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THE WORK-LIFE VIEWS OF THE NURSE MANAGER DURING TRANSITION FROM PRIMARY CARE TO PATIENT-FOCUSED CARE

by

Patricia Welch Dittman

A Thesis Submitted to the Faculty of the
College of Nursing
in Partial Fulfillment of the Requirements for the Degree of
Master of Science in Nursing

Florida Atlantic University

Boca Raton, Florida

December 1995

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Patricia Welch Dittman

This thesis was prepared under the direction of the candidate's thesis advisor, Dr. Marilyn Ray, College of Nursing, and has been approved by members of her supervisory committee. It was submitted to the faculty of the College of Nursing and was accepted in partial fulfillment of the requirements for the degree of Master of Science in Nursing.

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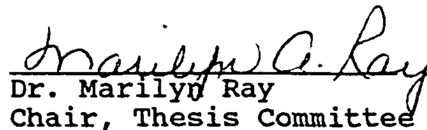
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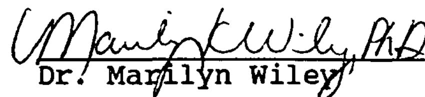
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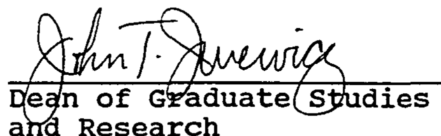
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I also wish to thank the educators and management staff at Holy Cross Hospital for cheering me on to the finish line.

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ABSTRACT

Author: Patricia Welch Dittman

Title: The Work-Life Views of the Nurse Manager During Transition from Primary Care to Patient-Focused Care

Institution: Florida Atlantic University

Thesis Advisor: Dr. Marilyn Ray

Degree: Master of Science in Nursing

Year: 1995

The purpose of this descriptive study was to investigate the work life of the nurse manager during the transition from primary care to patient-focused care. The sample population includes nurse managers who were in administrative roles at the time of transition from primary care to patient-focused care delivery model. Exploratory descriptive data were collected by an open-interview, semi-structured format utilizing focused questions with three nurse managers who participated in the study. The study adds significantly to the current debate on caring, nursing, nursing administration, patient-focused care, and nursing care delivery systems.

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Dedication

This thesis is dedicated to David, my husband, friend, and soulmate. Thank you for your loving support. You have always been there for me. This is also dedicated to my son, D.J., for always understanding and loving me.

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CHAPTER I

INTRODUCTION

As nurse administrators, we stand at the horizon of health care reform, struggling with the delicate balance of quality of care and economic restraints. This balance includes the management of human and material resources with the common denominator of maintaining quality patient care. Nurse administrators face the challenge of creating or facilitating caring environments in which the practice of nursing can occur.

Leininger (1986) stated that the most unifying, dominant, and central intellectual and practice focus in nursing is caring. To promote caring, nurse administrators need to be grounded in a human science philosophy which forms the foundation for the health care system to embody caring values. Gadow (1985) articulated a human caring framework advocating for the inversion of the relationship between cure and care, thereby allowing caring to be adopted as the highest commitment to patients. This advocacy for patients is not new to nursing, but through the years, we, as a profession, have struggled to give voice to our concerns about patient welfare.

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Nursing is not a series of tasks that is measured by the efficiency of its product. Brown (1991) proposed that nursing's central and guiding value undergirding its very being is caring, and the aesthetic in nursing has to do with giving form to caring values through its art. When using an aesthetic lens, nursing becomes an expression of caring in which to view its very essence. While the health care consumer is more familiar with the need for quality care and consumer satisfaction issues, competition and reasonable health care costs have dominated the news.

The outcries from the public over the years have stimulated politicians to claim that quality health care is a right for all Americans. In a 1993 State of the Union Address, President Clinton remarked that every American should have the security of comprehensive health benefits that can never be taken away (The President's Health Security Plan, 1993). Even though the health plan proposed by the President was not adopted by the Congress of the United States, we know that some form of health care reform will be passed in the near future. Financial changes related to reimbursement and capitation is prompting nurse administrators to look at new forms of health care delivery systems. Patient-focused care is one of these alternative health care delivery systems. The underlying premise calls for a redesign of the traditionally known organization of health care.

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Historically, health care institutions have experimented with many forms of nursing care delivery systems. Some of these traditional models of nursing care have included functional, team, and primary nursing. Functional nursing was a model that delineated specific roles for all caregivers. There were functions that were assigned to each caregiver, that is, medication nurse, treatment nurse, admission nurse. Unlicensed personnel were responsible for the activities of daily living. This model facilitated the nursing staff to work independently and caused fractioning of care delivered and received by patients.

Team nursing became popular in the 1960s and 1970s. This model was based on the idea that a team consisted of a team leader, a registered nurse, and team members that could be a combination of licensed and unlicensed personnel. The role of the team leader was to coordinate the care of each of the patients on the team. Team members were responsible to report all treatments, procedures, and activities to their team leader who was then responsible to provide an overall report to the next nursing shift. The team leader acted as a liaison to physicians concerning progress reports, and was subsequently responsible for obtaining necessary orders for treatment.

Primary nursing is the latest example of a recent model. In this model, each nurse is responsible for the care

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of a small group of patients. The primary nurse makes decisions in conjunction with physicians about how that care will be administered and leaves instructions to be followed by those who care for the patient in the primary nurse's absence. Manthey (1990) described primary nursing as decentralized decision-making, which is defined at the level of action. The level of action in caring for patients in hospitals is the bedside. Decentralization means decision-making responsibility, and authority is allocated to staff nurses at the bedside. A primary nurse is defined by Manthey (1990) as a professional who engages in autonomous decision-making based on an identifiable body of knowledge acquired in a formal education program.

The foundation of the current patient-focused care is the performance of tasks by multi-skilled caregivers who have expanded roles. This shift in consciousness projects a reduction in human and material resources, while providing a patient-centered quality environment. The reduction in human resources is based on cross-training of direct patient caregivers and ancillary personnel, flattened managerial structure, empowerment of staff, organized patient care work teams, and similarly grouped patient populations. In a discussion of work redesign, Strasen (1988) stated that no one model fits all organizational needs. What is essential is that a leader must believe in this new method of care delivery before it can become a reality to the staff.

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Although the nurse manager is in a position to link the caring interactions between patients and staff, they must always be aware of the fiscal requirements in managing a financially sound health care system.

Significance of the Study

As we experiment with alternative health care delivery systems, it will be imperative to understand how nurse managers view their responsibilities with regard to the total operation of their units. The role of nurse managers, as key personnel in any health care environment, is to maintain the pulse of their unit's culture by allowing caring and creativity to blossom and flourish among the nursing staff, while at the same time managing the material resources. Constant evolution of patient and staff welfare is of the utmost importance to determining the need for change to meet the needs of the patient population. Nurse managers must be flexible in their day-to-day work life. By virtue of their position in the organization, nurse managers can influence staff and administrators to practice caring in their approach to patients regardless of the type of care delivery system. Because fiscal accountability has been determined by most health care institutions as a priority for nurse administrators, it is important for the nurse manager to direct his/her budgetary decisions to their effect on the patient being cared for. Paterson and Zderad (1988) stated that for nursing practice to be humanistic,

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awareness of self and others is essential. Nurse managers working with patient-focused care must become knowledgeable about this new approach to health care delivery and the managerial practices affected by this model.

Review of the literature reveals very little research related to the role of the nurse manager using a patient-focused care model. Clouten and Weber (1994) described a patient-focused care model as one that is based on professional responsibility, practice, accountability, empowerment, customer-focused quality care, leadership, and cross-differing professional roles. The nurse manager in this environment needs to feel comfortable with issues like blurring of professional roles, overseeing ancillary practice parameters, acceptability of staff to be empowered, quality cross-training processes, and a constant focus on who the customers are.

The use of the multi-disciplinary team concept in patient-focused care has opened up the possibility of leadership roles for nursing outside the nursing profession. Nurse managers need to be able to articulate the difference between administration and nursing administration, and to quantify and qualify what nurses and non-nurses do when interacting in the clinical setting with patients. Little is written about the role of the nurse manager in this new environment, and even less is known about their caring interaction with patients, families, and staff. Therefore,

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the feedback of the nurse manager's views concerning their work life during the transition from a primary care to a patient-focused care delivery system will be important to the nursing profession in preparation for future changes related to health care reform.

