physical assessment
c. Ordering a radiograph and magnetic resonance imaging scan
d. Administering a blood transfusion
e. Completing a home environment assessment
f. Preparing the patient for discharge
g. Telephoning the patient post discharge

Each of these processes can be evaluated in terms of timeliness, appropriateness, accuracy, and completeness. Process variables include psychosocial interventions, such as teaching and counseling, and physical care measures. Process also includes leadership activities, such as interdisciplinary team conferences.

When process data are collected, a set of objectives, procedures, or guidelines is needed to serve as a standard or gauge against which to compare the activities

This set can be highly specific, such as listing all the steps in a catheterization procedure, or it can be a list of objectives, such as offering information on breastfeeding to all expectant parents or conducting weekly staff meetings.

The American Nurses Association (ANA) Standards of Care are process standards that answer the question: What should the nurse be doing, and what process should the nurse follow to ensure quality care?

Outcome

An *outcome* is the result of all the health-care providers' activities. Outcome measures evaluate the effectiveness of nursing activities by answering such questions as: Did the patient recover? Is the family more independent now? Has team functioning improved? Outcome standards address indicators such as physical and mental health; social and physical function; health attitudes, knowledge, and behavior; utilization of services; and customer satisfaction.

The outcome questions asked during an evaluation should measure observable behavior, such as the following:

a. Patient: Wound healed; blood pressure within normal limits; infection absent
b. Family: Increased time between visits to the emergency department; applied for food stamps
c. Team: Decisions reached by consensus; attendance at meetings by all team members

Some of these outcomes, such as blood pressure or time between emergency department visits, are easier to measure than other, equally important outcomes, such as increased satisfaction or changes in attitude. Although the latter cannot be measured as precisely, it is important to include the full spectrum of biological, psychological, and social aspects. For this reason, considerable effort has been put into identifying the patient outcomes that are affected by the quality of nursing care. A major problem in using and interpreting outcome measures is that outcomes are influenced by many factors. For example, the outcome of patient teaching done by a nurse on a home visit is affected by the patient's interest and ability to learn, the quality of the teaching materials, the presence or absence of family support, information (which may conflict) from other caregivers, and the environment in which the teaching is done. If the teaching is successful, can the nurse be given full credit for the success? If it is not successful, who has failed? It is necessary to evaluate the process as well as the outcome to determine why an intervention such as patient teaching succeeds or fails. A comprehensive evaluation includes all three aspects: structure, process, and outcome. However, it is much

more difficult to gather and monitor outcome data than to measure structure or process.

ITQ

What aspects of healthcare is often evaluated?

Feedback

A CQI program can evaluate three aspects of health care: the structure within which the care is given, the process of giving the care, and the outcome of that care. A comprehensive evaluation should include these three aspects.

9.3 Risk Management

An important part of CQI is **risk management,** a process of identifying, analyzing, treating, and evaluating real and potential hazards. The Joint Commission (JC) recommends the integration of a quality control/risk management program to maintain continuous feedback and communication. To plan proactively, an organization must identify real or potential exposures that might threaten it.

Risk is one of the most overlooked areas in small businesses in spite of the fact that it is clear to most small business owners that operating any business involves risk. While taking a risk and winning is fun, prudent business owners take care to minimize the risk, just as you would in any other type of risky venture you undertake.

Tip

A good risk management system is a continuous process of analysis and communication

In the 1990s, the field of risk management expanded to include managing financial risks as well as those associated with changing technology and Internet commerce. As of 2000, the role of risk management had begun to expand even further to protect entire companies during periods of change and growth. As businesses grow, they experience rapid changes in nearly every aspect of their operations, including production, marketing, distribution, and human resources. Such rapid change also exposes the business to increased risk. In response, risk management professionals created the concept of enterprise risk management, which was intended to

implement risk awareness and prevention programs on a company wide basis. "Enterprise risk management seeks to identify, assess, and control sometimes through insurance.

The main focus of enterprise risk management is to establish a culture of risk management throughout a company to handle the risks associated with growth and a rapidly changing business environment. Writing in Best's Review, Tim Tongson recommended that business owners take the following steps in implementing an enterprise wide risk management program:

1. Incorporate risk management into the core values of the company,
2. Support those values with actions,
3. Conduct a risk analysis,
4. Implement specific strategies to reduce risk,
5. Develop monitoring systems to provide early warnings about potential risks, and
6. Perform periodic reviews of the program.

The term risk management is a relatively recent (within the last 20 years) evolution of the term "insurance management." The concept of risk management encompasses a much broader scope of activities and responsibilities than does insurance management. Risk management is now a widely accepted description of a discipline within most large organizations.

As a nurse, it is your responsibility to report adverse incidents to the risk manager, according to your organization's policies and procedures. In many states, this is a legal requirement.

Risk events are categorized according to severity. Although all untoward events are important, not all carry the same severity of outcomes.

1. **Service occurrence.** A service occurrence is an unexpected occurrence that does not result in a clinically significant interruption of services and that is without apparent patient or employee injury. Examples include minor property or equipment damage, unsatisfactory provision of service at any level, or inconsequential interruption of service. Most occurrences in this category are addressed within the patient complaint process.
2. **Serious incident.** A serious incident results in a clinically significant interruption of therapy or service, minor injury to a patient or employee, or significant loss or damage of equipment or property. Minor injuries are usually defined as needing medical intervention outside of hospital admission or physical or psychological damage.
3. **Sentinel events.** A sentinel event is an unexpected occurrence involving death or serious/ permanent physical or psychological injury, or the risk thereof. The phrase, "or the risk thereof " includes any process variation for which a recurrence would carry a significant

chance of a serious adverse outcome. Such events are called sentinel because they signal the need for immediate investigation and response. When a sentinel event occurs, appropriate individuals within the organization must be made aware of the event; they must investigate and understand the causes of the event; and they must make changes in the organization's systems and processes to reduce the probability of such an event in the future.

The subset of sentinel events that is subject to review by JC includes any occurrence that meets any of the following criteria:

a. The event has resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition.
b. The event is one of the following (even if the outcome was not death or major permanent loss of function): suicide of a patient in a setting where the patient receives around-the-clock care (e.g., hospital, residential treatment center, crisis stabilization center), infant abduction or discharge to the wrong family, rape, hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities, surgery on the wrong patient or wrong body part.

Adhering to nursing standards of care as well as the policies and procedures of the institution greatly decreases the nurse's risk. Common areas of risk for nursing include:

a. Medication errors
b. Documentation errors and/or omissions
c. Failure to perform nursing care or treatments correctly
d. Errors in patient safety that result in falls
e. Failure to communicate significant data to patients and other providers. Risk management programs also include attention to areas of employee wellness and prevention of injury. Latex allergies, repetitive stress injuries, carpal tunnel syndrome, barrier protection for tuberculosis, back injuries, and the rise of antibiotic resistant organisms all fall under the area of risk management.

Adhering to standards of care and exercising the amount of care that a reasonable nurse would demonstrate under the same or similar circumstances can protect the nurse from litigation. Understanding what actions to take when something goes wrong is imperative. The main goal is patient safety. Reporting and remediation must occur quickly. Once an incident has occurred, you must complete an incident report immediately. The incident report is used to collect and analyze data for future determination of risk. The report should be accurate, objective, complete, and factual. If there is future litigation, the plaintiff 's attorney can subpoena the report. The report should be prepared in only a single copy and never placed in the medical record. It is kept with internal hospital correspondence.

Nurses have a responsibility to remain educated and informed and to become active participants in understanding and identifying potential risks to their patients and to themselves. Ignorance of the law is no

excuse. Maintaining a knowledgeable, professional, and caring nurse-patient relationship is the first step in decreasing your own risk.

It is important that the small business owner and top managers show their support for employee efforts at managing risk. To bring together the various disciplines and implement integrated risk management, ensuring the buy in of top level executives is vital. Luis Ramiro Hernandez wrote in Risk Management. "These executives can institute the processes that enable people and resources across the company to participate in identifying and assessing risks, and tracking the actions taken to mitigate or eliminate those risks."

Risk management involves identifying, analysing, and taking steps to reduce or eliminate the exposures to loss faced by an organization or individual

The practice of risk management utilizes many tools and techniques, including insurance, to manage a wide variety of risks. Every business encounters risks, some of which are predictable and under management's control, and others which are unpredictable and uncontrollable.

Risk management is particularly vital for small businesses, since some common types of losses—such as theft, fire, flood, legal liability, injury, or disability—can destroy in a few minutes what may have taken an entrepreneur, years to build. Such losses and liabilities can affect day to day operations, reduce profits, and cause financial hardship severe enough to cripple or bankrupt a small business. But while many large companies employ a full time risk manager to identify risks and take the necessary steps to protect the firm against them, small companies rarely have that luxury. Instead, the responsibility for risk management is likely to fall on the small business owner.

Basic risks such as fire, windstorm, employee injuries, and automobile accidents, as well as more sophisticated exposures such as product liability, environmental impairment, and employment practices, are the province of the risk management department in a typical corporation. Although risk management has usually pertained to property and casualty exposures to loss, it has recently been expanded to include financial risk management—such as interest rates, foreign exchange rates, and derivatives—as well as the unique threats to businesses engaged in E commerce. As the role of risk management has increased, some large companies have

begun implementing large scale, organization wide programs known as enterprise risk management.

