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# Development of a conceptual model for nursing service administration: A phenomenological study

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# Development of a Conceptual Model for Nursing Service Administration: A Phenomenological Study

A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy at Virginia Commonwealth University.

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# Dedication

I dedicate this dissertation to the following persons:

To my best friend and wife, Ann, who provided the support and encouragement that enabled me to complete this work. Together we shared the frustration and joy of the journey.

To my dad who taught me to think critically and my mom who taught me the caring art of nursing. And to both my parents who modeled and instilled in me a desire for continued learning and growth.

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Table of Contents

# List of Tables

# List of Figures

Abstract

Development of a Conceptual Model for Nursing Service Administration: A Phenomenological Study

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Disciplines are differentiated by the concepts of concern to each. The concepts that represent the frame of reference of nursing service administration have not been described. Conceptual models are needed as clear frames of reference in the complex health care system. Using phenomenological philosophy and chaos theory provides direction to describing the whole experience of nursing service administrators. A conceptual model for nursing service administration will provide a distinctive frame of reference in describing the lived experience of nursing service administrators.

This phenomenological study identified concepts that represent the essence of the lived experience of nursing service administrators. Using purposeful sampling, participants were selected from among the directors at two large teaching hospitals in the Mid-Atlantic region. In-depth unstructured interviews were conducted with five nurse administrators from each hospital. The interview content was

analyzed and synthesized into a conceptual model that represents the essence of the lived experience of nursing service administrators.

The foundation of meeting the needs of persons can be seen as the underpinning and motivating force for nursing service administration. The foundation is evident in relating to clients and staff. The playing field is the broader health care system characterized by dynamic boundaries, regulations, and turbulence. Most significantly, nursing service administration is not limited by the institutional boundaries. The concepts of vision, mentoring, communication, budgeting, collaboration, and facilitating build upon the foundation and are interrelated. These concepts interface with both staff and clients and extend beyond the institution into the larger playing field of the health care system.

The practice base of nursing is identified as a strength in health care administration. The emphasis on encompassing boundaries and the focus on the individual and not the organization, challenges the nursing service administrator to move beyond institutional walls in meeting the needs of clients and staff. The integration of the concepts provides guidance for nursing administration curricula. The conceptual model provides organization for thinking and a foundation for knowledge development.

# CHAPTER 1

Disciplines are differentiated from each other and are defined by the concepts of concern to the discipline. These concepts or the metaparadigm provide the frame of reference for the discipline. This frame of reference provides direction for the use and advancement of knowledge in the discipline. The concepts represent the essence of the discipline. The concepts of nursing service administration that would provide a coherent conceptual foundation remain unexplored. Identifying the concepts of concern to the discipline provides a framework that serves as a foundation for the advancement of knowledge. Thus, the world of nursing administration needs to be described to provide sound theoretical foundations for practice, education, and research.

A theoretical nursing perspective is not yet common to the practice of nursing service administration. Although administrative nursing practice is a recognized specialty area, it has not achieved theoretical growth equivalent to clinical nursing specialties (Jennings & Meleis, 1988; Young & Hayne, 1988). In evaluating the state of knowledge for nursing administration and future research needs, Shultz and Miller (1990) suggested that research on topics of importance

to nursing administrators has increased, but the concepts that provide a frame of reference for nursing service administration remain unexplored. The world of nursing service administration needs to be described in order to foster the development of knowledge within the discipline of nursing administration. The dearth of theory development in nursing service administration constrains the professional growth of nursing administration as a discipline (Smith, 1993).

In addition to the development of knowledge in nursing administration it is recognized that nursing administration borrows knowledge. When knowledge from one discipline is used in another, the particular frames of reference are important in evaluating the fit of the knowledge in the new frame of reference. Nursing service administration uses knowledge from disciplines such as business management, economics, organizational sociology, organizational psychology, and human relations (Blair, 1989). The significance of the knowledge borrowed from other disciplines is not in question. The important thing is an awareness of the frame of reference in which the borrowed knowledge is being used. It is this frame of reference for nursing service administration that needs to be described.

In this study use of the terms metaparadigm, conceptual model, and theory follows Fawcett's (1989) structural hierarchy of knowledge within the discipline of nursing. The hierarchy progresses in increasing levels of abstraction from

theory to conceptual model to metaparadigm. A structural hierarchy of knowledge allows the progression from a single metaparadigm to multiple conceptual models and multiple theories derived from each model.

The term conceptual model, and the synonymous term conceptual framework, refer to global ideas or significant concepts that are of interest to a discipline. Conceptual models are comprised of concepts--words describing mental images of phenomena, and propositions--statements about the relationships among concepts. The propositions integrate the concepts into meaningful configurations (Fawcett, 1989). A conceptual model provides a distinctive frame of reference determining how the world is viewed. Theories, like conceptual models, are made up of concepts and propositions. Theories, however, address phenomena with much greater specificity than do conceptual models (Fawcett, 1989). Although some writers consider the distinction between conceptual models and theory only a semantic issue (Meleis, 1991), a distinction is assumed in this research.

Conceptual models can apply to nursing as a whole or to nursing specialties, such as nursing service administration. The traditional conceptual models of nursing were developed as guides for clinical practice (Fawcett, Botter, Burritt, Crossley, & Frink, 1989). These clinical models of nursing have been adapted to nursing service administration by redefining the concepts. Fawcett et al. (1989) address the

modifications required in the concepts of nursing in order to apply them to nursing administration. The assumption is that the frame of reference of nursing and nursing administration are the same. Redefining the concepts is not the most effective way to promote knowledge development in nursing service administration. Conceptual models for clinical practice do not adapt well to nursing service administration since the frame of reference is different. Existing research has not described the world of nursing service administration (Shultz & Miller, 1990). Research that describes the lived experience of nursing service administrators is needed to explore the world of nursing service administration and develop a conceptual model for nursing service administration.

Conceptual models are useful because they portray graphically the organizing frame of reference for a discipline. Conceptual models provide a simplified world view that represents the discipline's significant concepts. The importance of conceptual models in theory development has been argued by Jacobson (1987). The frame of reference represented by the conceptual model provides basic organization for thinking. It is this organization of knowledge that contributes to the emergence of a discipline's theory base. The lack of a coherent conceptual foundation in nursing service administration has been noted by Henry (1989). Conceptual models are a needed part of the organizational progression in theory development. The utility of conceptual

models is important for the discipline of nursing, as well as for the specialty area of nursing service administration.

A coherent conceptual foundation for nursing administration is important in the complex health care environment. This complex environment impacts the future of nursing service administration and the need for conceptual models to provide a framework for organizing thinking. There is no question that nursing service administration takes place within the larger context of the health care system (Gardner, Kelly, Johnson, McCloskey, & Maas, 1991). The changes taking place in nursing service administration practice, including the expanded scope of responsibility of the nurse executive, support the need for conceptual model development for the scientific practice of nursing service administration (Johnson, Gardner, Kelly, McCloskey, & Mass, 1989). The increased complexity in the health care system increases the importance of conceptual models in providing an organizing framework. The more complex the health care environment, the more significant a conceptual model for nursing service administration is in providing an organizing framework.

The health care system is in crisis. Instability is one manifestation of the crisis. The instability is due to the simultaneous influence of political, financial, technological, regulatory, and demographic forces (Grohar-Murray & DiCroce, 1992). Health care is a unique market environment with third party payers, technological explosions, diverse cultural

values, and ethical dilemmas adding to the complexity. Governmental regulations are attempting to curb the spiraling costs. The importance of conceptual models is increased in this dynamic health care environment (Gardner et al., 1991). Conceptual models provide organization for thinking and will help accumulate an integrated body of knowledge to guide nursing service administration practice, education, and research in this complex and unstable health care system.

Conceptual model development can be a descriptive inductive process. This process is important because it helps provide a theoretical foundation for nursing knowledge. While conceptual models provide a context for the ordering of knowledge, they have not been used effectively in nursing service administration. Conceptual models can help advance a knowledge base for nursing administration.

Purpose

The purpose of this study is to develop a conceptual model that describes the lived experience of nursing service administrators. The focus is on identifying the concepts that represent the essence of nursing service administration as reported in the experiences of nursing service administrators. In other words, the focus is to explore the essence of the lived experience of nursing service administrators. A qualitative investigation is warranted to produce descriptive data (Taylor & Bogdan, 1984). Inductive methodology is used to identify concepts and develop insights from patterns in the

data. To describe nursing service administration as it is lived by people, phenomenological methods are used to develop theory inductively. Phenomenology leads the researcher to the knowledge in human experience (Parse, 1989). Uncovering the essence in experience provides the building block concepts for developing a conceptual model for nursing service administration.

Underlying Philosophies

There are two underlying philosophies for this study. The first is the phenomenological philosophy. Phenomenological philosophy provides a framework for a variety of qualitative research methods (Oiler, 1986). The term phenomenology is used for both general qualitative epistemology and a specific qualitative method (Omery, 1983). Epistemology is the branch of philosophy that concerns itself with the nature of knowledge (Munhall & Oiler, 1986). The distinction between the use of the word phenomenology as a research method and as a philosophy, is crucial to understanding the importance of phenomenology to qualitative research. It is the use of the term phenomenology, as philosophy, that adds importance to understanding the choice of research methods.

Phenomenology as philosophy involves assumptions about knowledge that are more than a method. Philosophy of science is the beliefs about how scientific knowledge develops and what is included in a discipline's knowledge. The two major theoretical perspectives that have dominated social science

are positivism and phenomenology (Taylor & Bogdan, 1984). The positivist seeks facts apart from the subjective states of individuals. The phenomenologist seeks understanding from the actor's own perspective. Swanson and Chenitz (1982) point out that positivistic approaches take understanding and knowledge farther from the lived experience in the world. It is important that research in nursing administration move beyond the traditional quantitative research approaches to illuminate the world of nursing administration (Shultz & Miller, 1990).

It is important to recognize the philosophical assumptions of qualitative approaches. The assumptions are not bound by a specific discipline and are thus a good choice for a descriptive study in nursing administration. Qualitative methods are most associated with the process of discovery and clarification (Munhall & Oiler, 1986). These philosophical themes can enrich nursing knowledge. Phenomenology as a philosophy leads the researcher to the wholeness of the situation and uncovers the knowledge of human experiences and interpersonal processes (Parse, 1989; Phillips, 1989). Describing phenomena as wholes keeps knowledge in touch with the lived experience in the world.

The second philosophy underlying this research is the new science generally referred to as chaos theory. Old science focused on analysis, prediction, and control, while the new science emphasizes chaos and complexity (Freedman, 1992). Scientific management becomes less useful as technology

creates an unpredictable, uncertain, and even uncontrollable world. In this complex world, patterns do occur, but the patterns are explored through examining systems as wholes and not through reductionistic analysis (Gleick, 1987). In examining the dynamics of the whole system it is understood that small changes can have large and unpredictable effects (Wheatley, 1992). Chaos theory is consistent with a phenomenological philosophy and provides further support for a qualitative descriptive study to explore nursing service administration.

Research Question

What are the identifiable concepts that represent the essence of the lived experiences of nursing service administrators?

Summary

Disciplines are differentiated by the concepts of concern to each. These concepts provide a frame of reference that gives direction for practice, education, and research. The concepts that represent the essence of nursing service administration have not been described. Conceptual models are needed as clear frames of reference in the complex health care system. Phenomenological philosophy and chaos theory provide direction to describing the whole experience of nursing service administrators. A conceptual model for nursing service

administration will provide a distinctive frame of reference in describing the lived experience of nursing service administrators.

# CHAPTER 2

## Literature Review

Model development will be reviewed as a qualitative process of phenomena interpretation through analytic induction. Next, the existing models for nursing administration will be described briefly. Review of the existing models will support the need for a phenomenological study of nursing service administration. Detailed analysis of the four existing models is not done, to limit bias in describing the lived experience of nursing service administrators. In a phenomenological descriptive study the goal is to uncover nursing service administration from the perspective of the research subject.

### Model Development

Conceptual model development is one of the essential activities in nursing (Meleis, 1991). The process of developing a model is similar to the interpretive case study in which researchers gather as much information as possible about a problem with the intention of interpreting the phenomenon through analytic induction (Merriam, 1988). The conceptual model provides a distinctive frame of reference that determines how the world is viewed. Conceptual models

represent the significant concepts or the global ideas that are of interest to a discipline.

Clarifying concepts is descriptive work using an inductive approach. The description of concepts identifies the basic building blocks to be used in conceptual model development. Concepts are mental images of phenomena and refer to the properties of a phenomenon (Fawcett & Downs, 1992). Concept development includes identifying and analyzing concepts. Concept identification involves observing and analyzing a system of real events in order to isolate the variables to identify the major components of the model. Concept development is a critical yet sometimes neglected step in theory development in nursing (Walker & Avant, 1988).

Concept development can be categorized using the basic approaches of analysis, derivation, and synthesis (Walker & Avant, 1988). Concept analysis is needed when concepts are already available in the area of interest, but they remain unclear, outmoded, or not useful. In analysis, one clarifies, refines, or sharpens concepts. Analysis can help clarify the use, nature, and properties of the concept. Concept derivation employs analogy in transposing and redefining a concept from one context to another. In other words, concept derivation involves the moving of a concept from one field to another. The meaning of the concept is changed and developed to fit the new phenomenon. Concept synthesis is a strategy for developing concepts based on observation or other forms of empirical

evidence. The purpose of concept synthesis is to generate new ideas. The strategy employs pulling together various elements of data into patterns or relationships not seen before to form a new whole or new concept. In theory-generating studies that use qualitative methods, concepts may not be evident until the results of the data analysis are presented (Fawcett & Downs, 1992).