Theoretical Framework

The Theory of Bureaucratic Caring (Ray, 1989) guides this study. The theory was formulated by investigation of the meaning of caring in the institutional culture of a hospital. The research showed that a dialectic existed between the thesis of caring and the antithesis of the bureaucracy resulting in a theory that incorporated, into a synthesis, caring and the bureaucratic dimensions. The theory establishes the need for a health care system that proposes a synthesis of caring (social, spiritual, ethical) and bureaucratic processes (economic, technological, legal, and political) to administrate and manage future health care organizations. The researcher's interest in exploring the role of the nurse manager during the transition period from a primary care to a patient-focused care delivery model was stimulated by her belief in caring in nursing administration. The researcher, therefore, was interested in how nurse managers gauge the quality product "caring," which is fundamental to the practice of nursing.

Purpose/Goals of the Study

The purpose of this descriptive study was to

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investigate the work life of the nurse manager during the transition from primary care to patient-focused care. The main objective of the study was to explore the descriptions of the meaning of the nurse manager's experience during this transition period. Descriptive research provided an open inquiry method for studying nursing phenomena. This type of research allowed the researcher to describe experiences of the nurse managers, thereby gaining greater understanding of the research participant's daily life. The primary goal of this research was to explore the work life of nurse managers by a description of the nurse manager's views. Definition of Terms (see Appendix A) provides common terms that nurse managers use in describing their daily life.

Research Question

The ensuing change in the health care environment challenges us to know more about the nurse manager and his/her role in a patient-focused care model. The study was guided by the following question: How do nurse managers view their day-to-day work life in the hospital during the transition from a primary care to a patient-focused care delivery system?

Summary

This chapter presented the introduction, significance, purpose, goal, and theoretical framework that guided this descriptive research study. The research question was also presented to provide the foundation for this qualitative

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study.

Chapter II will review the literature pertaining to caring, nursing, administration, patient-focused care, and nursing care delivery systems.

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CHAPTER II

REVIEW OF THE LITERATURE

Literature is limited on the role of the nurse manager in a patient-focused care model. There are many articles that describe patient-focused care as an alternative health care delivery model. Presented here is an overview of the philosophical and conceptual perspectives, as well as research articles, of caring in nursing, caring in nursing administration, patient-focused care, and nursing care delivery systems.

Caring in Nursing

The phenomenon of caring has gained great attention in nursing literature and research in the past decade. Nurse scholars have begun to philosophically analyze caring and have defined the nature of caring in nursing. Leininger (1986, 1990, 1991), Watson (1979, 1981, 1990), and Boykin & Schoenhofer (1993) have contributed significantly to the caring movement. Other nurse scholars such as Gaut (1981, 1983, 1986), Roach (1984), Ray (1981, 1984, 1987, 1989, 1994), and Griffin (1980, 1983) helped to clarify the concept of caring in nursing.

Leininger (1981, 1984, 1986), a nurse anthropologist and pioneer in the study of caring, viewed care as essential

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to human health and survival. She also stated that caring is the essence and central focus of nursing, and that caring behaviors and practices uniquely distinguish nursing from the contributions of other professions (1981, p. 4).

Ray (1984) studied caring in an institutional culture to examine the values of administrative and staff personnel to determine institutional values and identification of caring patterns. Ray utilized participant observation, including interviews for data collection from 192 participants, in her study. This research led to the development of a classification system of institutional caring. The categories of meanings identified for care are psychological, practical, interactional, and philosophical. A tension is identified between the ideal elements of humanism and the structure of bureaucracy. The research suggested that the caring elements of health care environments are influenced by the dominant culture which includes technical, political, economic, and legal dimensions. Ray showed that caring within an institutional framework depends on social-structural elements such as political, legal, technical, social, economic, ethical, spiritual, and humanistic elements. Thus, the bureaucratic caring that exists within the organization challenges nursing values rooted in human caring.

Ray (1987), using interviewing and observation techniques in her qualitative, phemonenological research

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study, generated meanings of caring experienced by nurses working in critical care. Based on one central question, "What is the meaning of caring to you in the critical care unit?" Ray developed underlying themes of caring. The expressions of caring in the critical care unit fell under five themes: maturation, technical competence, transpersonal caring, communication, and judgement/ethics. Ray stated that there is a dialectical process between a technical-ethical modality of care and an integrated techno-ethico-human caring modality.

In 1989, Ray published the Theory of Bureaucratic Caring, which proposed a synthesis of caring and bureaucratic processes. This ethnographic and grounded theory research was conducted in an urban, acute care hospital with 200 participants. The end product of this valuable research is the formal Theory of Bureaucratic Caring, which illuminated a synthesis between the thesis of caring as humanistic, social, educational, ethical, and religious/spiritual, and the antithesis of caring as economic, political, legal, and technological (bureaucratic). The implication for nursing practice is that caring views can co-exist with managerial views for the benefit of humankind in the health care system.

Valentine (1989) developed a conceptual model of caring from measures of caring obtained from nurses, patients, corporate health managers, and nursing theorists. The data

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collection methods for the study included interviews with corporate managers which asked about their views on caring, and a brainstorming exercise in which the other participants shared ideas about caring. The participants then sorted and rated these ideas, however, the limitations of this research are that the researcher did not describe how the ideas were rated. The sorted and rated data were then subjected to cluster analysis that produced conceptual maps to illustrate the similarities and differences of each idea. The rated data from the analyses were then organized by Valentine using the categorization schema developed by Ray (1984). The data revealed that nurses and patients recognize expressions of caring differently.

Appleton's (1990) phenomenological research study focused on caring within an organizational culture of academia. The study described and analyzed the meaning and experiences of caring during doctoral nursing education. Fundamental expressions of caring and a caring process were developed through this research, as well as challenges for the future for creating caring relationships and situations in academic environments.

Caring in Nursing Administration

Diamond (1985) utilized a phenomenological approach to explore the caring values, beliefs, and perceptions of nurse administrators. The researcher used semi-structured interviews to discover the meaning of care to the nurse

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administrator, and to provide a description and analysis of her caring practice. Reflection on the data led to thematic development to guide the data analysis. The findings demonstrated that caring has a wide variety of meanings and practices, and these are expressed according to personal and professional philosophies.

Cody (1988) used an exploratory approach to investigate the beliefs and experiences of the phenomenon of caring as it exists among nurse administrators. The sample consisted of 19 nurse administrators that responded to three open-ended questions relating to caring. The responses were analyzed using content analysis. Gaut's theoretical description of caring provided the framework for the study. The results support Gaut's conditions of caring: awareness, knowledge, intention, and positive change.

Nyberg (1989) identified five attributes for the nurse administrator to understand and develop in order to exhibit caring behaviors. According to Nyberg, these attributes include commitment, self-worth, ability to prioritize, openness, and the ability to bring out potential. The responsibility of the nurse administrator in relation to caring is threefold: (a) to understand caring as a philosophy and an ethic to be established by particular organizational processes and structures; (b) to develop skills related to caring behaviors that are utilized in formal relationships with individuals and groups; and (c) to

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be alert and responsive to opportunities to participate in situations involving nurse managers, nurses, administrative colleagues, and patients or families who have specific needs that allow the nurse administrator to behave as a caring person (Nyberg, 1989, p. 15).

Miller (1987) stressed the belief that it is crucial for nurse administrators to support the caring values of the nurses they manage. The value of caring as a foundation to nursing administrative practices must be recognized, maintained, studied, and enhanced. Miller stated that the human care component of nursing is too central to our practice to be lost, at a time when we are beginning to understand its importance to our professional identity.

Durham (1989) emphasized that humanism and caring must pervade the entire practice of nursing administration. This successful communication process, in which the two people involved share common organizational information, allows for trust, self-disclosure, and feedback to unfold. Nurse administrators must maintain a partnership with employees. Durham also redefined power from the view of the humanistic nurse administrator. She stated that power is achieved by empowering others; power is not finite or hoarded, but given away. She further stated that nurse administrators will grow in a personal and professional sense when they provide an environment that allows empowerment to grow.

