Perceptions of First line Nurse Managers

Managing Within A Climate of Fiscal Restraint

by

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Abstract

The purpose of this study was to examine the
perceptions of first line nurse managers of managing
within a climate of fiscal restraint. The literature
indicates that the first line nurse manager's role
continues to evolve; it is increasing in accountability
and responsibility, particularly in the area of
financial responsibility. As well, first line nurse
managers strongly influence the quality of care that is
delivered in Canadian hospitals. They have the
responsibility of ensuring that patients receive high
quality care delivered in a cost effective manner.

This study is part of a larger study by Acorn and
Crawford (1995) in which data were collected through a
survey completed by 200 first line nurse managers in 38
acute care hospitals in British Columbia. In this
study, a descriptive exploratory design was used to
examine the perceptions of nurse managers. Focus
groups were conducted to validate the data collected by
the open-ended questions in the Acorn and Crawford
study, as well as to further explore the perceptions of
first line nurse managers of managing within a climate

of fiscal restraint. These data were then analyzed
using content analysis. Data were first coded, then
organized under categories from which themes emerged.

The major themes that emerged from the data were;
enormity of change, impact of change, and the
management of change. The enormity of change resulted
from health care reform, decentralization of decision
making, increase in accountability and responsibility
of first line nurse managers, and changes to the
delivery of patient care. The impact of change
increased the workload of first line nurse managers,
contributed to less effective communication in the
facilities and resulted in uncertainty about their
future role in health care. First line nurse managers
used several strategies to control costs and obtain
technological and administrative support.

In summary, the health care industry in Canada is
rapidly changing and increasing in complexity, creating
major challenges for first line nurse managers in
meeting the standards for quality patient care.
The implications of the findings for administrative
nursing practice, nursing education, nursing research,
and hospital administrators are presented.

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CHAPTER 1: INTRODUCTION

A climate of fiscal restraint, technological explosion, and global competitiveness has forced society to deal with unprecedented rapid change (Canadian Nurses Association [CNA], 1993). So swift and unrelenting are the changes that the workplace has become an environment of chaos where uncertainty is the norm and change is the only constant (CNA).

Background

In the health care sector, the changes are known as restructuring and include downsizing or reduction in numbers of employees and hospital beds, mergers or consolidation of hospital facilities, and work redesign or changes in patient care delivery systems (Acorn & Crawford, 1995; Dick & Bruce, 1994; Roch, 1992). Roch suggests that the pressure to restructure the health care system will continue as governments struggle with increasing deficits.

This economic climate, which is the principal stimulus for rapid reform, has significant implications for the nursing profession. This is particularly true for nurse administrators whose responsibility is to

ensure the delivery of quality patient care in the most cost effective manner (CNA, 1988; CNA, 1993; Dick & Bruce, 1994; McCloskey, Gardner, Johnson & Mass, 1988). The responsibilities of nurse administrators are changing. One change is that organizations are reducing hierarchical levels, thus leading to increased responsibility and accountability at lower levels of management in the organization (Dick & Bruce, 1994). In nursing departments, this results in decentralization of decision making authority to the unit level. Nursing leaders advocate this management strategy as a means to improve managerial decisions resulting in better quality patient care while containing costs (Dick, & Bruce; Hodges, Knapp, & Copper, 1987).

Organizational changes are contributing to the evolution of the first line nurse manager's role by increasing its scope, responsibility, authority, and accountability (Carroll & Adams, 1994; Chase, 1994; Eubanks, 1992; Fullerton, 1993; Mark, 1994). This expanded role is being described as the key nursing position in the hospital setting with the role incumbent responsible for decisions affecting the

outcomes, quality, and cost of patient care. Eubanks describes this *new* nurse manager as the "linchpin in quality care and cost control" (p. 22). Eubanks also reports that nurse executives consider this the most critical management role in hospital facilities. Given the climate of fiscal restraint and the key position that first line nurse managers are assuming in the hospital, it would seem timely to identify their perceptions of issues related to fiscal restraint.

Purpose

The purpose of this study is to explore the issues of fiscal restraint as they relate to first line nurse managers. The research question is: What are the perceptions of first line nurse managers of managing within a climate of fiscal restraint?

Definitions

In the context of this study the following terms are defined:

1. First line nurse manager: a nurse responsible for the 24-hour management of one or more patient units. Individuals in this position may be referred to as nurse manager, head nurse, and/or unit manager.

2. Nurse executives: nurse managers who represent
nursing at the top administrative level. These
individuals are responsible for the department of
nursing and possibly other departments within the
organization. Other titles commonly held by these
individuals include chief nurse executive, vice
president of patient care services, vice president,
assistant president of nursing, director of patient
services, and/or director of nursing.

Significance

First line nurse managers are a group that can
provide insight into managing health care in a climate
of fiscal restraint. This study generates information
on those insights providing data on the management
practices of nurses. As well, the study provides data
on which future studies can be based.

How fiscal restraint affects the practice of first
line nurse managers may have implications for research
in nursing administration and education. Yet, it is
the pivotal role of first line nurse managers in
influencing the care of patients that makes this study
most relevant. Although the role may evolve and
increase in scope, it will continue to influence the

care patients receive. Information on the practice of first line nurse managers will ultimately benefit patient care which is the aim of nursing knowledge. In addition, this study will contribute to the limited Canadian research on the practice of nurse managers, particularly in a context of fiscal restraint.

CHAPTER 2: LITERATURE REVIEW

The literature review consisted of an extensive computer search in nursing, nursing and hospital administration, and business management data bases as well as a manual search of pertinent journals. No research was found on the effects of fiscal restraint within health care. Fiscal restraint is a relatively recent phenomenon and this may account for the dearth of research on the topic, particularly as it relates to first line nurse managers. Therefore, the literature review focused on topics of relevance to the study: health care reform within a climate of fiscal restraint and its impact on the evolving role of the first line nurse manager. Both anecdotal literature and research on these two topics are included. Literature that represents a Canadian perspective is presented whenever possible.

Health Care Reform

Advocates of controlling health care costs over the past two decades were generally met with indifference from politicians and bureaucrats. Consequently, reform did not occur. Instead of

developing efficient ways of delivering care, increasing amounts of money were spent on health care. This has resulted in Canadians having the most expensive publicly funded health care system in the world (Manga, 1992; Rachlis & Kushner, 1994; Roch, 1992). Given that federal and provincial governments are struggling to control deficits, health care reform has finally become a major focus of their attention (Manga).

Roch (1992) indicates that additional health expenditures will not improve the health of Canadians. Although Canada ranks only behind the United States in percentage of gross domestic product spent on health care, it ranks lower on many health indicators compared to other industrialized countries. Roch suggests that two factors are initiating health care reform: the lack of improvement in the health of Canadians despite increased spending and the increasing national debt.

In his article, Roch (1992) outlines restructuring objectives of the health care system for the 1990s. These include patient health status outcomes, and the effectiveness, efficiency, necessity, relevance, and economics of the services provided. Roch then reviews

the objectives using an economic framework which examines supply and demand from the patient and system levels. In summary, Roch lists ten emerging themes of restructuring, all of which have implications for nursing. Four of these have direct relevance both to nursing and to this study:

.No funding of hospital deficits

.Reductions in acute care hospital beds

.Continuing shifts to ambulatory and community care

.More efficient and economic use of nursing

 resources (p.11)

Roch then lists the following implications for nursing:

.Slower growth of employment opportunities

.Shift away from acute care hospitals to outpatient

 care and community care

.More appropriate use of nursing staff

.Increasing emphasis on management skills (p.11)

Roch suggests that within change lies opportunity for nursing, particularly in increasing the use of nursing skills, management ability, and autonomous practice.

Opportunity for nursing is the emphasis in Manga's (1992) article. However, Manga warns the nursing profession that, historically, nurses have not seized

opportunities as they have become available. The author makes reference to turf wars which previously occurred, particularly between nurses and physicians, and indicates that, with fiscal restraint, the turf wars will expand to include many other health care workers. Furthermore, the author claims that the turf wars are born of two issues: manpower substitution with cheaper categories of workers and increase in scope of service that nurses may provide, particularly services which nurses can provide at less cost than physicians. Manga suggests the nursing profession may be the most qualified and cost effective profession to provide certain primary health care services, but there is no guarantee that governments or bureaucrats will utilize nurses for these services. Manga believes nurses have a golden opportunity in the reform process but need to be politically active to reshape the health care system to their advantage.

O'Brien-Pallas (1992) echoes Manga's concerns by suggesting that to influence health policy, nurses need to develop political skills. O'Brien-Pallas focuses on nursing research and the need for additional studies on the cost effectiveness of nursing care, services, and

personnel. O'Brien-Pallas argues that, in order to
influence health care reform, strong empirical evidence
is needed on the cost effectiveness of nursing and the
services nurses provide.