Risk management is the identification, assessment, and Ranking of risks followed by coordinated and economical application of resources to minimize, monitor, and control the probability and/or impact of unfortunate events or to maximize the realization of opportunities. Risks can come from uncertainty in financial markets, project failures, legal liabilities, credit risk, accidents, natural causes and disasters as well as deliberate attacks from an adversary. Several risk management standards have been developed including the Project Management Institute, the National Institute of Science and Technology, actuarial societies, and ISO standards. Methods, definitions and goals vary widely according to whether the risk management method is in the context of project management, security, engineering, industrial processes, financial portfolios, actuarial assessments, or public health and safety.

Risk management in nursing attempts to analyze problems and minimize losses after a patient care error occurs. The strategies to manage risk include transferring the risk to another party, avoiding the risk, reducing the negative effect of the risk, and accepting some or all of the consequences of a particular risk. Certain aspects of many of the risk management standards have come under criticism for having no measurable improvement on risk even though the confidence in estimates and decisions increase.

In ideal risk management, a prioritization process is followed whereby the risks with the greatest loss and the greatest probability of occurring are handled first, and risks with lower probability of occurrence and lower loss are handled in descending order. In practice the process can be very difficult, and balancing between risks with a high probability of occurrence but lower loss versus a risk with high loss but lower probability of occurrence can often be mishandled.

Intangible risk management identifies a new type of a risk that has a 100% probability of occurring but is ignored by the organization due to a lack of identification ability. For example, when deficient knowledge is applied to a situation, a knowledge risk materializes. Relationship risk appears when ineffective collaboration occurs. Process-engagement risk may be an issue when ineffective operational procedures are applied. These risks directly reduce the productivity of knowledge workers, decrease cost effectiveness, profitability, service, quality, reputation, brand value, and earnings quality. Intangible risk management allows risk management to create immediate value from the identification and reduction of risks that reduce productivity.

Risk management also faces difficulties in allocating resources. This is the idea of opportunity cost. Resources spent on risk management could have been spent on more profitable activities. Again, ideal risk management minimizes spending and minimizes the negative effects of risks.

ITQ

What are the roles of Nurses in Risk management?

Feedback

Nurses have a responsibility to remain educated and informed and to become active participants in understanding and identifying potential risks to their patients and to themselves. Ignorance of the law is no excuse. Maintaining a knowledgeable, professional, and caring nurse-patient relationship is the first step in decreasing your own risk.

Methods of Risk Management

For the most part, these methods consist of the following elements, performed, more or less, in the following order:

1. Identify, characterize, and assess threats
2. Assess the vulnerability of critical assets to specific threats
3. Determine the risk (i.e. the expected consequences of specific types of attacks on specific assets)
4. Identify ways to reduce those risks
5. Prioritize risk reduction measures based on a strategy

Principles of Risk Management

The International Organization for Standardization (ISO) identifies the following principles of risk management:

Risk management should:

- create value
- be an integral part of organizational processes
- be part of decision making
- explicitly address uncertainty
- be systematic and structured
- be based on the best available information
- be tailored
- take into account human factors
- be transparent and inclusive
- be dynamic, iterative and responsive to change
- be capable of continual improvement and enhancement

Processes Involved in Risk Management

According to the standard ISO 31000 "Risk management -- Principles and guidelines on implementation, the process of risk management consists of several steps as follows:

1. Establishing the context: This involves-

   a. **Identification** of risk in a selected domain of interest
   b. **Planning** the remainder of the process.
   c. **Mapping out** the following; the social scope of risk management, the identity and objectives of stakeholders, the basis upon which risks will be evaluated, constraints.

2. **Identification of the risk:** After establishing the context, the next step in the process of managing risk is to identify potential risks. Risks are about events that, when triggered, cause problems. Hence, risk identification can start with the source of problems, or with the problem itself.
   - **Source analysis:** Risk sources may be internal or external to the system that is the target of risk management.
   - **Problem analysis**

When either source or problem is known, the events that a source may trigger or the events that can lead to a problem can be investigated. For example: stakeholders withdrawing during a project may endanger funding of the project; privacy information may be stolen by employees even within a closed network; lightning striking an aircraft during takeoff may make all people onboard immediate casualties.

The chosen method of identifying risks may depend on culture, industry practice and compliance. The identification methods are formed by templates or the development of templates for identifying source, problem or event. Common risk identification methods are:

- Objectives-based risk identification
- Scenario-based risk identification
- Taxonomy-based risk identification
- Common-risk checking

Risk charting

Assessment: Once risks have been identified, they must then be assessed as to their potential severity of loss and to the probability of occurrence. These quantities can be either simple to measure, in the case of the value of a lost building, or impossible to know for sure in the case of the probability of an unlikely event occurring. Therefore, in the assessment process it is critical to make the best educated guesses possible in order to properly prioritize the implementation of the risk management plan.

The fundamental difficulty in risk assessment is determining the rate of occurrence since statistical information is not available on all kinds of past incidents. Furthermore, evaluating the severity of the consequences

(impact) is often quite difficult for immaterial assets. Asset valuation is another question that needs to be addressed. Thus, best educated opinions and available statistics are the primary sources of information. Nevertheless, risk assessment should produce such information for the management of the organization that the primary risks are easy to understand and that the risk management decisions may be prioritized. Thus, there have been several theories and attempts to quantify risks. Numerous different risk formulae exist, but perhaps the most widely accepted formula for risk quantification is:

Rate of occurrence multiplied by the impact of the event equals risk

Composite Risk Index

The above formula can also be re-written in terms of a Composite Risk Index, as follows:

Composite Risk Index = Impact of Risk event x Probability of Occurrence

The impact of the risk event is assessed on a scale of 0 to 5, where 0 and 5 represent the minimum and maximum possible impact of an occurrence of a risk (usually in terms of financial losses).

The probability of occurrence is likewise assessed on a scale from 0 to 5, where 0 represents a zero probability of the risk event actually occurring while 5 represents a 100% probability of occurrence.

The Composite Index thus can take values ranging from 0 through 25, and this range is usually arbitrarily divided into three sub-ranges. The overall risk assessment is then Low, Medium or High, depending on the sub-range containing the calculated value of the Composite Index. For instance, the three sub-ranges could be defined as 0 to 8, 9 to 16 and 17 to 25.

Note that the probability of risk occurrence is difficult to estimate since the past data on frequencies are not readily available, as mentioned above.

Likewise, the impact of the risk is not easy to estimate since it is often difficult to estimate the potential financial loss in the event of risk occurrence.

Further, both the above factors can change in magnitude depending on the adequacy of risk avoidance and prevention measures taken and due to changes in the external business environment. Hence it is absolutely necessary to periodically re-assess risks and intensify/relax mitigation measures as necessary.

4. **Potential risk treatments:** Once risks have been identified and assessed, all techniques to manage the risk fall into one or more of these four major categories:

i. Avoidance (eliminate, withdraw from or not become involved)

ii. Reduction (optimize - mitigate)

iii. Sharing (transfer - outsource or insure)

iv. Retention (accept and budget)

Ideal use of these strategies may not be possible. Some of them may involve trade-offs that are not acceptable to the organization or person making the risk management decisions. Another source, from the US Department of Defense, Defense Acquisition University, calls these categories **ACAT**, for Avoid, Control, Accept, or Transfer. This use of the ACAT acronym is reminiscent of another ACAT (for Acquisition Category) used in US Defense industry procurements, in which Risk Management figures prominently in decision making and planning.

Risk avoidance: This includes not performing an activity that could carry risk. An example would be not buying a property or business in order to not take on the legal liability that comes with it. Another would be not flying in order not to take the risk that the airplanes were to be hijacked. Avoidance may seem the answer to all risks, but avoiding risks also means losing out on the potential gain that accepting (retaining) the risk may have allowed. Not entering a business to avoid the risk of loss also avoids the possibility of earning profits.

Hazard Prevention: Hazard prevention refers to the prevention of risks in an emergency. The first and most effective stage of hazard prevention is the elimination of hazards. If this takes too long, is too costly, or is otherwise impractical, the second stage is mitigation.

Risk reduction: Risk reduction or "optimization" involves reducing the severity of the loss or the likelihood of the loss from occurring. For example, sprinklers are designed to put out a fire to reduce the risk of loss by fire. This method may cause a greater loss by water damage and therefore may not be suitable. Halon fire suppression systems may mitigate that risk, but the cost may be prohibitive as a strategy.

Acknowledging that risks can be positive or negative, optimizing risks means finding a balance between negative risk and the benefit of the operation or activity; and between risk reduction and effort applied. By an offshore drilling contractor effectively applying HSE Management in its organization, it can optimize risk to achieve levels of residual risk that are tolerable.

