

LEADING IN A TIME OF CHANGE

The Challenge for the Nursing Profession A Discussion Paper

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EXECUTIVE SUMMARY

This four-part document aims to capture forces influencing patient care delivery today and provides tools for questioning whether resulting changes are for the better. While of interest to a broad nursing and health care audience, the document should be particularly useful to nurse administrators. Because in the face of rapid change it is nurse administrators who are charged with providing leadership and creating environments that result in quality nursing service.

While ensuring quality nursing service has always been the mission of nurse administrators, their role has changed considerably over the years. To provide a context for the discussion that follows, Part I of the document examines the evolution of the nurse administrator's role in relation to such developments as World War II, the growth of hospital nursing, and increased complexity of the health care environment.

Part II begins with a broad view, that of rapid change as a global phenomenon. This change is the result of such factors as increasing competition, massive technological advances, and the evolution of global markets. To adapt, organizations large and small have reevaluated and restructured, placing the emphasis on cost containment, greater efficiency, and increasing quality. As the business imperative pervades health care, these are also the directions of the environments in which health professionals work and in which clients strive towards health.

From an examination of global trends, discussion moves to current trends in Canadian health care. These trends include the consumer participation movement, role redefinition among health care workers, strategic partnerships, a shift of resources to community-based care, and aging of the population. Beyond trends, three emerging approaches to patient care delivery—program management, patient-centred care, and managed care—are given particular attention.

New approaches can hold considerable promise, or they can be counterproductive to the delivery of quality, cost-effective care. Part III examines the cost-quality equation from a nursing perspective and articulates principles that hospitals and community-based health care organizations must respect if efficient, effective, and high-quality nursing services are to be optimized. Advanced by the Canadian Nurses Association, the principles are:

- A chief executive nurse provides valued leadership
- Nurses are actively involved in decision making at the board and executive levels
- Nurses participate in strategic planning at the organizational level
- Nurses collaborate with other health professionals in determining standards of patient care
- Nurses determine the standards of nursing practice

- Quality improvement activities are in place and considered fundamental to the organization's operation
- The organization analyzes the potential impact of all decisions relative to nursing
- Nurses actively participate in the selection and assessment of technologies
- Nurses contribute to the development of clinical and management information systems
- Nurses have a key say in resource utilization
- Nurses shape their own staff development and professional education programming
- The organization fosters and supports nursing linkages with educational institutions.

Rephrased as questions in Part IV, the principles are useful tools for analyzing the impact of organizational change on the practice environment. The questions are not intended to stand in the way of change. Rather, they are intended to ensure that change occurs for the right reason: To ensure the protection and improved health of the Canadian public at a cost society can afford.

For those wishing to do further reading on any topics covered here, a chapter-by-chapter resource list is provided at the end of the document.

PART I

What's past is prologue.

William Shakespeare

THE EVOLUTION OF NURSING ADMINISTRATION

EARLY INFLUENCES

Throughout its over-350-year history and within a variously structured health care system, Canadian nursing has been guided by one main objective: that of ensuring high-quality care for the public. Today, with the health care system increasingly driven by the bottom line, giving voice to that objective has never been more important or more timely. That is happening, and the voice being heard is that of nurse administrators.

This is not surprising. From earliest times, nurse administrators have been charged with creating environments and providing leadership that result in quality nursing service. Inherent in this mission has been protection of the public. Thus the themes of appropriate education, standards of care, and adequate resources have figured prominently.

In the early years of the new world it was the French religious orders that provided the education, structure, and support needed to ensure quality care. They also provided a value system, with service built on altruism and self-sacrifice. These values were reflected in the first trained nurses to practice in Canada: three Augustinian nuns who came to Quebec in 1639.

One of the first nurse administrators in the new world was Jeanne Mance, a lay nurse from France sent to establish a hospital at a planned religious colony on the Island of Montreal. From 1642 and for over 20 years, Mance brought her health care knowledge to the administration of Hôtel Dieu hospital there.

If Mance helped advance the cause of quality health care in the new world, Florence Nightingale advanced it worldwide. As administrator of a British field hospital during the Crimean War in the 1850s, she dramatically lowered mortality and morbidity rates among the soldiers in her care (Kerr, 1988, p.30). But though a noted reformer and researcher, Nightingale is probably best known for initiating an organized system of nursing education for lay nurses throughout the world (Kerr, 1988, p.16).