Dick (1992) claims that nursing administrators are
making far-reaching financial decisions without the
necessary information, such as a sound understanding of
economics to make the decisions. Dick believes that
nurse administrators need information on topics such as
cost-benefit analysis of nursing care, cost effective
staff mix, case costing in hospitals, and cost benefits
of managed care and community care, in order to make
financial decisions.

Health care reform in this economic climate
requires nurse administrators to make difficult
financial decisions. Many of these decisions directly
affect the cost and the quality of patient care.
Health care reform, in the context of fiscal restraint,
influences who is responsible for making many of the
financial decisions. With a decrease in management
levels within organizations and the move to
decentralizing decision making to the unit level, many
financial decisions are the responsibility of first

line nurse managers.

The Nurse Manager's Evolving Role

Health care reform, decentralization of decision making, and, especially, fiscal restraint have contributed to significant changes in the first line nurse manager's role. Specifically, the scope of practice, administrative responsibilities, and fiscal accountability of first line nurse managers have increased (Fullerton, 1993; Hodges et al., 1987; Mark, 1994; Wells, 1990). Carroll and Adams (1994) reviewed the literature from 1982 to 1992 on the work and selection of first line nurse managers. These authors report that nurse executives consider the first line nurse manager's role pivotal to achieving organizational goals and that the role is increasing in authority, accountability, and responsibility. However, their findings provide little empirical data about this expanding role and even less about the methods for selecting first line nurse managers. Carroll and Adams claim it is difficult to draw conclusions about the work of first line nurse managers as the studies reviewed differed greatly in design, instrumentation, sampling technique, and reporting of

results.

In an earlier study, Hodges et al. (1987) surveyed
a random sample of 288 chief nurse executives (CNEs) in
American hospitals on the practice and education of
head nurses. The CNEs were asked to complete a 35-item
questionnaire to elicit information on the head nurse's
role, average salaries, educational preparation, and
the effectiveness of clinical nurse specialists in head
nurse positions. The authors found that head nurses
who worked in decentralized agencies had more scope and
responsibilities as opposed to their counterparts in
centralized agencies. The findings also suggested that
head nurses lack the formal education needed to fulfil
the demands of the current role. CNEs would hire
master's-prepared head nurses if they were available,
believing they were more effective in the position than
baccalaureate-prepared nurses and/or clinical nurse
specialists.

From a Canadian perspective, two reports were
found regarding the role of the first line nurse
manager. Baxter (1993) conducted an exploratory
descriptive study to examine head nurses' perceptions
of their roles. The convenience sample of 20 head

nurses was selected from a large tertiary care hospital
in British Columbia. Using Mintzberg's (1973)
framework for describing managerial work, Baxter
reported that these head nurses perceived themselves as
managers. Furthermore, because of decentralization of
nursing departments, head nurses were managing larger
budgets and reported needing additional education with
regards to "developing and monitoring budgets,
manipulating resources within financial constraints,
and justifying resource utilization" (Baxter, 1993; p.
15).

Fullerton's (1993) article provides an anecdotal
review of the changing role and educational preparation
of first line nurse managers. In most large Canadian
hospitals, the head nurse position is evolving to that
of first line nurse manager, with increasing
responsibilities and exclusion from membership in a
nurse union. Fullerton acknowledges that no
literature was found to support this observed trend in
Canada and concludes that anecdotal or research
accounts should be forthcoming.

Summary of Literature Review

In reviewing the literature, there is a notable

lack of empirical data on health care reform and its effects on the evolving role of first line nurse managers. Furthermore, there is little reported on how fiscal restraint within health care influences the practice of first line nurse managers. However, several themes emerge from the limited research and anecdotal accounts. One is that health care reform is only in the beginning stages and, therefore, will continue to have an impact on the way care is delivered for years to come. Second, economic forces have had a major impact on the Canadian health care system and will continue to influence the way care is delivered. Third, the first line nurse manager's evolving role has been shaped by these factors and more. Because little is known about the expanded role of first line nurse managers under health care reform in the context of fiscal restraint, more exploratory studies are needed.

CHAPTER 3: METHODS

The design, sample and setting, data collection procedures, data analysis, and ethical considerations are discussed in this section. Limitations and assumptions of the study are also outlined.

Research Design

A descriptive exploratory design was used to examine the perceptions of first line nurse managers managing in a climate of fiscal restraint. A descriptive study focuses on a specific event for the purpose of describing phenomena rather than explaining them (Polit & Hungler, 1995). Exploratory studies are an extension of descriptive studies with the aim of providing a richer understanding of phenomena under study (Polit & Hungler). This design is appropriate when little is known about the topic, as is the case in this study.

Sample Selection and Setting

This study is part of a larger study by Acorn and Crawford (1995) in which a survey was conducted of 200 first line nurse managers in 38 acute care hospitals throughout the province of British Columbia. In the

current study, a purposeful sample of first line nurse managers from two acute care hospitals in the Lower Mainland of British Columbia was chosen for focus group interviews. Both hospitals had participated in the Acorn and Crawford survey. As well, both hospitals provide tertiary care services to citizens and number between 350 and 550 acute care beds. First line nurse managers who had held their positions for at least one year were asked to participate in the interviews. Six first line nurse managers participated in one focus group interview and seven in the second.

<p style="text-align:center">Data Collection Procedures</p>

The chief nurse executives of the two hospitals were contacted by one of the co-investigators of the larger study to obtain agreement for staff participation in focus groups conducted by this researcher. The co-investigator outlined the topic under study and the time commitment involved. Following this, logistics of the interviews were planned by phone by this researcher. Confirmation of dates, place of the interviews, and name and number of participants was obtained. Prior to each focus group, participants were requested to complete a demographic

questionnaire (Appendix A) including information about age, educational level, and experience.

Focus Groups

Focus group interviews of first line nurse managers were conducted to: 1) validate the data collected by the open-ended questions in Acorn and Crawford's (1995) study, and 2) further explore the perceptions of the managers with regards to managing within a climate of fiscal restraint.

Focus group interviews are a qualitative data collection tool used to elicit the perceptions of homogeneous groups of individuals on a topic of interest to the researcher (Krueger, 1994). Focus group interviews can be distinguished from other group processes (i.e., therapeutic, sensitivity, advisory, planning, nominal, delphic) by the presence of six characteristics (Krueger). First, the group consists of 6 to 10 participants, although this may range from 4 to 12. To determine the ideal number, it is important to consider two factors. The group must be small enough for all participants to be involved and large enough to ensure diversity in opinions.

Second, the interviews should be conducted in a

series so that internal and external influences can be assessed for their effects. For example, one group may seem to be unwilling to participate. The lack of participation may be because a crisis occurred before the interview and the participants' thoughts were elsewhere. Internally, one individual may dominate the interview making it difficult for others to state their opinions. If the interviews are conducted in a series, a particular different result from one group may be accounted for as the internal and external influences are likely to be apparent to the researcher.

Third, the homogeneity of the group is determined by the purpose of the study. However, the researcher has to be cautious not to overlook certain characteristics that may inhibit disclosure by the members. For example, familiarity among participants, such as in work groups, may inhibit disclosure, particularly if there are any hierarchical levels of power in those groups.

Fourth, the purpose of focus groups is to elicit the perceptions of individuals rather than reach consensus or find solutions to problems. The fifth characteristic is that these interviews produce

qualitative data in a more natural environment than do
other data collection tools (individual interviews or
open-ended survey questions). That is, the
participants influence each others' responses just as
in real life situations. Last, the researcher
predetermines the subject of the interview for the
purpose of learning more about a particular event,
experience, or topic. Open-ended questions, logically
sequenced and carefully developed, are used to elicit
the information which the researcher seeks.

The focus group interview offers several
advantages over individual interviews (Krueger, 1994).
One, the cost of conducting focus groups compared to
individual interviews is considerably less. For
example, if one is trying to elicit the perceptions of
20 individuals, this can be done with three focus group
interviews compared to 20 individual interviews.
Another advantage is that a large amount of information
can be collected in a relatively short period of time
resulting in quicker results. Third, the sample size
can be increased by using focus groups. In qualitative
research, a large sample is desirable but not always
reasonable due to cost and time of individual

interviews.

Another advantage is that, the environment is more life-like, that is, participants respond to what other individuals say, which, in turn, influences how they respond. This type of group dynamic often enriches the discussions bringing forth ideas that otherwise might be left unsaid. Last, the focus group technique yields results that are easily understood unlike statistical charts which may require a background in statistics for interpretation.

The focus group interviews in this study were conducted by this researcher who also analyzed the data.

<div align="center">Interview Guide</div>

The questions for the focus group interviews are often referred to as the interview guide or questioning route and are the core to effective and successful interviews (Krueger, 1994). Morgan (1993) suggests 10 to 12 well-developed questions for a two-hour interview as sufficient. The questions should be predetermined, open-ended, and follow a logical, sequential order (Krueger, Morgan).

The questions for the focus group interviews in

this study were developed utilizing the findings from the Acorn and Crawford (1995) study, and from the literature. Acorn and Crawford used open-ended questions (Appendix B) in their survey instrument to elicit information pertaining to the current climate of fiscal restraint.