Risk sharing: Briefly defined as "sharing with another party the burden of loss or the benefit of gain, from a risk, and the measures to reduce a risk." The term of 'risk transfer' is often used in place of risk sharing in the mistaken belief that you can transfer a risk to a third party through insurance or outsourcing. In practice if the insurance company or contractor go bankrupt or end up in court, the original risk is likely to still revert to the first party. As such in the terminology of practitioners and scholars alike, the purchase of an insurance contract is often described as a "transfer of risk." However, technically speaking, the buyer of the contract generally retains legal responsibility for the losses "transferred", meaning that insurance may be described more accurately as a post-event compensatory mechanism.

Risk retention: Involves accepting the loss, or benefit of gain, from a risk when it occurs. True self insurance falls in this category. Risk retention is a viable strategy for small risks where the cost of insuring

against the risk would be greater over time than the total losses sustained. All risks that are not avoided or transferred are retained by default. This includes risks that are so large or catastrophic that they either cannot be insured against or the premiums would be infeasible. War is an example since most property and risks are not insured against war, so the loss attributed by war is retained by the insured. Also any amounts of potential loss (risk) over the amount insured is retained risk. This may also be acceptable if the chance of a very large loss is small or if the cost to insure for greater coverage amounts is so great it would hinder the goals of the organization too much.

Create a risk management plan: Select appropriate controls or countermeasures to measure each risk. Risk mitigation needs to be approved by the appropriate level of management. For instance, a risk concerning the image of the organization should have top management decision behind it whereas IT management would have the authority to decide on computer virus risks.

The risk management plan should propose applicable and effective security controls for managing the risks. For example, an observed high risk of computer viruses could be mitigated by acquiring and implementing antivirus software. A good risk management plan should contain a schedule for control implementation and responsible persons for those actions.

According to ISO/IEC 27001, the stage immediately after completion of the risk assessment phase consists of preparing a Risk Treatment Plan, which should document the decisions about how each of the identified risks should be handled. Mitigation of risks often means selection of security controls, which should be documented in a Statement of Applicability, which identifies which particular control objectives and controls from the standard have been selected, and why.

Implementation: Implementation follows all of the planned methods for mitigating the effect of the risks. Purchase insurance policies for the risks that have been decided to be transferred to an insurer, avoid all risks that can be avoided without sacrificing the entity's goals, reduce others, and retain the rest.

Review and evaluation of the plan: Initial risk management plans will never be perfect. Practice, experience, and actual loss results will necessitate changes in the plan and contribute information to allow possible different decisions to be made in dealing with the risks being faced. Risk analysis results and management plans should be updated periodically. It is also important to keep in mind the distinction between risk and uncertainty. Risk can be measured by impacts x probability.

Risk in business

Means of measuring and assessing risk vary widely across different professions The various means of doing so may define different professions, e.g. a doctor manages medical risk, a civil engineer manages risk of structural failure, etc. A professional code of ethics is usually focused on risk assessment and mitigation (by the professional on behalf of client, public, society or life in general).

ITQ

What are the methods of identifying a risk?

Feedback

Risks are recognized by the following means. Identify, characterize, and assess threats; Assess the vulnerability of critical assets to specific threats; Determine the risk (i.e. the expected consequences of specific types of attacks on specific assets); Identify ways to reduce those risk and; Prioritize risk reduction measures based on a strategy.

Risk Communication

Risk communication is a complex cross-disciplinary academic field. Problems for risk communicators involve how to reach the intended audience, to make the risk comprehensible and relatable to other risks, how to pay appropriate respect to the audience's values related to the risk, how to predict the audience's response to the communication, etc. A main goal of risk communication is to improve collective and individual decision making. Risk communication is somewhat related to crisis communication.

Seven cardinal rules for the practice of risk communication

(As first expressed by the U.S. Environmental Protection Agency and several of the field's founders)

- Accept and involve the public/other consumers as legitimate partners.
- Plan carefully and evaluate your efforts with a focus on your strengths, weaknesses, opportunities, and threats.
- Listen to the public's specific concerns.
- Be honest, frank, and open.
- Coordinate and collaborate with other credible sources.
- Meet the needs of the media.
- Speak clearly and with compassion.

Risk Management in Nursing

Losses in nursing practice may include financial loss as a result of malpractice or absorbing the cost of an extended length of stay for the patient. They can also include negative public relations and employee dissatisfaction. If quality management was 100% effective, there would be no need for risk management. In the current healthcare environment, however, risk management departments are needed and utilized.

Risk management has blossomed since the malpractice crisis in the 1970s. Before that time, healthcare was assumed to be safe and of high quality except for a very few expectations. Healthcare professionals were revered, and medical treatment was not questioned. The abundance of liability suits in the 1970s had people doubting the validity of their faith in quality healthcare. The inclusion of risk management standards in the 1990 JCAHO guidelines further emphasized the importance of risk management.

The risk management department has several functions. These include the following:

- Define situations that place the system at some financial risk such as medication errors or patient falls.
- Determine the frequency of those situations that occurred.
- Intervene and investigate identified events.
- Identify potential risks or opportunities to improve care.

Each individual nurse is a risk manager. The nurse has the responsibility to identify and report unusual occurrences and potential risks to the proper authority. One method of communicating risks is through incident reporting. Incident reports should be a nonpunitive means of communicating an incident that did cause or could have caused harm to clients, family members, visitors, or employees. These reports should be used to improve quality of care and decrease risk.

Risk is present in all aspects of practice. The changing nature of primary care means that community nurses will increasingly be expected to adopt roles that have traditionally been undertaken by other professionals and which may be associated with higher levels of risk

Although these developments offer opportunities to enhance patient care, nurses must also be aware of the implications for their own accountability. One way to embrace this accountability, and to meet the demands of clinical governance, is to engage in risk management. By adopting the principles of risk management nurses can act proactively to ensure they provide a high quality service that meets patient needs.

Hospital-based nursing faces difficult challenges from the vantage point of risk management. Encouragingly, the continuous and passionate work of nurse leaders to improve patient safety and quality is clearly interfaced with decreasing liability and risk of harm. Many risk management challenges and corresponding strategies are the same as nationwide clinical initiatives in patient safety. The role of the nurse manager in directing patient care and influencing change from a risk perspective is paramount to success.

Risk management is the process by which vulnerabilities are identified and changes are made to minimize the consequences of adverse patient outcomes and liability. Related clinical initiatives to reduce risk and harm should be part of a larger organizational commitment to patient safety. In a true culture of safety, everyone in the organization is committed and driven to keep patients safe from harm. It's under the umbrella of a patient safety culture that risk managers and nurse leaders effect the most successful clinical change.

Human error is often unavoidable, unpredictable, and unintentional. Nurse managers and risk managers conduct root cause analyses (RCAs), which are opportunities for organizational learning and development of corrective action strategies. However, RCAs are reactive responses; organizations should also employ proactive risk assessments for vulnerabilities that can be corrected.

Let's look at the top challenges experienced within large teaching community hospitals and how they can be addressed. The case examples are hypothetical cases.

Patient Identification

Case*: It's 9 a.m. The transporter arrives to take Mrs. S for a computed tomography scan with contrast. The patient says she's not supposed to have any tests, but the transporter insists she's on the schedule and the radiology department is very busy so they have to hurry. Mrs. S has the exam. Mrs. J, in the other bed, was actually scheduled for the test.*

In almost every case of mistaken patient identification there's human error. Factors usually involved, as identified by staff nurse interviews and surveys, include being in a hurry, not following policy, language barriers, missing ID bands, staff carelessness, and patients answering to the wrong name. In the above case, staff didn't listen to the patient and there was a lapse in the patient identification process both at the patient's bedside and in the testing area. It's no wonder that the first Joint Commission National Patient Safety Goal (NPSG) concerned patient identification.

Risk management strategies revolve around the basic patient safety rule of using two patient identifiers to verify identity. Encouraging

patient involvement in combination with active listening skills of staff is key. Using a second identifier that patients know, such as their date of birth or last four digits of their Social Security number, facilitates patient participation. To hardwire this practice during patient transport, the use of a "Trip Slip" or "Ticket to Ride" has been implemented in many organizations. It's modeled after the Time-Out process, during which right patient and right procedure are verified before commencement of a procedure. Although it takes extra time and can lead to transport delay, it's an excellent strategy to avert ID error and improve handoff between departments.

Some organizations have chosen patient identification as a "red rule," meaning the two-identifier rule must be followed without exception or there are defined consequences. Correct specimen labeling is another vulnerable area in the patient identification arena. The importance of bedside labeling using two identifiers, akin to what's done for blood transfusion administration, is vital. Chance of mislabeling increases when the process is moved away from the bedside. There's promise of hard-wiring patient identification processes using technological solutions. Bar code scanning devices are being used in medication administration and glucometer testing; more applications such as in bedside specimen labeling are expected.

Hospital-*Acquired Infections* (HAIs)

***Case**: Mr. H was brought into the ED unresponsive and hypotensive. In the ED, a femoral line was placed for emergency access. After transferring him to the ICU, the femoral line wasn't changed as per hospital protocol and CDC recommendations. Approximately 48 hours later the patient became febrile with an elevated white blood cell count. Blood cultures were positive in 4/4 bottles for enterococcus.*

HAIs are often avoidable complications that are in the public eye and under scrutiny by regulatory agencies, insurance companies, and malpractice attorneys. A press release from the Association for Professionals in Infection Control and Epidemiology states that the greatest challenges to preventing central line–associated bloodstream infection (CLABSI) are policy enforcement, adequate education, comprehensive surveillance/data management, and full

hospital leadership commitment. These factors are present in all healthcare organizations struggling to decrease HAIs.