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Patient-Focused Care

Baxter, McLaughlin, & Thomas' (1994) descriptive research surveyed 295 acute care hospitals with a questionnaire to investigate the restructuring of nursing care by the addition of unlicensed assistive personnel. The results of this study suggest that the majority of hospitals using unlicensed assistive personnel did not standardize hiring requirements, orientation, measurement of cost effectiveness, or registered nurse supervision. These results raised a concern or fear in the professional nurse whose commitment to his/her patient is paramount. The professional nurses surveyed in the study felt that the lack of standardization in the entry level phase of employment for the unlicensed assistive personnel is costly in the quality of nursing care provided.

Sather's (1992) qualitative research study reviewed the social and psychological processes of nurses in a new patient-focused care delivery system. These basic social and psychological processes became the organizing framework for the explanatory substantive theory of empowered self-management. The focus of this study was to explore the paths and processes of empowerment which led to the discovery of self-management. Data were collected over a five-month period using a constant comparative approach that involved interviews, participant observation, and pertinent documentation. Areas of concern were the nurses' lack of

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knowledge/experience in the areas of advanced clinical decision-making, work allocation, communication, and management. These phenomena developed as the study evolved, and the sampling became focused on the nurses who demonstrated the drive toward empowerment and self-management. The limitations of this grounded theory study were that the phenomena related to the nurses' lack of knowledge appear to be set aside for the nurses who exhibited empowerment and self-management.

Townsend (1993) spoke about the principles and assumptions associated with patient-focused care. Many hospitals are implementing this popular model to place the patient at the center of care, thereby increasing patient and staff satisfaction, as well as facilitating the decrease in costs. The identified components of patient-focused care include the principles and assumptions of aggregating patients by similarities of diagnoses, and acuity in redeploying services, cross-training multi-skilled workers, simplifying systems and documentation, and redesigning facilities. This model of nursing care differs from others in the past due to its use of the multi-skilled caregiver component. The multi-skilled caregiver, unaware of professional practice guidelines, has the potential to misinterpret the responsibilities of each health care discipline. Clinical pathways, standardized patient care planning, total quality management, shared governance, and

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role clarification are components of patient-focused care. The author further reported that the most important stage in the planning of redesign inherent in patient-focused care is to include the key stakeholders of all the affected disciplines by involving them in all phases of the proposed change.

In her article "The Move to Patient-Focused Care," Brider (1992) described the object of patient-focused care as a decentralization of ancillary services and the cross-training of staff to supply up to 90% of the services on the nursing unit. In her analysis, she stated that critics of the patient-focused care concepts fear that cross-training cannot prepare nurses and others to perform as specialists in other disciplines, and that nurses' roles may be blurred.

Porter-O'Grady (1994) in an editorial, described how hospitals are changing care delivery, with the driving force being economics. His findings revealed six areas of concern: (a) majority of caregivers' time was not spent on delivery of care; (b) structural barriers (bureaucratic); (c) departmentalization; (d) non-integration of care; (e) services performed by high-level skilled caregiver; and (f) discharge planning (Porter-O'Grady, 1994, p. 32). Sound progress in system changes is measured in years, not months. The changes required by any form of health care reform will take many years due to the extensive altering of a complex health care system. Porter-O'Grady (1994) stated that

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nursing has always stood beside those in need of care. From that vantage point, he stated that nurses understand the importance of building collegial relationships with other disciplines. When you build on nursing's history of advocacy and caring, the value of nursing will always be validated and exemplified.

Nursing Care Delivery Systems

Munroe (1988) studied the influence of registered nurse staffing on the quality and cost of nursing home care. This quantitative research investigation, using regression analysis and descriptive statistics, included 455 California skilled nursing home facilities. The results suggested that increasing the ratio of RN staffing in nursing homes may positively influence facility quality without significantly affecting operating costs by downsizing registered nurse turnover. There was also a positive relationship exhibited between nursing home quality and the ratio of RN hours to licensed vocational nurse (LVN) hours per resident day.

Huston's (1993) commentary on health reform described the potential impact on hospital nursing service. The author suggested that universal access, cost containment, and criteria for health reform pose many implications for nursing. One of the implications is an increase in the need for qualified registered nurse personnel with leadership characteristics and management abilities. She indicated that there will also be a need to identify alternatives to "high-

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tech" nursing care so that patients' needs may be met safely at the lowest cost possible.

Murphy, Pearlman, Rea, & Papazian-Boyce (1994) addressed issues of work redesign of a community hospital in New Jersey. The hospital focused on a return to basics, a redefinition of barriers, system changes, and role responsibilities. The authors reviewed their outcomes both objectively and subjectively in several areas: staff and patient satisfaction, recruitment and retention, physician ancillary and community feedback using pre and post evaluations. Successful outcomes included improvement in recruitment and retention, as well as increased patient, staff, and community satisfaction.

In an article on models of nursing care in a changing environment, Christensen & Bender (1994) stated that these nursing care models articulate the restructuring of care to assure quality of care, patient satisfaction, and cost containment. Some of the models included paired practice, case management, patient-focused care, cross-training, and product line management. To meet the challenges of future health care delivery, nurses must be aware of predicted trends: decreasing specialization of health care personnel, flexibility of the traditional nursing role, increased community-based care, and expanded roles for nursing.

Summary

In summary, this chapter presented a review of the

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literature that addressed caring in nursing, caring in nursing administration, patient-focused care, and nursing care delivery systems. The results of these studies identified caring as perceived by many participants including patients, family members, student nurses, and nurse administrators as important. One area lacking scientific research was the nurse manager's work life views during the transition from primary care to patient-focused care.

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CHAPTER III

PROCESS OF INQUIRY

The researcher chose a qualitative research approach for this study to gain knowledge to increase understanding of the views of the nurse manager when changing from primary nursing to a patient-focused care delivery system. In-depth exploration of the phenomenon of the nurse manager's work life views during the transition from primary care to patient-focused care is best represented by using a descriptive study design. A descriptive study method is appropriate when there is a need to describe phenomena, and there is little information about the phenomena. Burns and Grove (1987) stated that descriptive studies are a means to gain information about characteristics within a particular field of study. Waltz and Bausell (1981) claimed that a descriptive design may be used for multiple purposes, including identifying problems with current practice, developing theory, justifying current practice, making judgements, or determining what others in similar situations are doing.

Descriptive designs provide descriptions of the variables in order to assist in the answering of the questions proposed by the researcher. The level of detail

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concerning the description of the variables depends on the knowledge of the researcher prior to the data collection period. Burns and Grove (1987) articulated descriptive designs as varying in levels of complexity. The relationships between the variables are identified to obtain an overall picture of the phenomenon. The results of the descriptive study will provide detailed information on the variables not for prediction as such, but over time to assist with the comparable nature of the variables. Brink and Wood (1994) stated that descriptive designs meet the criteria of a Level I study based on little prior knowledge of the variables or the population under the study.

This descriptive research examined the work life views of the nurse managers during the transition from primary care to patient-focused care delivery models using the Theory of Bureaucratic Caring to guide the study (Ray, 1989).

Table 1 outlines the descriptive research process (Ray, 1995) that was used in this study:

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Table 1

The Descriptive Research Process

Identification of the problem	Data Collection Procedures	Data Analysis	Discussion of Results	Recommendations
Introduction to problem/ phenomenon of interest	Sample	Coding of data	Results of data analysis/ central thesis	Nursing administration
			Development of conceptual model	
	Site	Identification of concepts	Relationship of data analysis to literature	Nursing practice
	Research techniques (interviewing)	Categorization of conceptual units of meaning		Nursing education
				Nursing research
	Validity and reliability			
	Ethics of research			

Identification of the Problem

In the past two years, enormous changes have been occurring in the health care system. Issues to link quality and cost with a greater emphasis on cost containment have dominated the health care dialogue. Caring has been the indicator of quality from this rsearcher's perspective. The amount of current nursing research concerning the role of nurse managers and their caring interactions with patients, families, and staff is, however, extremely limited. To assist nurses and the nursing profession in preparation for the future changes related to the health care system, it became apparent that nurse managers' work life views in different nursing care delivery systems need to be described. This descriptive research study, therefore, focused on the work life views of the nurse manager during the transition from primary care to patient-focused care implementation in a general hospital.

Data Collection Procedures

Sample

The sample population included nurse managers who were in administrative roles at the time of transition from primary care to a patient-focused care delivery model. Participants were registered nurses employed as nurse managers who were not known to the researcher prior to the research study. The participant's names were provided by a nurse administrator employed at the research hospital site.