As with Nightingale's first school of nursing, established in conjunction with St. Thomas's Hospital in London, England, education for the practice of nursing "was born and nurtured" in hospitals (Kerr, 1988, p.238). But as Kerr points out, most new schools failed to fully apply the fundamental philosophy of the Nightingale model, that of financial autonomy. Schools thus found themselves dependent on hospitals and indebted to provide them with "a cadre of willing hands". The first Canadian training school for nurses that was organized on the Nightingale principles opened in St. Catharines, Ontario, in 1874 (CNA, 1968).

In the late 19C and early 20C, many hospitals were staffed largely by nursing students, with graduate nurses holding supervisory positions. Thus one of the first struggles relative to standards of care became that of replacing students with graduate nurses as primary providers of care (Kerr, 1988, p.240). Another initiative in this regard was the move to organized nursing and the drive for registration of nurses to ensure appropriate standards of education.

**THE GROWTH
OF HOSPITAL
NURSING**

The push for appropriate standards of education manifested itself in another way, with nursing leaders seeking higher education for nurses at Canadian universities (CNA, 1968, p.33). The first basic baccalaureate program was established at the University of British Columbia in 1919. And a year later, McGill University established the first course for graduate nurses in teaching and supervision.

Most early nursing graduates in Canada worked private duty, first in homes and later in hospitals. But by the end of World War I, notes the CNA history *The Leaf and The Lamp*, "district, school, municipal, industrial and other public health nursing functions were on the upswing, providing new outlets for skilled nurses" (1968, p. 33).

Despite this, a number of factors caused a shift to hospital employment for nurses. For one thing, advances in science in the early part of the 20C meant that the quality of care in hospitals could equal that provided in the home. With the Great Depression of the late 1920s and the 1930s, meanwhile, fewer people could afford to be cared for at home (CNA, 1968, p. 34). And in 1939, World War II was declared. Following the declaration, military hospitals were established in Canada to provide training for those going overseas and to treat military personnel on their return. By the war's end there were 60 military hospitals in Canada, 34 overseas hospitals and two hospital ships (Gibbon & Mathewson, 1947, p.455).

On the heels of the war came the federal government's Hospital Incentive Grants. Creating more than 46,000 new hospital beds between 1948 and 1953 (Taylor, 1987), they increased the need for staff nurses and changed the pattern of nursing practice (Lemieux-Charles & Wylie, 1992). The statistics tell the story: In 1930, 25% of nurses worked in hospitals; in 1960, 59% (Hall, 1964).

With such rapid growth in the number of hospital-based nurses, there was a corresponding need for nurse administrators but little time to adequately prepare them for this role. Concern over the role and preparation of the nurse administrator was reflected in a 1953 study by the Canadian Nurses Association. The study, which focused on the functions and activities of head nurses in a general hospital, resulted in publication of a manual for head nurses in 1960. A year later, the CNA and the Canadian Hospital Association established the nursing unit administration program, which continues today and is being transferred to McMaster University School of Nursing.

According to Lemieux-Charles and Wylie (1992), the influence of both the military and the religious orders was still evident in nursing departments of the 1940s and 1950s. They characterize that influence as the "top down" approach: multiple layers of administration with communications and decision-making systems slow to respond to staff and patient needs.

Out of this environment, and under the influence of popular theorists of the time, the new organizational approach of participative management emerged in the late 1960s and persisted throughout the 1970s and into the 1980s

**ADMINISTRATIVE
PRACTICE
EXPANDS**

(Lemieux-Charles & Wylie, 1992). With participative management, communication lines were shortened and head nurses assumed greater responsibilities. Meanwhile, the role of Director of Nursing grew ever more complex, demanding knowledge in such areas as management theory, finance, policy development, and labor relations.

New responsibilities and the growing complexity of the health care environment increased the demand for more managerial and leadership preparation for nurse administrators at all levels. This demand crystallized at the 1980 biennial convention of the Canadian Nurses Association when the membership requested the association to conduct a study on the education of nurses for nursing administration.

The membership request led to a study and, in 1983, to the development of a guiding document for all nurse managers: *The Role of the Nurse Administrator and Standards for Nursing Administration*. Revised in 1988, it underlines that professional and environmental changes are dramatically expanding the nature of nursing administrative practice.