Conceptual models are inductively developed when generalizations are formulated about observed events. A major limitation of inductive concept clarification is becoming mired in minor concepts (Norris, 1982). The identified concepts must be grounded in the lived experience and pursued with scientific rigor to assure that the focus is on the major concepts. Phenomena must be understood as wholes and analysis should not emphasize prediction. Fawcett (1989) identified that conceptual models develop from observations, intuitive insights, and deductions that creatively combine ideas.

It has been noted that disciplines are differentiated from each other by the different phenomena or concepts that are of concern to each. Jennings and Meleis (1988) have called for the use of nursing domains of health, person, nursing, and environment in building conceptual models for nursing administration. The domains or significant concepts of health, person, nursing, and environment begin to focus the discipline of nursing (Fawcett, 1989). While identification of these concepts begins to narrow the focus of nursing, the need for

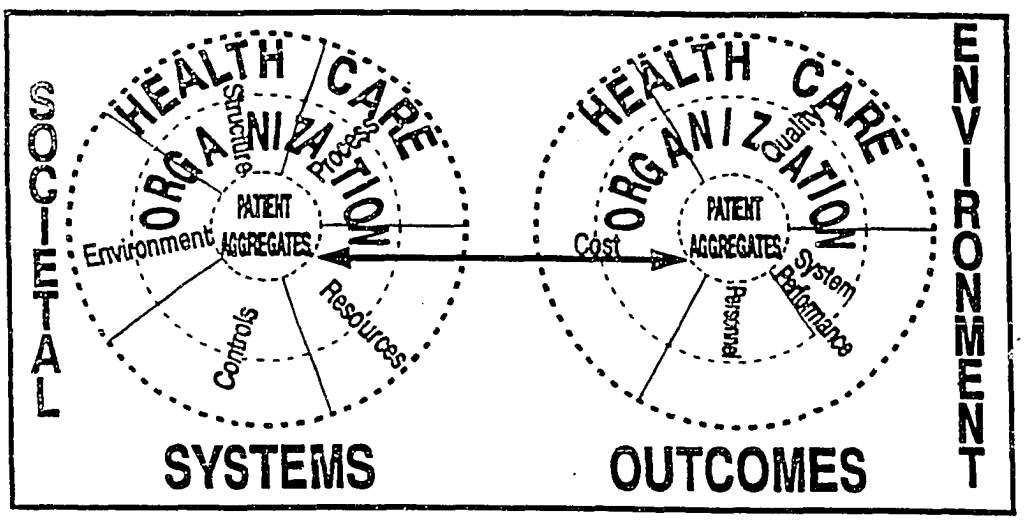
more explicit focus remains (Newman, Sime, & Corcoran-Perry, 1991). The domains of health, person, nursing, and environment are necessary in exploring the concerns of nursing service administration, but they may not be sufficient in describing the concerns of nursing service administrators. The practice of nursing service administration needs to be explored and described further.

Existing Models for Nursing Administration

Review of the literature identified four conceptual models for nursing administration. The Iowa Model of Nursing Administration provides a nursing perspective for administrative activities and indicates the interactions between systems and outcomes in nursing administration practice (Gardner et al., 1991). The Nursing Administrative Practice Perspective is a macro, ecologic, open systems, conceptual model (Neidlinger & Miller, 1990). Nyberg (1990) presented an integrative model with foundations in human care and economics. The Nursing Administration Systems Model uses the systems perspective to explain nursing administration's uniqueness (Scalzi, 1989).

The Iowa Model of Nursing Administration, depicted in Figure 1 represented nursing administration as two domains of knowledge. The domains of systems and outcomes each had three levels: patient aggregates at the center, then the organization, and lastly, the health care level (Gardner et al., 1991). There were interactions between the domains and

Figure 1. The Iowa Model of Nursing Administration



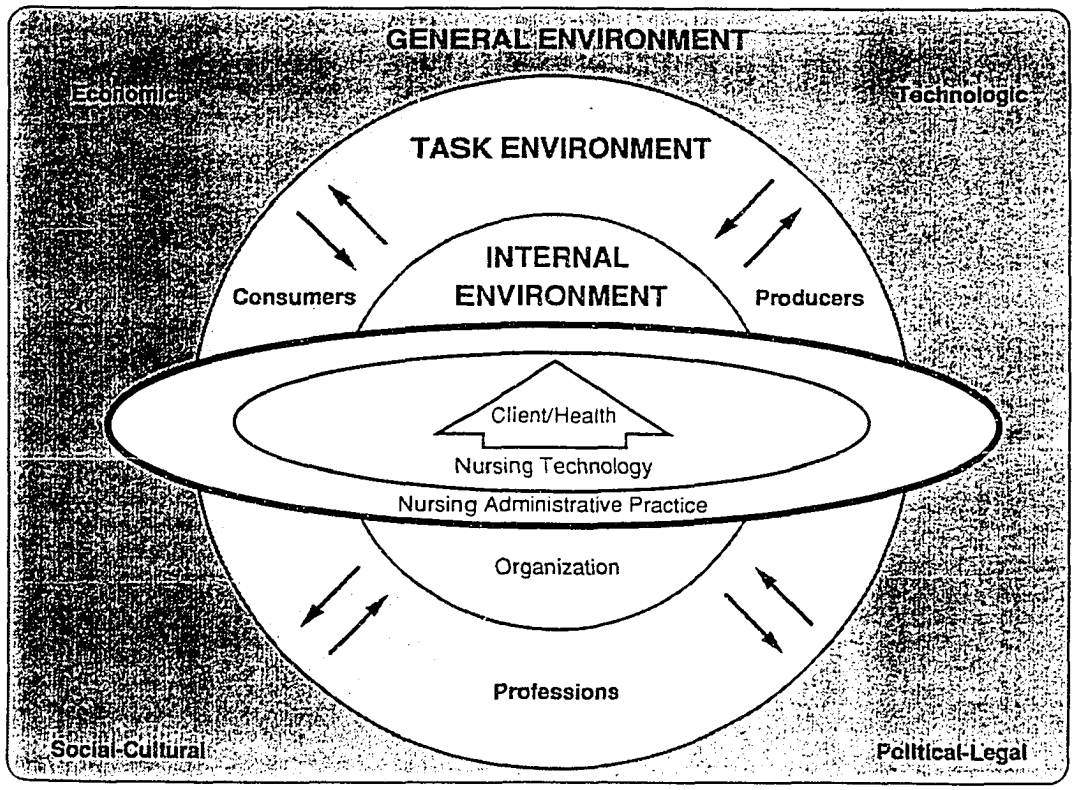

Note. From "Nursing Administration Model for Administrative Practice" by D. L. Gardner, K. Kelly, M. Johnson, J. C. McCloskey, & M. Maas, 1991, Journal of Nursing Administration, 21, p. 38. Copyright 1990 by the NSA Program, The University of Iowa College of Nursing. Reprinted by permission.

among the levels. The variables in the model were identified by review of the literature and defined by the authors (Gardner et al., 1991). Content validation was completed by a team of nursing administrators and nursing administration faculty. A strength of the model is the focus on outcomes as a specific area of knowledge (Johnson et al., 1989).

The Nursing Administration Practice Perspective (NAPP) depicted in Figure 2 encompassed and expanded the domains of nursing, person, health, and environment (Neidlinger & Miller, 1990). The environment was represented as having internal, task, and general sectors. Health and client were the unifying themes central to the model that spanned the environmental boundaries (Neidlinger & Miller, 1990). Nursing technology surrounded the central core. Nursing administrative practice surrounded nursing technology. Both nursing technology and nursing administrative practice extended beyond the organizational boundaries into the task and general environments (Neidlinger & Miller, 1990).

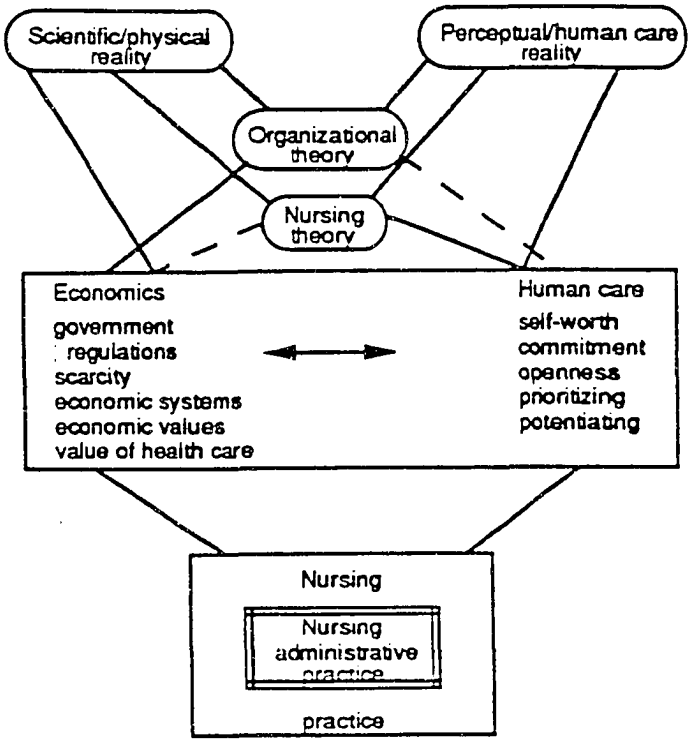
The integrative model (Nyberg, 1990) presented a theoretical model that identified the philosophies, theories, and concepts that influence the practice of nursing administration (see Figure 3). Components of the model include philosophy, organizational theory, nursing theory, economics, and human care. The concepts were identified through analysis of the literature. An empirical study was conducted that led to modifications of the theoretical model (Nyberg, 1990).

Figure 2. The Nursing Administrative Practice Perspective




Note. From "Nursing Care Delivery Systems: A Nursing Administrative Practice Perspective" by S. H. Neidlinger and M. B. Miller, 1990, Journal of Nursing Administration, 20, p. 44. Copyright 1989 by S. H. Neidlinger and M. B. Miller. Reprinted by permission.

Figure 3. The Integrative Model



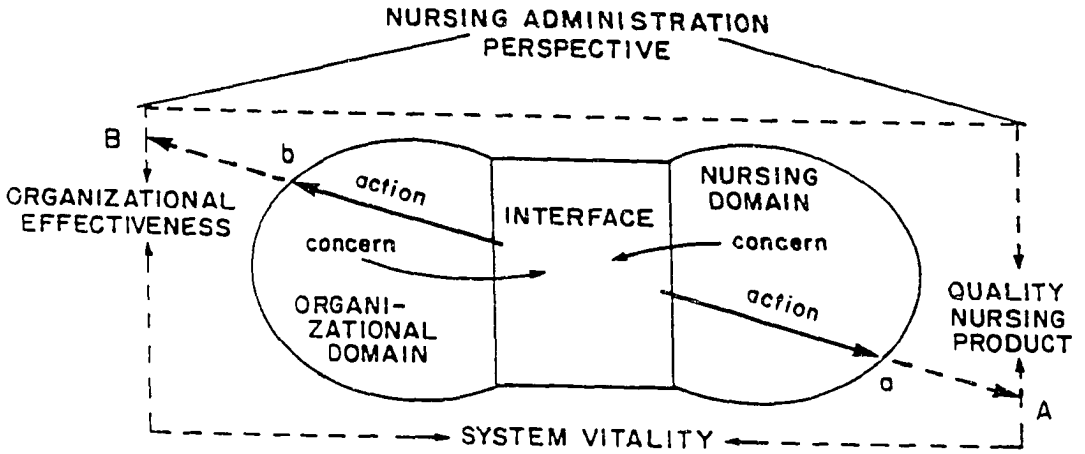

Note. From "Theoretic exploration of human care and economics: Foundations of nursing administration practice" by J. Nyberg, 1990, Advances in Nursing Science, 13(1), p. 83. Copyright 1990 by Aspen Publishers, Inc., Reprinted by permission.

A questionnaire was used to examine perceptions of human care and thoughts about economics. Nyberg's (1990) research confirmed the elements of the theoretical model.

The Nursing Administration Systems (NAS) Model depicted in Figure 4 combined the nursing domain and the organizational domain to illustrate a perspective that goes beyond two interfacing domains (Scalzi & Anderson, 1989). In the NAS model the nurse administrator used the system perspective in addressing multiple concerns, viewing the concerns as system concerns with one system goal (Scalzi & Anderson, 1989). The NAS model advanced a new definition of nursing administration that identified nursing administrations' uniqueness as the system perspective. A study was conducted to examine the accuracy of the NAS model in describing the practice of nursing administration in Home Health Agencies. Results supported the existence of two subsets (clinical nursing and management) with some interdependence (Scalzi, 1989).

Empirical deductive methods have been used in developing these conceptual models for nursing administration. The choice of research methods is important, because the philosophical underpinnings of a research method shape the constructed knowledge and thus, research methods will determine how nursing knowledge develops (Munhall,1989; Smith, 1989). Descriptive methods are important in discovering the knowledge in practice. A phenomenological methodology was

Figure 4. The Nursing Administration Systems Model




Note. From "Conceptual model for theory development in nursing administration" by C. C. Scalzi and R. A. Anderson. In Dimensions of Nursing Administration (p. 139) Edited by B. Henry, C. Arndt, M. Di Vincenti, & A. M. Marriner-Tomey, 1989, Boston: Blackwell Scientific Publications. Copyright 1989 by Blackwell Scientific Publications. Reprinted by permission.

used in this study to develop a model. This study presented the development of a model grounded in the practice of nursing service administration.

These four models provide organization for thinking about nursing service administration, but are not sufficient in describing the lived experience of nursing service administrators. The existing models were not developed through research studies grounded in practice. The purpose was not to explore the dimensions of nursing service administration through descriptive studies. There is a need to comprehensively explore the dimensions of nursing service administration. The wholeness of the lived experience of nursing service administration needs to be captured in a useable model.