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The researcher assumed that participants have work life views concerning the changes in nursing care delivery systems, and would be willing to share their viewpoint(s) with a researcher in their field. Nurse managers were contacted by the investigator and asked whether or not they would like to participate in a research study. An initial oral agreement was received with formal consent obtained prior to the data collection (interviews). The sample size included three participants, which is adequate for a descriptive study of this nature.

Participants were contacted by telephone prior to the data collection to determine interest, to schedule interview times, and to obtain a verbal consent. Written informed consent was obtained prior to the interview.

Site

The setting for this study was a 200-bed,corporate, for-profit hospital located in the Southeastern United States. The data collection (interviews) were performed in the offices of the nurse managers involved in the study (see Appendix B).

Research Techniques

Interviewing

The interview setting needs to be comfortable and confidential, allowing participants to feel relaxed and to speak freely. The interviews were scheduled at a mutually convenient time for approximately one hour in length. Each

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participant was provided a copy of their consent form as a reference. The interviews were audiotaped for future transcription and analysis and were maintained in a locked storage box. These tapes were later destroyed at the completion of the research study. Confidentiality and anonymity were maintained at all times during this research study, and participants did not receive any monetary compensation for their involvement. Data from interviews of nurse administrators formed the basis of discovery, and the descriptions facilitated the development of a conceptual framework which provided for a discussion and recommendations for change.

Exploratory descriptive data were collected by an open-interview and semi-structured format utilizing focused questions (see Appendix C) (Polit & Hungler, 1991). The researcher's goal was to elicit truthful answers that provided for a rich description of the work life views of the nurse managers during the transition from primary care to patient-focused care.

The research questions were designed to facilitate a description from the nurse manager on views related to primary care, patient-focused care, and nursing care delivery models. The interview process prompted an opportunity for discovery and description of patterns of work life with recommendations to assist nurse managers with choices and preparation for a smooth transition in health

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care delivery systems.

Voluntary informed consent (see Appendix D), where the participants fully understood the aim of the project and understood that he/she could discontinue the interview at any time, was used (Munhall, 1982). Each participant was given a copy of the Informed Consent for his/her records. Demographic data such as age, sex, education, and years of experience was collected to further identify the sample.

Validity and Reliability

The issues of validity and reliability in qualitative research are important to the worth of the study. Sandelowski (1986), based upon ideas from Guba and Lincoln (1982), made it clear that qualitative methods are frequently viewed as failing to achieve scientific merit when judged according to assumptions guiding positivist science. However, qualitative researchers must continue to provide evidence of credibility in their work. In this study, reliability of the coding process (content analysis) was established through interrater analysis, whereby another researcher reviewed a sample of the transcripts that were coded. Comparison of the data between the two researchers established qualitative reliability. Validity was established by accepting the work life views of the participants as valid. The study results will be shared with the participants and peers in the nursing profession to assist in validating the subject studied, as well as adding

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to the nurse's knowledge on the subject of new delivery systems in nursing administration and caring.

Sandelowski (1986) proposed strategies to achieve rigor in qualitative research by the following processes of auditability, truth value and applicability, consistency, neutrality, and confirmability. Auditability was achieved when the researcher provided a description, explanation, or justification of how the researcher became interested in the subject matter, how the researcher viewed the thing studied, the specific purposes of the study, how subjects came to be included in the study, the impact the subjects had on the researcher and each other, data collection, setting, data analysis, how various elements of the data were weighed, inclusiveness and exclusiveness of the categories, and techniques to determine truth value and applicability of the data. Truth value and applicability of a qualitative study were determined by several specific strategies. These strategies included checking the representativeness of the data and of coding categories and examples used to present the data, triangulating or comparing across data sources; descriptions, explanations, or conceptualizations about the data, and the typical and atypical elements of the data; deliberately trying to discount a conclusion drawn about the data; and obtaining validation from the subjects themselves. Consistency in qualitative research which emphasizes the uniqueness of human situations is difficult to measure,

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however, Guba and Lincoln (1982) proposed that a study is auditable when another researcher can clearly follow the decision trail used by the investigator in the study. Neutrality refers to the freedom from bias in the process and product of research. Guba and Lincoln (1982) suggested that confirmability is the criterion of neutrality in qualitative research. Confirmability was achieved when auditability, truth value, and applicability were established.

Ethics of the Research

The ethics of informed consent to participate in a nursing research study must comply with the type of research study proposed. The Informed Consent Form (see Appendix D) outlines the purpose, voluntary participation, procedure, confidentiality, benefits and risks, and contacts to clarify any questions or ethical concerns. It was submitted to the Florida Atlantic University Institutional Review Board for approval (see Appendix E). The researcher proceeded with the data collection after approval was granted. Prior to the interview process, informed consents were obtained verbally and in writing from research participants (see Appendix D).

Each voluntary participant was over eighteen years of age and received a copy of his/her Informed Consent Form for future reference. The researcher reviewed the procedures concerning the audiotape-recorded interview process, as well as confidentiality and anonymity with the research

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participants prior to data collection.

The risks associated with this study were minimal, and the participants were instructed to share any feelings of fatigue or psychological discomfort with the researcher. Participation in this study was thought to benefit the participants in the future of the profession of nursing because they were able to develop insight into what was occurring in their hospital environment.

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CHAPTER IV

DATA ANALYSIS

This chapter outlines the descriptive method of research to answer the question, "What are the work-life views of the nurse manager during transition from primary care to patient-focused care?" The descriptive research process (Ray, 1995) was used to outline data collection and data analysis procedures including coding and categorizing data. This process subsequently facilitated the identification of concepts, categorization of conceptual units of meaning, and the development of the conceptual model relating to the subject of analysis.

Coding of the Data

A descriptive method of data analysis illuminated the process of coding qualitative data. Categories were highlighted from the transcripts of the nurse managers who were interviewed. Because a theory was used to guide the research, this researcher coded the data first as the data were described by participants and second, in relation to the categories identified in the Theory of Bureaucratic Caring (Ray, 1989). The caring categories from this theory include humanistic, social, educational, ethical, religious/spiritual, economic, political, legal and

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technical. Through this coding process, concepts and categorization of conceptual units of meaning were identified (see Appendix F).

Identification of Concepts

The researcher read and re-read the transcriptions of the interviews numerous times before highlighting words or phrases which appeared as the essence of the nurse managers' views to the proposed questions. The researcher tape-recorded all interviews to capture this essence of work-life views of the nurse managers during transition from primary care to patient-focused care. To capture the full meaning of the interview process, the transcripts reflect the letter "P" which represents a participant's response, and "R" refers to a question asked by the researcher. Upon completion of this component of the descriptive process, the researcher began the categorization of conceptual units of meaning (see Appendix F).

Categorization of Conceptual Units of Meaning

The conceptual units of meaning that began to emerge in this descriptive research study were compared to the caring categories outlined in the Theory of Bureaucratic Caring: economic, technical, ethical, educational, legal, social, and political.

(E) Economics; (T) Technical; (Eth) Ethical; (S) Social; (L) Legal; (Ed) Educational; (P) Political.

Question #1: Describe the Difference Between Primary Care and Patient-Focused Care Delivery Models.

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Conceptual Units of Meaning:

1. Task-oriented (T)
2. Cost-effective (E)
3. Decentralized (E)
4. Productivity (E)
5. RN/patient ratios (E)
6. Care of the patient (T)
7. Patient/family focus (Ed)
8. Technical role RN (T)
9. Manager's role (T)
10. Team building (S)
11. Re-design (E)
12. Collaborative practice (T)

Question #2: Describe the Care Partner Component of Patient-Focused Care.

Conceptual Units of Meaning:

1. Role clarification (T)
2. Task-oriented (T)
3. Hands on (T)
4. Delegation (T)
5. Trust (Eth)
6. Communication (S)
7. Team building (S)
8. Territorial (S)

Question #3: What are the Nurse Manager's Concerns and Considerations With Regard to Transition from Primary Care to Patient-Focused Care?

Conceptual Units of Meaning:

1. Preparation for change (P)
2. Education (Ed)
3. Staff involvement (S)
4. Time line (P)
5. Communication (S)
6. Frustration (S)
7. Competency (L)
8. RN/Patient ratios (E)

Question #4: What Preparation Measures Were Instituted to Prepare the Nursing Staff for Change in the Care Delivery System?