Data from these open-ended questions were analyzed using content analysis techniques to identify common themes. The themes arising from the data were: Fiscal restraint has created many internal and external pressures on first line nurse managers; first line nurse managers have little input into the making of decisions that they are expected to sell to staff; first line nurse managers' workloads have increased; cutbacks have affected staff morale and the care and services provided to patients; fewer resources are available to meet the demands of increasing workloads; and work redesign is being implemented to enable staff to work more effectively within limited resources. These themes were then used to guide the development of the questions for the focus group interviews (Appendix C).

The interview questions were developed by the co-

investigators of the Acorn and Crawford (1995) study, a research assistant, this researcher, and a consultant experienced in focus group methods. They were then tested with a pilot group of six first line nurse managers to evaluate the clarity in the wording of the questions, the sequencing of the questions, and the omission of any important questions (Krueger, 1994; Morgan, 1993). The consultant on focus group interviews attended the pilot to evaluate this investigator's ability to facilitate the group discussion. Krueger suggests it is important that the moderator direct the participants' responses as this affects the validity of the data.

<center>Analysis</center>

The focus group interviews were recorded so that transcription and content analysis of the data could be performed. The interview data were transcribed by a professional transcriber and reviewed by the researcher to assess for completeness and/or errors in transcription.

Content analysis is a strategy for analyzing recorded data in a systematic and objective manner (Polit & Hungler, 1995). Content analysis is a

particularly useful measurement technique for nursing
research as it can be successfully applied to many
types of recorded information. The phenomena
frequently studied in nursing (i.e., perception,
attitudes, needs) can elicit large volumes of data that
provide richness and depth about the topic under study.
To avoid the loss of the richness and depth of data,
content analysis is recommended (Polit & Hungler,
1995; Waltz, Strickland, & Lenz, 1984).

The process of content analysis involves analyzing
the data for categories which are further reduced to
themes. The categories are identified by codes (tags
or labels) and are clustered to organize the data from
which conclusions are drawn (Miles & Huberman, 1994).
The categories into which the data are organized can be
predetermined, that is, derived from the theory guiding
the research question or from the data themselves by
clustering to identify categories as described
previously. Waltz, Strickland, & Lenz (1984) suggest
that both strategies can be used as long as the purpose
of the categorization is adhered to (i.e., the
categories link the theoretical background of the
investigation with the data and also provide the basis

from which conclusions are drawn).

Although some of the richness of the data can be lost through the reduction process, the purpose of this type of analysis determines the amount of simplification not the procedure itself (Waltz, Strickland, & Lenz, 1984).

Rigor

To ensure reliability in content analysis, both consistency in identifying the units (unitizing reliability) and consistency in assigning units to categories (interpretive reliability) are important (Waltz, Strickland, & Lenz, 1984). In this study, thesis committee members analyzed a section of the transcribed data using the coding scheme developed by this researcher. This was to assess the degree to which they recognized the codes and their descriptors in the data. This method enhances the reliability of the coding scheme.

The validity is highly context dependent and should be addressed throughout the design of the study. Considerations include sample appropriate to supply the data on the topic of interest, analysis methods appropriate for the type of data collected, and

handling of data executed properly so the analysis is not adversely affected.

Ethical Considerations

As previously stated, this study was conducted under the auspices of the larger study by Acorn and Crawford (1995) which was approved by the University of British Columbia Behavioural Sciences Screening Committee for Research and Other Studies Involving Human Subjects. The nursing executives of the two hospitals chosen for the focus groups were given a copy of the UBC ethical approval certificate. The participants were requested to sign a written consent for the taped interview (Appendix D). The consent outlined the purpose of the study, time commitment, and confidentiality of the participants' identities and facilities in which they were employed. The right to withdraw from the study at any time or refusal to answer any questions without penalty to employment were also outlined.

Limitations and Assumptions

A limitation of this study is that the findings are not generalizable to other groups due to the purposive sampling technique used.

It was assumed that first line nurse managers would disclose the desired information in a group setting. Furthermore, it was assumed that the focus group interview format would facilitate discussion among the participants.

CHAPTER 4: FINDINGS

In this chapter the findings from the focus group interviews of first line nurse managers are presented and discussed. The characteristics of the participants are described in the first section, with the themes presented and discussed in the second section. There are three major themes, each with corresponding sub-themes: enormity of change, impact of change, and management of change. The findings are compared to the literature where applicable.

Participant Characteristics

Thirteen first line nurse managers participated in the study. All were female, ranging in age from 34 to 55 years with a mean age of 44. The years of supervisory experience ranged from 3 to 20, with a mean of 9.5 years. Three of the first line nurse managers held a diploma in nursing, seven held a baccalaureate degree in nursing, and two held baccalaureate degrees from non-nursing programs. One first line nurse manager held a master's degree in a discipline other than nursing. Two of the baccalaureate-prepared participants were within a year of completing the

master's degree in nursing. Eight of the 13 participants had completed the questionnaire in the Acorn and Crawford (1995) study.

The participants shared their experiences willingly and confirmed that fiscal restraint was having a significant impact on practice. The participants indicated that their role has changed over the years and that it has been dynamic in nature. However, fiscal restraint has added a new dimension that none of them had experienced during their careers. One of the participants expressed the impact in this way:

> It is very difficult right now because we have a whole generation, myself included, of nurses who have grown up in a system that anyone could have anything they wanted. Virtually, there was nothing in the way of patient care that could not be provided. There was not a lot of talk about, you know, of cost benefit, that kind of thing like there is now and it's very difficult for people to take a step back and say well, we cannot have it like that anymore for very good reasons. People, well, the nurses that I work with anyways, still

have not let go of the way it has always been in our entire lifetime as nurses and look at new ways of doing things because that's, we just don't have the background or the insight or the education to be able to necessarily do that and it is terribly difficult. It's a mourning, grieving loss type of process that everyone is going through.

All of the participants had budgetary responsibility for their areas and, therefore, were knowledgeable about the topic of the study, providing appropriate participant input.

Themes

The findings indicate that the enormity of the change occurring in the health care sector is a major theme. Four corresponding sub-themes, health care reform, decentralization, accountability and control, and delivery of care, emerged from the data. Impact of change is the second theme; its sub-themes are increased workload, communication, and uncertainty of change. The third theme is management of these enormous changes. The sub-themes of strategies and support identified both strengths and gaps in how first line nurse managers manage these changes.

Enormity of Change

In the focus group interviews, the first line
nurse managers identified that change is and will be a
constant for health care workers. They articulated that
change in itself is not the issue. Rather, it is the
amount and magnitude of the change. As one participant
described:

And I think, you know, we go over hills and
valleys don't we? Where our head comes above water and,
by jove, we might even swim a stroke or two and then
there is a wave. You know, a month from now we might
be... But right now, right now, we're having a gale and
the waves are pretty big.

Keeping pace with the changes has proven to be a very
complex process. The first line nurse managers
indicated that the traditional strategy of working from
a strategic plan, identifying a necessary course of
action, and implementing the action plans over time
lines is no longer a functional process. Either the
strategy plan is outdated or the number of changes
required simultaneously in the action plan has made the
planning and implementation of time lines impossible
tasks.

The evaluation of implemented action plans is non-existent, because, before the evaluation process is started more changes have been introduced, eliminating the need to evaluate the original change in the action plan. Furthermore, the evaluation process is costly and, therefore, is given a low priority by hospital administrators in the face of scarce resources.

First line nurse managers identified the impetus for the enormity of changes as the government health care reform which includes, but is not limited to, decreased funding to acute care hospitals. This is consistent with the findings in the literature that suggest national debt is initiating the rapidity of health care reform (Roch, 1992). Hospital administrators' strategies to deal with funding cuts have drastically changed the way hospitals operate. Decentralization of decision making to unit levels and changes in managers' authority and accountability are some of the examples that emerged from the data. Hospital operational changes have affected the type of care and the way in which patient care is delivered. Health care reform, being the broadest of the changes, is discussed first.

Health Care Reform

Many issues arose out of the changes that health care reform imposed. Support for health care reform was positive among these first line nurse managers even though they raised concerns. One first line nurse manager commented:

> I am very supportive of the whole health care reform. There has been excessive waste and abuse of our system and we have watched it go on for years and the health care reform is only coming out of, out of all the financial problems that were there and, otherwise, we would have never got into health care reform, so health care reform is good.

Another talked about the future:

> I can really see down the road because we are trying {the health care system} to link into the community, bring all the dollars into one pot so as a program we're controlling the dollars, without saying, that is hospital dollars and that's community. So I think the outcome for patient care and family care is going to be very positive if we can do that.