Summary

The review of the literature on model development for a discipline has shown model development to be essential descriptive work. Identification of the concepts of concern to nursing service administrators is important in the process of developing conceptual models for nursing service administration. The existing models for nursing administration provide organization for thinking about nursing service administration, but were not developed through descriptive research studies. The existing conceptual models do not explore comprehensively the world of nursing service

administration. An inductive descriptive research method is needed to understand the essence of the lived experience of nursing service administrators.

CHAPTER 3

## Methodology

Qualitative research methods offer opportunities to expand nursing knowledge in general and nursing service administration knowledge in particular. The strength of the phenomenological method is not theory testing, but rather theory development (Donaldson, 1987). Phenomenology describes experience as it is lived by people. The phenomenological method is an inductive descriptive research method (Donaldson, 1987; Stanford, 1987). The term phenomenology means the study of something as it appears.

Various versions of the phenomenological methodology have been presented. Salsberry (1989) identifies the similarities in the versions as the three foundational processes of the phenomenological method. This research was guided by these three processes. The first process of investigating particular phenomena includes three operations, intuiting (grasping the particular uniqueness of the phenomenon), describing (explaining the phenomenon through use of metaphor and negation to see the uniqueness of the phenomenon), and analyzing (investigating the elements and interrelationships of the intuited phenomenon). The second process of

investigating general essences is to intuit general essences from the perceived particulars. Essences refer to the properties or dimensions of a phenomenon. The third process is to apprehend the essential relationships within and between essences (Oiler, 1986; Salsberry, 1989). The primary requisite of phenomenology is that no preconceived notions, expectations, or frameworks be present or guide the researchers as they gather and analyze the data (Omery, 1983).

Scientific Rigor

The phenomenological method requires skill in implementation. Prior to engaging in a phenomenological study, researchers bracket their beliefs in relation to the phenomenon being studied. Bracketing is the suspension of beliefs, personal experience, and theoretical grounding about the phenomenon being studied. Bracketing is done to limit bias and to attempt to see the phenomenon as it truly is. Perfect bracketing is not possible, but it can be used to avoid imposing preconceived structure in the interview process.

The criteria of credibility, fittingness, and auditability, have been set forth as appropriate for judging scientific rigor in qualitative studies (Sandelowski, 1986). A study is credible when people recognize an experience from the descriptions in the study and a study meets the criteria of fittingness when its findings are meaningful and applicable in terms of others' experiences. This study's findings were critiqued by reviewers rich in administrative experience to

provide feedback on credibility and fittingness. The feedback was given by the dissertation committee members and two nursing administrators not involved in the study. A study and its findings are auditable when another researcher could arrive at the same conclusions. Thus, experienced qualitative researchers were used to verify the decision trail in the data analysis. Through periodic examination of the transcripts and discussion with the researcher, three experienced qualitative researchers verified that the decision trail was plausible.

Reliability in qualitative research means consistent identification of patterns over time, persons, situations, and methods (Rosenthal, 1989). While this is true in part, it must be kept in mind that reality is assumed to be multiple and constructed (Sandelowski, 1993). The concepts of reliability are usually dealt with in data collection procedures (Brink, 1989). Stability and equivalence were addressed by asking participants to clarify and elaborate on a content area. When participants spoke about a particular area, the researcher often said, "Tell me more about _____" or "give me an example from a situation in which you were involved". Internal consistency was observed within each individual interview when looking for patterns in the data. Repetition and multiple examples demonstrated consistency.

Qualitative research emphasizes validity because the methods allow researchers to be close to the empirical world (Taylor & Bogdan, 1984). Brink (1989) identified concurrent

validation as the most crucial validation procedure in qualitative research. Assumptions about validity or the usefulness of data are (a) no one is lying, (b) everything that people say is a part of their lives and makes sense, (c) nothing people tell you is irrelevant, and (d) there is no absolute truth (Wiseman, 1974). These assumptions are important as the researcher works to identify significant statements and their meanings. It is the researcher's job to find the meaning in the lived experience. Qualitative analysis results in a representation or essence and should not be flooded with detail (Sandelowski, 1993). Through contemplative dwelling with the data, the researcher's privileged position is joined with the view of the lived experience described by the subject, to create the structure of the experience (Parse, 1989). No two researchers will produce the same result since the structure is the joining of the researcher and the lived experience.

In this study, the concerns of reliability and validity were also dealt with by conducting three pilot interviews. These pilot interviews were conducted with nurses whose knowledge and experience in nursing service administration was considered rich. The nurses held master's degrees and were situated in executive nursing positions. The researcher's qualitative interview skills were evaluated by an experienced qualitative researcher. The nurses were given an interview critique form to complete (see Appendix A). The interview

critique provided data to evaluate the unstructured, open ended interview process. The data collection procedures and analysis methods further addressed reliability and validity issues.

Sampling Plan

Purposeful samples are commonly used in qualitative research (Morse, 1989). Purposeful or judgmental sampling is a type of nonprobability sampling. This type of sampling is useful when seeking experts or subjects rich in data (Polit & Hungler, 1993). In this study, subjects rich in data were desired.

The sampling plan begins with a rationale for selection of participants. The world of nursing practice and the world of administration come together in nursing service administration. Nursing service administrators need to understand the concerns of both the professional nurse and the executive (Neidlinger & Miller, 1990). It is these combined worlds that need to be explored. Therefore, the population of interest is nursing service administrators in positions that experience both the world of the executive and the world of the professional nurse. The assumption is that all levels of nursing service administration experience both worlds; however, the sampling rationale is to identify participants who will provide rich data. The level of nursing service administration chosen, is a nursing service administrator who has responsibility for several nursing service units. This

level is above a single unit manager. Nursing service administrators who have responsibility for several nursing units generally have administrative experience since this is not an entry level administrative position. The titles used for this level of position vary from institution to institution. In this study, the title director was used to represent the chosen level of administration. Directors were selected to provide rich data in experiencing both the world of nursing practice and the world of administration.

Using purposeful sampling, participants were selected from the directors at two large teaching hospitals in the Mid-Atlantic region. Five participants were interviewed from each hospital. All of the subjects that were approached agreed to participate. Because there were only five positions at the defined level of administration at each institution, no selection among the directors was necessary. All ten participants were female. Nine participants held master's degrees and one held a baccalaureate degree. Richness of experience was supported by the demographic data. Total experience in nursing ranged from 13 to 34 years. The number of years in nursing service administration (including single unit management) ranged from 7 to 19 years. A variety of types and levels of nursing service administrative experience was reported. An area of clinical specialty was identified by 9 of the 10 participants and included critical care, emergency nursing, labor/delivery, oncology, pediatrics,

medical/surgical, neuroscience, neurosurgery, and recovery room. Refer to Table 1 for further demographic data describing the sample.

The study was approved by the Virginia Commonwealth University School of Nursing Research Committee and access to the sample was gained through the chief nursing officers and other appropriate institutional channels. As an initial descriptive study, the focus was narrowed and limited by the level of administration and the type of institution represented in the selected sample.

Data Collection Methods

The data collection process for this study included completion of a demographic sheet (see Appendix B) and in-depth unstructured interviews (see Appendix C for Interview Guide). The researcher talked with the participants to obtain the information on the demographic sheet. This was done prior to beginning the interview as an informal time to build rapport. The audio taped interviews lasted from 45 minutes to 90 minutes.

In-depth qualitative interviewing has been described as nondirective, unstructured, nonstandardized, and open ended interviewing (Taylor & Bogdan, 1984). The interviewer is the research tool and must learn what questions to ask and how to ask them. Pilot interviews are important in developing and evaluating these skills. The interview process is directed

Table 1
Demographic Data of Sample (n=10)

1. Gender

| | Frequency |
|---|---|
| Female | 10 |
| Male | 0 |

2. Basic Nursing Education

| | Frequency |
|---|---|
| Associate Degree | 3 |
| Diploma | 1 |
| Baccalaureate | 6 |

3. Highest Earned Degree

| | Frequency |
|---|---|
| Baccalaureate (nursing) | 1 |
| MSN or MA (nursing) | 8 |
| MS or MA (other than Nsg) | 1 |

4. Number of Years in Nursing

Range = 13 - 34
Mean = 22.1

5. Number of Years in Nursing Service Administration (includes single unit management)

Range = 7 - 19
Mean = 14

6. Clinical Specialty
(some participants indicated more than one area)

| | Frequency |
|---|---|
| Critical Care | 2 |
| Emergency Nursing | 1 |
| Labor and Delivery | 1 |
| Oncology | 1 |
| Pediatrics | 1 |
| Medical/Surgical | 2 |
| Neuroscience | 1 |
| Neurosurgery | 1 |
| Recovery Room | 1 |
| None | 1 |

Table 1
Demographic Data of Sample (n=10)
(continued)

7. Types of Nursing Administration Positions Held in the Past

| | Frequency |
|---|---|
| Single Unit Manager | 5 |
| Assistant Director | 3 |
| Director (responsible for several units) | 10 |
| Eve./Night Supervisor | 1 |
| Coordinator (administrative line position) | 2 |
| Clinical Specialist | 1 |
| Assistant Vice President Nursing | 1 |
| Vice President Nursing | 1 |

toward understanding the participant's perspective on professional experiences.

Rapport and nondirective questions are important early in the interview process (Taylor & Bogdan, 1984). The interviewer needs to be nonjudgmental. In asking participants to reveal their perspectives, the interviewer must not offer judgment or contradiction. In-depth interviewing requires patience. Participants are allowed to talk at length as the interviewer sensitively focuses the interview process. Communicating a sincere interest in what participants are saying is imperative throughout the interview. Lastly, one of the keys to sucessful interviewing is knowing when and how to probe (Taylor & Bogdan, 1984). In qualitative interviewing, one probes to uncover the details and meaning of participants' experiences. The interviewer is interested in detailed day-to-day experiences that contain embedded knowledge. Asking participants to clarify and elaborate are key responses.

Participants were given an interview introduction (see Appendix D) and were asked to read and sign an informed consent form (see Appendix E). Participants were given a copy of the consent form. Participation in the study was voluntary and strict confidentiality was maintained. Each participant was asked to be available for an in-depth interview. Participants have few tangible rewards to gain from the interview process so treating participants as people and not merely sources of data can make the interview process more

rewarding. Probing questions were asked depending upon responses to the stimulus questions. Conducting pilot interviews allowed the researcher to develop qualitative interview skills. The interviews were tape recorded to capture more than is possible than by relying on memory. Interviews were transcribed by professional transcribers.

Data Analysis

Data to be analyzed included demographic data and transcribed interview content. Demographic data were used to describe the sample. The researcher checked the transcribed tapes for accuracy, and then listened for themes and essences. A theme is a statement that captures an aspect or dimension of a phenomenon (Taylor & Bogdan, 1984). The data were grouped and transformed into themes and subthemes. Three expert qualitative researchers reviewed the transcripts periodically, to verify consistency of theme identification. Through discussion of the interview data with these experts, the decision trail was verified as plausible.

Manually working with the data increases the researcher's familiarity with the data and ability to analyze the data. The procedural steps were (a) reading all of the subjects descriptions in the verbatim transcripts to get a feeling for them, (b) identifying significant statements that describe the phenomenon, (c) discovering and describing the meanings of the significant statements, (d) grouping the statements into themes, (e) labeling the themes to reflect the lived

experience, and (f) identifying relationships among themes. The researcher's intuition is a major tool used in interpreting data (Drass, 1980). Recognizing the underlying philosophies of phenomenology and chaos theory, the data were treated as describing the whole experience of the nursing service administrators. The significant statements evolved into the conceptual model as the researcher lived with the data. The grouping and labeling of the significant statements as themes, occurred simultaneously with the identification of relationships among the themes. As the researcher continued to be immersed in the data, the essence of nursing service administration emerged from the rich examples provided by the participants.

Themes were synthesized into a general structural description. The composite understanding of the world of nursing service administration is represented in the conceptual model. The conceptual model represents the themes and relationships among the concepts of concern for nursing service administrators. The conceptual model also represents the essence of the lived experience of nursing service administrators.

# CHAPTER 4

## Findings

The findings presented in this chapter represent the analysis of the data collected to describe the essence of the lived experiences of ten nursing service administrators in two settings. The interviews from the two settings were indistinguishable in uncovering the essence of the lived experience represented in the conceptual model. The identified concepts used in the conceptual model emerged from all the interviews. Quotations from the nursing service administrators are used to illustrate the identified themes. Examples that most clearly represent the themes and meanings of the identified concepts were selected. The conceptual model is a structural description of the lived experience of nursing service administrators as described in the interviews.

### The Foundation for Nursing Service Administration

The lived experience of nursing service administrators as reported by the 10 participants demonstrated that meeting the needs of persons is the foundation for nursing service administration. The world of nursing service administration is shaped by the value of meeting persons' needs and not by external factors such as regulations or economics. An

integration of a nursing perspective and values is represented in meeting persons' needs. One informant illustrated this by saying, "I do make the assumption that most nursing administrators are extremely people-oriented. It comes from our nursing background and is probably what drove us into nursing in the first place all those years ago." This foundation is evident in all participants' descriptions and focuses on meeting the needs of both clients and staff. See Figure 5 for a structural representation of the foundation for nursing service administration. The examples support that meeting the needs of persons is the underpinning and motivating force as nursing service administrators relate to staff and clients.