The bundle checklist has become a relatively simple yet powerful strategy to standardize practice. When each critical step is identified, agreed on, observed at each procedure, and supported by hospital leadership, then you have the recipe for decreasing risk. Nursing must be empowered to stop the process, which clearly makes a huge difference. The Institute for Healthcare Improvement first introduced the use of a bundle checklist during the successful 100K Lives Campaign in 2005, later followed by a related Joint Commission NPSG. And it works: You can't forget important steps when you have a real-time guide to check off at the procedure. The key here is that all concerned follow the process, communicate with each other, and don't regard it as an exercise in post procedure penmanship.

Other strategies include gathering and using process and outcome data along with daily surveillance and intervention by both nurses and infection control practitioners. After each CLABSI it's helpful to have a multidisciplinary process to identify root causes and needed system improvements. A red rule supporting use of the insertion bundle checklist can be effective. These strategies work for all HAIs, not just CLABSI.

Enforcement of the golden rule of hand washing is an important facet on the road to reducing risk from HAI. As with all efforts to improve safety, best practice must be identified and shared, along with identifying and fixing barriers. A recent publication from The Joint Commission Center for Transforming Health Care provides a matrix on hand hygiene that outlines contributing factors, solutions, and level of impact. Strategies include improving accessibility of dispensers and sinks, efficiency of workflow, and just-in-time coaching for reinforcement.

Communication/escalation

Case: *Mrs. F has been in labor for 10 hours. Her electronic fetal monitoring has started to show absent variability with prolonged decelerations. Nurse N asks the resident to look at the strips; the resident recommends the nurse to keep observing. After 10 minutes of no improvement, Nurse N escalates to the attending physician, who assures her the baby will be born soon and nothing more*

needs to be done. Baby F is born with an Apgar score of 2 and 4, requiring resuscitation and NICU admission.

Prenatal death/loss of function is on the top 10 Joint Commission Sentinel Event List. In this case the nurse attempts to communicate her concern and escalates to an attending, but is in a difficult situation: She's reached the top of the physician tree, it's a time-sensitive situation, and there's no agreement on case urgency. Several factors challenge nurse communication and escalation, including fear of disruptive behavior, cultural/gender perceptions and experiences, as well as clinical competency and mutual trust and respect. An analysis of nurse claims from 1997 to 2007 revealed that communication and escalation are two of the top three recommendations to reduce risk for nursing liability.

One remedy specific to this case scenario is the development of an OB Rapid Response Team, one in which the nurse is permitted to request the team. When called, the team of OB experts responds to the situation, thus relinquishing the nurse from any further escalation. Rather than experiencing frustration, the nurse feels empowered to provide a safe environment for patients and promote good outcomes. Other remedies include an organizational code of conduct with zero tolerance of disruptive behavior, chain of command policies, multidisciplinary team training, and use of structured communication techniques.

Medication Administration

Case: *A 30-year-old man comes into the ED Level I trauma unit as one of several victims of a motor vehicle accident. A new ED nurse picked up multiple medications as prescribed on this patient and was distracted by the physicians giving additional verbal orders. She forgets to label two syringes that contain clear liquid, one meant to be given I.V. and the other subcutaneously. She inadvertently administers the subcutaneous medication I.V.; the patient subsequently codes and dies.*

Medication error is also on the top 10 Joint Commission Sentinel Event List. Multiple vulnerabilities existed for this error to occur: An emergency situation, multiple distractions, verbal orders, novice nurse, and failure-to-label syringes are obvious ones. Interruptions occur in at least 50% of medication administrations, and each interruption is associated with over a 10% increase in procedural

failures and clinical errors.

Syringe labelling is a basic safety procedure and even a Joint Commission NPSG. Why would a nurse fail to label syringes not prepared and immediately administered at the bedside? Once again, the risks add up: interruptions, perception of low risk, rushing, possibly even a lack of labels. Engaging staff, especially involved staff, in identifying barriers and their fixes goes a long way. Consistent reinforcement of the process is essential.

Many other major risk areas besides syringe labelling exist in the omnipresent nursing responsibility of medication administration: failures in medication reconciliation, transcription, pharmacy prescription review, and more. Electronic solutions are most beneficial in advancing safety and decreasing risk. Computerized provider order entry features clinical alerts, standardized orders, clarity, immediate transmission to pharmacy, and decreased turnaround time for medication availability. Bar code medication administration eliminates transcription, manual documentation of medication administration, and many sources of error.

Clinical alarms

***Case**: A cardiac patient requiring continuous heart rate and rhythm monitoring died in January after developing a lethal arrhythmia for 22 minutes and systole for 17 minutes before being found by staff members.*

You can't avoid reading about this very public alarm tragedy in newspapers and nursing journals. Alarm problems are on the 2010 top 10 medical device hazard list from the ECRI Institute, a non-profit healthcare research organization. Multiple research studies identify caregiver fatigue from false and nuisance alarms as problematic, leading to distrust in alarms and even tampering. The recent Gulf of Mexico oil rig explosion was found to involve alarm bypasses due to false alarms. Alarm fatigue is a real and daunting challenge, as more and more patient-care equipment is beeping at the bedside and in patient-care units.

Strategies to reduce risk include layering of alarm systems such as monitor technicians, integrating alarms into nurse beepers or phones, improving audibility of high-priority alarms, and modifying equipment, so alarms can't be turned off. Reducing

nuisance/false alarms is critical and involves competency skills; lead placement, signal assessment, individualization of alarms, alarm recognition, and troubleshooting skills can be taught but need practice and experience to perfect. Standardized procedures for clinical alarm monitoring, communication, and documentation responsibility are necessary. Random audits and observations on alarm response times and procedural expectations promote accountability and opportunity for education and learning. Frequent inspections and testing of the alarm systems, possibly on each shift, should also be adopted.

Infusion Pump Safety

***Case**: Mr. B is in the ED after sustaining a non-hemorrhagic stroke; a heparin infusion of 12 units/kg/hour is prescribed. The nurse programs the pump to 12 mL/hour without using the pump's medication library. The mistake isn't caught until the patient's partial thromboplastin time is overtherapeutic, 6 hours later.*

Of all medication errors, I.V. medications are twice as likely to cause patient harm. Use of smart pumps with customized medication libraries, rules, and dose alerts is recommended, but "smart pumps aren't smart on their own." The FDA has issued guidelines requiring infusion pump manufacturers to supply more test data before approval due to over 700 deaths and 50,000 complaints reported to the FDA in the last 5 years. There's even been a recent recall of an infusion pump by a well-known manufacturer.

Successful strategies to improve infusion pump safety and reduce error include:

* easy-to-use technology
* standardized infusion ordering protocols
* 100% compliance with dose mode
* drug library that mirrors clinical practice
* protocols to support override verification
* staff education and involvement
* data analysis, preferably with wireless, concurrent data transmission
* use of data to make appropriate library or practice changes

* vendor support
* partnership with biomedical engineering
* random auditing.

Falls

***Case**: An 82-year-old male is admitted to a medical floor with a diagnosis of dehydration, pneumonia, and urinary tract infection. He's confused at times, especially at night. A fall risk assessment is completed on admission, which puts him at high risk for falls. Fall precautions are taken, and the family insists on a 1:1 companion. While the companion was preparing the patient's evening tea, the patient fell from his bed and fractured his hip, requiring an open reduction internal fixation.*

Patient falls is another Joint Commission top 10 sentinel event. But even under the most monitored situations, patients fall. Initial and ongoing fall risk assessment with a concurrent fall risk reduction care plan is important. Interventions include call bell placement, frequent rounding, regular toileting, proximity to the nurses station for observation, low beds, mobility alarms, enclosure beds, wristbands, room signage, color-coded blankets or socks, and companions. An interdisciplinary approach individualized to the patient is beneficial, for example, collaborating with pharmacy for medication interactions, which may affect balance or cognition, as well as physical therapy for strengthening. A dilemma sometimes facing nursing and risk management is balancing patient independence with maintaining safety. As the scenario depicts, even a 1:1 companion doesn't prevent falls.

Several statewide associations have implemented collaboratives around fall safety. A "SAFE from FALLS" patient-care bundle was developed by the Maryland Patient Safety Center:

F: falls risk screening

A: assessment of risk factors

L: linked interventions

L: learn from events

S: safe environment.

A statewide campaign of the same name is being promoted by the Minnesota Hospital Association, with over 100 participating

hospitals. Numerous tools and protocols are available on the association's website. Lining up strategies with consistent application will reduce risk from falls. When feasible, discuss with the patient their vulnerability to falls and the safety plan to promote participation.