The first line nurse managers suggested that health
care reform would be beneficial to patients only if
redistribution of funding was managed in a way to
support the needs of the patients. For example, if
hospitals are being downsized and cutting services,
then the services and the funding need to be
redistributed to agencies or groups who can best
provide them at the least cost. These first line nurse
managers had concerns that health care reform was not
unfolding the way the government has suggested. That
is, the dollars are not being shifted to the community
although services are being cut. They also expressed
concern that certain groups of patients were not
receiving the care they needed in acute care and/or the
community because of the funding cuts in health care.
The first line nurse managers believed that health care
reforms will continue for the foreseeable future as
funding is decreased. This belief is echoed in the
literature, as Roch (1992) states "...the theme for
health care during the 1990s will be one of
restructuring and refocussing" (p. 8). One commonplace
management strategy to bring down costs in the health
care industry is decentralization.

Decentralization

    As hospitals reorganize, the levels of management are being decreased, with the decision making authority moving downward. These two changes are mutually exclusive even though it would appear they need not be. Participants from one focus group noted that their organization had both changes occurring (i.e., decreasing management levels and decentralizing of decision making). They reported that the authority for certain decisions (i.e., bringing staff in on overtime) was decentralized to the unit level, but, for many decisions, it was unclear who was responsible to make which decisions. Several issues arose related to decentralization of decision making.

    First, there were many positive comments supporting decentralization. First line nurse managers felt the quality of the decisions was better and that the increased authority in decision making allowed them to address issues more expediently. After reviewing the literature on centralization of authority, Wells (1990) indicated that "Decentralization is now synonymous with effective nursing management and high employee morale" (p. 3). Support for decentralization was expressed in

this comment: "I think I said before the good thing about decentralization ... is the good opportunities we have to give staff what we want, you know, we don't have to wait any longer to get it passed by so many people."

The first line nurse managers also indicated that, in most cases, the authority to make decisions had been passed along with the responsibility. Another expressed that it would be advantageous if decision making authority could be delegated to the staff nurse level. This first line nurse manager felt it would enable nurses to focus on managing the whole of patient care as opposed to focusing on patient care tasks.

Several concerns were raised by the first line nurse managers about the changes decentralization brought in their workplace. For example, first line nurse managers believed work was being "dumped" on them from various departments in the hospital. It was suggested that, as responsibility increased for many hospital managers, their authority to make decisions allowed them to delegate work to others. It was further suggested that, with this new authority, the majority of the tasks were being given to first line nurse managers. For example, one first line nurse manager described how another

department had the responsibility to send information (a letter) to all staff members in the hospital. A person in this department sent the first line nurse managers the information, requesting them to disseminate it to all staff members. This first line nurse manager, who had over 100 staff reporting to her, felt that it was really not appropriate for her to spend her time doing this, particularly when there were other established ways within the hospital to disseminate information of this type.

In another situation, the first line nurse managers described how manuals from other departments were sent to them to be updated. The first line nurse managers were required to identify the necessary changes, arrange to have them corrected, and then to obtain a new manual.

These examples indicate that first line nurse managers' workloads are being increased by some of the changes resulting from decentralization. Whether the negative effects outweigh the positive or whether the negative effects of decentralization are temporary as roles are clarified is not known.

Accountability and Control

The first line nurse managers indicated that their

accountability was clear (i.e., to continuously improve the quality of patient care and do it with less money). However, their authority and control over certain activities was less explicit. For example, control over patient admissions or cancellation of surgeries differed from unit to unit. If a unit was extremely busy and staffing was minimal, certain first line nurse managers could limit admissions or cancel surgeries instead of bringing staff in on overtime pay. However, this process has changed recently as one first line nurse manager stated:

> In our place you know, sometimes you have to limit the number of admissions for the day based on your resources and só forth. A few months ago, it was much clearer as to how that transpired. Right now, we're in a very grey zone and that creates a lot of problems for all the disciplines as to are we doing more cases? Are we not doing more cases? There's a time element that people need to know by a certain hour and there's a lot of confusion within that and it's even hard to know why that is become more blurred now then just two or three months ago and a lot of it into fiscal items, is it okay today that

we can use the overtime but yesterday it wasn't? This example supports the first line nurse managers' suggestion that they have the accountability for managing the resources but not always the authority or control to match workload to resources. The first line nurse managers indicated that accountability without authority or control is very frustrating and undermines their credibility as it appears they are inconsistent in their management of matching workload and resources.

Another issue deals with the communication aspect of decision making. It was expressed by one first line nurse manager that "we are so decentralized that we're not connected." She indicated that with so many changes, it was difficult to keep up with who was responsible for what. Although this information was often discussed in committee meetings, the numerous changes made it difficult to attend all these meetings. There were many decisions for which no one seemed to know who was responsible which added to the feeling of being disconnected.

The first line nurse managers indicated that another area of difficulty was controlling staffing budgets. Many first line nurse managers felt they

needed to increase their staffing quotas but, instead, were struggling with ways to maintain the present levels. For example, staff sick time has a major impact on budget because of the replacement costs for absenteeism. The first line nurse managers have to balance the levels of staffing with the costs of replacement. If they replace all staff who call in sick they cannot come in on budget. If staff who are sick are not replaced, the workload of those staff who are working increases and first line nurse managers believed this resulted in even higher levels of absenteeism. The dilemma here is that many of the first line nurse managers believed that resources needed to be increased in certain areas to prevent overruns in their budgets during the year. However, they did not have the authority to move resources around or to spend more money in ways they believed would eventually save money. The literature indicates that, in order for first line nurse managers to be able to control costs while improving the quality of patient care, they need to have increased authority to match this responsibility (Eubanks, 1992).

Delivery of Care

Several examples were given by the first line nurse managers about imposed changes to care delivery that were necessary due to budget cuts. As one first line nurse manager expressed:

> In general, I think patients get better care all the time in spite of stress that new technology and changes in the department and all of these have put on us. Some of the results for patients have been particularly good and I'll give you an example, *Clinical paths* which were put in place on my unit for strictly fiscal reasons.... The result was better care. That was a case where there was an improvement in service.

Clinical paths are defined by Crummer and Carter (1993) as follows " A critical pathway describes a course of hospitalization for patients with similar problems and treatment plans. Critical pathways are standardized to describe the course of events that lead to a successful patient outcome" (p. 31). This first line nurse manager indicated that patients were receiving better care because the outcomes were explicit. If this change in practice had not occurred for this group of patients,

they might have had a prolonged hospital course. Moreover, they might not have received the appropriate interventions deemed necessary for their problems, resulting in a lesser quality of care.

Another example was given in which clinical paths were used to streamline patient care throughout hospitalization. In this particular example, the length of stay was being decreased, the patients were spending less time in critical care areas, and invasive equipment was removed from patients sooner. It is believed that the less time a patient has invasive equipment, the sooner recovery begins, resulting in earlier hospital discharge. Money is saved by decreasing the length of hospital stay for patients. Furthermore, the current belief is that patients recover faster in their own homes which is beneficial in terms of fiscal and human costs.

In another example, this time in extended care, the practice was to awaken all patients (65 to 75) at ten o'clock at night and two and six in the morning to change their incontinence devices. Findings from a study conducted at another facility revealed that this practice was disruptive to sleep and costly in terms of

supplies. As a result, staff omitted the two o'clock
awakening. A first line nurse manager in the current
study indicated that incontinence products were one of
the major expenditures in her area. This first line
nurse manager adopted the practice of not awakening the
patients at two o'clock. The first line nurse manager
reported that the saving in money was substantial and,
more importantly, the improvement in patients'
behaviour, after a uninterrupted night's sleep, was
impressive.

Another first line nurse manager provided the
example that in labour and delivery it was common
practice to admit patients to hospital who presented in
false labour. That practice has changed in the last
couple of years, and patients are now released after
assessment and not admitted to hospital. The first
line nurse manager reported that this resulted in
considerable savings. Money was saved because of fewer
admissions, but, more importantly, patients were being
subjected to less medical intervention which is cost
saving in both fiscal and human terms. It was
suggested by more than one first line nurse manager
that fiscal restraint was the impetus for health care

providers to reexamine how care is being delivered in their areas. The results of the changes in the way care is provided not only showed cost savings but improvement to the care clients were receiving or even *better care*, according to the first line nurse managers.

The changes in the delivery of care were seen as both positive and negative. The first line nurse managers indicated that some changes resulted in improved patient care while others indicated that, although there appeared to be benefits, formalized evaluations of changes were necessary before making this assumption.

Summary

The findings indicate that the first line nurse managers believed that change was now the constant and that change would continue to be rapid and of great magnitude. The first line nurse managers generally agreed that health care reform was necessary but had concerns that patient services might be diminished in the process. The concept of decentralization was supported in theory, but had some negative consequences in practice. However, the negatives may be resolved as

decentralization is implemented in their respective facilities.

The first line nurse managers also supported the increase in accountability but were concerned that the authority and control did not always match. The changes in care delivery systems was generally positive, even though the changes were initially opposed. The first line nurse managers suggested more research was necessary to properly evaluate some of the changes occurring in the care delivery systems. However, the trend will continue as Collins and Noble (1992) write:

> Canadian hospitals have entered an era in which economic constraint has been, and will continue to be, a dominant factor in health care delivery. This constraint, coupled with increasing consumer and stakeholder demands, have forced hospitals to review seriously the programs they offer and their methods of delivery. Canadian hospitals are being downsized, managing with leaner organizational structures and are still being asked to do more with declining resources (p. 4).