Meeting the needs of clients is reflected in the practice base referred to by participants. The clinical background of nursing service administrators keeps them connected to the needs of clients as they carry out their roles in nursing administration. One nurse related:

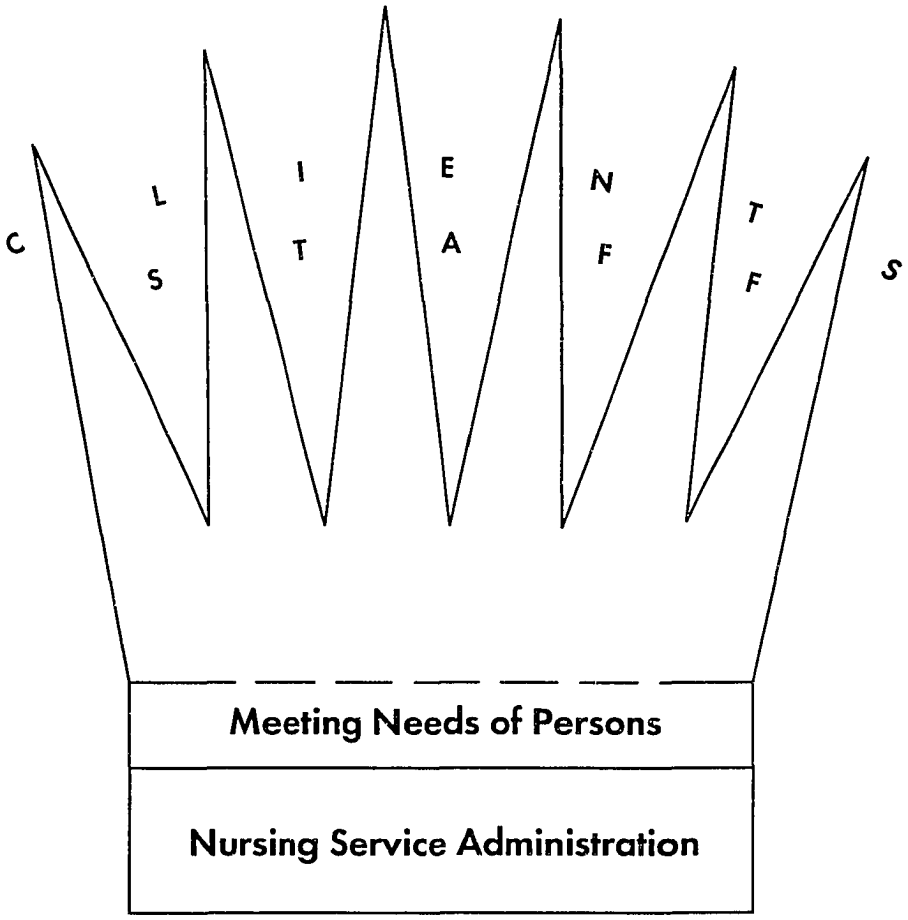
> By and large the majority of nursing administrators started out being hands-on clinicians. And we worked our way into the world of administration either through education or through sheer perseverence.

Another participant expanded:

> I feel like being a nurse and having nursing experience really allows me to be much more effective in what I do, because I am able to relate to clinical decisions that

Figure 5.

The Foundation for Nursing Service Administration



> need to be made. I just came from a meeting, talking with a whole room of staff members about major renovations that are required, which means a lot of changes and I'm able to talk to both the health care administration side, while we are going through what this means, and also deal with the real life issues of models of care and how we are going to move that ahead. And I think that's real essential in today's administrator. That they're not only representing nursing, but they are able to receive the whole picture and know their ace or the real strength is that they understand the largest component of hospital administration, which is the patient care piece.

Meeting the needs of clients has meaning not only in relation to nursing, but it serves as a strength in the world of administration. Nursing service administrators described their clinical backgrounds as providing an understanding of situations that is lacking in administrators without clinical experience.

> I have an ability to make judgments about patients for whom I care that other people cannot make because of my nursing background. Now how that makes me different as a leader, I think, is I can probably put into context much more quickly some of the health care issues that are macro issues especially, and some of the micro issues, than other people in administrative roles.

Another participant gave the following example:

> I have a business manager at the service center who reports to me and he just finished his master's degree in hospital administration. Bright, bright, young fellow, did his residency here with us. But, really from, you know he's been with me a little over a year now and doing fairly, autonomous but, I mean, that first year was a lot of hand-holding because he had no basis to make his decisions although he had the bigger framework of how things fit together in the business world piece. But, he had no understanding of what that really meant, how it looked when you finished. And so I think it has been a good experience for him. I mean, I take him on clinical rounds with me. He's involved. I have to go with the chairman of the department on clinical rounds so that, you know, when we are talking about developing a mid-life health center, we're talking about doing a breast program; he has a much better sense of what that involves rather than just what the finances and space look like. And I really do feel like I have a real advantage over other administrators, in having the hands-on knowledge they don't have.

This participant went on the say:

> What a nurse brings to that [referring to administrative decisions] is, I think, is the ability to be more discriminatory and to be able to have insight into what

> the problems really are, what's really significant, what isn't significant and what needs to be done.

These examples demonstrate that the client care focus is clearly evident in all the interviews, yet it is only one area in which the theme of meeting persons' needs is evident. Meeting the needs of persons as a foundation for nursing service administration is broader than just a client care focus. The integration of nursing values is also evident in interactions with staff. Meeting the needs of persons provides a broader foundation in the lived experience of nursing service administrators. The broad meaning of meeting the needs of persons is evident in this participant's example.

> That's not to say that I don't think business concepts are important. I think they are and I always find good things in reading 'Managing for Excellence' or 'In Search of Excellence', or 'Thriving On Chaos'. I always find things I can use, but I think that what I don't find is this notion of how do we take the helping role, how do we take the supportive role that we understand and know and do very well as nurses and translate that into leadership behaviors?

All of the participants gave rich examples of meeting the needs of persons as they interacted with staff in their roles as nursing service administrators.

> I supervise the unit coordinators who really are supervisors or head nurses for our units' direction. So

for them to be able to manage and to lead their groups, I've got to provide them information so that they can do that in some sort of framework. I also think that I need to provide them with autonomy so that they have the opportunity to move with that information in whatever way seems to make sense to their particular work unit. I will have to tolerate, that's not a leadership characteristic, but anyway, I have to tolerate or have some level of tolerance for the ability that they bring to their job and what they are going to do with that information. I have people who are prepared educationally at different levels, experientially, at different levels, and I feel that, as a leader, it is important for me to be accepting of them as they are and to provide guidance to help them grow and develop in ways that help them do things better, not necessarily to restrict them or put them in a mold of some sort or another because they're not all at the same level. They're not going to all be at the same level, so I call that tolerance and that's probably not a good word, but it's the best one I can think of right now.

Staff growth is one way the participants demonstrated meeting the needs of staff. Following is an example.

My role in the more sense is to, [sic] I believe is to insure that the staff develop and grow. I support people in being creative. I like people that provide solutions to the problems that they present. And I think that as a

> manager your responsibility is to help people grow and develop and become strong in whatever field they are in.

There is a valuing of the persons and relationships evident in the examples that gives meaning to the lived experience of nursing service administrators. One participant clearly linked clients and staff in the theme of meeting the needs of persons.

> The things that really, uh, make me excited are, number one, when I know that a patient has been able to come into the institution, has been able to follow a pathway, and I'm not calling this a clinical pathway or critical pathway, but follow a pathway navigating the institution and their progress from their baseline back to hopefully their baseline or the best level of wellness they can attain. That they had an excellent experience. That they had the support they needed. That they had the intervention they needed. That they had the education they needed and that they are able to reflect on this experience as a positive one, where they learned. I also want the nurse to experience the same thing.

Rounds on the units were one way that the participants used to stay connected to client and staff needs. One nurse said, "I am aware of what impact the decision has on the front line caregiver." Making rounds on clinical units helps

facilitate the connectedness to the foundation of meeting the needs of persons. Another participant stated:

> But in any event, the idea for me is to be able to see people where they work, to talk to them where they work, and to know what the problems are not just with themselves, but with their patients and some of the other issues. And I have first-hand, kind of hands-on, ability to take care of business in that way. Fewer surprises for me, they know me better. They're more likely to approach me when they have problems that are of concern to them, that are not getting resolved at the unit level and everybody's more comfortable with everybody.

The foundation of meeting the needs of persons influences the whole world of nursing service administration. It influences the world view; it influences how time and energy are spent; and it ultimately influences the outcomes of nursing service administration. One participant said:

> I guess that, as a nursing administrator, I'm generally focused on, this is going to sound very simplistic, basically it boils down to the reason we're in business is to provide good patient care and I feel that it's my bottom line responsibility to make sure that happens. And so a lot of my job will generally concentrate around how to get that done. Who are the people that need to be there as resources to staff? What level of staff do you have? Do you have a chance to start a new program, to

look at all the pieces and try and put it together right from the beginning, setting the direction?

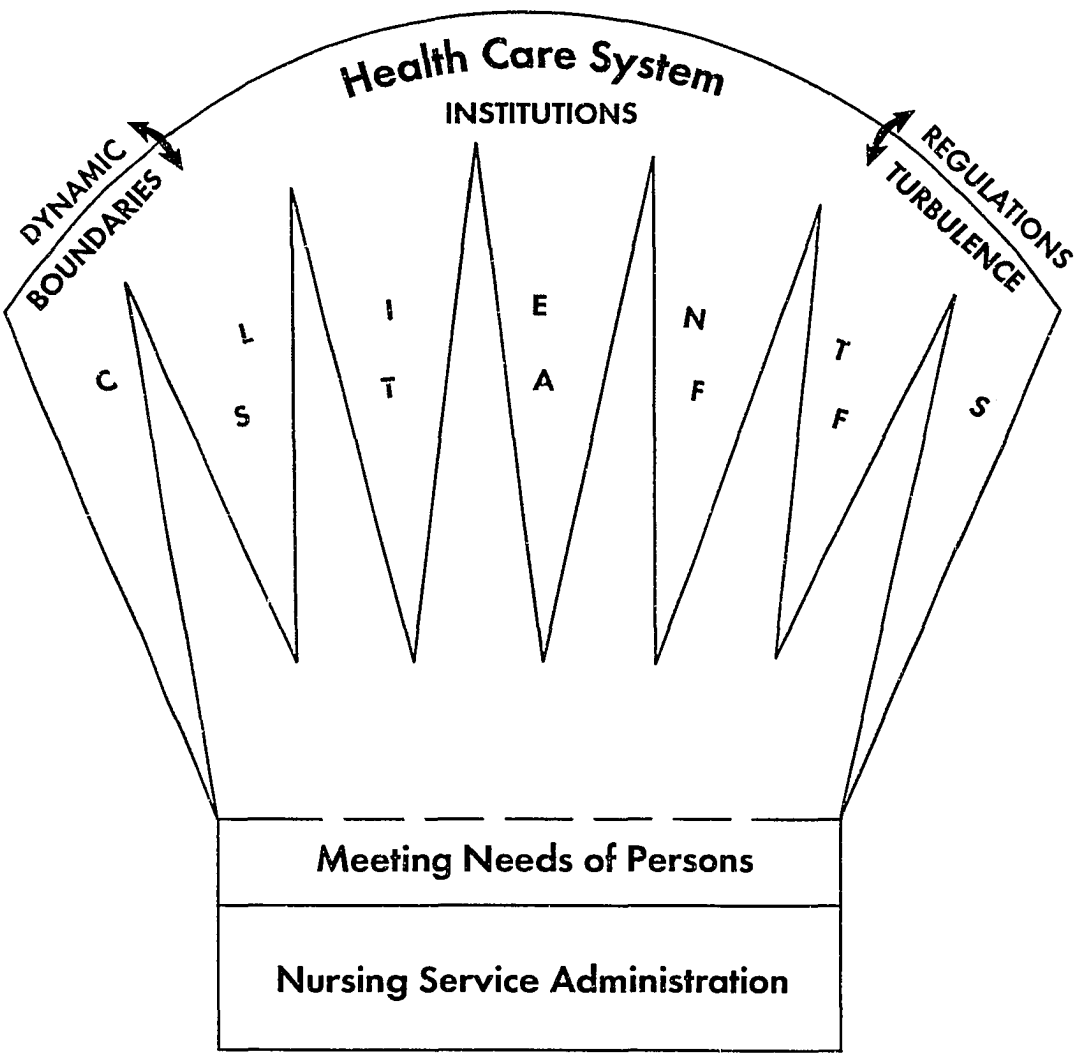
The world of nursing service administration is driven by the foundation of meeting the needs of persons. This relational focus is demonstrated in meeting the needs of both clients and staff. Meeting the needs of persons as a foundation links the other aspects in the lived experience of nursing service administration. The foundation is a strength that gives meaning for the other concepts in the world of nursing service administration.

The Playing Field for Nursing Service Administration

The realm or the playing field for nursing service administration is also clearly addressed by participants. The playing field is the health care system. This broad view was described by all the informants. Figure 6 represents the health care system as the playing field for nursing service administration. The playing field is drawn to demonstrate that the realm for nursing service administration is the whole health care system. Nursing service administrators were not limited by their institution nor by the discipline of nursing, but saw themselves operating in the larger health care system. When talking about a broader view, one participant said, "One way it comes to be is through reading and trying to keep current on what is going on in the health care industry, as an industry, and not just being mired into what is going on here." Another said, "In terms of what I think about as the

Figure 6

The Playing Field for Nursing Service Administration



larger environment, in terms of the context or the milieu in which we operate, that to me is always the health care system."

The broad view of the playing field for nursing service administration crosses disciplines and goes beyond institutional boundaries. One participant said, "I hardly even see myself as a nursing service administrator, because the issues that we work with are really much more health care administration." When talking about a spinal cord program another participant related,

> The impressive thing is the continued interest of all the disciplines. From physicians to PT [physical therapy] to OT [occupational therapy], social services, out in the outlying community, um, and the continued interest of the consumer and the consumer seeing themselves as part of a process. This project goes on to show that we also see ourselves as the hub of, um, a program, a program which is for the spinal cord injured patient and by the spinal cord injured patient. We don't want to leave out of that our colleagues and spinal cord injured people in the far reaching corners of our state. So we are developing a program where there is a cascading effect. Where, when a patient leaves us, that patient goes back to their community with a packet of information on the most recent findings about spinal cord care, cards from people who are the communicating person from each discipline. So

> there is a direct phone number and that is given to that person and a packet for the physician and for the primary nurse and then, um, home health care nurses, whoever is in the community. So every one has access. We also want to offer programs where we go out into the communities and teach. But we also offer sabbatical programs where community people can come to us and have an experience working in our spinal cord program here so that they get updated information.