Of particular interest here are the environmental changes, which are discussed in greater detail in the chapters that follow. The changes include altered funding bases, rapidly changing technology, growing consumer participation, and complex organizational structures.

With individual and collective rights gaining prominence, meanwhile, the management approach for the 1990s and beyond is what Lemieux-Charles and Wylie (1992) call "democratic". It is an orientation, they say, that will demand management skills in negotiation, collaboration, group processes, and communication. But more, say the authors: "The future will require nurse managers who understand the `business' of nursing, including new developments in the field, as well as the `business' of health service delivery" (p.253).

Working within a rapidly changing health care environment and the information age, however, managers of today and tomorrow will need even more than this. They will also need to display resourcefulness, flexibility and adaptability—attributes that Canada's pioneer nurses knew more than a little about.

PART II

In the not-too-distant past one could bring closure to any change before another commenced. Today one can never see the completion of a change before other change events emerge on the horizon.

*Tim Porter-O'Grady, EdD, RN
in Nursing Administration Quarterly, Fall 1992*

RAPID CHANGE: A GLOBAL PHENOMENON

In a few seemingly short years, the combined forces of technology, financial constraint and global competition have generated a rate of change unseen in history. That change has touched every society and every level of society—shaking convention, creating uncertainty, creating opportunity.

Organizations large and small have reevaluated and restructured, placing the emphasis on cost containment, greater efficiency, and increasing quality. To endure, activities and departments must show that they add value. There is no room for waste or mediocrity. According to Nadler (1992):

The forces that are causing the rethinking of organizational architecture have become fairly evident: increasing competition, massive social and technological change, increasing government participation in economic affairs, and the evolution of global markets and thus global competition. Perhaps most importantly, the rate of change is increasing. Organizations therefore need to increase their capacity to deal with uncertainty (p.4).

These are the directions of today and the directions of tomorrow. And as the business imperative pervades health care, they are, increasingly, the directions of the environments in which health professionals work and in which clients strive toward health.

CURRENT TRENDS IN CANADIAN HEALTH CARE

If the health care environment is changing, the need for change was underlined by a wave of federal and provincial health care commissions and task forces that began in 1983. The reviews were sparked by concerns over rising health care costs, dissatisfaction with the organizational structure of health care delivery, human resources requirements, diffusion of technology, and quality and accessibility of care (Angus, 1991). Among these, fiscal concerns were front and centre.

Recommendations of the reviews are resulting in significant reforms to provincial health care systems. The reforms include decentralization of administrative and political authority, a shift of resources toward community-based health care, and increased emphasis on health promotion and disease prevention.

KEY FORCES SHAPING THE HEALTH CARE ENVIRONMENT

- ⊗ Decentralization of political and administrative authority
- ⊗ Shift of resources to community-based care
- ⊗ More emphasis on health promotion and disease prevention
- ⊗ Growing public knowledge and expectations
- ⊗ Strategic partnerships
- ⊗ Consumer participation movement
- ⊗ Emphasis on outcomes and continuous

These are not the only forces shaping the current health care environment, however. The consumer participation movement, so evident in society at large, is translating to greater public input into health policy. A measure of this is increasing public representation on planning bodies and hospital boards. Meanwhile, the diffusion of technology is redefining the roles of health care providers and in many cases greying the boundaries between them.

Technology's pervasiveness is particularly evident in the computerized information systems that increasingly control health care delivery. Information is such a hot commodity, such an important means of controlling uncertainty in both internal and external environments, that a growing number of Canadian health care organizations now employ a chief information officer. This individual's job: to establish a comprehensive, organization-wide system that provides timely information to the board, executive, management, and clinical and operations staff (Brunelle & Protti, 1992). Information technology has also begun to revolutionize organizational design by providing an alternative to hierarchy as the primary means of coordination (Nadler, 1992, p.5).

Meanwhile, the key architect of organizational design, the chief executive officer (CEO), could soon undergo somewhat of a revolution too—in the United States at least. In an article called "CEO Selection Trends in the 1990s", Armitage and Bain (1992) note that in the private sector in the past decade there has been "a pronounced trend towards hiring generalists—

candidates with cross-industry and cross-functional experience—as opposed to those within the specific industry" (p.31). With health care organizations facing significant changes in the next 10 years, they say, it would be beneficial for boards to explore non-traditional sources of executive succession, including the private sector. Indeed, some of the provincial health care reviews suggested looking to private-sector management techniques as one possible direction for improving efficiency in health care delivery.