The impact of these changes for first line nurse

managers is great as the findings indicate in the following discussions.

Impact of Change

The demands placed on the first line nurse managers grow daily. These increased demands are from administrators, other disciplines, nursing staff, and from patients and their families to do more. One first line nurse manager described these demands in this way: "On top of still having to do a very demanding job which is only growing more demanding, because we're asking people to do more with less and then do it better on top of all of that."
Another stated:

> We are constantly in a position of justifying our existence, we are working with staff who work very hard, are expected to do a very comprehensive role but as [she] said, I think do it faster and cheaper and more, more of it right now and that is a real challenge.

Still another stated:

> The problem is that the hospital is trying to do, to do a great many changes without necessarily having the fiscal backing to do it, and it's sort

> of two things going on at the same time. I mean
> I find it extremely difficult to deal with that,
> we are dealing with the four or five and six
> changes going on at the same time.

The first line nurse managers described the impact of the changes as an extremely difficult challenge to meet, particularly because the complexity of the challenges grew daily.

One sub-theme of the impact of change that emerged from the data as a result of the demands was the increase in the first line nurse manager's workload. The changes affected the communication structures within the facilities, a fact which they believed had a major impact on their workload. Communication issues arose as a second sub-theme of the impact of change. Underlying the concerns around workload and communication was the third sub-theme, uncertainty. Regardless of how much commitment and effort they put into their jobs the first line nurse managers believed that the environment of uncertainty was ever present.

Increased Workload

The data from the first line nurse managers' focus group interviews clearly indicated that they believed

that their workloads were increasing. With the changes
in organizational structures resulting in fewer
managerial positions, the first line nurse managers
felt they, more than others, were experiencing
increased workloads. There were several reasons for
this. For example, the first line nurse managers
reported that work normally carried out by other
departments is now being delegated to them.
Departments are introducing new programs and delegating
the implementation and follow up of these programs on
the units to first line nurse managers. One first line
nurse manager described how she was asked to do *yet
another job.* When she explained to the person how busy
her schedule was the response was "I am not asking you
for 100% of your effort, I am only asking 10%." As the
first line nurse manager explained, "If you put 10%
into that and 10% into the 12 other projects that you
have you have 120% and you do not have a good job of
anything." The first line nurse managers explained
that these projects were in addition to their normal
workload, which was already demanding.

Several first line nurse managers commented that
staff support needs have increased dramatically as

staff try to cope with the changes. For example, sick time has increased, the number of grievances has increased, and issues that are not usually of concern have become a focus. Two of the first line nurse managers from different hospitals indicated they were spending the majority of their time supporting frustrated staff. They suggested that imposed hospital changes have created an environment in which they spent most of their day "fighting fires and picking up the pieces." As one first line nurse manager stated "...because the sick time is way up, the overtime is up, it's ridiculous and who has to deal with it, we have to."

The public is also placing increasing demands on the health care system. Patients and their families are more involved in their care, more knowledgable about health care, and concerned that the changes will have negative consequences for them. The first line nurse managers suggested that it is the public's perception that they are losing something with the changes and some clients respond by demanding services that were never available to begin with. The first line nurse managers also indicated that these

misconceptions were in part due to the lack of effective communication. Communication is the second sub-theme of the impact of change and is discussed next.

Communication

Communication is a broad term generally used to denote information exchange (Mish, 1983). In the context of this discussion, it relates to issues of information exchange for first line nurse managers in a changing environment. Many issues were raised in the focus group discussions about the need for effective communication, that is, the necessary information being given to the appropriate person at the right time. In a study by Chase (1994), both the knowledge of and ability to carry out effective communication was seen as the most significant skill necessary for first line nurse managers.

It was suggested that as the amount and magnitude of change increased, communication became less effective. Furthermore, the first line nurse managers suggested there was far too much information exchanged and that it was a major waste of time. As one first line nurse manager stated:

> The left arm sometimes doesn't know what the right
> arm is doing and we can have inservices and
> several booked at the same time... we have so many
> forms of communication, I don't know how the staff
> can possibly keep up.

The first line nurse managers indicated that there was
confusion with the amount of information to be
disseminated.

As another stated:

> How many different bulletins and flyers etc. are
> coming out and we've got computers and we've got
> voice mail... suddenly anyone has the authority to
> leave me messages on my voice mail, plus send a
> bulletin, a special bulletin, and then put it in
> the regular bulletin that goes around.

This statement revealed that the dissemination of
information was very disorganized, there was
information overload, and the necessary information was
not reaching the appropriate people in a timely manner.

Another first line nurse manager claimed that the
mail was piled table high and that it was almost
impossible to deal with all this information. There
was also discussion about information being announced

before the people most likely to be affected by the information were consulted. For example, it was announced in a general hospital meeting that a unit was closing as of a certain date. The first line nurse manager responsible for this area was unaware of this closure, and the impact of this news was devastating to the staff. The first line nurse manager was put in the awkward position of having to try and support staff members while dealing with her own feelings in this situation.

The communication issues are very complex. As more changes occur, the need to communicate effectively is heightened. However, with so much information being disseminated, communication actually became less effective. This greatly affected the first line nurse managers as it became increasingly difficult to provide the appropriate information in a timely manner. This gave raise to speculation and rumours which seemed to heighten the uncertainty that first line nurse managers and staff were experiencing. Uncertainty is the third sub-theme of the impact of change and will be discussed next.

Uncertainty

Feelings of uncertainty may be experienced during times of change and this was the case with these participants. The uncertainty was strongly expressed with regards to the future of the first line nurse managers' role, their job security, and the effects that changes in the first line nurse manager's role would have on professional nursing practice as well as on patient care. During discussions of these issues, emotions, such as frustration, anger, and powerlessness, were verbalised.

The uncertain future of the participants' role was expressed by one individual in this way:

> As far as the head nurse position is concerned, I don't think either of us wake up any day knowing whether or not we're going to have a job in a week from now. There's complete uncertainty within all of our jobs, and that in itself is something that we haven't experienced before, I haven't experienced before.

The first line nurse managers expressed how this uncertainty had a major impact on the daily level of stress they were experiencing. As one stated:

So certainly agreeing with everything everyone has

said about the issues in terms of stressors on

us, continuing education, job uncertainty,

increasing responsibility and the need to always

justify existence and say why should I have this

job or why should this job exist. It is very

stressful and feeling such lack of control in our

environment that we just kind of, which way are we

being pushed now or pulled now and I think that

carries down to the staff as well.

The first line nurse managers verbalized powerlessness

over future uncertainty regarding job loss as one

stated:

And I think we ought to relate to what's happening

in the society in general, you know we're singing

the same song that everyone is in the corporate

setting is singing. You know, we've got that

fear outside at least. You've got a job so don't

make waves.

Another stated:

So directly how it [fiscal restraint] impacts on

me, is that there's now an element of

uncertainty within the head nurse role. I perceive

that they are cutting back and changing the

standard role and also the different titles.

The first line nurse managers expressed frustration not

only with the increasing responsibility but also with

the expectations of administrators for additional

educational preparation. In order for first line nurse

managers to keep pace with the added responsibility,

they indicated there was pressure to obtain the

necessary education using their own resources. It was

felt by individuals that there were no rewards or

incentives in place for first line nurse managers to

advance their education. With fiscal restraint,

monetary rewards were not forthcoming but most

distressing was the fact that there would most likely

not be a job for them to return to if you took the time

and money to advance their level of education. However,

the first line nurse managers indicated that most of

them were in school as well as managing full-time jobs.

They suggested that with all the changes there would be

layoffs, and, therefore, competition for limited

positions. The higher the education level they

obtained, the better positioned they would be to

successfully compete to keep their jobs.

The literature supports this trend to hire master's-prepared nurses as managers (Hodges, Knapp, & Cooper, 1987; Mark, 1994). One reason that master's-prepared nurses were desirable was for their ability to think critically. Henry (1992), in a study of 97 community hospital first line nurse managers and 110 metropolitan teaching hospital first line nurse managers found, "For critical thinking ability there was a significant (p<.05) main effect of education with master's-prepared managers scoring significantly higher (p<.05) than either the baccalaureate or diploma associate degree groups" (p. 74). Mark compared data collected from a 1992 survey of chief nursing executives in Virginia with several other reports. Findings indicated that chief nurse executives (CNEs), particularly CNEs from larger hospitals (>300 beds), were more willing to hire master's-prepared nurses.

Other participants expressed frustration over whether there would always be nurses in the first line nurse manager role. One participant stated:

> We are in the throes, as of May, of going into program management. We have a team leader who is a social worker and there originally was not to be

a head nurse by December within program management
and we're still in the throes of deciding whether
there will be a head nurse and will that position
be part-time and what the functions will be from a
nursing perspective.