Conceptual Units of Meaning:

1. Lack of preparation (P)
2. Team building (S)

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3. RN/patient ratios (E)
4. Role responsibilities (T)
5. Employee involvement (S)
6. Corporate decision-making (P)
7. Buy-in time (E)
8. Communication (S)

Question #5: What Training Was Needed to Prepare the Nursing Staff for Patient-Focused Care?

Conceptual Units of Meaning:

1. Competency (L)
2. Role clarification (T)
3. Team building (S)
4. Ancillary department skills (T)
5. Task oriented (T)
6. Resource person (T)
7. Limited education (P)
8. Performance issues (L)

Question #6: What Were the Effects of Decentralization of Support Services on the Management of Patient Care Unit?

Conceptual Units of Meaning:

1. Needs assessment (Ed)
2. Resource person (T)
3. Practice parameters (T)
4. Standards of care (Eth)
5. Administrative support (T)
6. Business-oriented (E)
7. Fiscal awareness (E)
8. Trust issues (Eth)
9. Poor employee involvement (S)
10. Competency (L)
11. Problem solving (Eth)
12. Broaden scope of practice (T)

Question #7: Describe the Effects of Coordination of Care With the Multi-Skilled Patient Care Partner.

Conceptual Units of Meaning:

1. Positive (S)
2. More personnel (E)
3. Task-oriented/care partner (T)
4. Technical - RN role (T)
5. Territorial (T)
6. Delegation (T)
7. Standards of care (E)
8. Competency (L)

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9. Team building (S)
10. Trust (Eth)
11. Productivity (E)

Question #8: Describe the Case Manager's Responsibilities in Patient-Focused Care Delivery.

Conceptual Units of Meaning:

1. Length of stay (E)
2. Utilization review (E)
3. Appropriateness of care (Eth)
4. Discharge planning (E)
5. Financial (E)
6. Critical pathways/guidelines (E)
7. Task-oriented (T)
8. Managed care (E)

Question #9: What are Your Views Regarding the Care Received by Patients in a Patient-Focused Care Delivery System?

Conceptual Units of Meaning:

1. Quality care (Eth)
2. Acuity increasing (Eth)
3. RN/patient ratios (Eth)
4. Staffing mix (E)
5. Unsafe (Eth)
6. Patient education (Ed)
7. Patient satisfaction (P)
8. Team approach (S)
9. Re-design (E)
10. Competency (L)
11. Competition (E)

Question #10: What Do You Believe is the Future for Patient-Focused Care in Relation to Health Care Reform?

Conceptual Units of Meaning:

1. Financially sound (E)
2. Concern acuity increasing (Eth)
3. Budget (E)
4. RN/patient ratios (E)
5. Competency (L)
6. Delegation of unskilled workers (T)
7. Quality of care (Eth)
8. Community expectations (P)
9. Cost effective (E)
10. Patient safety (Eth)
11. Quality vs. bottom line (E)

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Cumulative Data From Questions 1 Through 10:

1. Economic (27)
2. Technical (23)
3. Ethical (14)
4. Social (14)
5. Legal (7)
6. Educational (5)
7. Political (4)

Summary

This chapter outlined the process of coding the data and the identification of concepts. Based on the concepts identified, the researcher categorized each concept into a more defined conceptual unit of meaning. Each conceptual unit of meaning was then assigned a caring concept based on the definitions provided in the theoretical framework, the Theory of Bureaucratic Caring (Ray, 1989). The results of the data analysis will be discussed in the next chapter.

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CHAPTER V

DISCUSSION OF RESULTS

Results of Data Analysis/Central Themes

In this chapter, the researcher will discuss the results of the data analysis and the central thesis that developed. Based on the central thesis the Theory of Bureaucratic Caring (Ray, 1989), the researcher developed the following caring conceptual model of work life of nurse managers. The caring concepts were determined by the nurse manager participants as important to their work life views during transition from primary care to patient-focused care.

Economics

Economics was the number one reason or caring category that the nurse manager felt when making the transition from primary care to patient-focused care. Nurse administrators today want to practice within a humanistic framework where caring can be nurtured, but they find themselves constantly challenged by financial management, i.e., managed capitation and managed care contracts. The multiskilled workers and unlicensed personnel pit the administrator against economic corporate mandates. During this transition time, nursing faces a loss of self identity increased risk of alienation and confusion (Ray, 1989).

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Economics is defined as the factors related to the meaning of caring: money, budget, insurance systems, allocation of scarce (human and material) resources in maintaining the economic viability of the organization (Ray, 1989). The following are the participants' expressions reflective of the meaning of each conceptual unit of meaning.

Nurse Manager - Critical Care Units: On a daily basis, the case manager goes around and checks the patients for length of stay types of issues and difficult placements. She is very involved with Social Service, insurance companies, trying to manage the clinical course of the patient. They use clinical pathways more as a recommendation in terms of length of stay, outlier and expenses incurred related to the procedure.

Nurse Manager - Medical/Surgical: We meet with the case managers and social workers to discuss the patients we thought were discharge planning problems. We discuss not only the patients that were in the hospital eight days or $12,000.00, but also patients that are newly admitted for potential problems. This process assists with the safe return of the patient back into his environment.

Nurse Manager - Step Down Units: I had read before we changed to patient-focused care that patient-focused care brought the care to the patient, rather than the patient having to go some-where else in the hospital. Actually, with

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the exception of EKG and phlebotomy, which are now performed on the unit, the patients still have to go off the unit for just about any diagnostic test.

> So, from the standpoint of it is really wonderful to bring the caregivers to the patient, it is not always cost-effective or practical. A good example is radiology. This department would be difficult to decentralize based on the cost of putting an x-ray machine on each unit.

<u>Technical</u>

Technical issues were the second most common caring category that the nurse managers felt during their transition process from primary care to patient-focused care. Technological/physiological is used to describe factors related to the meaning of caring: use of machinery in relation to maintaining the physiological well-being of the patient, non-human resources, and the knowledge and skill needed to operate machinery to support the patient (Ray, 1989). An example of some of the technical issues these nurse managers felt are as follows:

The nurse manager's view from the step down area, relating to technical concerns are outlined from a passage from her transcript:

> There are more bodies on the unit, but there are less licensed nurses on the unit. The change in the acuity of the patients that I have seen in this facility over the last five years is tremendous. A good percentage--I would say at least 25% of our 66-bed unit--would not have been allowed out of the

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critical care area. Now we are taking care of those type of critical care patients in the step down unit with less of a nurse-patient ratio than we had prior to patient-focused care.

Nurse Manager - Critical Care Units: One of the things we did differently from the other area was the way we use care partners. The reason for that is our particular product line, being trauma, cardiac surgery, high acuity, patients that frequently needed intensive, invasive procedures and constant observation, were not the type of patients the care partner could be assigned to. We really felt that there were not a lot of tasks that the nurse could give to any kind of assistive personnel, other than errand running, baths, and EKG's.

Ethical

Ethical was the third most important caring category that the nurse administrative participant revealed during the transition phase in the care delivery system of their unit. Ethical is defined as the following factors related to the meaning of caring: "right" acting by religious, legal, or moral behavioral standards by respect and trust of and dedication to persons (Ray, 1989).

Nurse Manager - Medical/Surgical: We, as nurse managers, were very familiar with the practice of nursing, but were unfamiliar with other disciplines' standards of care or practice. We needed to work together as managers and jointly discuss any concerns related to the care of our patients.

Nurse Manager - Critical Care Units: There were a lot of territorial boundaries. Some of the reasons they made me feel uncomfortable were that they were afraid that this was the first step towards elimination of their position. That was truly never our intent. Once the employees saw that we were not out to change their agenda, or that there was no hidden agenda, things improved. But for awhile, there was a real trust issue concern.

Nurse Manager - Step Down Units: I think the only difficulty that we see at this point--something that is probably going to take the financial department years

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> to come to grips with--is the acuity of the patient versus FTE's, i.e., productivity. Unreasonable assignments are something we need to be aware of so that we never have an unsafe RN/patient ratio.

Social

Social was the fourth caring category discussed in the interviews. Social is used to describe the factors related to the meaning of caring: communication, social interaction, and support; understanding inter-relationships, involvement, and intimacy; knowing clients, families, and colleagues; humanistic potential for growth and development by acts of compassion and concern; love and empathy (Ray, 1989).