Programs were not limited by the discipline of nursing or the boundaries of the institution, but were guided by the foundation of meeting the needs of persons in the health care system.

Community involvement is important in this broad view of nursing service administration. Another example follows.

> I believe that hospitals are really nothing if we are not connected to our communities. That we need to be good stewards. That we need to be involved in our community. And I think it is not only good business strategy, but it's also a personal and ethical responsibility when you are working with the health care in your community.

The playing field even in these tertiary care institutions extended in growing ways beyond the boundaries of the hospital. Another participant described:

> It is something that I have really enjoyed, is the ability to take my knowledge of this segment of the

university and move it out to the rest of the university or even into the community and work on broader projects. This nurse went on to speak about a task force on violence, "I was chosen to step beyond the balance of the traditional role, nursing's role, even hospital administration's role, out to the university's role. And that was really exciting."

The playing field extended outside the country in a number of participants' descriptions.

> The world's children are my children I guess is my point of view. And what I would like to go about as a long-term thing, as a nursing administrator, is again, facilitate better health care and a more educated approach to care for children throughout the world.

Another nurse said:

> We're only a short step away from being able to see what's happening in surgery at the hospital across the country, or around on the other side of the world. And, our physicians here are doing active consultations on the phone on patients that are on the operating tables in Japan, Italy, wherever. That's going on right here now.

One of the characteristics of the health care system seen in the preceding examples is dynamic boundaries. Dynamic boundaries are boundaries that are changing and moving. The moving boundaries reflect the ongoing exchange of energy and redefining of the system. The changing nature of the health care system boundaries was repeatedly illustrated as tertiary

care hospitals redefined their boundaries to include communities and new groups of consumers. The examples demonstrated increasing involvement outside of the institution motivated by the foundation of meeting the needs of persons. Where the institution ended and where nursing service administration reached was always changing.

Regulations are another characteristic of the health care system that the participants introduced.

> External regulation is a big piece of it, which is growing, and our ability to manage monitoring of all those regulations is diminishing over time. That continues to be a big focus. How do you manage to meet those regulations?

Most of the nurses mentioned regulations and legislation that impact their worlds.

> We ended up writing the policies, developing the new committee, developing new procedures and forms and monitoring of the whole big process of introducing new equipment, new devices, new technology, new to this institution. And linked very closely to that is the institution's compliance with all of the federal regulations out there related to medical devices. Cause there has been lots of new technology and new legislation and regulation in that field in the last year.

The participant went on to say, "There is stress involved when there are so many changes involved in not only the technology

of your business, but the regulation of your business in the environment in which you are working."

Turbulence is another characteristic of the health care system that the participants described. Turbulence referred to the complex and unpredictable nature of the health care system. Regulations and technology were linked to turbulence in many examples, although not all participants spoke about technology. One nurse said, "There are no simple paths anymore which I think is part of why it takes longer to get stuff done." Another participant reflected the turbulence by saying, "I am unable to keep up with the latest information." Another said, "One of the problems with our system is that we make the budget in February and we can't start it until July. Well, it's a whole different landscape then."

The turbulence was seen as stressful. For example, "I think that in this day and age of health care reform and financial reorganization, restructuring, which most hospitals are going through, it is also, I think, a very stressful time." Another participant described the turbulence and stress in this example.

> So as nurses, our training is based on defining parameters and predicting what's going to happen next. And, therefore, when we move into a role where the lines and the barriers become fuzzier and the predictability of what's going to happen in our world is harder to make. It creates conflict and it creates stress for a nursing

administrator that I think may be different than other administrators.

Turbulence, as a characteristic of the health care system, is also used to mean unpredictable by the participants. An illustration follows.

> I think that I have been in administration long enough that there was a time, it may sound a little pompous, but I really do think that I knew what the rules and the regulations were and where the boundaries were and how far you could go. And there was a lot of, a world that had a great deal of predictability. Even as long as I have been in this position at this hospital, I'm starting my sixth year, and even as long, as much as, 4 or 5, or 3 or 5 years ago, I would find myself saying, coming up against a problem then say oh, I know this problem. I've been here before. There were different faces and different names. It may have been a different hospital, but this is the same problem. And I know I would solve this problem. I know where to go to solve it. The health care world, health care environment that we are living in now, the only thing that I know is that it will be different a year from now, probably a year from now, certainly no more than two years from now. And I'm not sure how different it is going to be. My sense is that each year out is going to be more and more different, rather than more and more alike, as it has in the past.

> And that's because of the regulatory changes obviously that will happen and the restructuring that will happen in the work, while it is to remain competitive and financially sound. It's also going to change though just because of the shear, the massive advances in technology.

The health care system is seen and highlighted as unique by some of the participants. The playing field is identified as the health care system and differentiated from other industry or business.

> I don't think you can purely transplant the industrial model or the business model into health care. I think those places that have tried that have had some major problems. It's like with clients, you just can't just, it's not that clean cut to where you can do that.

The playing field is the unique health care system, that goes beyond nursing, the individual institution, and business models. The boundaries of the health care system and the institutions in the health care system are dynamic and changing. Regulations and turbulence are identified as characteristics of the playing field. Meeting the needs of persons in the health care system provides the framework for understanding the other concepts uncovered as the essence of the lived experience of nursing service administrators.

Concepts in the Lived Experience of Nursing Service Administrators

The concepts of vision, mentoring, communication,

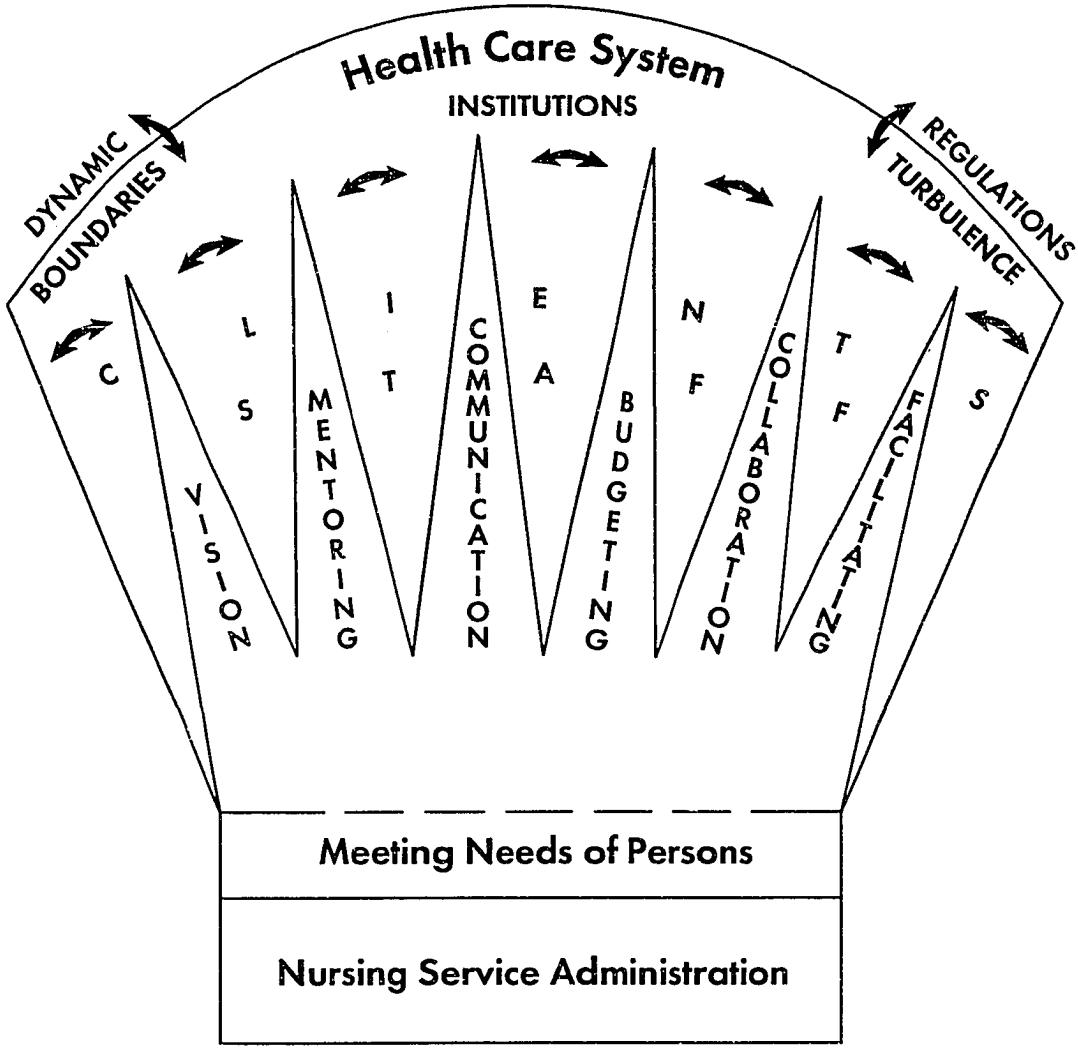
budgeting, collaboration, and facilitating are found in all interviews across both settings. There was no attempt to identify or categorize concepts at a particular level. The meanings and the words used for the concepts were those used by the participants. The concepts are presented in no particular order as each is described and illustrated. These concepts are grounded by the foundation of meeting the needs of persons and are carried out on the playing field of the health care system. See Figure 7 for a structural description or conceptual model for nursing service administration. The concepts are represented as rays of light that diffuse and interact with each other. The two dimensional representation is limited in demonstrating that the concepts are equidistant from each other and all interact.

Vision. Participants described vision as strategic and creative thinking. Vision involved looking for new ways to meet the needs of clients in the changing health care system. One nurse said:

> The visionary stuff is helping us as a whole, as a work group, my unit coordinators and myself are referred to as my work group, to look at how we're going to get to some future, and to look at the impact of, for instance, our budgetary issues right now at the hospital, every hospital, how we're going to do better, not necessarily with less, but do better with no more.

Figure 7

Conceptual Model for Nursing Service Administration



And another said:

> I guess I see it as my responsibility to provide some direction for the division or for the group of nurses that I'm working with. In a broad sense, but in a very specific sense to come with some specific goals that need to be reached and then bring to the group. Let me back up and say I'm a fairly participative type of manager and so I usually try to, I certainly have thought it through ahead of time, but like to bring things, that it's possible to bring, to the larger leadership group within an organization, some of the decisions and get some consensus and input. I think it is the task of the leader to have that vision.

One participant related, "I think in the clinical area that part of my role is to look at developing new ventures and partnerships for them outside the in-patient, the 4 walls of the hospital." Another said, "I am more responsible for program planning, for vision, and for guiding and developing the practice."

Participants described the need for creative new ways for seeing things. One nurse related:

> I think it's trying to find creative time, carve out some time to, um, create vision. I probably haven't said too much about that, but trying to carve out the time for creating a vision or having a moment to stop and think what could be, how can we be better? That's hard to do

but, I'm usually very stimulated when I'm reading articles or books or that kind of thing. While I'm in conferences, um, I have a little piece of paper beside me all the time, as I get ideas I write, jot those down. When I'm in meetings I take my calendar which has a little notepad on it and write ideas down in the meeting. I always try to have a pen and paper handy so when you get the creative idea you can document it.

Even in an unpredictable world, vision was seen as important. One nurse gave this example.

I try to always be a year or two ahead of what is going on right now. That's frustrating for my staff in some ways, but in other ways it takes us a year or two to get some things in place and if we don't try and anticipate what is going to happen down the road, we are not ready for it. It takes us a while so I think that to me, one of the key things about trying to lead a strategic support department is to be a strategic thinker and to be saying, for example, about three years ago actually four or so years ago, I began to identify that we had potential revenue generation power in our continuing education efforts. At that point the School had a program and felt threatened by our being an independent CE [continuing education] provider, because they were providing CEs. So we worked out an arrangement to provide under them and we quietly built that, so that at the point in time when the

> School stopped doing CE, we were in a good position and this year we had a revenue budget of over 100 thousand dollars. And that has been critical to our success in holding the strength of the department in the current budget crunches that are coming at us just wave upon wave. If we hadn't started doing that work four years ago, we wouldn't be in a position to have that kind of revenue strength right now. That's an example of what I think is a key leadership behavior in this role.

Vision is described as strategic and creative thinking. It is important in the world of nursing service administration to help continue meeting the needs of persons in the changing health care system.

Mentoring. The concept of mentoring also emerged as a theme in the interviews. Mentoring is clearly grounded by the foundation of meeting the needs of staff. The following is an illustrative example.