EMERGING APPROACHES TO PATIENT CARE DELIVERY

PROGRAM MANAGEMENT

In the past few years, private-sector business concepts have pervaded hospitals and community-based health care organizations, leading to dramatic changes in patient care delivery. Emerging are such approaches as program management, patient-centred care, and managed care. They can occur alone or in combination.

A defining feature of most new approaches is decentralization, with or without organizational restructuring. Decentralization, a shifting of authority and responsibility downward in an organization, means decisions are taken where they have major impact. In the process, costs are reduced by eliminating the need for middle management. Herewith, a closer look at some currently-popular approaches to patient care delivery.

One change affecting patient care delivery is the redesign of organizations along lines other than such traditional and functional ones as finance, nursing and medicine. In particular, several Canadian hospitals and community-based health organizations have grouped clinical units into programs—also known as product lines—as a way of tracking costs associated with specific patient groups. This will, goes the thinking, lead to more efficient and effective health care. Mental Health, Oncology and Paediatrics are examples of such program or product-line groupings.

In hospitals, each program has its own budget and is often headed by a program management team consisting of a physician chief or chair, a nursing director, and an administrator. The chair may report to the chief executive officer or to a vice president level in the organization. This approach assumes that because physicians are the gatekeepers to the system then they should have sole decision-making authority for resource allocation. In some hospitals the position of program chair may be filled by nurses, administrators, or physicians.

Sometimes, program management is superimposed onto the traditional hospital management system, creating a matrix organization with vertical and horizontal reporting structures. This is the case at The Credit Valley Hospital, where nursing directors have dual responsibility and accountability. On the one hand they are responsible for the effective operation of nursing units within their program. On the other hand, they are accountable to the vice president of nursing for the quality of nursing care ("Programme management expands", 1992).

If program management is sometimes superimposed onto the traditional hospital management system, however, more often it replaces it. This means that discipline-specific infrastructures and line authority are eliminated and the disciplines absorbed into the program structure. In some cases, the position of chief executive nurse has been eliminated entirely.

PATIENT-CENTRED CARE

Another model of patient care delivery emerging in Canada is patient-centred, or patient-focused, care. At Sunnybrook Health Science Centre in Toronto, Ontario, the only Canadian institution to embrace this approach to date, a major restructuring is in progress. Gone is the hierarchical, department-focused structure of the past. Replacing it is a decentralized system organized around the patient.

The hospital's eight clinical units are being collapsed into three. Each unit is led by a full-time vice president of operations and a part-time vice president medical—a physician ("Nursing opportunities promised," 1993, p.2). The vice president of operations may be a nurse, but is not necessarily so.

Clinical units contain four or five patient service units made up of like groups of patients. Each unit is accountable for its own budget and functions as a mini-hospital—complete with its own diagnostic services. According to Sunnybrook's CEO, Peter Ellis, bringing such services as x-ray to the unit means minimum disruption and less wasted time for staff and patients ("Nursing opportunities promised," 1993, p.2).

Ellis also envisions a system where a nurse would be responsible for a small number of patients along with a multi-skilled worker who would handle the non-nursing duties ("Nursing opportunities promised, 1993, p.2). The concept of the multi-skilled worker is not a new one, says Brider (1992):

The patient-focused movement is capitalizing on solutions forged in high-tech industry: Train workers for multiple tasks and erase administrative "barriers". Centralized departments, the theory goes, breed inefficiencies that drive up the cost of care and undermine its quality.

Although Sunnybrook's approach to patient care delivery is new to Canada, examples of it can be found throughout the United States. Writing in American-based *Hospitals* magazine, Sherer (1993) calls patient-centred care one of the health care field's hottest catchphrases—a catchphrase that is, according to the magazine's editor, "long on rhetoric and short on detail" (Grayson, 1993, p.4).

In an attempt to flesh out the term and determine how far the concept had penetrated hospital management practices, the magazine conducted a survey of hospital CEOs in the United States in October 1992. For the purposes of the survey, patient-centred care was broadly defined as "the redesign of patient care so that hospital resources and personnel are organized around patients rather than around various specialized departments." (Sherer, 1993, p.14).

Of the 311 CEOs who responded to the survey, "nearly half said they are either planning to or are already implementing patient-centred care programs" (Sherer, 1993, p.14). At the time the survey was conducted, about 45% of these programs were less than one year old, and 46% were less than three years old.