Anger and frustration were expressed over the possible
impact of not having nurses in first line nurse manager
positions and how that would influence professional
nursing practice.

One first line nurse manager, who was working in a
program management structure, believed there were not
any infrastructures in place for staff nurses to
discuss practice issues. She indicated that the head
nurse is responsible for ensuring practice standards on
the units and implementing changes in practice for
nurses. The head nurse also assesses the impact of
practice changes which includes ensuring that policies
and procedures are established, and that staff nurses
have the education and skills, as well as the knowledge
of their responsibility, with regard to the change in
practice.

This first line nurse manager believed that staff
nurses should be responsible for their own professional

practice. However, without the first line nurse manager, the liaison between staff nurses and input into changes that affect their practice may be lost. Moreover, the first line nurse managers reported that organizational structures were not in place for staff nurses to provide the necessary input. This discussion raised concerns that nursing would not be represented within the program management structure without the head nurse position.

The logistics of ensuring that staff nurses represent nursing in meetings within program management structures needs to be developed. It was suggested that nurses' schedules are not flexible enough to allow a nurse with patient assignments to attend meetings. The first line nurse managers did not believe this was a logistical problem with other disciplines, as they have the flexibility to schedule their work around meetings. The concern was that nursing has been challenged with providing 24-hour coverage. Providing nursing input at meetings, which generally occur between the hours of 8am and 4pm, would prove to be very difficult.

Another concern raised by the first line nurse managers was that, if first line nurse managers were

non-nurses, patient care would be compromised. This was implied by the first line nurse managers because they believe, that nursing as a profession was undervalued (by senior administrators) even though it was nurses who were the best advocates for patients. Because nursing was undervalued, first line nurse managers could be replaced by non-nursing managers whose focus was cost effectiveness rather than quality patient care.

Summary

The impact on the first line nurse managers' practice from the changes in health care driven by the fiscal environment was significant according to the findings from the focus group interview data. Although there were many issues related to increasing workloads, the stress of the working environment, lack of effective communication, and the stress of potential job loss, the first line nurse managers' greatest concern was that of the professional practice environment and its eventual impact on patient care. They believed if nursing lost its advocacy role for patient care standards, which currently is linked to the first line nurse manager's role (Sovie, 1994),

patient care would suffer.

The third theme is the management of change. This theme together with the sub-themes, strategies to manage change and support in times of change (technological and administrative), are discussed in the following section.

Management of Change

It was evident from the focus group discussions that change had an impact on all aspects of the first line nurse manager's role. The complexity and magnitude of the changes provided rich discussions about the strategies used to manage changes. Moreover, discussions on managing resources and the support needed (technological and administrative) to meet the challenges was discussed.

Strategies To Manage Change

The first line nurse managers gave several examples of how they managed the changes that resulted from shrinking budgets and increasing workloads. First, before first line nurse managers can effectively manage these changes they must be aware of their respective patient populations and financial data. The literature indicated that cost effective quality care

can be realized by first line nurse managers (Eubanks,
1992; Mark, 1994; Sovie, 1994). Sovie suggests that a
master's degree in business is no longer a suitable
alternative because of the critical role that nurses
play in achieving quality care and desired patient
outcomes. Sovie has suggested that graduate level
education in nursing is required for the position of
first line nurse manager as well as sufficient theory
in business management techniques.

One of the first line nurse managers expressed the
importance of knowledge about financial data in this
way:

> One of the things I think all of us have been
> doing is really looking at our data not only in
> terms of length of stay and patient data but
> all our financial data and really looking at where
> we are spending our money and how we are spending
> our money. So that's sort of, even before we
> develop any sort of strategies to deal with it.
> And so we get the reports now we need to be able
> to justify where we are spending it.

Once this awareness was evident to first line nurse
managers, strategies were developed to raise the

awareness of staff, physicians, and students about the
cost of supplies and diagnostic tests. As one first
line nurse manager expressed:

> We have the staff very involved in that they have
> gone around and put up the cost of things and they
> are looking at the budget sheets and they are
> measuring them from month to month to look and see
> if they have made a difference and the house staff
> the same thing. We orient the house staff every
> time they come through the door and uh, the
> equipment they use, the supplies, the Swans Ganz
> catheter which costs $206.00.

Another first line nurse manager found that labelling
items with the price was very beneficial in raising
staff awareness of cost. This resulted in staff making
suggestions on how to reduce usage of expensive items.
Linen was mentioned by several of first line nurse
managers as being a very expensive supply item. The
laundry costs per piece of linen are charged to the
units. When the managers and the staff became aware of
this, several strategies were introduced: using the
same blanket several times before putting it in the
laundry, or decreasing the number of flannels used

(more expensive than flat sheets), and not changing the bed sheets on a daily basis unless it was necessary. Once these strategies were in place, laundry costs were drastically reduced.

The first line nurse managers identified that awareness and education of staff were necessary to facilitate the change that cost effectiveness is everyone's fiscal responsibility. Once this concept (that everyone has a role in fiscal responsibility) was accepted by staff and physicians, changes occurred in clinical practice that reflected cost effective practices. For example, practices that were carried out on a routine basis were scrutinized. One of the first line nurse managers described how this concept helped staff examine routines that led to change in practice. She stated:

> That is the kind of future that I see is looking at what it is we are doing for people instead of carte blanche, doing everything for everybody, really justifying why it is that someone should get it and someone else does not get it or whatever, and that will ultimately result in some cost containment as well I would think.

The first line nurse managers described how practices
were changed that were both beneficial in cost savings
and patient care. For example, one unit examined the
routine blood work scheduled and found a cost saving in
decreasing the number of the blood tests being done.
They changed this routine by decreasing routine
bloodwork and all other tests were done only if
necessitated by the patient's condition. This
individualized or customized care benefited patients by
reducing the number of unnecessary and uncomfortable
procedures without compromising patient care.
Furthermore, it saved the hospital money and decreased
staff's workload. One first line nurse manager
validated this occurrence with this statement:

> We have also, from a patient perspective, had a
> considerable savings over the last couple of years
> in patient stay and just in labour in that people
> coming in early labour or false labour, un, are
> now sent home, sent home on pass rather than
> hanging onto them for hours on end when they are
> not in established labour and that has actually
> saved a whole lot of money in interventions as
> well. Harder to prove but it appears that our

cesarean section reduction rates go down when we practice that.

Another area in which strategies were employed to save money was replacement of staff on sick calls and holidays. Although there were union constraints with regards to staff schedules, there were savings when not all staff who called in sick were replaced, which has been the usual practice. The strategy involved educating the staff about assessing the actual workload on the unit and determining if they needed a 12-hour replacement or someone for only a portion of the shift. The staff were delegated the task of replacement of staff when first line nurse managers were unavailable.

Another strategy was to offer staff members leaves of absence or vacations particularly during slower periods which occur during summer and/or the Christmas season. There were substantial savings when staff were on paid holidays, but did not have to be replaced. Although there were many excellent examples given where strategies produced savings or promoted cost effectiveness, the first line nurse managers indicated there were resources still being wasted. Examples were given of hospital-wide programs that were initiated

which had a direct impact on the cost of delivering care. It was suggested that there were many hidden costs that unit budgets had to absorb in order for the initiatives to be a success. It was also suggested that there was a lack of, or inappropriate, impact analysis done before certain changes were implemented which resulted in wasted resources. Specific examples have been withheld to respect confidentiality.

Another strategy indicated by these first line nurse managers was to develop or enhance the support structures within their facilities. Support in times of change will be discussed next.

Support In Times of Change

Two categories of support emerged from the data: technological and administrative. The first line nurse managers suggested that the need for technological and administrative support increased as more changes occurred. In order to manage the changes, the first line nurse managers believed they needed data to give them direction in their decision making. One first line nurse manager stated:

> We have a problem in that we do not have
>
> equipment that is current. We need the technology

of today. We do not have it. We need it to
originate you know prompt decisions that are based
on sound data. We do not have that data. We
cannot get it fast enough because the systems
are not in place.

The first line nurse managers indicated that access to
patient data was limited. For example, their facility
did not have the technology to generate reports they
needed, or to support financial decisions that needed
to be made. There was general agreement among all the
first line nurse managers that technological support
was lacking.

Technological Support. As previously mentioned,
there was rich discussion among the first line nurse
managers in the focus group interviews about the
growing workload and increasing demands placed on them.
One frustrating aspect about the increased demands was
the lack of clerical and technical support to assist
them in coping with these changes. These first line
nurse managers were responsible for the supervision of
20 to 70 full-time equivalent positions (individual
staff numbers are greater as many positions are filled
by part-time workers) and managed budgets from $800,000

to $3.3 million (Acorn & Crawford, 1995; Crawford &
Acorn, 1995, in press). The majority of first line
nurse managers reported they had no secretarial support
while a few reported that they had very limited access
to such support. In discussing this issue, one first
line nurse manager stated:

> The other thing I think too that, to me, it's a
> gender issue because I don't know of any other
> manager that has the responsibility that we have
> and it becomes more and more and more; we have no
> secretarial help.