> For me mentors also certainly were role models in the way they conducted themselves. I think a good mentor stimulates the person they're mentoring, the energy, the motivation to keep moving and to keep looking and to keep trying. And when everything falls apart, is still there to pick up the pieces, but to be as objective as possible and to respect. I think both people have to respect the equality on both sides. I think because I felt very well mentored by a few folks, what a difference that has made

in terms of my career, in terms of approach to things and how they ended up. I feel an obligation to share some of that with other people and I think you tend to, probably. Sometimes they find you, sometimes you find them. When I do talks on survival strategies and management, I talk about the need to utilize mentors and to be much more aggressive in looking for mentors because I think it is something that nursing has not traditionally done well with. By presenting it either in the academic setting, or and. [sic] I think there's a tremendous boost that can be gained by having a good mentor. We don't socialize our own very well in nursing and since we're frequently seen in the work environment as competitive, particularly in this day and age, I think it's very helpful to have somebody that believes in you very strongly and can be an objective person in terms of some of the tough stuff. I guess I sort of feel it's my privilege to do that for somebody else. I have mentored several people, as I am still in touch with the people that have mentored me. They are still in touch with me even though it's a different setting. For me there's tremendous personal satisfaction in being able to help somebody grow in that direction. I think it's something I would like to see brought down to the unit level, senior staff to new orientees and actually we were talking, when I left _____ we were starting not just a preceptor program,

> but a mentoring program. It also builds professional cohesiveness and valuing of one another, which is another thing we don't do a very good job of in nursing, particularly when people get out on the floors as new staff and are overwhelmed with the acuities. It's every man for himself, and we've just got to get past that mentality or we're going to die. I think that it is a pretty important piece of what good management, good leadership should be about.

The valuing of relationships is evident in this example. The turbulent work environment also gives meaning to mentoring in this example. Another nurse related:

> But as far as the leader goes, I think that you need to provide role modeling for your staff, staff that work for you, staff that you're connected with. Teach them something. Out of every experience that they have, make them look at it a different way. Celebrate the successes and acknowledge the failures, but don't punish them for it.

The numerous examples of mentoring were long, but rich in demonstrating the connectedness of the concepts and the motivation that stemmed from the foundation of meeting the needs of persons. Another example illustrated the connectedness between the ideas of staff growth and meeting the needs of clients.

> Another area that I get involved in, and it has to do I

guess a lot with mentoring, but it is patient satisfaction. When there is an issue with a patient or family complaint and it is unresolved, I am called in to assist. I can give two examples of that. One, we had a delusional 94-year-old patient who became combative, was confused, disoriented and apparently, and the story is unclear, but apparently she was restrained and the perception of the daughter was that she was restrained without explanation and that a nurse was not in attendance, that it was intended, that restraining the, [sic] and that she felt that the experience was unsatisfactory. This person, this little woman, this 94-year-old woman, upset about this and felt that these people needed to be fired and she was very upset about it. I talked with the daughter at great length and the administrative coordinator at that time. I realized that regardless of our justification, it wasn't satisfactory to this woman whose mother was restrained. Because the mother had not resolved it herself and she'd go delusional with ramblings about it and that was distressing to the daughter. So, I made a visit to the nursing home where the mother was with the daughter and talked with the mother, apologized for her experience. I found there was no wrong doing on the part of the nursing per se, but there was somewhat, I guess we could say, there was a lack of sensitivity to this woman in that she

> was left in a room and tied and we know that that happens but, um, we talked about it. And I talked with the daughter and the mother and the administrative coordinator about reassuring them that number 1 we wanted to relay this woman's experience in how it felt to the daughter and how it felt to the mother. But as well that would be an opportunity for us to talk to staff to help staff understand what they must be thinking as they go in to restrain a patient. We took that back to staff in the staff meeting and did an educational thing and then sent a letter back to the daughter saying we had done this. And she told me that the mother had now forgotten this and felt that it had been resolved because someone had come out and told her that we were going to take care of it. So a little thing, but did resolve an issue.

The nurse went on with a second example and then said, "Those things are hard for me to do because they are uncomfortable, but they are things that I think are important and so in the world of nursing administration, these are the things that I think I prioritize."

Mentoring is important in the lived experiences of nursing service administrators. The administrators demonstrated a valuing of relationships and growth as they stimulated and supported staff. The meaning of mentoring is grounded by the foundation of meeting the needs of persons and recognizes the turbulent work environments.

Communication. Communication is seen as central to the nursing service administrators' roles. One nurse said:

> In terms of how I communicate that, I try to be a very forthright and clear communicator. I try very hard. I think communication is the absolute key and heart of this whole thing and if you cannot be open to listening back to your own people, whether they agree with you or not, and try to incorporate that disagreement into what you think, that's been very important for me.

Another related:

> I spend a lot of my time in communicating. Moving mail back and forth, meeting with people, um, and the communication can be trying to do brain storming on new things, new ways to do things, doing evaluations of projects, figuring on which new projects we are going to take on, looking at problems, looking at the future, where we are going and I guess I spend most of my time communicating.

Information management is seen as important in providing the needed information to staff. Supporting staff by providing them with meaningful information is one way of meeting the needs of staff. One nurse described it this way.

> Ways that I think that I provide leadership is to try to provide in the context of the institution, not only the institution, but I guess health care as a whole, the

information that people need in order to think about how they're going to plan their work.

Another said:

> We get lots of information that's not prepared in a format that we can make any sense out of and what unit coordinators, who are busy managing their units in day-to-day operations tend to do is look at that and say, "Oh, another piece of paper with a lot of numbers on it. What does this mean to me?" And if nobody asks them questions, they leave it alone, you know, like it's not bothering them, so they don't let it bother them. So I not only have to sort of make it exciting for them, I have to be sure that they understand how it's relevant to them and to figure out ways to put the data together in a more helpful way. So I spend a lot of time trying to figure out and actually doing, putting data together to figure out how it is more helpful, how it is more meaningful, how we can apply that information to our setting, how it can help us in a day-to-day retrospective way.

One participant provided a summary statement.

> One of my goals, if I could fix it, would be to be able to provide each nurse manager the real information they need to manage their units from the issues of how much they're spending per day, how much we reimburse per day, and the impact of charging or not charging, what we're

losing in lost charges, etcetera, etcetera, all those sorts of things. I feel very certain that, if our nurse managers had that data, that they would manage differently, that they would use that information in a very constructive way to be very fruitful in terms of providing better and actually being able to correct problems that now exist in some of those areas.

One last area of communication described by the nurses is networks outside the institution. The desire for links with resources outside the institution reflects the broad playing field for nursing service administration.

I've been interested in pursuing the connection with other nursing services throughout the state, and particularly the region. How can we get together to, while our administrators and physicians are working together, how we can get together to pull together really strong networks of care for the people in this region?

Another said:

The networks. If we can get beyond the health care providers, as groups of providers, can get beyond the territorial issues and try to work together, you know look at a region and define what is in the best interest of the region. Who does what best? And how do we get that? The population in this defined region is very key

to our survival. Our survival, not just _____ [identified a particular institution]. I mean just their survival as an industry.

Communication is central to the lived experience of nursing service administrators. Information management is one part of communication that is important as a way of meeting the needs of staff. Networks reflect the broad playing field of the health care system and refer to communication with resources outside the institution.

Budgeting. Another concept discussed by all participants is budgeting. Budgeting is one of the identified concepts that represents the essence of the lived experience of nursing service administrators. Budgeting is a term frequently used by the participants. The term budgeting was chosen because the meaning goes beyond financial concerns and includes budgeting of time and resources. The bottom line is not dollars, but meeting the needs of persons. One nurse said, "Budget is a major part of any nursing exec's life and how can we do what we need to do with the constraints?" When talking about budgeting another nurse said, "I think that's a critical issue for the credibility of nursing administration, vis-a-vis the hospital administration."

Again, the concept builds upon the foundation of meeting the needs of persons.

Well, unfortunately the reality is that we, um, we are all, I think, consumed by financial concerns these days

> as health care is reorganizing. And I think there are several things that I do in this area. One is, again because of my nursing background, because my initial training was as a clinician, is to try to bring to the table the balance that we are all striving for, develop the financial aspects of the care of the patient with the quality of the care. And that is so difficult to do. And, but yet, because of my own personal beliefs and values, and I think I see that in most of my years. I think that we are constantly trying to do that. And that is a role that we all take on as we are interfacing with other administrators throughout the health sciences, as decisions are made. How do you? If you? [sic] What is the cost of the maintenance decision? Not only in dollars and cents, but what? How will it change patient care and what are the clinical outcomes that will happen with this decision? So it's a continuous balancing act: every meeting, every step we take, every decision we make. What markets are we going into? What new products are we going to develop? What are we, you know, how much support are we going to get in this area and in that area? How can we streamline? How can we provide better information? They are all related.

This illustration communicates the interrelated nature of all the identified concepts. The information management part of

communication is cited by the nurse as relating to the financial concern. Another participant related:

> Sometimes I think people fail to see the connection between strategic decisions of the hospital and the financial implications of the strategic decisions or the implications of the current financial situation on strategic decisions. And that is very difficult to do depending on the level of the operations that you are in and whether you even have access to that information. So a lot of my responsibility would be to translate the information from any forms where I have received it to the unit managers.

Budgeting is also seen as taking place on the larger playing field of the health care system.

> And I think there is not a newspaper or a magazine or a journal that you don't pick up that doesn't talk about health care reform and restructuring and refinancing and reducing cost and streamlining and cost containment and the millions and zillions of buzz words that are going around. And what I try very hard to do in my role is to take that back to the unit base level and talk to the clinicians about that. And help them get beyond the confines of their unit and their patients and understand how that is a part of the bigger whole of the division of nursing, of health sciences center, of the university, of the state.

Participants described the broad links that budgeting has to the community.

> Businesses are looking at their health care costs going up. Large number of dollars that each employee costs them and that gets translated into the pricing for their product. The community is worried about, has seen their insurance, the value of their insurance dropping. And I think we are all, the days of being fat and happy are over with and we just need to really take a look at how we can do things efficiently and effectively. Unfortunately, with the health care plans in looking at reducing cost and looking at increasing access, the only increase access is to go out into the community.

Another participant said:

> Well, I don't think you can make any decision without looking at, does it make good business? But that doesn't mean just the financial performance for the next quarter. And I think, unfortunately, all institutions or many institutions, we live in quarterly reports. You don't look in what does this mean five years from now? Yes, it may cost something to bring somebody out into the community, but what does that mean in terms of how you are viewed when you go out into a company and you want them to be part of your HMO [health maintenance organization] or whatever?

Budgeting is one of the identified concepts that represents the essence of the lived experience of nursing service administrators. Budgeting is more than a financial concern. It is grounded by the foundation of meeting the needs of persons and takes place in the larger health care system. Budgeting is interrelated with all the other identified concepts.

Collaboration. Collaboration is another concept that emerged from the interviews as a theme in the lived experience of nursing service administrators. Collaboration represents crossing disciplines to streamline the health care system in meeting the needs of persons. Streamlining refers to increasing efficiency in the health care system. Collaboration is important in addressing the efficiency of services. One participant said, "I interact heavily with the medical staff, the administrative staff, the heads of other departments, [and] community agencies." An example from another nurse follows.

> I have just been at a meeting talking about a non-housestaff unit and what does that mean? What is it going to look like ... It is going to hit x-ray, the admitting office, the nursing department, the medical department; there will be a few surgeons in there. We'll probably have some nurse practitioners and that's a whole different group. What's the secretarial support? I mean they need to dictate their notes, of course. And they

> need those patients to turn over in a twinkle of an eye so housekeeping certainly has to be part of that discussion. Can they do it? I don't think there's hardly an issue that is black and white, that you can look at it and say we can do that. And yet you're planning ahead. By the end of the day you've called all the right people and you've got it done. I think that there are very few things that we do that are that simple so that generally your environment extends into every other discipline on campus and off, in truth.

Another example follows:

> There was a need, I saw the opportunity to do some, some real bridge building with one of my units and one of the out-patient areas. And when the medicine department got a, well, they hired a director type person for their out-patient clinics. I went to her with a proposal to have one of my managers manage not only the current in-patient unit, but also assume management of the hematology/oncology clinics in the cancer center, as well as sharing some nurses' costs, figuring out the cost sharing. That has been in place for three months and has worked out very, very well. And that person in medicine is now coming and saying okay, where else can we, you know, the division which costs both the in-patient and out-patient areas [sic]. Cause they are two very separate distinct administrations. I mean they are like this

[nurse indicated separateness with her hands]. And how you bridge that when patients have to flow through both and the opportunities for streamlining systems I think would be wonderful.

The participants described numerous instances of collaboration with pharmacy and other departments. The interrelated nature of the concepts is evident in all the examples.

One of the other things that I am very excited about was we developed a chronic lung care clinic and my stoma therapist and I worked in partnership with the department of plastic surgery. We are sharing a stoma therapist. We developed a contract to share them for research so they are working with one of the best known national and international plastic surgery researchers in the world and they are working with the practicing part of the department of plastic surgery. And they opened the chronic wound care clinic. And that wound care clinic opened in May and we have gone beyond expectations. We thought we'd see 200 patients the first year. Uh, just through December we saw 180 patients. So we know that by the first year we are gonna more than, have more than accomplished our goal. And we are now marketing externally. That was only with internal marketing. So we are real impressed with that. We know that we are making a little money.

Collaboration has meaning in crossing disciplines to streamline the health care system. Meeting the needs of clients including those in the community is the driving force for the collaborative endeavors of the nursing service administrators.

Facilitating. Facilitating is one of the themes that emerged among all the interviews. Facilitating is part of the essence of the lived experience of nursing service administrators. For example one nurse said:

> I see the role of the, of any administrator, including nursing administrators, be in a role of a facilitator, a person who can help remove obstacles and remove the barriers that, that tend to exist between one department and another department.

Another participant related, "I honestly believe that nursing executives at whatever level, their role is to facilitate the work of nurses who are caring for patients, whatever it takes to get that done, needs to get done." Nurses described the meaning of facilitating, "Facilitating by helping people learn to do for themselves. I try real hard not to do for people." Another participant explained:

> So, it was facilitating in that way. Again, it is not so much direct day-to-day involvement. It is more helping people come up with ideas and pointing them in the right directions for them to get their ideas off the ground.

Meeting the needs of staff and clients can be seen as the foundation for facilitating in the examples. Another nurse said:

> My facilitative style clearly fits with the de-centralized focusing and philosophies. It fits with the growing recognition that changes have to be made at the clinical practice level and that changes have to be made in the actual care delivery system which can't be made from the bureaucratic top down approach. So actually, I think, my own personal feeling is that my style fits much better with the contemporary trends and the recognition of where decision-making should occur than a lot of others.