According to the survey, 87.6% of the hospitals implemented the programs because they believe they are the best way to provide high-quality patient care. Meanwhile, just over half of survey respondents (54.5%) claimed their desire to lower hospital costs was a motivating factor.

BASIC TENETS OF PATIENT-CENTRED CARE

- @ Decentralized services moved closer to the bedside
- @ Cross-training to create multi-skilled workers
- @ Work redesign
- @ Grouping of similar patient populations

Still, over half of all respondents (53%) indicated they were not planning to adopt patient-centred care programs. Said Terry L. Jones, chief operating officer of Gaston Memorial Hospital in Gastonia, North Carolina:

I haven't seen any hard-core evidence of whether patient care and hospital resources have improved as a result of these initiatives. I'm not willing to spend our capital dollars, given limited reimbursement, for something on a trial basis. It's like a clinical drug. I'm waiting for more long-term information before I even think about taking on such a commitment (Sherer, 1993, p.15).

Bain Farris, president and CEO of St. Vincent Hospitals and Health Services in Indianapolis, *has* taken on such a commitment. Interviewed for *Hospitals*, he underlined that while patient-centred care can offer considerable savings over the long term, those savings are a by-product of time, dedication, patience, and doing things right the first time. His caution:

People who want to do this for financial reasons should know that it's just not worth it....It requires much too much of a commitment. There are other faster and more direct ways to save money (Sherer, 1993, p.15).

MANAGED CARE

Recent concern over health care's bottom line has focused attention on the concept of managed care, which Lamb and Deber (1992) view as a continuum that ranges from a few managed care approaches to complex and sophisticated managed care systems. Subject to management are the providers of care and the users of services.

A managed care approach, say the authors, "involves application of a management policy or procedure that affects either the financing or delivery of a service to achieve a specific goal" (p.159). Case management, because it aims to coordinate care or reduce length of stay in hospital, is an example of a managed care approach. The case manager—ideally a nurse—tracks the patient through the system and oversees the critical path he or she must follow to achieve a desired and timely outcome. It is an increasingly popular strategy for controlling costs, reducing inappropriate use of services and improving quality of care—especially continuity of care.

The idea of a managed care system, on the other hand, "is that for a predetermined amount of money, a specific and comprehensive *range* of services (rather than *number* of services) will be provided as required and

the delivery of these services will be organized, monitored, and controlled so as to meet established health care delivery goals" (Lamb & Deber, 1992, p.159). Here, the financing and delivery of comprehensive health care services for a defined group of individuals are combined. Lamb and her colleagues cite cost containment and quality of care as the two most frequently mentioned goals of managed care mentioned in the literature (Lamb, Deber, Naylor & Hastings, 1991).

Health maintenance organizations (HMOs), which emerged as alternative health care delivery models in the United States in the 1970s, are examples of managed care systems. Other models include Vi-Care, in Victoria; health service organizations in Ontario; and preferred provider organizations in the United States (Lamb, Deber, Naylor & Hastings, 1991).

In recent years, the number of health maintenance organizations in the United States has grown steadily, with over 600 nationwide in 1987. But the HMO concept has also attracted attention in Canada. Indeed an editorial in *The Globe and Mail* of May 13, 1993, hailed the HMO concept as a possible solution to medicare's woes. Calling the current fee-for-service system a direct incentive for physicians to overtreat, it embraced the notions of capitation and competition inherent in HMO models:

The capitation system is simple: instead of billing for each service performed, the HMO receives a single annual payment, out of which it must pay for all costs needed to keep the "subscriber" healthy. The difference between this flat fee and the costs of care is the HMO's profit. Competition among HMOs ensures this incentive to minimize costs is not ignored, a constant stimulus to innovation and discovery.

In the U.S., it is typically the consumer or employer who pays the HMO; in our system, it would be the government....("A medicare we can afford", 1993, p. A24).

Capitation and competition are not the only marks of health maintenance organizations, however. Rather, Lamb and her colleagues describe HMOs according to what they call managed care's three main elements:

- formal agreements among payers, users and providers;
- risk assumption by those who deliver health care; and
- utilization management aimed at minimizing financial risks, meeting the terms of the formal agreements, and achieving the goals of health care (Lamb, Deber, Naylor & Hastings, 1991).