Hospital-acquired pressure ulcers

***Case**: A 74-year-old frail female with a history of diabetes and chronic obstructive pulmonary disease was admitted from a long-term-care facility for difficulty breathing. Her condition deteriorates and she's intubated and sedated. A skin assessment isn't completed upon admission. On day 5 of admission, a nurse documents a Stage II pressure ulcer on the sacrum and a Stage I on both heels. There's sparse documentation throughout her hospital stay, and the transfer summary to the long-term care facility is silent on the condition of the patient's skin. Upon arrival at the nursing home, the admitting nurse documents Stage III pressure ulcers.*

Documentation! It's essential, and the lack of it in this case clearly demonstrates increased liability. Assessment and documentation of findings is the third of the top three recommendations to reduce liability in the nurse claims study mentioned in case #2. A comprehensive skin assessment must be done upon admission, with periodic reassessments throughout the hospital stay, including at the time of any transfers. Clearly documented present-on-admission skin breakdown is critical not only for reimbursement purposes, but also from the risk and standards of care perspectives. Risk assessment using established measures such as the Braden scale standardizes practice.

Frequency of ongoing risk assessments and documentation must be defined by the organization. Assessment every shift of pressure areas is minimal for patients at high risk. Monthly prevalence rounds with sharing and benchmarking of unit and overall outcomes facilitate goal achievement. Turning and positioning as part of regular patient rounding is fundamental, along with staff education at all levels in prevention, assessment, pressure ulcer staging, and intervention techniques. The value of the certified wound-care nurse specialist both in individual cases and for overall program development can't be overstated. Developing unit

champions for daily coaching and resource is another good strategy. Bundled preventive measures such as "Skinsavers" pull it all together:

S: suspend heels

K: keep the head of bed at 30 degrees

I: inspect skin daily and at every turn

N: nutrition and hydration

S: side-lying positioning 30-degree angle

A: apply moisture barrier if incontinent

V: vigilant skin care and moisture

E: encourage mobility

R: reposition at least every 2 hours

S: support surfaces bed and chair.

"Catchy" bundles help staff stay focused on necessary steps and promote accountability.

Clinical Competency

***Case**: Mrs. L is receiving chemotherapy via a peripheral line. The float nurse encounters resistance to flow and repositions the patient's arm. Two hours later the patient complains of severe burning at the site and the nurse notes the I.V. is infiltrated with significant redness and swelling. She discontinues the line and applies a warm compress, but is unaware of the protocol for chemoinfiltrations. The patient develops compartment syndrome and requires surgical intervention.*

"Right staffing" as a management responsibility involves more than quantity; it also means matching staff competencies to patient needs. Managers must identify required competencies based on the population served and standards of care in the clinical area, including documentation and communication skills, and then regularly assess staff competencies. It not only makes sense but also is a Joint Commission Standard (HR 01.06.01). Availability of 24-hour staff resources is a component of facilitating clinical competency. Temporary staff, whether per diem, float, or agency, can only be assigned patients within their scope of practice and competency level. The primary nurse must also recognize the relationship of clinical competency to patient safety when

delegating patient-care responsibilities to others. Nursing staff unable to demonstrate a competency should be helped to achieve it through coaching, education, and subsequent observation. Sometimes a nurse may fail to achieve the performance standard, and if the reasons can't be identified and rectified, then another position must be chosen by the practitioner to ensure patient safety and organizational/individual liability reduction. Staff and managers should collaborate at all levels to ensure the right people are in the right places at the right time.

Retained Foreign Bodies

***Case**: The surgeon is closing the patient's abdomen after a difficult colectomy and is assured by the scrub and relief-circulating nurse that the final count is correct. The relief-circulating nurse was heard arguing with the charge nurse during the final count. During the cavity count, the resident pulled a lap pad from the sterile field to secure a "bleeder." The patient is transferred to the postanesthesia care unit, and several hours later a routine abdominal X-ray identifies a foreign body behind the liver.*

Retained foreign bodies are on both The Joint Commission Sentinel Event and ECRI Institute's top 10 hazard lists. Root causes of foreign body retention include distraction, fatigue, human counting error, lack of count procedures, difficult operations, and other factors. Risk reduction strategies include using a shoebag-type lap pad holder for easy visualization of all counted laps. Counts when staff change, at cavity closure, and at skin closure (final count) are best practice. Whenever the circulating nurse is relieved there should be a handoff to include the count. Lap rings must never be detached. A time out during the final count, in which there's no conversation or distraction, is another remedy. An X-ray before leaving the OR can be done in high-risk cases.

Technology in this arena, which looks to hardwire success, is radiofrequency identification, where sponges are tagged and a wand is swept over the surgical area to identity any retained sponges. Cost-benefit analysis would be expected following your organization's value analysis procedures. This is one of many OR safety tools available to reduce risk of surgical error.

Leadership

Looking at the strategies identified for each challenge, it's evident that there are overall leadership approaches to reducing risk and harm and improving patient safety. Three steps to success are identified by The Joint Commission's Center for Transforming Healthcare:

1. Set expectations
2. Educate
3. Build accountability through measurement, feedback, leadership, and coaching.

It's not as easy as 1-2-3, but sustainable change is possible using this leadership "bundle for change," combined with a systems approach that concentrates on the conditions under which individuals work, identifying barriers and implementing changes to remove them. "We cannot change the human condition, but we can change the conditions under which humans work." Nurse and organizational leaders must provide needed resources and send consistent messages about safety and expectations. It takes a long time for culture to change, so tenacious and passionate nurse leaders are a necessity.

Steps in the Risk Management Process

These steps are

1. determining the objectives of the organization,
2. identifying exposures to loss,
3. measuring those same exposures,
4. selecting alternatives,
5. implementing a solution, and
6. monitoring the results.

Characteristics of a Strong Risk Management Programme

1. Senior management champions the programme
2. They are inclusive
3. They are transparent
4. They are holistic
5. They are proactive

ITQ

What is Risk Management?

Feedback

Risk management is a process of identifying, analysing, treating, and evaluating real and potential hazards. The Joint Commission (JC) recommends the integration of a quality control/risk management program to maintain continuous feedback and communication. To plan proactively, an organization must identify real or potential exposures that might threaten it.

Conclusion

The importance of risk management in projects can hardly be overstated. Awareness of risk has increased as we currently live in a less stable economic and political environment. By implementing an effective risk management program, companies protect their ability to compete. Nothing is more fundamental to business success.

ITQ

What steps are involved in the risk management process?

Feedback

The steps involved in the risk management process includes determining the objectives of the organization, identifying exposures to loss, measuring those same exposures, selecting alternatives, implementing a solution, and monitoring the results.

Tip

Risk management in nursing involves the development and implementation of strategies to prevent patient injury, minimize financial loss, and preserve agency assets

Energy should be put into preventive activities such as providing a safe physical environment, fostering good personnel relations, satisfying patient desires, and providing high quality service. Risk management should include patient relations, safety and security, quality assurance, quality management, and liability control. Every nurse should bear it in mind that she is a risk manager, and should be able to identify and properly manage risks as they arise.

ITQ

Why is there a need for risk management in Nursing practice?

Feedback

Risk management is essential in nursing practice because of the losses in nursing practice. These losses may include financial loss as a result of malpractice or absorbing the cost of an extended length of stay for the patient. They can also include negative public relations and employee dissatisfaction. If quality management was 100% effective, there would be no need for risk management. In the current healthcare environment, however, risk management departments are needed and utilized.

Study Session Summary

Summary

In this Study Session, we considered the discussion of quality improvement. We also examined the aspects of health care that needed to be evaluated. Finally, we explored through the concept of risk management

Assessment

Assessment

SAQ 9.1 (tests Learning Outcome 9.1)
Discuss the Relevance of Quality Improvement to Nursing

SAQ 9.2 (tests Learning Outcome 9.2)
What is a Strategic Plan?

SAQ 9.3 (tests Learning Outcome 9.3)

What are the Processes involved in Nursing Risk Management?

Study Session 10

Nursing Practice and the Law

Introduction

In this study session, we will define law and state its sources. We will also list types of laws and examine relevant laws to nursing practice. Finally, we will discuss the concept of use of standards in nursing negligence.

Learning Outcomes

Outcomes

When you have studied this session, you should be able to:

10.1 define law

10.2 state the sources of law

10.3 list the types of laws

10.4 examine laws relevant to nursing practice

10.5 discuss the concept of use of standards in nursing negligence

Terminology

Law	the system of rules that a particular country or community recognizes as regulating the actions of its members and may enforce by the imposition of penalties
Constitution	a body of fundamental principles or established precedents according to which a state or other organization is acknowledged to be governed

10.1 Meaning of Law

The word *law* has several meanings. For the purposes of this chapter, *law* means those rules that prescribe and control social conduct in a formal and legally binding manner. Laws are created in one of three ways:

a. *Statutory laws* are created by various legislative bodies, such as state legislatures or Congress. Some examples of federal statutes include the Patient Self-Determination Act of 1990 and the Americans with Disabilities Act. State statutes include the state nurse practice acts, the state boards of nursing, and the Good Samaritan Act. Laws that govern nursing practice are statutory laws.
b. *Common law* develops within the court system as judicial decisions are made in various cases and precedents for future cases are set. In this way, a decision made in one case can affect decisions made in later cases of a similar nature. This feature of American law is based on the English tradition of case law: "judge-made law". Many times a judge in a subsequent case will follow the reasoning of a judge in a previous case. Therefore, one case sets a precedent for another.
c. *Administrative law* is established through the authority given to government agencies, such as state boards of nursing, by a legislative body. These governing boards have the duty to meet the intent of laws or statutes.