Some of the nurse managers' views concerning the importance of good communication and involvement of staff in the decision-making component of change:

> Nurse Manager - Step Down Units: If I were given the opportunity to convert a hospital, I would spend a lot of time on communication. This was not included in our preparation for patient-focused care. There was absolutely no buy-in on the part of the staff because someone from corporate said you will do this. The backlash from this was a whirlwind of issues that lasted a year.

> Nurse Manager - Critical Care Units: The staff's feedback was that they were not involved initially, and they did not feel they had a good understanding of the patient-focused care concept. It is hard for the staff to be supportive to change when they don't view themselves as part of the team.

> Nurse Manager - Medical/Surgical: Instituting patient-focused care has been exciting and difficult in the beginning. There was a lot of negativity, but we overcame it, and this has made us a closer group. I see the staff climbing up through the clouds, and they feel really good about themselves and patient-focused care.

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Legal

The fifth caring concept was legal as described by the nurse managers participating in this research study. Legal is defined as the factors related to the meaning of caring: accountability, responsibility, rules and principals to guide behavior, informed consent, client and professional rights, rights to privacy, problems of malpractice, and liability leading to the practice of defensive medicine and nursing (Ray, 1989).

The nurse manager participants discussed issues of competency as it relates to determining the level of acceptable practice.

> Nurse Manager - Critical Care Unit: The entire critical care division completed a competency program so that they were comfortable with floating to any unit and getting to know each other so they'd be comfortable with different staff members. We went as far as to make all the nursing stations look the same including supplies. The actual competency program included classroom and return demonstration. We had over 100 nurses, so it was a massive undertaking.

> Nurse Manager - Medical/Surgical: I think that the future of patient-focused care will be based on issues of competency. I can only relate this to the skill of phlebotomy, which is a skill that must be maintained. We currently have approximately 90 care partners in the nursing division, and it is very difficult to keep all of them proficient in a skill, i.e., phlebotomy sticks. If they don't continually use that specific skill, they will lose it.

> Everybody learned phlebotomy and EKG, but as it turned out and evolved over the last three years, the care partners pretty much do all the EKG's, and the nurses are responsible for the phlebotomy. This is probably a secondary issue to competency and feeling proficient in a skill.

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Educational

The sixth caring concept from this descriptive research project was educational. Educational is used to describe the factors related to the meaning of caring: information, teaching, and informal and formal educational programs, and use of audiovisual media to convey information (Ray, 1989).

The following excerpt is from the transcripts of the nurse managers involved in this research study. The nurse managers discuss their views on education and its role in preparing staff for change.

> Nurse Manager - Step Down Unit: The educational preparation for the change to patient-focused care was minimal. Someone from corporate came to the hospital and said, "You will be the first hospital to convert to this new form of patient care delivery." It was less than a month lead time from the time corporate made the decision to patient-focused care was on line. Some of our staff were still in training programs when it was decided that the hospital would be functional on patient-focused care.

> Nurse Manager - Medical/Surgical: I feel patient-focused care delivery model lends itself to patient and family education. The use of the care partner allows for the nurses to be free to get involved in rounds with the physician and available to patients and families for necessary education.

> Nurse Manager - Critical Care Unit: The nurse managers in patient-focused care were now responsible for the management of other disciplines. There was a need for education related to the practice parameters, problem solving, daily routines, job descriptions, and any specialized procedures. This was not provided. This made the transition period more difficult.

Political

Political was the last caring concept related by the nurse managers in their research transcripts. Political is

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described as the following factors related to the meaning of caring: role and gender stratification in the functioning of the hospital among physicians, administrators, and nurses; team nursing (of the division of labor); decision-making; patterns of communication; union activities; processes of negotiation; confrontation; external government and insurance company influences; uses of power, protege, and privilege; and in general, competition for scarce (human and material) resources to maintain and sustain the organization (Ray, 1989).

The nurse managers refer to political issues as they relate to their corporate, for-profit environment.

> Nurse Manager - Critical Care Unit: We were the last units to transition to patient-focused care. It was a corporate decision to have each nursing area go on-line with patient-focused care at a different time. So, my staff had an opportunity to hear a lot of horror stories from the other units. As a manager, this was a problem. I had to focus all my efforts on team building and stressing the need for constant refining to make this new patient care delivery system work.

> Nurse Manager - Medical/Surgical: The first floor was on-line with patient-focused care approximately four to six months before our unit began--a lot of informal communication between staff causing more anxiety about our change in the care delivery system. This caused frustration among staff. As a nurse manager, it was hard to try to alleviate this frustration because I was not sure how the big picture would work.

The conceptual model of work life views of nurse managers (see Appendix G, Figure 1) is presented as a synopsis of the results of this research study. The model represents a synthesis of decision-making input and caring outcomes that the nurse manager balances as part of her

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operational responsibilities. The value of this model is its graphic interpretation of how nurse managers make daily decisions using caring concepts, i.e., economics, technical, ethical, educational, social, legal, and political. These caring concepts are balanced to produce caring outcomes, i.e., quality of care, patient care ratio, acuity levels, customer satisfaction, competent staff, and fiscal responsibility. This model represents caring as the common thread, and that caring is preserved in the decision-making process of nurse managers. Nurse managers are fiscally conscious, but it is important that the holistic and humanistic component is always present. The conceptual model of the work life views of nurse managers supports Ray's (1989) views of a synthesis of bureaucracy and caring in practice.

Summary

This chapter outlined the results of data analysis and the development of a central thesis based on the Theory of Bureaucratic Caring (Ray, 1989). A conceptual model of the work life views of nurse managers represented how nurse managers synthesize their decision-making input and caring outcomes in terms of their operational responsibilities. The results of this research demonstrated that caring is the dominant value in nursing and is sustained throughout the process of "downsizing" in the current economic climate of health care delivery.

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CHAPTER VI

SUMMARY AND RECOMMENDATIONS

Discussion of Relevant Literature

This chapter discusses the results of the research study on work life views of nurse managers, and recommendations for change. The researcher returned to the literature to determine whether or not there was a relationship between the results of the data analysis and current research on nursing care delivery system changes. A retrospective literature review begins with the researcher becoming familiar with any relevant research studies published before or after the initial literature interview. This included updating the researcher's original computer search.

Several articles explored the essence of caring in the practice of nursing administration. Care as the essence of nursing management can be incorporated into any aspect of nursing management, including preparation for change, budget/fiscal issues, support to staff, economics, and development of an aesthetic nursing administration.

According to Boykin (1990), the budgetary process is critical to creating a caring environment. From a caring perspective, it must be the commitment that drives the

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budget that drives the commitment. In discussing the role of a caring administrator, Boykin (1990) stated, " . . . decisions must be made with a commitment to caring" (p. 252). Within all aspects of administration, decisions that respect the value of caring are made guided by conscience, values, and beliefs.

Ray, et al, (1995) spoke about new paradigm strategies to facilitate economic ethical caring. These strategies include reflection-in-action, mental models, covenantal relationships, and shared vision which can facilitate a new consciousness in this time of complexity and chaos in health care. Ray, et al, (1995) also stated that nurse administrators must examine the assumptions underlying caring and the bottom line, as well as the organization's relationship with employees and its influence on productivity.

Senge (1990) suggested that administrators should share their visions in the organization and encourage self-expression. A vision that is truly shared reflects the personal views held by the many individuals in the organization. A shared vision is a force of impressive power that creates a common identity and commitment to move toward creativity that demands that the vision become a reality.

Blancett and Flarey (1995) discussed the challenges to be faced by health care professionals in the re-organization of the health care system. Successful outcomes will be

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contingent on the level of commitment to achieve solid human relationships. The human product of health care organizations is delivered to human beings; thus, the success of that service depends on human relationships. The magnitude of re-engineering needed for nursing and health care to be ready for the future depends on staff support during times of transition. These transition times require the staff to adjust their usual work patterns and processes and also calls them to meet the challenge to create and support a new vision.

The phenomena of caring has been studied from the perspective of patient, staff nurse, and nurse manager. Traditionally, nursing's vision of caring related to care of patients and families. Recently, more research illustrated how caring is unfolded within the practice of nursing administration.

Implications for Nursing

What is critically important to nurse administration is the value of caring as evidenced in the conceptual model, Work Life Views of Nurse Managers, in terms of the fact that caring is not only related as an input, but also a caring outcome.