Despite recent media interest in HMOs, governments in Ontario and Quebec acted on their interest in the concept in the 1980s. In 1988, for example, the Quebec government examined the HMO model with a view to how it might be applied within a system of universal health care. And in 1989, it announced its intent to experiment with, and receive proposals for, new organizations called "organisations de soin intégrés de santé" (OSIS). According to Lamb and her colleagues:

The OSIS will be a nonprofit organization that provides comprehensive services either directly or by contract arrangement to residents who live in a geographic area and voluntarily join the organization for a specified period of time....The OSIS will be prepaid on an adjusted capitation basis with adjustments related to the characteristics of the clients. An OSIS will be able to allocate its budget autonomously so that the possibility of offering attractive non-insured services to clients exists. There is an assumption that decreased hospitalization, an emphasis on prevention, use of controls, and use of interdisciplinary teams with enhanced use of non-physician personnel will generate savings (Lamb, Deber, Naylor & Hastings, 1991, p.25).

In Ontario, meanwhile, The Toronto Hospital finally received Ministry of Health approval for its proposed comprehensive health organization (CHO) in September 1989. While the proposed CHO incorporates many characteristics of American HMOs, attempts have been made to shape a model that is appropriate for the Canadian context. Integrating such key features as case management, health promotion and education, quality of care measurement, and risk assumption, the CHO will recruit its initial base of patients from The Toronto Hospital's family and community medicine practice. The overall purpose of the CHO will be "to provide comprehensive, coordinated services to a group of enrolled users, integrating the academic activities of teaching and research" (Lamb, Deber, Naylor & Hastings, 1991, p.52).

Only time will tell if managed care systems can succeed as alternative health care delivery approaches within Canada's universal health care system. Conclude Lamb and Deber (1992):

Applications of managed care systems to Canada will have to take specific features of Canadian health care into consideration. In particular, attention will have to be given to how to attract and retain patients and how to ensure that health professionals participate in management decisions. Incentives rather than deterrents, as well as managed care approaches that focus on quality of care rather than only cost containment, will be necessary (p. 164).

PART III

The accumulating evidence is overwhelming: nurses are enhancing the quality of care by promoting health and lowering total system costs. What is absolutely clear is that nursing is a bargain, in or out of the hospital.

**Claire M. Fagin, RN, PhD,
in the American Journal of Nursing, October 1990**

NURSING AND THE COST-QUALITY EQUATION

NURSES MAKE A DIFFERENCE

Variouly introduced to Canadian health care organizations, managed care, patient-centred care and program management are touted as antidotes to the health care system's woes. Where health care budgets are strained, the new models promise cost efficiency. Where there is duplication of services, they promise streamlining. And where traditional hierarchies are slow to respond to staff and patient needs, the new models promise decentralization with decision making on the front lines. Underscoring all the models is the promise of responsive care focused squarely on the patient.

While focused on the patient, new models translate to significant changes for health care professionals—whether they work in institutions or the community. For staff nurses, for instance, decentralized decision making can mean enhancement of their professional role. For nurse administrators, the perpetual pressure to focus on the bottom line can threaten a shift away from the human values on which the nursing profession is based. But whatever the changes to their own role, nurses measure the value of new models by the models' ability to achieve an appropriate balance between quality care and cost-effectiveness.

As key stakeholders and one of only two constants for patients in all health care settings, nurses are qualified to speak out on the issues of both cost and care. Over 10 years ago, the World Health Organization identified nurses as the health care professionals with the greatest potential for ensuring cost-effectiveness. And in 1985 Dr. Halfdan Mahler, Director-General of the World Health Organization (WHO), recognized nurses' expertise in working with clients in the community. Speaking of the slow progress toward the WHO goal of *Health for All by the Year 2000*, Mahler said that it was "time that nurses were brought in much more than hitherto...as leaders and managers of the primary health care/Health for All team..." (WHO Press, 1985). Nurse-run primary health care pilot projects across Canada—some integrating a research component to measure outcomes—are evidence that this is happening.

In a 1989 survey of 663 hospital CEOs in the United States, meanwhile, the executives ranked nursing care as the most significant factor in providing high-quality patient care in their institutions (Koska, 1989, p.32). Nursing care is the main reason patients go to hospital. And it is among the key factors that set institutions and agencies apart. As studies have shown, for example, hospitals with a high proportion of RNs provide better care, as reflected in lower mortality rates. (Hartz et al, 1989).