ITQ

What are the ways by which laws can be created?

Feedback

Laws are created as Statutory, Common and Administrative laws.

10.2 Sources of Law

The Constitution

The U.S. Constitution is the foundation of American law. The Bill of Rights, comprising the first 10 amendments to the Constitution, is the basis for protection of individual rights. These laws define and limit the power of the government and protect citizens' freedom of speech, assembly, religion, and the press and freedom from unwarranted intrusion by government into personal choices.

State constitutions can expand individual rights but cannot deprive people of rights guaranteed by the U.S. Constitution. Constitutional law evolves.

As individuals or groups bring suit to challenge interpretations of the Constitution, decisions are made concerning application of the law to that particular event. An example is the protection of freedom of speech. Are obscenities protected? Can one person threaten or criticize another person? The freedom to criticize is protected; threats are not protected. The definition of what constitutes obscenity is often debated and has not been fully clarified by the courts.

Statutes

Localities, state legislatures, and the U.S. Congress create statutes. These can be found in multivolume sets of books and databases. At the federal level, conference committees comprising representatives of both houses of Congress negotiate the resolution of any differences on wording of a bill before it becomes law. If the bill does not meet with the approval of the executive branch of government, the president can veto it. If that occurs, the legislative branch must have enough votes to override the veto or the bill will not become law.

Nurses have an opportunity to influence the development of statutory law both as citizens and as health-care providers

Writing to or meeting with state legislators or members of Congress is away to demonstrate interest in such issues and their outcomes in terms of the laws passed. Passage of a new law is often a long process that includes some compromise of all interested individuals.

Administrative Law

The Department of Health and Human Services, the Department of Labor, and the Department of

Education are the federal agencies that administer health-care–related laws. At the state level are

departments of health and mental health and licensing boards. Administrative agencies are staffed with professionals who develop the specific rules and regulations that direct the implementation of statutory law.

These rules must be reasonable and consistent with existing statutory law and the intent of the legislature. Usually, the rules go into effect only after review and comment by affected persons or groups. For example, specific statutory laws give state nursing boards the authority to issue and revoke licenses, which means that each board of nursing has the responsibility to oversee the professional nurse's competence.

ITQ

What is peculiar about the creation of "Statutes"?

Feedback

Localities, state legislatures, and the U.S. Congress create statutes. These can be found in multivolume sets of books and databases. At the federal level, conference committees comprising representatives of both houses of Congress negotiate the resolution of any differences on wording of a bill before it becomes law. If the bill does not meet with the approval of the executive branch of government, the president can veto it. If that occurs, the legislative branch must have enough votes to override the veto or the bill will not become law.

10.3 Types of Laws

Another way to look at the legal system is to divide it into two categories: criminal law and civil law.

Criminal Law

Criminal laws were developed to protect society from actions that threaten its existence. Criminal acts, although directed toward individuals, are considered offenses against the state. The perpetrator of the act is punished, and the victim receives no compensation for injury or damages. There are three categories of criminal law:

1. *Felony:* the most serious category, including such acts as homicide, grand larceny, and nurse practice act violation

2. *Misdemeanor:* includes lesser offenses such as traffic violations or shoplifting of a small dollar amount

3. *Juvenile:* crimes carried out by individuals younger than 18 years; specific age varies by state and crime

There are occasions when a nurse breaks a law and is tried in criminal court. A nurse who distributes controlled substances illegally, either for personal use or for the use of others, is violating the law. Falsification of records of controlled substances is a criminal action. In some states, altering a patient record may be a misdemeanour.

ITQ

To what end was criminal laws developed and what are their categories?

Feedback

Criminal laws were developed to protect society from actions that threaten its existence. Criminal acts, although directed toward individuals, are considered offenses against the state. The perpetrator of the act is punished, and the victim receives no compensation for injury or damages.

The categories of criminal law include felony, misdemeanour, and juvenile.

Civil Law

Civil laws usually involve the violation of one person's rights by another person. Areas of civil law that particularly affect nurses are tort law, contract law, antitrust law, employment discrimination, and labor laws.

Tort

The remainder of this chapter focuses primarily on tort law. A tort is a legal or civil wrong carried out by one person against the person or property of another. Tort law recognizes that individuals in their relationships with each other have a general duty not to harm each other.

Quasi-Intentional Tort

A quasi-intentional tort has its basis in speech. These are voluntary acts that directly cause injury or anguish without meaning to harm or to cause distress. The elements of cause and desire are present, but the element of intent is missing. Quasi-intentional torts usually involve problems in communication that result in damage to a person's reputation, violation of personal privacy, or infringement of an individual's civil rights. These include defamation of character, invasion of privacy, and breach of confidentiality.

Negligence

Negligence is the unintentional tort of acting or failing to act as an ordinary, reasonable, prudent person, resulting in harm to the person to whom the duty of care is owed. The legal elements of negligence consist of duty, breach of duty, causation, and harm or injury. All four elements must be present in the determination. For example, if a nurse administers the wrong medication to a client, but the client is not injured, then the element of harm has not been met. However, if a nurse administers appropriate pain medication but fails to put up the side rails, and the client falls and breaks a hip, all four elements have been satisfied.

The duty of care is the standard of care. The law defines standard of care as that which a reasonable, prudent practitioner with similar education and experience would do or not do in similar circumstances.

Malpractice

Malpractice is the term used for professional negligence. When fulfillment of duties requires specialized education, the term malpractice is used. In most malpractice suits, the facilities employing the nurses who cared for a client are named as defendants in the suit. Vicarious liability is the legal principle cited in these cases. *Respondeat superior,* the borrowed servant doctrine, and the captain of the ship doctrine fall under vicarious liability.

An important principle in understanding negligence is *respondeat superior* ("let the master

answer"). This doctrine holds employers liable for any negligence by their

employees when the employees were acting within the realm of employment and when the alleged negligent acts happened during employment.

ITQ

How else can we view the legal system?

Feedback

Another way to look at the legal system is to divide it into two categories: criminal law and civil law

10.4 Other Laws Relevant to Nursing Practice

Good Samaritan Laws

Fear of being sued has often prevented trained professionals from assisting during an emergency.

To encourage physicians and nurses to respond to emergencies, many states developed what are now known as the Good Samaritan laws. When administering emergency care, nurses and physicians are protected from civil liability by Good Samaritan laws as long as they behave in the same manner as an ordinary, reasonable, and prudent professional in the same or similar circumstances. In other words, when assisting during an emergency, nurses must still observe professional standards of care. However, if a payment is received for the care given, the Good Samaritan laws do not hold.

ITQ

At what point do Good Samaritan laws cease to exist? hold even after payment for health care services have been made

Feedback

Good Samaritan laws cease to exist once payment has been received for the health care services. It does exist beyond this point.

Confidentiality

It is possible for nurses to be involved in lawsuits other than those involving negligence. For example, clients have the right to confidentiality, and it is the duty of the professional nurse to ensure this right.

Tip

Confidentiality a set of rules or a promise that limits access or places restrictions on certain types of information

This assures the client that information obtained by a nurse while providing care will not be communicated to anyone who does not have a need to know. This includes giving information by telephone to individuals claiming to be related to a client, giving information without a client's signed release, or removing documents from a health-care provider with a client's name or other information.

Slander and Libel

Slander and libel are categorized as quasi-intentional torts. Nurses rarely think of themselves as being guilty of slander or libel. The term *slander* refers to the spoken word, and *libel* refers to the written word. Making a false statement about a client's condition that may result in an injury to that client is considered slander. Making a written false statement is libel. For example, stating that a client who had blood drawn for drug testing has a substance abuse problem, when in fact the client does not carry that diagnosis, could be considered a slanderous statement.

Slander and libel also refer to statements made about co-workers or other individuals whom you may encounter in both your professional and educational life. Think before you speak and write.

Sometimes what may appear to be harmless to you, such as a complaint, may contain statements that damage another person's credibility personally and professionally.

ITQ

What is Slander?

Feedback

Slander refers to spoken statements capable of causing harm to other's professional capabilities. These are spoken words with the potential to destroy reputation.

False Imprisonment

False imprisonment is confining an individual against his or her will by either physical (restraining) or verbal (detaining) means. The following are examples:

■ Using restraints on individuals without the appropriate written consent

■ Restraining mentally handicapped individuals who do not represent a threat to themselves or others

■ Detaining unwilling clients in an institution when they desire to leave

■ Keeping persons who are medically cleared for discharge for an unreasonable amount of time

■ Removing the clothing of clients to prevent them from leaving the institution

■ Threatening clients with some form of physical, emotional, or legal action if they insist on leaving Sometimes clients are a danger to themselves and to others. Nurses need to decide on the appropriateness of restraints as a protective measure. Nurses should try to obtain the cooperation of the client before applying any type of restraints. The first step is to attempt to identify a reason for the risky behavior and resolve the problem. If this fails, document the need for restraints, consult with the physician, and carefully follow the institution's policies and standards of practice. Failure to follow these guidelines may result in greater harm to the client and possibly a lawsuit for the staff.