The current language in health care delivery systems locates quality in terms of product or the product line as a material resource. The product in this study, however, is not only a material resource such as technology or skill,

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but is related to the interaction itself. This study supports this researcher's view that the quality product "caring," which is fundamental to nursing practice, has been sustained as input process and outcomes (see Figure 1).

The implications for nursing through this research study demonstrate that nurse administrators need to be supported by corporate systems in all areas of nursing care delivery. The following recommendations will illuminate significant areas for transformation change in nursing administration, nursing education, and nursing research.

Recommendations

This study described the work life views of nurse manages during transition from primary care to patient-focused care. The data analysis and the conceptual model confirm that many caring concepts based on the theoretical framework, Theory of Bureaucratic Caring (Ray, 1990), emerged during the nurse managers' decision-making process. The bureaucratic caring concepts of economics, technical, social, educational, legal, and political, all influence the work life views of the nurse manager participant. For this reason, the implications of the findings from this study will be discussed with respect to nursing administration, education, practice, and research.

Nursing Administration

This descriptive research study adds to the nursing literature on caring and the caring-based practice of nurse

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administrators. It illuminated the views of nurse managers and encourages continued support for nurse administrators who strive to promote caring-based practice within the bureaucratic arena of health care organizations and changes toward new nursing care delivery models.

Future qualitative and quantitative research should study the effect of bureaucratic health care organizations on caring attitudes across all levels in the institution. Further research on the changes associated with health care reform would be beneficial to future nurse administrators.

Nursing Education and Practice

Creating an environment for caring nurse administrators is a challenge to the profession of nursing. Nyberg (1989) discussed the need to start the creation of a caring environment in the educational system where nurses socialize to see themselves as professionals, and where nurse administrators are taught the skills of commitment, openness, prioritizing, and potentiating as basic to their role. These skills need to be continued and developed through nurse administrators in the practice setting so that nurses and others can support each other in their daily routine. Research ideas for the future should include studies that reflect caring attributes of students in nursing education programs in comparison to nurses currently employed to determine if or how the bureaucratic institution affects attitudes of caring.

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Nursing Research

We have limited knowledge on how nurse administrators learn to make decisions and balance all the necessary caring concepts for a quality outcome. Implications of this research study are that economics, technical, ethical, educational, social, legal, and political are used by nurse managers during times of change or chaos. At the edge of chaos, nurse managers make choices on a daily basis to provide quality health care while meeting the demands of limited economic resources.

Research for the future should include what the nurse manager's role is in the financial decision-making process of their health care organization. Another beneficial study should look at the level of financial preparation the nurse manager receives to assist in the role of budgetary accountability.

Summary

The implications of this study describe the work-life views of nurse managers during times of transition. The results of this study validate that caring concepts are part of the daily decision-making responsibilities of the nurse manager. Nurse managers need to be aware of their peers' accountability related to caring outcomes of quality of care, patient satisfaction, competency of staff, acceptable nurse/patient ratios, and financial balancing.

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APPENDIX A

DEFINITION OF TERMS

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APPENDIX A

Definition of Terms

Work Redesign:
A multidisciplinary approach to restructure the work environment within a sociotechnical system model.

System:
1. A set or arrangement of things so related or connected as to form a unity or organic whole, such as a solar system, supply system, or delivery system.
2. A set of facts, principles, and rules classified to show the links between the various parts.

Model:
1. Anything of a particular form, shape, quality, or construction intended for imitation.
2. A person or thing considered as a standard of excellence to be imitated.

Theory:
1. Originally a mental viewing, contemplation.
2. That branch of an Art or Science consisting of knowledge of its principles and methods, pure as opposed to applied science.

Primary Nursing:
Decentralized decision-making model that calls for a level of action concerning decision-making to be at the bedside. Patients are assigned to a Primary Nurse who is responsible and accountable for the care that each patient receives. In the absence of the Primary Nurse, the Associate Nurse oversees the care of the Primary Nurse's patients by following the established plan of care.

Patient-Focused Care:
A model of patient care that calls for a total redesign of the patient care delivery system to meet the medical plan of care for each patient. Fragmentation of clinical services is decreased by using multiskilled caregivers who have assumed expanded roles.

Case Management:
A system of health assessment, planning service procurement, delivery/coordination and monitoring to meet multiple needs of the client.

Managed Care:
A system for the strategic management of cost and quality outcomes. The system is comprised of six

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components: standards critical paths, critical paths, analysis of positive and negative variances from the critical paths, timely case consultation for the caregiver, health care team meetings, and variances trended.

* Definitions were adopted from various administrative references.

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APPENDIX B

LETTER OF SUPPORT

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APPENDIX B

March 3, 1995

To Whom It May Concern:

TRICIA DITTMAN has permission to perform a qualitative, descriptive research project at Delray Community Hospital. This research project will include interviews with three Directors of Patient Focused Care Units.

Sincerely,

MSN RN CNAA

Jean Iapichino, MSN, R.N., C.N.A.A.
Assistant Administrator
Patient Care Services

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LE036

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APPENDIX C

RESEARCH QUESTIONS

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APPENDIX C

Research Questions

1. Describe the difference between Primary Care and Patient-Focused Care delivery models.

2. Describe the care partner component of Patient-Focused Care.

3. What are the nurse manager's concerns and considerations with regard to transition from Primary Care to Patient-Focused Care?

4. What preparation measures were instituted to prepare the nursing staff for a change in the care delivery system?

5. What training was needed to prepare the nursing staff for Patient-Focused Care?

6. What were the effects of the decentralization of support services on the management of the patient care unit?

7. Describe the effects of coordination of care with the multiskilled patient care partner.

8. Describe the case manager responsibilities in Patient Focused Care delivery.

9. What are your views regarding the care received by patients in a Patient-Focused Care delivery system?

10. What do you believe is the future for Patient-Focused Care in relation to health care reform?

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APPENDIX D

INFORMED CONSENT FORM

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APPENDIX D

Informed Consent Form

Project Title: The Work Life Views of Nurse Managers During Transition from Primary Care to Patient-Focused Care

Investigator: Patricia Welch Dittman, RN, BSN

Purpose:

The purpose of this study is to gain a description of the views of nurse managers during the transition from primary care to patient-focused care. Descriptive data will be collected. The knowledge will help the nursing profession understand important views of nurse managers in terms of transitions of patient care delivery systems.

Voluntary Participation:

You must be at least eighteen years of age to participate in this study. Your participation in this study will be completely voluntary, and you may withdraw from the study at any time without loss of benefits. You are being asked to participate because, as a nurse manager, you are rendering change and can describe those changes as your institution replaces the delivery system model from primary care to patient-focused care.

Procedure:

If you agree to participate, you will be interviewed in one audiotape-recorded interview which will last approximately forty-five to sixty minutes. After the first interview, an additional interview may be necessary to clarify statements made in the first interview. The interview will be scheduled at a time and place convenient for you, with no interruptions during the interview process. During the audiotape-recorded interview, you will be asked to describe your views of yourself as a nurse manager during the transition period from primary care to patient-focused care. The central research question is, "Describe your views, perceptions, thoughts, and responses concerning restructuring from primary care to patient-focused care in your institution."

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Confidentiality:

All interview information will be confidential. Your identify will remain anonymous. After your interview has been transcribed by a professional transcriber, the transcriptions will be coded by a number. The tapes will be destroyed after the completion of the study. Transcriptions may be reviewed by an expert thesis committee, but anonymity will be preserved. Excerpts from our dialogue will be used to support the research findings. Identifying characteristics of your excerpts will be disguised so that your identity will be unrecognizable. Study results may be shared with the nursing profession in the form of presentations and publications. Your name will not be disclosed at any time.

Benefits and Risks:

Participating in this study will be of no immediate benefit to you. However, the information learned from this study may benefit your future or the future of the profession of nursing. There are no financial costs associated with your participation, and you will not be paid for your participation. The risks associated with participating in this study are minimal. You may feel fatigued during the interview process. Sharing your thoughts and feelings with the researcher may be uncomfortable. If psychological discomfort becomes a potential hazard because you are sharing painful experiences, you are free to discuss your feelings with the researcher in order to reduce any undesirable effects, and counsel can also be sought from a practitioner of your choice. The researcher will be made available to you whenever necessary. You are encouraged to ask questions at any time.