But perhaps nothing more clearly underlined the difference nurses make to a hospital and the difference a hospital can make to a nurse, than did the landmark magnet hospitals study, which focused on why nurses stay in their jobs and the reasons for their job satisfaction (McClure, Poulin, Sovie & Wandelt, 1983).

THE MAGNET HOSPITALS REPORT

Researchers drew on the perceptions of directors of nursing and staff nurses at 41 hospitals identified for their particular ability to attract and retain professional nurses. The interview questions included: "How is nursing viewed in your hospital and why?", "What makes your hospital a good place for nurses to work?", and "Can you describe nurse involvement in various ongoing programs/projects whose goals are quality of patient care?"

The magnet hospitals report underlines that staff nurses perceived directors of nursing and nursing leadership staff as particularly important to a hospital's magnetism. Opportunities for professional practice and the quality of that practice were other key factors contributing to the hospitals' magnetism. In all the hospitals, participatory management was the prevailing philosophy. As such, practicing nurses were actively engaged in decision making at all levels. States the magnet hospitals report:

Nurses are expected to participate in nursing and organizational affairs. They report being involved in evaluating and selecting new equipment and patient care supply items and in the selection of those items most advantageous to patient care. They are also extensively involved in the planning for new services and take part in such activities as the design of new patient care areas, the planning and development of computerized patient information systems, and the creation and implementation of special health education programs for patients and members of the community at large (McClure, Poulin, Sovie & Wandelt, 1983, p.15).

Structurally, responsibility was decentralized to patient care units. The study noted: "nursing staff clearly view themselves as responsible and accountable for the quality of patient care." Committees were seen to play a key role in involving nursing staff in the affairs of the hospital and nursing organization. Significantly, nurses were represented on all committees where patient care was discussed.

TODAY'S MAGNET HOSPITALS

The findings of the magnet hospitals study are as valuable and relevant today as they were when the study was conducted over 10 years ago. Indeed in the United States investigators still evaluate institutions for magnet hospital status. According to Kramer and Schmalenberg (1993), who conduct such investigations and have done much follow-up work based on the magnet hospitals report, hospitals desire this evaluation for at least two reasons. First, "the magnet hospital study is the only study specifically assessing the quality of nursing care as a measure of the 'goodness' of the hospital." The second is that having magnet hospital status is considered the mark of excellence, the "gold standard". As such it affects recruitment. Some recruiters receive applications from nurses who say they will work only in a magnet hospital (Kramer and Schmalenberg, 1993).

In the May 1993 issue of *Nursing Management*, Kramer and Schmalenberg discuss what they look for in a magnet hospital and its nurses and describe Chicago's Edward Hospital (EH), which recently achieved magnet hospital status:

One of the critical magnetizing factors we look for is evidence of autonomous, empowered behavior and then we look backward to see what facilitated that behavior and forward to see results of the behavior. In our recent assessment of Edward Hospital, we found many examples of such behavior....

Without the kind of support at the Board and CEO levels found at EH, it is doubtful that an environment could be created within the nursing department so that competent, empowered nurses can function autonomously in delivery of high quality patient care. Both the hospital's mission and value statement and nursing practice philosophy speak to valuing and striving for individual autonomy and empowerment. The desire for and valuing of empowered staff must pervade the entire organization (p.59).

SUPPORTING PROFESSIONAL NURSING PRACTICE

As the magnet hospitals report and follow-up investigations make clear, quality care doesn't just happen. Rather, it is the product of environments that support professional nursing practice.

This concept is integral to the following principles, which the Canadian Nurses Association sees as essential building blocks in the rapidly changing architecture of health care. The principles apply wherever nursing is practiced, within whatever structure. Used as a checklist, they can guide nurses and others in analyzing the impact of organizational change on the nursing practice environment. (Also see following chapter, "Questioning Change: Some Tools".)

CNA's PRINCIPLES FOR A PROFESSIONAL PRACTICE ENVIRONMENT

Clients have a right to high-quality, efficient, and effective nursing services. Whether speaking of hospitals or community-based agencies, those services are optimized when the following principles are respected.