The first line nurse managers felt there was a lack of
respect from senior administrators because they were
not provided with services that managers (mostly males)
in the private sector would simply not work without.
Although the first line nurse managers acknowledged
there is a cost attached to providing secretarial
services, they suggested that if they were non-nursing
managers with equivalent responsibility, they would be
provided with this service.

The essence here is the enormous responsibility
these first line nurse managers are coping with,
without even the basic managerial supports. In another

quote, a first line nurse manager stated "there are an
awful lot more things we could do more efficiently if
we had the technology available to us. I mean you guys
would probably be able to cope a bit better with a
secretary right now...". The technology support
discussion centered on office information systems that
were lacking. Although most had access to personal
computers, the programs were limited, and/or the
printers were shared, and one had to walk to another
floor or building to pick up the printed work. It was
mentioned that E-mail and modems would be helpful.

Administrative Support. The first line nurse
managers verbalized the lack of support from senior
management in terms of projects being implemented
without the resources needed to carry them out. This
situation would challenge the first line nurse managers
to have staff accept projects when it was evident that
the educational or fiscal resources were not available.
It was expressed by one first line nurse manager this
way:

> Two things I see is that in situations like we
> just spoke about that the management need to
> support the senior management and support us and

they are asking us and we are talking money a bit, but they are asking us to be fiscally responsible and we, I think all of us are and if we make our decision, if they say maybe it's not the best decision but that's the best decision you could make at this time. The next time look at this, but the support is not there and I do not expect our directors to be around all the time because they have a lot of work as well, but it would be nice if we could see them now and again or even they could just come by whatever, but basically just support people.

The first line nurse managers were not feeling supported but did not want to place blame. The discussions about the lack of support were qualified with comments about how difficult it was for everyone.

It was also suggested that senior management would not always support first line nurse managers on issues that arose between physicians and first line nurse managers. For example, this scenario was described:

Well, it's interesting because I, I was trying to set my priorities and, and I thought you know, I was doing an OK job and so I, you know, I have

an assistant head nurse and so they are running
the day-to-day operations and I was trying to get
into my office to organize all of the different
decentralization things and the groups and then
you know, the new computer system and all that
kind of stuff. The physicians complained to the
director they did not see me, and so, you know,
that was fine. So we had this discussion and I
said OK.

This first line nurse manager believed she was changing
her practice to meet the demands of change, and when
the director spoke to her about the physicians'
concerns she did not feel supported. There were
discussions regarding the lack of support from senior
management in terms of respect for first line nurse
managers and nursing staff.

First line nurse managers emphasized the need for
first line nurse managers to support each other.
Although they wanted support from senior management, it
was suggested that this was out of their control and
that real support could come from each other. One
first line nurse manager phrased it this way:

Really, in these times, I think we really need to

support each other with the difficulties we are
all encountering and, yesterday or the day
before, someone made a comment to me that, well,
you know, some head nurses really have as heavy a
workload as other head nurses and I thought, well,
if nursing is getting into that kind of a, how do
I, how can I measure what her workload is? I mean
it is not for me to judge and uh, all our roles
are very different in the different areas and a
lot of different issues in terms of staffing,
whether they're junior staff, senior staff, anyway
but it just struck me that if within nursing we
are starting to fragment like that.

The first line nurse managers expressed concern that
some first line nurse managers were starting to judge
each other's workload and this was creating divisions
within the nursing ranks. This had the potential for
devastating effects and what was really needed was
support from each other, not criticism.

Through the discussions, comments suggested that
support needs had increased as a direct result of the
changes and it was explicit that senior management,
directors, first line nurse managers and staff, and

physicians were all needing increased support. The
first line nurse managers strategized how they might
give as well as receive support in times of change.

Summary

First line nurse managers described creative
strategies to deal with the changes brought on by
fiscal constraints. However, they claimed that managing
change required money to be spent on technology and
clerical assistance that was currently lacking. The
first line nurse managers suggested that information
systems were needed to process the massive amount of
patient data in a useful way. Administrative support,
both financial and personal, for first line nurse
managers was lacking. The first line nurse managers
agreed that personal support from senior management was
not likely to increase and, therefore, it was more
important than ever to support each other.

<div align="center">Chapter Summary</div>

The enormity of changes will continue in the
health care industry for some time to come. The changes
will continue to be rapid and foreign even to seasoned
first line nurse managers. The impact will continue to
affect the practice of first line nurse managers in all

aspects of their role. Whether the impact is workload, lack of timely information, or uncertainty, it is the future. How the first line nurse managers are going to survive in the rapidly changing health care climate is a matter of managing the changes. Strategies used to date have been creative but not enough in themselves to continue to manage future changes. There are no text book answers, but the first line nurse managers recognized that supporting their colleagues was an important step in managing the changes that fiscal restraint has imposed on their practice.

CHAPTER 5: SUMMARY, CONCLUSIONS, AND IMPLICATIONS

A summary of the study is presented and
conclusions drawn from the findings are discussed in
this section. As well, the implications for
administrative nursing practice, research, education,
and hospital administrators will be outlined.

Summary

The purpose of this study was to examine the
perceptions of first line nurse managers of managing
within a climate of fiscal restraint. Canada's health
care system will continue to be influenced by the
economic climate during the next decade. First line
nurse managers play a pivotal role in the quality of
the care delivered to patients. Therefore, it is
important that research be conducted to determine how
they manage the delivery of patient care within a
climate of fiscal restraint.

Reports in the literature indicate that early
advocates for health care reform to control costs were
ignored by governments as reform was politically
unpopular. However, health care reform is now a major
focus of both provincial and federal governments as

they struggle to control the spiralling Canadian deficit.

The literature indicates that the first line nurse manager's role continues to evolve, and it is increasing in accountability and responsibility, particularly in the area of financial responsibility. Also, first line nurse managers strongly influence the quality of care that is delivered in Canadian hospitals. Thus, it is the first line nurse managers who have responsibility of ensuring that patients receive high quality care in a cost effective manner.

A descriptive exploratory design was used to examine the perceptions of first line nurse managers of managing within a climate of fiscal restraint. This study is part of a larger study by Acorn and Crawford (1995) in which data were collected through a survey, completed by 200 first line nurse managers in 38 acute care hospitals in British Columbia.

In the current study, focus groups were conducted to validate the data collected by the open-ended questions in the Acorn and Crawford study and to further explore the perceptions of first line nurse managers of managing within a climate of fiscal

restraint.

The data collected from the focus groups were recorded, transcribed verbatim, and analyzed using content analysis. Content analysis is a strategy for analyzing recorded data in which it is first coded, clustered, then organized under categories from which themes begin to emerge.

The findings indicate that the health care industry in Canada is rapidly changing and increasing in complexity. These changes are creating major challenges for first line nurse managers in meeting the standards for quality patient care in an environment of dwindling resources.

Three themes emerged from the focus group data: enormity of change, impact of change, and management of change. The first line nurse managers indicated that the enormity of change resulted from health care reform, decentralization of decision making, increase in accountability and responsibility, and changes to the delivery of patient care. The first line nurse managers believed that health care reform is necessary to contain costs. However, the managers percieved that patients will only benefit from health care reform if

funding is redistributed to agencies that can provide the best service at the least cost.

Decentralization of decision making was viewed as a positive management strategy as it was seen to expedite unit level decisions that benefited both patients and staff. Accountability and control proved to be problematic to the first line nurse managers as the authority and control did not match their scope of responsibility, therefore, making it extremely difficult for them to ensure cost effective quality patient care. The first line nurse managers indicated that the changes to care delivery practices have resulted in cost benefits. They believed that shorter lengths of hospital stay and fewer invasive procedures beneficial for most patients. However, there was concern that some patients would not benefit from the changes and, in fact, patient outcomes might be worse. These sub-themes are consistent with reports in the literature.

The impact of change posed difficulties for the first line nurse managers in that they reported an increase in workload, less effective communication, and uncertainty of their future role in health care. The

uncertainty stemmed from their concern that they might be replaced by non-nurse managers with advanced levels of education with a business focus. Although senior administrators' educational expectations for the first line nurse manager's position had increased, there was little support from senior administrators to obtain the same. The uncertainty regarding their role particularly concerned the first line nurse managers because of the potential negative impact this might have on patient care.

Many strategies were proposed by the first line nurse managers for managing change within a climate of fiscal restraint. The lack of technological and administrative support systems were seen to pose particularly difficult challenges for the first line nurse managers. Management of change was also seen to require support from first line nurse managers' colleagues, senior hospital administrators and technological advances. A significant support system they identified was their own colleagues which they recognized as a rich, but underulilized resource.

Conclusions

The following conclusions were derived from the findings of the study:

1) The health care environment in British Columbia is rapidly changing, adding to the complexity of delivering quality care in a constrained economic environment.

2) First line nurse managers' accountability and responsibilities are increasing particularly with regards to financial accountability.