Contracts:

If there are any questions or ethical concerns regarding your participation in this study, you may contact the researcher, Patricia W. Dittman, or the thesis committee chairperson, Dr. Marilyn Ray, through the Florida Atlantic University College of Nursing at (407) 367-2872, or Florida Atlantic University Human Subjects Committee at (407) 367-2313.

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Participant Statement:

This study has been explained to me. Participation is of my own accord. I understand that any future questions I have will be answered by the researcher. General results of the study will be furnished upon request.

Participant Signature ______________________ Date___________

Researcher Signature _______________________ Date___________

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APPENDIX E

INSTITUTIONAL REVIEW BOARD CONSENT

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APPENDIX E

INSTITUTIONAL REVIEW BOARD
Human Subjects Review Committee

MEMORANDUM

DATE: April 21, 1995

TO: Marilyn Ray,
Patricia Dittman,
Nursing

FROM: Brett Laursen, Chair

RE: H95-44 "Work-Life Views of Nurse Managers During Transition form Primary Care to Patient-Focused Care"

The Institutional Review Board (IRB) has reviewed the above protocol. Under the provisions for expedited review, the proposed research has been found acceptable as meeting the applicable ethical and legal standards for the protection of the rights and welfare of the human subjects involved.

It is now your responsibility to keep the IRB informed of any substantive change in your procedures and if you encounter any problems of a human subjects' nature.

Please do not hesitate to contact either myself (6-1120) or Elisa Gaucher (7-2318) with any questions.

BL: ceg

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APPENDIX F

CONCEPTUAL UNITS OF MEANING

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thing that we did differently from the other areas was the way that we used care partners. And they do answer to me, but we do not use care partner teams the same way the other areas do. And the reason for that was with our particular product lines, that being trauma, cardiac surgery, high acuity, cardiac patients that frequently have balloons or stints and our MICU patients which are very frequently on ventilators. We really felt that there were not a lot of tasks that the nurses were doing that they could give up to any kind of assistive type of person other than basic baths, errand running, doing EKGs, those kind of things. So our care partner is different than the other areas in that respect. So I'd say our biggest change from primary care to patient focused was the supervisory role.

R How was that accepted, that change?

P Well, the housekeepers accepted it very well, the pharmacists had a little problem at the beginning that they felt they should not be answering to someone who is not a pharmacist and did not have their expertise. But we sat down and met, and I think once they realized that what we wanted was their expertise for them to teach the nurses and we really structured what they would be doing in terms of the round on the patients every day, anything that has to do with our medication delivery system, they are responsible for keeping track of that, changing that as they see fit, making recommendations for what medications we do and do not

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than primary care because with the involvement of a care partner, a care partner could easily do a lot of the tasks that the nurses were at that time doing. Basically, the care partners do all the baths, the vital signs, all the ambulations, they do not do any invasive type procedures with the patients. They're pretty well trained and they do a lot of things to take the time for education programs, for making rounds with physicians and really being involved with the family and the educational portion to be able to take care of the patient at home at the time when they're discharged. We prepare them for discharge at the time they're admitted. And in primary care, we did a portion of that, but it wasn't as well organized and documented as it is right now. So patient focused has moved us along in more of an educational focus, which is what we need for our patients.

R Explain to me the difference in staffing ratios between primary care and patient focused care.

P In primary care, a nurse would probably have anywhere between 5 and 6 patients herself or himself where a care partner or a CNA, they would probably have maybe one for every 25 patients. So her main task then would be many to pass water into the life, but not really get involved in the direct patient care that was mainly the responsibility of the RN or the LPN. Now in patient focused, we have an 8 to 1 ratio, but we also have the partnership of a care partner. So between the two, you accomplish all the tasks in those rooms for those patients.

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R M.L., I want to thank you for being able to take part in this research for the thesis. The first thing we'll do is, if you get a chance, you can review all the questions, the ten questions I'll be asking you, and then we'll just do them one by one in order as they come. Number 1, Describe the difference between primary care and patient focused care delivery models?

P Well, I think that the differences that you might see described in the journals and the differences that we actually experience might be a little different. Things that I had read before we did it were that patient focused care brought the care to the patient, rather than the patient having to go somewhere else in hospital for the care. There was more continuity if people take good care of the patient. If there are ten people in the room every day, there were only two or three. Actually, with the exception of EKG and phlebotomy which is now performed on the unit, the patients still have to go off the unit for just about any diagnostic test outside of lab work. So from the standpoint of the idea of it, it's really wonderful to bring the caregivers to the patient. But sometimes cost-wise, it's just not practical. A good example was radiology. When we first started, they were thinking about putting an x-ray machine on every floor so that all other further x-rays would be right done on the unit, and someone would be trained, you know, to do those x-rays. But it was not cost effective to do that because that person still had a lot of downtime, and that

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APPENDIX G

CONCEPTUAL MODEL OF WORK LIFE VIEWS OF NURSE MANAGERS

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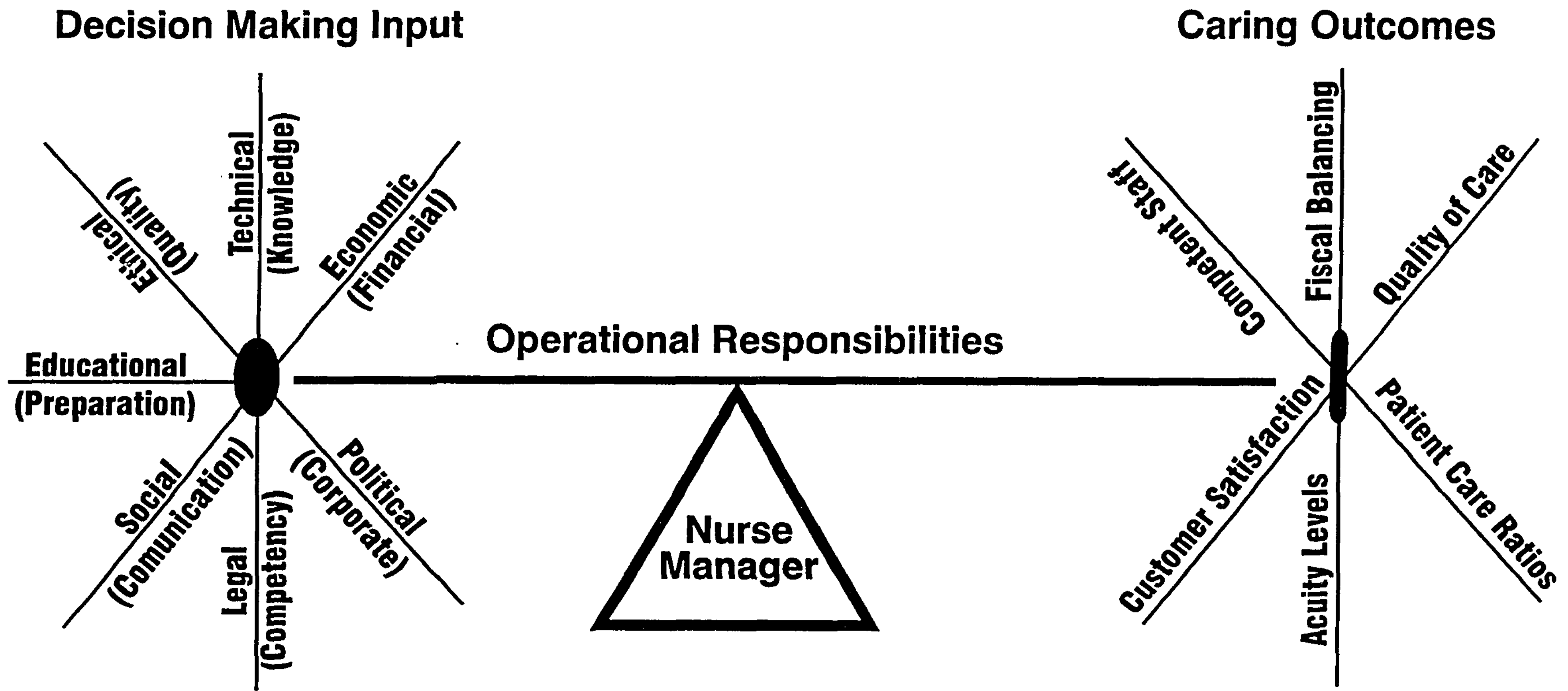

Figure 1. Conceptual model of work life views of nurse managers

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