To protect themselves against charges of negligence or false imprisonment in such cases, nurses should discuss safety needs with clients, their families, or other members of the health-care team. Careful assessment and documentation of client status are also imperative; confusion, irritability, and anxiety often have metabolic causes that need correction, not restraint. There are statutes and case laws specific to the admission of clients to psychiatric institutions. Most states have guidelines for emergency involuntary hospitalization for a specific period. Involuntary admission is considered necessary when clients are a danger to themselves or others. Specific procedures must be followed. A determination by a judge or administrative agency or certification by a specified number of physicians that a person's mental health justifies the person's detention and treatment may be required. Once admitted, these clients may not be restrained unless the guidelines established by state law and the institution's policies provide. Clients who voluntarily admit themselves to psychiatric institutions are also protected against false imprisonment. Nurses need to find out the policies of their state and employing institution.

ITQ

With respect to mentally handicapped individuals, what is the role of a nurse?

Feedback

A nurse does not reserve the right to restrain all classes of mentally handicapped individuals. Rather, mentally handicapped individuals should be observed to be capable of causing harm to themselves or to other individuals before any action is taken.

Assault and Battery

Assault is threatening to do harm. Battery is touching another person without his or her consent. The significance of an assault is in the threat: "If you don't stop pushing that call bell, I'll give you this injection with the biggest needle I can find" is considered an assaultive statement. Battery would occur if the injection were given when it was refused, even if medical personnel deemed it was for the "client's good."With few exceptions, clients have a right to refuse treatment. Holding down a violent client against his or her will and injecting a sedative is battery. Most medical treatments, particularly surgery, would be battery if it were not for informed consent from the client.

Standards of Practice

Concern for the quality of care is a major part of nursing's responsibility to the public. Therefore, the nursing profession is accountable to the consumer for the quality of its services. One of the defining characteristics of a profession is the ability to set its own standards. Nursing standards were established as guidelines for the profession to ensure acceptable quality of care. Standards of practice are also used as criteria to determine whether appropriate care has been delivered. In practice, they represent the minimum acceptable level of care. Nurses are judged on generally accepted standards of practice for their level of education, experience, position, and specialty area. Standards take many forms. Some are written and appear as criteria of professional organizations, job descriptions, agency policies and procedures, and textbooks. Others, which may be intrinsic to the custom of practice, are not found in writing.

State boards of nursing and professional organizations vary by role and responsibility in relation to standards of development and implementation. Statutes, professional organizations, and health-care institutions establish standards of practice. The nurse practice acts of individual states define the boundaries of nursing practice within the state. In Canada, the provincial and territorial associations define practice. Institutions develop internal standards of practice. The standards are usually explained in a specific institutional policy (for example, guidelines for the appropriate administration of a specific chemotherapeutic agent), and the institution includes these standards in policy and procedure manuals. The guidelines are based on current literature and research. It is the nurse's responsibility to meet the institution's standards of practice. It is the institution's responsibility to notify the health-care personnel of any changes and instruct the personnel about the changes. Institutions may accomplish this task through written memos or meetings and in-service education.

With the expansion of advanced nursing practice, it has become particularly important to clarify the legal distinction between nursing and medical practice. It is important to be aware of the boundaries between these professional domains because crossing them can result in legal consequences and disciplinary action. The nurse practice act and related

regulations developed by most state legislatures and state boards of nursing help to clarify nursing roles at the various levels of practice.

ITQ

What are the possible charges a nurse could face?

Feedback

A nurse can be charged to court for the following reasons. He/she could be charged for negligence, breech of confidence, slander, libel, assault, battery, and poor standard of practice.

10.5 Use of Standards in Nursing Negligence

Malpractice Actions

When omission of prudent care or acts committed by a nurse or those under his or her supervision cause harm to a client, standards of nursing practice are among the elements used to determine whether malpractice or negligence exists. Other criteria may include but are not limited to:

- State, local, or national standards
- Institutional policies that alter or adhere to the nursing standards of care
- Expert opinions on the appropriate standard of care at the time
- Available literature and research that substantiates a standard of care or changes in the standard

Patient's Bill of Rights

In 1973 the American Hospital Association approved a statement called the Patient's Bill of

Rights. These were revised in October 1992.Patient rights were developed with the belief that hospitals and health-care institutions would support these rights with the goal of delivering effective client care. In 2003 the Patient's Bill of Rights was replaced by the Patient Care Partnership. These standards were derived from the ethical principle of autonomy.

Informed Consent

Without consent, many of the procedures performed on clients in a health-care setting may be considered battery or unwarranted touching. When clients consent to treatment, they give health-care personnel the

right to deliver care and perform specific treatments without fear of prosecution.

Although physicians are responsible for obtaining informed consent, nurses often find themselves involved in the process. It is the physician's responsibility to give information to a client about a specific treatment or medical intervention. The individual institution is not responsible for obtaining the informed consent unless the physician or practitioner is employed by the institution or the institution was aware or should have been aware of the lack of informed consent and did not act on this fact.

Some institutions require the physician or independent practitioner to obtain his or her own informed consent by obtaining the client's signature at the time the explanation for treatment is given. The informed consent form should contain all the possible negative outcomes as well as the positive ones. Nurses may be asked to obtain the signatures on this form. The following are some criteria to help ensure that a client has given an informed consent:

■ A mentally competent adult has voluntarily given the consent.

■ The client understands exactly to what he or she is consenting.

■ The consent includes the risks involved in the procedure, alternative treatments that may be available, and the possible result if the treatment is refused.

■ The consent is written.

■ A minor's parent or guardian usually gives consent for treatment.

Ideally, a nurse should be present when the physician is explaining the treatment to the client. Before obtaining the client's signature, the nurse asks the client to recall exactly what the physician has told him or her about the treatment. If at any point the nurse thinks that the client does not understand the treatment or the expected outcome, the nurse must notify the physician of this fact. To be able to give informed consent, the client must be fully informed fully. Clients have the right to refuse treatment, and nurses must respect this right. If a client refuses the recommended treatment, a client must be informed of the possible consequences of this decision.

Implied consent occurs when consent is assumed. This may be an issue in an emergency when an individual is unable to give consent.

All health-care personnel are accountable for their own actions and adherence to the accepted standards of health care. Most negligence and malpractice cases arise from a violation of the accepted standards of practice and the policies of the employing institution.

Expert witnesses are called to cite the accepted standards and assist attorneys in formulating the legal strategies pertaining to those standards. For example, most medication errors can be traced to a violation of the accepted standard of medication administration, originally referred to as the Five Rights which have been amended to Seven Rights:

1. Right drug

2. Right dose

3. Right route

4. Right time

5. Right client

6. Right reason

7. Right documentation

Appropriate Documentation

The adage "not documented, not done" holds true in nursing. According to the law, if something has not been documented, then the responsible party did not do whatever needed to be done. If a nurse did not "do" something, that leaves the nurse open to negligence or malpractice charges.

Nursing documentation needs to be legally credible. Legally credible documentation is an accurate accounting of the care the client received. It also indicates the competence of the individual who delivered the care. Charting by exception creates defense difficulties.

When this method of documentation is used, investigators need to review the entire patient record in an attempt to reconstruct the care given to the client. Clear, concise, and accurate documentation helps nurses when they are named in lawsuits. Often, this documentation clears the individual of any negligence or malpractice. Documentation is credible when it is:

■ **Contemporaneous** (documenting at the time care was provided)

■ **Accurate** (documenting exactly what was done)

■ **Truthful** (documenting only what was done)

■ **Appropriate** (documenting only what could be discussed comfortably in a public setting)

Tips for Avoiding Legal Problems

• Keep yourself informed regarding new research related to your area of practice.

• Insist that the health-care institution keep personnel apprised of all changes in policies and procedures and in the management of new technological equipment.

• Always follow the standards of care or practice for the institution.

• Delegate tasks and procedures only to appropriate personnel.

• Identify clients at risk for problems, such as falls or the development of decubiti.

• Establish and maintain a safe environment.

• Document precisely and carefully.

• Write detailed incident reports, and file them with the appropriate personnel or department.

• Recognize certain client behaviors that may indicate the possibility of a lawsuit.

End-of-Life Decisions and the Law

When a heart ceases to beat, a client is in a state of cardiac arrest. In health-care institutions and in the community, it is common to begin cardiopulmonary resuscitation (CPR) when cardiac arrest occurs. In health-care institutions, an elaborate mechanism is put into action when a client "codes." Much controversy exists concerning when these mechanisms should be used and whether individuals who have no chance of regaining full viability should be resuscitated.

Do Not Resuscitate Orders

A do not resuscitate (DNR) order is a specific directive to health-care personnel not to initiate CPR measures. Only a physician can write a DNR order, usually after consulting with the client or family. Other members of the health-care team are expected to comply with the order. Clients have the right to request a DNR order. However, they may make this request without a full understanding of what it really means.