Stimulating is described as a characteristic of facilitating.

> Well, I see my role as really keeping all the wheels going, kind of a stimulus for a lot of things. If you'd have asked me what I did, I'd probably say I don't really do much, you know? I mean I don't go and produce huge documents on my own, those kinds of things. Really what I do is, really stimulate the planning, stimulate the movement forward, brainstorming, get to that kernel, that nut that needs to be gotten to. So it's really a lot of interactive pieces.

The relational aspect of facilitating is also evident in the examples that participants gave. Facilitating took place

in the turbulent and stressful environment of the health care system. Advocacy and empowering are some relational aspects of facilitating that participants described. One participant explained, "I think we've talked indirectly about the concept of advocacy. In my mind the practice of nursing is patient advocacy and the practice of administration is nursing advocacy." Another nurse said:

> So that they feel like that they have a real live person that they can talk to and that can explain things to and who is their advocate in the system, in the organization. ... I want my role to be one in which, very much, as much as possible, a hands on role and a very visible humanistic role, so that in the stressful environment of a hospital of a health sciences center, that employees that work within their region are, really feel like I'm there for them. I'm there to support them, to be their advocate.

Another said:

> I think another way that I provide leadership is to encourage and guide and empower the people under me. Those are three different things, but they all roll together. I think encouraging people to come up with their own ideas to try to be flexible, and I'm not always as flexible as I would like to be. Sometimes I think, oh, that isn't going to work, and I have to try and back up and say, "All right. Well, tell me why you think that's

> going to work." People have to have a sense that you trust them and that you know they can do the work so that's part of encouraging. Guiding is to give other strategies, to give suggestions, to say, "Have you thought about this?", to say, "Try that and let me know what happens.", in ways in which you do structure and you give suggestions. And you say, "Well, I'm not sure that will work with this particular person. What if we try something else?" So that's the guiding part. The empowering part is to say, "This is yours. This is your problem. This is your project. This is yours to do." I think that has been very important.

Facilitating is part of the essence in the lived experience of nursing service administrators. The meaning of facilitating is shaped by the foundation of meeting the needs of persons and takes place in the stressful environment of the health care system. The relational aspect of facilitating includes stimulating, advocacy, and empowerment.

Summary of the Conceptual Model for Nursing Service Administration

The concepts that represent the essence of the lived experience of nursing service administrators were identified in all the interviews and across both settings. The conceptual model represents the words and meanings supported by the participants' examples. The foundation of meeting the needs of persons can be seen as the grounding and motivating force for

the concepts of vision, mentoring, communication, budgeting, collaboration, and facilitating. The foundation is evident in relating to clients and staff. The playing field is the broader health care system characterized by dynamic boundaries, regulations, and turbulence. Most significantly, nursing service administration is not limited by institutional boundaries. The concepts of vision, mentoring, communication, budgeting, collaboration, and facilitating are presented in no particular order. They are interrelated and influence each other. These concepts interface with both staff and clients and extend beyond the institution into the larger playing field of the health care system.

Other Data

Themes used in the conceptual model emerged from all the interviews. In other words, commonalities were identified to represent the lived experience of nursing service administrators. However, one theme emerged from one of the institutions and not the other. This theme from one institution is not included as part of the conceptual model. A concern with the status of nursing was described by all five participants from one institution and was not mentioned by any of the nurses from the other institution.

Status of nursing focuses on the recognition of nursing and is addressed as a concern inside the institution. One nurse said, "I would like to see _____ get, particularly nursing get the kind of recognition I believe it deserves."

Another said, "I think my major goal, and it is the most difficult to attain, is to change and strengthen the professional practice environment for nurses that practice here." Participants gave some examples of the struggle for increased nursing status. When comparing a problem with the intern match one nurse said:

> Now it occurs to me that I know there wasn't that kind of response when we had nursing vacancies, ... We're still supposed to do the same job. The level of support for both [support for nursing and medicine] is not even compatible.

The concern with the status of nursing is seen in the ways the needs of staff were met. One participant said, "So we did support groups. We developed giving back recognition as a major piece of what you have to pay attention to." The concern for the status of nursing influenced the examples and the other identified concepts. Other than the concern for the status of nursing, the interviews from the two organizations were indistinguishable in uncovering the concepts that represent the essence of the lived experience of nursing service administrators.

# CHAPTER 5

## Discussion and Summary

This study identified concepts that represent the essence of the lived experience of nursing service administrators. A general structural description of nursing service administration was presented using the concepts in a conceptual model. This chapter presents a discussion of the conceptual model and the identified concepts. The study is a descriptive phenomenological study. In that light, only general comments in relation to the other existing models of nursing administration are included. Recommendations for the nursing profession as well as recommendations for further study are included.

### Conceptual Model Discussion

The strength of qualitative research is inductive theory development. This phenomenological study uncovered the knowledge in practice. The inductively developed conceptual model provides organization for thinking in the complex health care system. Describing the concepts of concern to nursing service administrators articulates an explicit focus for the discipline of nursing service administration. The concepts represent the frame of reference that describes the essence of

the world of nursing service administration. The essence provides direction for the use and advancement of knowledge. The conceptual model provides a coherent frame of reference that represents the wholeness of the lived experience of nursing service administrators.

The analysis and findings are consistent with the underlying philosophies of phenomenology and chaos theory. Both phenomenology and chaos theory direct the researcher to examine phenomena as wholes. In this light, the data were treated as describing the whole experience of the nursing service administrators. The identified concepts of concern were examined in understanding the system as a whole. Consistent with phenomenology, the meaning of the concepts was pursued from the participants perspective through the use of examples. The unpredictable nature of the health care system, as described by the participants, illustrates one aspect of the fit with chaos theory.

The data are rich and coherent in moving toward the conceptual model for nursing service administation. The participants proved to be reliable and interested in generously telling their stories. They were willing to openly share the essence of their lived experience as nursing service administrators. The rich data and numerous examples as presented in the findings are not flooded with detail to avoid losing the essence of the data. Uncovering the essence, grounded in practice, is a strength of qualitative research.

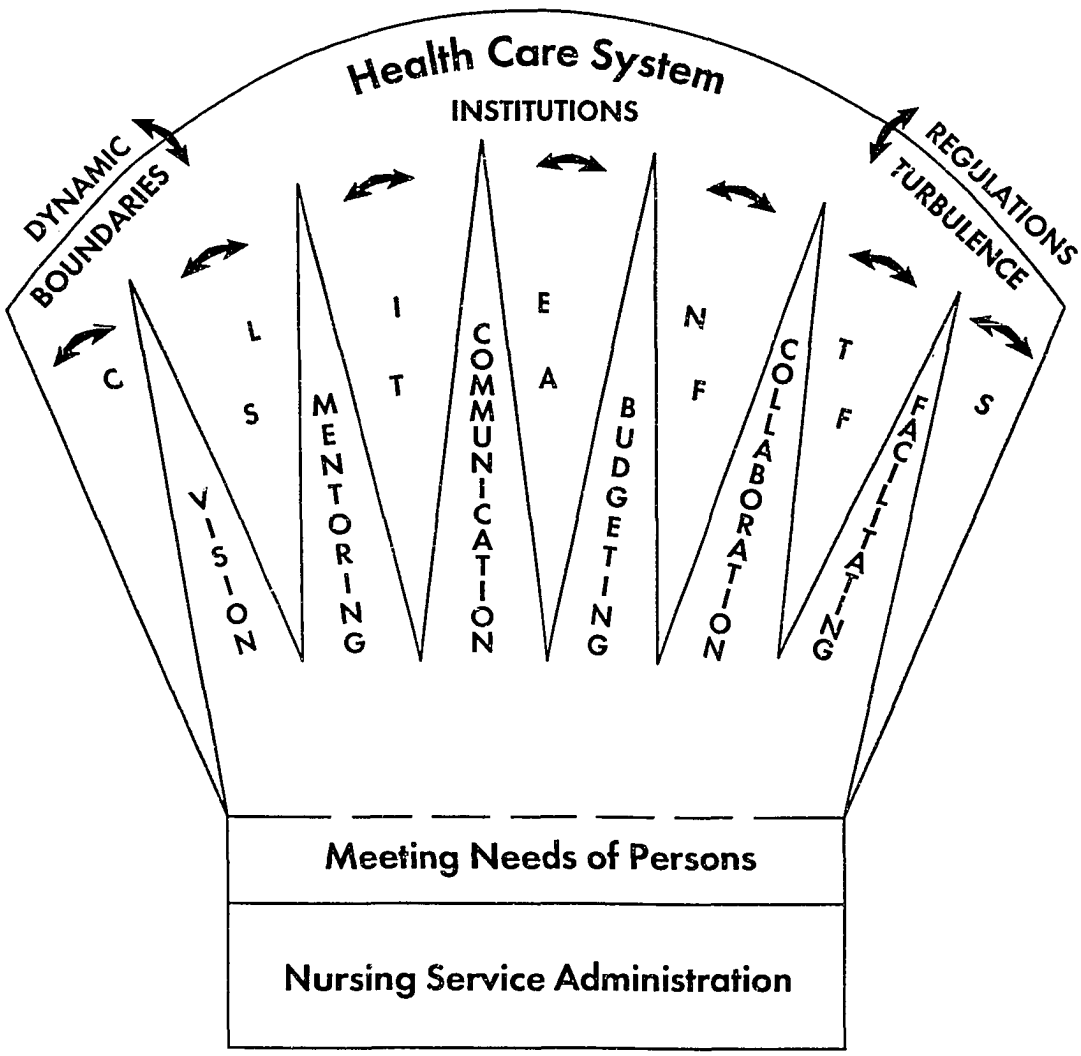
This strength and richness can be lost in detail. The concepts and their meanings are the themes that capture the essence of the lived experience of the nursing service administrators.

In this model, (see Figure 8) the significance of the identified foundation for nursing service administration should not be underestimated. Nursing service administration cannot lose sight of the foundation of meeting the needs of persons in the changing health care system. This foundation needs to be clearly articulated because meeting the needs of persons reflects the essence of the lived experience of nursing service administrators. The foundation provides a basis for nursing service administration that keeps the nursing profession on track while adapting in a changing health care system. Meeting the needs of persons provides the grounding view to process the complex and changing world of nursing service administration.

The relational foundation is demonstrated in meeting the needs of both clients and staff. Although participants often said patients, the term clients was chosen for this model to reflect the focus on individuals both inside and outside the institution. Clients was also chosen to reflect the variety of needs that the nursing service administrators addressed. In addition to caring for ill persons, participants described education and other responsibilities which represent meeting the needs of persons.

Figure 8

Conceptual Model for Nursing Service Administration



The emphasis is meeting the needs of persons, not meeting the needs of the organization. This focus on individuals does not mean there is not an organizational concern, but the underpinning focus is on the individual. This grounding value minimized tension through providing the nursing service administrators with a clear focus to guide their decision making. The bottom line question is, "Will this meet the needs of individual persons?" not "Is this good for the institution?"

The identification of the playing field as the health care system directs nursing service administration to participate within the whole system. The realm is called the playing field, to use common language and avoid the varied meanings of the term environment. A line representing a boundary between the institution and the health care system is not shown on this conceptual model. The identification of the playing field as the whole health care system, emphasizes an encompassing boundary, not crossing boundaries between the hospital and the health care system.

The health care system is described as having dynamic boundaries. It is hard to represent changing boundaries in a static two dimensional model. The informants identified the boundaries for the playing field as the health care system. A solid line that moves was chosen to represent the boundaries instead of a broken line. A broken line tends to emphasize permeability not movement. The health care system is also

characterized by regulations and turbulence. Technology was sometimes mentioned and may have been assumed as part of turbulence. The turbulent nature of the health care system creates a stressful work environment for nurses.

The metaparadigm concepts of health, person, nursing, and environment focus the discipline of nursing. The concepts in the conceptual model for nursing administration provide a more explicit focus. The identified concepts of vision, mentoring, communication, budgeting, collaboration, and facilitating are part of the essence of the lived experience of nursing service administrators. In identifying these concepts, the analysis did not focus on uncovering concepts at a particular level. The significant statements, meanings, and even the words, were those used by the nursing service administrators in describing their experiences. These concepts are presented in no particular order. The conceptual model represents these concepts as rays of light that diffuse and interact with each other. The two dimensional representation is limited in demonstrating that the concepts are equidistant from each other. The concepts are part of the whole conceptual model that represents nursing service administration. Their meanings can not be separated from the foundation and the playing field.

Vision is creative thinking in planning for meeting the needs of persons as the health care system changes. This concern is not diminished by the unpredictable nature of the

health care system. Mentoring addresses valuing relationships and growth in a turbulent work environment. Communication includes information management to provide the necessary data for staff. Communication also involves building networks outside the institution. The term budgeting was chosen because the meaning goes beyond financial concerns and includes budgeting of time and resources. The bottom line is not dollars, but meeting the needs of persons. The meaning is guided by the focus on individual needs and does not highlight organizational survival. Collaboration has meaning in crossing disciplines and streamlining the health care system to meet the needs of persons. Integration of services is incorporated as an aspect of streamlining to increase efficiency of health care delivery. Facilitating embodies the relational view of nursing service administration through stimulating, empowering, and advocacy in a turbulent and stressful environment.