3) Overall changes to care delivery practices are believe to have positive outcomes for patients; however, the outcomes need to be measured more extensively.

4) First line nurse managers are concerned about being replaced by non-nursing managers because nursing knowledge is essential when making decisions with regards to changes in care delivery practices.

5) The level of technological and administrative support available to first line nurse managers in managing change is inadequate creating an additional stressor which adds to the burden of managing change.

Implications

The findings of the study have implications for administrative nursing practice, education, research, and hospital administrators as discussed below.

Administrative Nursing Practice

The role of the first line nurse manager is expanding in scope, accountability, responsibility, and, particularly, in the area of financial accountability. This challenges the first line nurse manager to possess skills of clinical expertise in a specialized field, to have an understanding of the economic climate, and knowledge of business plans, while keeping abreast of technology and innovative ways to streamline care delivery systems. The skills of financial analysis and management as well as negotiation, conflict resolution, labour relations, and leadership need to be enhanced.

Given the need for the skills described above, the following issues should be addressed by nurse administrators/first line nurse managers. First, how does one in this position acquire the necessary skills? What are first line nurse managers' responsibilities versus those of administration in providing support to

identify the necessary skills needed in a changing
environment? What role does administration play in
providing the opportunity for education versus the
individual's own responsibility to identify and acquire
the skills?

Second, how does administration determine the
criteria needed to select this individual in a changing
environment? (i.e., when the skill sets are rapidly
changing)? What is the most appropriate way to
provide the skills, given the rapid nature of change?
For example, is this an issue for hospitals or
educational institutions or both? These questions have
potential implications for nursing education.

Nursing Education

The challenge for nurse educators is to respond to
the demands that the rapidly changing health care
environment is placing on individuals in/or interested
in first line nurse manager positions. Curricula need
to focus on administrative skills, business or
financial management, trends in health care, people
management, change management, and nursing practice in
the context of today's health care. To meet all of
these requirements poses many logistical problems for

educators. For example, how would a curriculum be developed to meet these needs without making the programs so lengthy and costly that they would be impractical? How do programs meet the needs of individuals already in management positions as opposed to those individuals interested in pursuing a career in nursing management? These are important questions that are in need of early attention.

In the focus groups, the first line nurse managers suggested that graduate nursing programs incorporate preceptorships for new managers. They also suggested that there were not enough educational opportunities within the hospitals to support managers currently in positions.

The findings indicated that the first line nurse managers were concerned that non-nurses would replace first line nurse managers because they possess more business skills. To prevent this from occurring, the first line nurse managers identified that it would be advantageous to acquire the necessary business skills to meet the demands of the position. They indicated that there is a need for courses in financial management rather than an MBA. However, they also

suggested that it was a difficult balancing act to manage their workloads in the increasingly demanding environment and, simultaneously, to meet their educational requirements.

Nursing Research

Research on the evolving role of first line nurse managers is limited, particularly in Canada. Findings indicated that the first line nurse managers' areas of responsibility differed in patient population, number of beds, staff and actual budget amounts, but that the managerial issues were similar. For example, educational issues around financial planning and human resources (supporting others in times of change, and labour relations issues) were concerns for all of them. Further research is needed on the role of first line nurse managers in the Canadian health care system or, more specifically, first line nurse managers in British Columbia.

Research on master's-prepared nurses currently in first line manager positions should compare types of programs (i.e., master's in nursing administration and master's in business administration) and performance. What are the perceptions of managers of how their

programs have assisted them in their current positions?

Nurses need to study the impact of changes in care delivery practices for example, if early discharge is accomplished is the patient being readmitted at other facilities? Are sevices required in the community for patients who are disharged early and, if so, are they available. Lastly, this study needs to be repeated using a larger sample size and including hospitals outside the Lower Mainland.

Hospital Administrators

In times of change, particularly when resources are limited, hospital administrators must draw to an even greater extent on valuable human resources. The first line nurse managers are a valuable asset because of the key role they play in the provision of quality cost effective patient care. Hospital administrators need to work collaboratively with their first line nurse managers to ensure that patient care is not compromised during the rapidly changing fiscally restrained environment. Resource allocation is an increasingly complex process in times of fiscal restraint. Hospital administrators may draw on first line nurse managers' clinical expertise so that

resources are not wasted and are redistributed to where they can be utilized most effectively. This should include ensuring that first line nurse managers are receiving the support they need to maintain or improve the quality and cost effectiveness of patient care.

In conclusion, this study has examined the perceptions of first line nurse managers of managing within a climate of fiscal restraint. The findings indicate the complex challenges with which first line nurse managers deal. The study provides direction for first line nurse managers and hospital administrators who are responsible for delivering quality patient care in a changing and fiscally challenging environment.

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Appendix A

Demographics

Age at last birthday _____

Highest educational level:

__ Nursing Diploma

__ Nursing Diploma with additional certificate/courses

__ Baccalaureate Degree in Nursing

__ Baccalaureate Degree Other

__ Masters Degree in Nursing

__ Masters Degree Other

Years of experience as a first line nurse manager: __

Completed questionnaire in Spring 1994:

__ yes

__ No

Thank you for your participation in this focus group interview.

Appendix B

Survey Questions

1. A climate of fiscal restraint including cuts, downsizing/rightsizing, regionalization of health care and the move to providing health care "closer to home" is present in many agencies. List 3 (or more) ways the present climate of fiscal restraint has had an impact on your role as a first line nurse manager.

2. Please identify strategies that you have implemented or are planning to implement to work more effectively with limited resources (e.g., hospital-community partnership programs, development of joint or collaborative departmental programs within your facility etc.).

3. Please list the factors which would make your job as a first line nurse manager easier in this present fiscal climate (excluding more money).

Adapted from Acorn, S., & Crawford, M. (1995). Decentralized organizational structures and first line nurse managers. Journal of Nursing Administration, 25(10), 5, 27.

Appendix C

FOCUS GROUP INTERVIEW QUESTIONS

RESEARCH QUESTION: WHAT ARE THE PERCEPTIONS OF FIRST
LINE NURSE MANAGERS OF MANAGING WITHIN A CLIMATE OF
FISCAL RESTRAINT?

<u>TRIGGER QUESTIONS</u>:

Health care reform has largely been spurred on by the
present climate of fiscal restraint that is predicted
to continue as governments struggle to control deficits
and contain costs.
The purpose of this group interview is to hear what
"you" as first line nurse managers have to say about
managing in a climate of fiscal restraint.

1. Therefore, thinking back over the past few months
can you tell me what the impact the climate of fiscal
restraint has had on your role as a first line nurse
manager?
Probe: Please elaborate on how fiscal restraint has
influenced your workload.
Probe: Please elaborate on the impact the present
climate of fiscal restraint has had on your staff.

2. What impact is the climate of fiscal restraint
having on patient care?

3. Please describe the strategies that you as a nurse
manager have implemented or are planning to implement
on your units to work more effectively with limited
resources.

4. What would make your job as a first line nurse
manager easier in the present climate of fiscal
restraint (excluding more money)?
Probe: Please elaborate on the issue of autonomy.
Probe: Please elaborate on the interdisciplinary
working relationships in your area.

Are there any other points you would like to raise?

Appendix D: Consent Form

THE UNIVERSITY OF BRITISH COLUMBIA

School of Nursing
T206-2211 Wesbrook Mall
Vancouver, BC V6T 2B5
Tel:(604) 822-7417
Fax:(604) 822-7466

I understand the purposes of this study, "Decentralized Organizational Structures and First Line Nurse Managers", are to examine 1) fiscal restraint, culturally diverse environments, and technology as factors contributing to organizational complexity and 2) the relationships between decentralization and job satisfaction, organizational commitment, and professional autonomy of first line nurse managers. Data have already been collected through a self-administered questionnaire. Therefore, focus group interviews will be conducted to explore the factors contributing to organizational complexity in further depth.

I understand that I will be asked to participate in a focus group interview, conducted by Claire O'Quinn, to explore the issues surrounding managing in a climate of fiscal restraint. Six to eight first line nurse managers will participate in this focus group interview which will not exceed two hours in duration. The interview will be tape recorded for transcription into written format at a later time. Once the interviews are transcribed, the tapes will be destroyed.

My name and any identifying information will not be revealed in the study. Confidentiality has been assured because a code number known only to Claire O'Quinn and the two co-researchers will identify the tapes and written copies of the recorded information.

I am under no obligation to participate in this study and refusal to participate will not affect my employment in any way. I understand that If I participate, I can withdraw at anytime, refuse to answer any questions or ask to have part or all of the tape erased. I will receive a copy of this form.

All my questions have been answered and if I have any further question, I can contact Claire O'Quinn at XIX-XXXX or the co-researchers: Dr. Sonia Acorn, XIX-XXXX; Ms. Marilyn Crawford, XIX-XXXX.

Date:_____Signature:_____

I understand the nature of this study and give my consent to participate.

Date:_____Signature:_____

I acknowledge receipt of a copy of this consent Form.