ITQ

What should a nurse know about informed consent?

Feedback

Without consent, many of the procedures performed on clients in a health-care setting may be considered battery or unwarranted touching. When clients consent to treatment, they give health-care personnel the right to deliver care and perform specific treatments without fear of prosecution.

Although physicians are responsible for obtaining informed consent, nurses often find themselves involved in the process. Often times, they serve as a witness to the process of obtaining an informed consent by the physician.

Study Session Summary

Summary

In this Study Session, we defined law and stated its sources. We also listed the types of laws and examined relevant laws to nursing practice. Finally, we discussed the concept of use of standards in nursing negligence.

Assessment

Assessment

SAQ 10.1 (tests Learning Outcome 10.1)
Define Nursing Negligence

SAQ 10.2 (tests Learning Outcome 10.2)
What is Confidentiality

SAQ 10.3 (tests Learning Outcome 10.3)
What is Informed Consent

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Notes on Self-Assessment Questions

SAQ 1.1

The following are qualities a good leader must possess Integrity, Courage, Attitude, Initiative, Energy, Optimism, Perseverance, Balance, Ability to handle stress, Emotional intelligence.

SAQ 2.1

Management is defined as a process by which an organization makes use of its human, physical and financial resources to achieve set goals and objectives. It takes place within a structured organizational setting with prescribed roles. It is directed towards the achievement of aims and objectives through emphasis on structure and on focusing attention on what is good for the organization.

- Division of work
- Authority
- Discipline
- Unity of command
- Unity of direction
- Subordination of individual interests to the general interest
- Remuneration
- Centralization
- Scalar chain
- Order
- Equity
- Stability of tenure of personnel
- Initiative
- Esprit de corps

Being a psychologist, Maslow observed that man's needs build up from basic needs at the base to higher needs at the top. It moves from physiological needs to Food, Clothing and Shelter, Love through self-esteem and Self Actualization. Managers nowadays now focus on helping members of their organization feel self-esteem while at their jobs while being able to provide physiological needs with the ultimate purpose of self-actualization from doing their duties

SAQ 3.1

Planning is a systematic process that involves selecting missions and objectives and the actions to achieve them. It is a principal duty of all managers within the division of nursing. It seeks to help guarantee

success in achieving goals and objectives and in effective utilization of available personnel and facilities. The long-term effect is cost effectiveness in achieving set goals and objectives. A process that depends on different contributing factors focuses on choosing amongst alternative courses of action.

SAQ 3.2

There are three types of planning and these are Long range, Medium Range and Short Range Planning. The Middle Range planning lasts between 6-12 months.

Planning is classified using the criteria of Time limit, the Comprehensive nature of the project and the Elements involved in the Project.

SAQ 4.1

Organizing in Nursing seeks to establish enduring set of shared values, beliefs, and assumptions. It is taught to new nurses by their mentors as the standard to assess patient needs, provide care, and relate to fellow caregivers. This helps to ensure a consistency in the services provided by any nursing staff with in the same organization. All efforts are then directed to maintaining the same standard to ensure that whoever provides nursing care does so in compliance with the set values.

SAQ 5.1

Delegation is the assignment of responsibility or authority to another person to carry out specific activities. It is one of the pillars of management leadership. However, the person who delegated the work remains accountable for the outcome of the delegated work. Delegated tasks must be Specific, Measurable, Agreed, Realistic, Time bound, Ethical and Recorded. Delegation helps to Improve Nursing Care by encouraging giving off duties to junior colleagues to improve their abilities. The best way to start is to consider the activities you used to do before you were promoted to the present position occupied. The activities leaders were more comfortable doing as junior responsibility holders, so someone junior can do them now. Tasks in which you have experience are the easiest for you to explain to others and so to train them to take over. You thus use your experience to ensure that the task is done well, rather than to actually perform the task yourself.

SAQ 6.1

The concept of motivation cannot be overemphasized. A manager is required to create and maintain an environment in which individuals work together in groups towards the accomplishment of common objectives. A manager cannot do a job without knowing what motivates people. The building of motivating factors into organizational roles, the staffing of these roles and the entire process of leading people must be built on knowledge of motivation. It is necessary to remember that levels

of motivation varies both between individuals and within individuals at different times. Today, in the increasingly competitive environment, maintaining a highly motivated workforce is the most challenging task. The art of motivation starts by learning how to influence the behaviour of the individual. This understanding helps to achieve both, the individual as well as organizational objectives. Motivation is a powerful tool in the hands of leaders. It can persuade convince and propel people to act.

SAQ 7.1

Communication is primarily an interactive process and the message being sent is never more important than the people engaged in the process. In addition to being aware of the communication process, there are also certain skill sets that relate to effective communication. These interpersonal communication skills can be grouped into the following five key categories:

- *Listening Skills*–active or conscious skills required to truly listen, understand, and effectively respond to what a person is saying.
- *Assertion Skills*–verbal and nonverbal behaviors that allow a person to maintain respect, satisfy needs, and defend rights without dominating, abusing, or controlling others.
- *Conflict Resolution Skills*– abilities that allow a person to deal with conflict, while preserving or promoting closer relationships when the conflict is resolved.
- *Collaborative Problem-Solving Skills*–a means of resolving conflicts and solving problems effectively.

SAQ 8.1

The role of the nurse manager is critical in the provision of effective and high quality care in any patient care delivery setting. This individual is actually the Chief Executive Officer (CEO) of that clinical area. She or he is accountable and responsible for patient safety and quality. This includes all of the nurse sensitive indicators recognized by regulatory and accrediting bodies, patient satisfaction, and financial performance. In addition, the nurse manger represents the direct caregiver voice at nursing leadership decision-making tables. This person has to advocate up to management for nurses and other staff, but also interpret and manage organizational decisions that come down to the unit.

SAQ 9.1

Quality Improvement is a structured organizational process for involving personnel in planning and executing improvements to provide quality health care that meets or exceeds expectations set by healthcare professionals. To achieve quality health care, Quality Improvement activities use evidence-based methods for gathering data and achieving desired results comparing present quality conditions to the prospects of future improvements in the same quality conditions. It usually involves

identifying areas of concern continuously collecting data on these areas of concern, analyzing and evaluating the data, and implementing needed changes. Some of these areas of concern particularly important to Nursing include medication errors and infection rates. The purpose of Quality Improvement is usually to improve upon the prevailing situations and attempting to achieve new possibilities.

A strategic plan is a short, visionary, conceptual document that serves as a framework for decisions or for securing support and approval of intended plans and projects. It provides a background for more planning. It usually contains missions and goals and usually an analysis of the Strengths, Weaknesses, Opportunities and Threats of plans can be done.

The first process in Risk Management is Establishment of Risk Context. This usually involves Identification of risks in a particular area of interest, planning how risks would be ranked and Mapping out the scope of the Risk Managers' involvement in the management process. The second Process is in Risk Identification, with particular attention to Risk Source analysis to determine if it is internal or external sourced. Problem analysis is next to determine the extent of the concerns at hand. Once risks have been identified, they must then be assessed as to their potential severity of loss and to the probability of occurrence and recurrence. It then finally is important to treat all the aspects of risks via Risk Avoidance, Risk Reduction, Risk transfer and Risk Retention.

SAQ 10.1

Nursing Negligence is the unintentional occurrence of acting or failing to act as an ordinary, reasonable, prudent nursing professional, resulting in harm to the person to whom the duty of care is owed. The legal elements of negligence consist of duty, breach of duty, causation, and harm or injury. All four elements must be present in the determination. For example, if a nurse administers the wrong medication to a client, but the client is not injured, then the element of harm has not been met. However, if a nurse administers appropriate pain medication but fails to put up the side rails, and the client falls and breaks a hip, all four elements have been satisfied.

SAQ 10.2

Confidentiality defines the legal right a care giver owes the patient to ensure no part of the health care sought from them is shared with a third party without due approval. This assures the client that information obtained by a nurse while providing care will not be communicated to anyone who does not have a need to know. This includes giving information by telephone to individuals claiming to be related to a client, giving information without a client's signed release, or removing documents from a health-care provider with a client's name or other information.

SAQ 10.3

Informed Consent describes the Process where the care receivers based on adequate truthful information provided by the health care givers take healthcare decisions. Usually a Physician undertakes the process, but many times Nurses are also involved in the process. Some institutions require the physician or independent practitioner to obtain his or her own informed consent by obtaining the client's signature at the time the explanation for treatment is given. The informed consent form should contain all the possible negative outcomes as well as the positive ones. Nurses may be asked to obtain the signatures on this form. The following are some criteria to help ensure that a client has given an informed consent. A mentally competent adult has voluntarily given the consent. The client understands exactly to what he or she is consenting. The consent includes the risks involved in the procedure, alternative treatments that may be available, and the possible result if the treatment is refused. The consent is written. A minor's parent or guardian usually gives consent for treatment. It is important to remember that patients can refuse the care being offered by the health care givers and this is in fact is the purpose of informing them before consent is sought.

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