Relationship to existing models. The existing models for nursing administration provide organization for thinking, while this study's conceptual model describes the essence of nursing service administration. The wholeness of the lived experience stems from the foundation. Meeting the needs of persons provides a different focus than the existing models. Both staff and clients are included in meeting the needs of persons through nursing service administration. The Iowa Model of Nursing Administration has the level of patient aggregates

at the center (Gardner, Kelly, Johnson, McCloskey, & Mass, 1991), but a guiding foundation is not clearly presented. The focus is on the two domains of systems and outcomes. The Nursing Administration Practice Perspective (NAPP) has health and client as central to the model (Neidlinger & Miller, 1990), but staff are not clearly included. The integrative model (Nyberg, 1990) presents the components of the model in interaction. Philosophy, theory, and concepts provide the theoretic underpinnings. Human care is one of the concepts, but it is not presented as a foundation. The Nursing Administration Systems (NAS) Model (Scalzi, 1989) presents nursing and organizational domains as combined in one system, but the model does not present a foundation. The focus is on organizational effectiveness. The major difference between this study's model and the existing models is the clearly presented foundation of meeting the needs of both staff and clients. The foundation focuses on the individual and not the organization.

The playing field is another key aspect of the model to relate to the existing models. The Iowa Model of Nursing Administration emphasizes distinction between the levels of organization and health care (Gardner et al., 1991). The NAPP model also demonstrates more distinction between sectors of the environment. Internal, task, and general sectors are identified (Neidlinger & Miller, 1990). The integrative model does not directly address the health care system. However,

regulations are identified in relation to the concept of economics. The purpose of the integrative model is to represent the theoretic underpinnings of nursing administration (Nyberg, 1990). The NAS model also does not address the health care system. This study's model identifies the unique health care system as the playing field for nursing service administration and broadens the focus beyond the institution.

The concepts of vision, mentoring, communication, budgeting, collaboration, and facilitating are not presented as key to the existing models for nursing administration. Budgeting is part of the general environment in the NAPP model and is also evident in the integrative model as seen in the concept of economics. The concepts identifed in this study reveal increased understanding of the nature of nursing service administration. They are the concepts of concern that represent the essence of the lived experience of the nursing service administrators.

Each model is unique and can provide understanding from the frame of reference that it provides. Previous models begin to focus and organize a view of nursing service administration. This study's model addresses the essence of nursing service administration and increases understanding of the whole experience of nursing service administrators.

Discussion of Other Data

The status of nursing is of concern to the participants in one institution and not the other. Because this finding is not found at both institutions, it is not included in the conceptual model for nursing service administration. Although unique to one institution, the concern with the status of nursing is not surprising given nursing's history. Nursing has struggled for respect and recognition for much of its history. The concern with status of nursing may be common to many institutions.

Recommendations for Nursing

This study is timely and critical for nursing service administration because of the health care crisis. The potential for continued restructuring of roles and delivery systems increases the importance of clearly describing the world of nursing service administration. A clear frame of reference guides the discipline of nursing service administration in the changing health care system.

The implications for nursing administration begin with the recognition of the foundation of meeting the needs of persons. The participants stressed the importance of nursing's practice base in providing the context for making decisions. The foundation is not solely a unique nursing view, but is a strength in health care administration. Recognizing the practice base as a strength in health care administration provides direction for education. The type of education for

nursing service administrators has been debated. The findings of the study support remaining connected to nursing's practice base and support the importance of clinical awareness in health care administration. The findings do not preclude education from other disciplines, such as business administration, but there is support for remaining connected to the practice base and values of nursing.

Recognition of the broad view of nursing service administration provides direction for the role of nursing in health care reform. The broad playing field for nursing administration provides some direction for nursing in the changing health care system. The new emphasis on primary and preventive care in the community is supported by the focus on meeting persons' needs outside of institutions. The encompassing boundaries of the model support the movement to community/neighborhood based health care delivery. Nursing service administrators need to be aware of the focus outside the institution to continue leading nursing as the delivery of health care changes and moves beyond institutional boundaries.

The use, development, and integration of the concepts is another important nursing implication. The concept of vision provides direction for how to view planning in a changing health care system. The unpredictable nature of the health care system does not preclude vision, but directs the nursing service administrator to recognize pattern variability. Mentoring encourages the development of structures to

stimulate and support staff in their growth. Recognition of the turbulent work environment is important in the mentoring process. The need for information management and networks are necessary for good communication. The concept of budgeting as part of the whole model clarifies the need to understand economic theory in the frame of reference of nursing service administration. The focus on meeting the needs of the individual and not primarily the organization guides the application of economic theory in nursing service administration. Collaboration encourages nursing service administrators to cross disciplines to streamline the health care system. Lastly, facilitating emphasizes the importance of maintaining an awareness of relationships in carrying out the roles of a nursing service administrator.

Curricula in nursing administration can find some guidance in the conceptual model for nursing administration. The conceptual model provides some indication for priorities and focus in curriculum development in nursing service administration. The broad view of the playing field demonstrates the importance of focusing on the whole health care system. The relational aspects stemming from the foundation and demonstrated in concepts such as mentoring and facilitating illustrate the need for content that deals with human relations. The concept of communication reflects the importance of information management skills. Collaboration suggests the importance of interdisciplinary awareness and

budgeting reflects the financial knowledge necessary to function in the world of nursing service administration. The characteristic of regulations demonstrates the significance of policy knowledge. Turbulence speaks to the underlying philosophies, such as chaos theory, that may provide helpful ways to understand and cope with the changing health care system. The guidance implied in the findings is especially helpful in directing curricula planning for programs offering masters degrees in nursing administration.

The conceptual model provides organization for thinking, a distinctive frame of reference determining how the world is viewed. This framework serves as a foundation for knowledge development. The development of knowledge for practioners, faculty, and researchers will be fostered by the description provided by these findings.

Recommendations for Future Research

The findings of this phenomenological descriptive study need further exploration. Replication of findings would expand and support a model that describes the essence of nursing service administration. Replication of the study in similar settings and comparable levels of administration is a first step in a research plan. In addition to conducting interviews, field observation of nursing service administrators would expand the findings. The next step is the use of longitudinal studies to expand the data. Chaos theory directs nursing toward longitudinal designs, which focus on change over time.

In a turbulent and changing health care system it is important to identify whether the concepts that represent the essence of nursing service administration change over time. Identification of changes that happen in the health care system during the study should be tracked to ascertain the effects on the concepts of concern to nursing service administrators.

Two other areas that need further study are the effects of the level of administration and the type of institution on the concepts of concern for nursing service administrators. The identified concepts that represent the essence of nursing service administration were limited by the chosen level of administration and the type of institution used in this study. Exploration of different levels of nursing service administration would expand the understanding of the concepts that provide a frame of reference for nursing service administration. Which concepts of concern are the same and which are different in describing the essence of nursing service administration at different levels. Are the concerns of a single unit manager the same as the chief nursing executive? Different types of institutions also need to be explored to more fully understand the scope of nursing service administration. Are the concepts that represent the essence of nursing service administration the same at community hospitals, long term care facilities, and outpatient settings?

Nursing is a science whose scholars are just exploring the theory of chaos. Conceptual model development has some potential for further advancement using chaos theory. A dynamic or changing system is best described nonverbally by an image (Vicenzi, 1994). Chaos theory provides a new way to represent the concepts of concern for nursing service administration. Phase space is a multi-dimensional visual field that can be generated by computerized methods (Vicenzi, 1994). These images may help nurses understand the holism in the world of nursing service administration.

Several additional studies could be included in future research. The conceptual model could be examined in a comparative study with other existing models. The model could be tested for validity of the identified concepts and the structure evaluated through review by nursing service administrators. The concepts that represent the essence of nursing service administration could also be compared to the concepts of concern for administrators from other practice based disciplines.

Summary

Disciplines are differentiated by the concepts of concern to each. These concepts provide a frame of reference that gives direction for practice, education, and research. The concepts that represent the essence of nursing service administration have not been described. The essence can be represented using the identified concepts in a model.

Conceptual models are needed as clear frames of reference in the complex health care system. Using phenomenological philosophy and chaos theory provides direction to describing the whole experience of nursing service administrators. A conceptual model for nursing service administration will provide a distinctive frame of reference in describing the lived experience of nursing service administrators.

This phenomenological study identified concepts that represent the essence of the lived experience of nursing service administrators. Using purposeful sampling, participants were selected from among the directors at two large teaching hospitals in the Mid-Atlantic region. In-depth unstructured interviews were conducted with five nurse administrators from each hospital. The interview content was analyzed identifying themes and synthesized into a conceptual model that represents the essence of the lived experience of nursing service administrators.

The concepts that represent the essence of the lived experience of nursing service administrators were identified among all the interviews and across both settings. The conceptual model represents the words and meanings supported by the participants examples. The foundation of meeting the needs of persons can be seen as the underpinning and motivating force for nursing service administration. The foundation is evident in relating to clients and staff. The playing field is the broader health care system characterized

by dynamic boundaries, regulations, and turbulence. Most significantly, nursing service administration is not limited by institutional boundaries. The concepts of vision, mentoring, communication, budgeting, collaboration, and facilitating build upon the foundation and are interrelated. These concepts interface with both staff and clients and extend beyond the institution into the larger playing field of the health care system.

The conceptual model provides increased understanding of the essence of the lived experience for nursing service administrators. The wholeness of the lived experience is captured in a usable model. The conceptual model provides organization for thinking and a foundation for knowledge development. The practice base of nursing is identified as a strength in health care administration. The emphasis on encompassing boundaries and the focus on the individual and not just the organization, challenges the nursing service administrator to move beyond institutional walls in meeting the needs of clients and staff. The integration of the concepts provides guidance for nursing administration curricula. The implications provide direction for education, service, and research in nursing service administration.

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# Appendix A

## Interview Critique

1. Were the questions clear?

2. Were there any words that were problematic?

3. To what extent did you feel the questions steered your responses?

4. Were there times when you wanted to say more?

5. What was the process like for you?

6. What are your thoughts/predictions about how other nurse executives will respond to this interview process?

7. How could the written materials be improved?

8. Other comments:

## Appendix B

## Demographic Sheet

1. Gender.

2. Basic nursing education.

3. Highest level of education.

4. Total years in nursing.

5. Number of years in nursing service administration.

6. Clinical specialty.

7. Types of nursing administration positions.

8. Types of clinical units presently responsible for.

# Appendix C

## Interview Guide

- Tell me about your world of nursing service administration.
- Tell me how you spend your time and energy as a nursing service administrator.
- Give me examples from your experience as a nursing service administrator.

# Appendix D

## Introduction

## Nursing Service Administration: A Phenomenological Study

I am trying to identify what are the areas of concern for nursing service administration. I am interested particularly in how nursing service administrators define their world. On what areas of concern do nursing service administrators spend their time and energy? A beginning step in the process of defining nursing service administration involves describing the building block concepts. My long-term goal is to develop a conceptual model for nursing service administration.

I am using a phenomenological process to lay the ground work for developing a model. In this process I ask nursing service administrators, such as you, to talk about their meanings of nursing service administration and the areas of concern they see from their knowledge and experience. I am interested in what nursing service administration is for you and your work. In those terms, I am looking at the lived experience of being a nursing service administrator.

Appendix E

Informed Consent Form

This Informed Consent Form explains the procedures involved in the study and the possible benefits and risks of being in the study. Please read the entire form, initial the bottom of each page in the space provided, and sign your full name on the last page.

Title of Study: Development of a Conceptual Model for Nursing Service Administration: A Phenomenological Study

Investigator's Name:

H. Michael Wenger, R.N., M.S.N.

Doctoral Student VCU/MCV School of Nursing

Introduction:

I understand that I will be interviewed about nursing service administration. I understand the purpose of this study is to develop a conceptual model that describes the lived experience of nursing service administrators. I have been given a written introduction to the purpose of the study. The interview will be tape recorded. The tape recording will be transcribed by a clerical professional who will not know me.

Benefits:

I understand the benefits of the study will be to contribute to knowledge development in nursing service

Participant's Initials: _____

administration. There are no direct benefits to the participants.

Risks, Inconveniences, Discomforts:

I understand that no risks have been identified for this study. The only inconvenience of participation will be the time for the interview.

Cost of Participation:

I understand there is no cost to be in this study.

Research Related Injury:

In the event of physical and/or mental injury resulting from my participation in this research project, Virginia Commonwealth University will not provide compensation. If injury occurs, medical treatment will be available at the MCV Hospitals. Fees for such treatment will be billed to me or appropriate third party insurance.

Confidentiality of Records:

I understand that information from this study is confidential. Confidentiality will be protected by the use of code numbers on the tapes and transcriptions. Only the researcher or research consultant will have access to the information. I understand that the researcher will write a report when the study is completed. The report will not identify any nurse administrators.

Participant's Initials: _____

Withdrawal:

I understand that I can participate or withdraw from the study at any time. The investigator will answer any questions that I have.

Current Telephone Numbers for Questions about Research and Participant's Rights:

H. Michael Wenger - (daytime/emergency)

Dr. Lorna Mill Barrell Dissertation Committee Chairperson -

VCU/MCV School of Nursing Box 567

Richmond, VA 23298-0001

VCU/MCV Committee on the Conduct of Human Research -

Consent:

I understand that my signature below shows that I have read this form fully, I have received a copy of the form, and I agree to participate in this study.

Signature of subject: _____ Date _____

Witness Signature: _____ Date _____

Participant's Initials: _____

# Vita

H. Michael Wenger was born on March 3, 1954, in Sellersville, Pennsylvania, and is an American citizen. He graduated from Christopher Dock Mennonite High School, Lansdale, Pennsylvania, in 1972. He received his Bachelor of Science in Nursing from Goshen College, Goshen, Indiana, in 1977 and subsequently was a staff nurse at Elkhart General Hospital, Elkhart, Indiana, for a year. Then he was a staff nurse at Rutland Regional Medical Center, Rutland, Vermont, for two years. He received a Master of Science in Nursing from Indiana University, Indianapolis, Indiana, in 1981. He has been on the faculty of Eastern Mennonite College in Harrisonburg, Virginia since then.