- @ A chief executive nurse provides valued leadership
- @ Nurses are actively involved in decision making at the board and executive levels
- @ Nurses participate in strategic planning at the organizational level
- @ Nurses collaborate with other health professionals in determining standards of patient care
- @ Nurses determine the standards of nursing practice
- @ Quality improvement activities are in place and considered fundamental to the organization's operation
- @ The organization analyzes the potential impact of all decisions relative to nursing
- @ Nurses actively participate in the selection and assessment of technologies
- @ Nurses contribute to the development of clinical and management information systems
- @ Nurses have a key say in resource utilization
- @ Nurses shape their own staff development and professional education programming
- @ The organization fosters and supports nursing linkages with educational institutions.

CNA's principles for a professional practice environment recognize that there are structures fundamental to the integrity of nursing and the practice of nursing in health care organizations. As outcome- and product-oriented systems and structures are introduced into those organizations, it is important that these structures be maintained and respected. Herewith a closer look at each principle and why it is important.

A chief executive nurse provides valued leadership. As the magnet hospitals report underlined, one of the most visible marks of a supportive environment for professional nursing practice is a director of nursing, or chief

executive nurse. Why? According to staff nurses interviewed for the landmark study, directors articulated the philosophy of nursing that prevailed in the institution, with a central focus on the quality of patient care. They interacted with staff nurses on a one-to-one basis and in regularly scheduled meetings. They were viewed as strong nurse advocates. Visible in the institution and accessible for support and problem resolution, the directors encouraged nurses in their continuing self-development.

Now, as then, the chief executive nurse provides visionary leadership for both nursing and the organization, embracing excellence in patient care as the central value and promoting collaborative and interdisciplinary management and processes. Such leadership is particularly important at a time of rapid transformation in health care. Says Porter-O'Grady (1992):

Times are transforming and demand a leader who is comfortable with the conditions and circumstances of transformation....The leader puts form to change and sees emerge a generative process that leads to newer and better ways of being and doing. It is in this process that the character and content of transformation are found. If health care is to be healthy and cost effective over the long term it will take a leader who can harness the complexities and energies of the time (p.23).

In providing leadership, the chief executive nurse represents the profession, professional standards, and professional accountability within the health care organization. In so doing, the chief executive nurse creates an empowering environment that fosters creativity, risk taking, and growth. This means being at once role model, mentor and coach. At the same time, the chief executive nurse is responsible for improving the knowledge of boards of directors and non-nurse managers regarding the nursing enterprise (Meilicke, 1990, p.31).

Nurses are actively involved in decision making at the board and executive levels. Active nursing involvement in decision making at the board and executive levels recognizes nurses' pivotal role in patient care delivery. As Smith (1992) points out, the "legitimate interest of nurses in the management of acute care hospitals" was recognized by the governments of Alberta and Ontario, which directed hospital boards to appoint nurses as among their voting members and to major committees (p. 129).

Involving nurses in decision making at the top makes sense for another reason. According to Nadler and Ancona (1992), CEOs seem to feel the need for a broader base of participation in providing leadership for organizations.

The authors note the growing trend toward executive teams to replace the traditional Chief Executive Officer/Chief Operating Officer model. The fundamental rationale for establishing such teams, they say, is the creation of synergy—"effective coordination of functions and activities so that the performance of the whole is greater than the sum of the parts."

After joint research and in-depth consultation, much of it with *Fortune* 500-type organizations, Nadler and Ancona concluded that three issues drive the need for and management of executive teams: responding to the complex and

often changing external environment; managing the diverse yet interdependent units inside the organization; and shaping executive succession.

Nurses participate in strategic planning at the organizational level. A strategic plan is built around an organization's mission and expresses the organization's scope, its goals, and the actions required to fulfill its goals in the context of the environment. More than simply laying down a set of intentions, though, strategy is behavioral—a pattern of resource allocation decisions (Bliss, 1992, p.234). Where health care organizations are concerned, those decisions affect everything from research and educational programs to human resources and equipment.

Ultimately, though, all decisions relate to the mission of providing quality patient care. Nurses are key to fulfilling that mission and to meeting the goals that flow from it. According to Bliss (1992), effective strategy development means ensuring that "the right people debate the right issues and ask the right questions" (p.238). As the consistent presence for patients, nurses are certainly among the "right" people.

Being part of the planning team is particularly important given today's fast-changing environment. Within such an environment, says Bliss (1992), the written strategic plan will always be wrong. It is the thinking behind the plan that is important:

It is the shared understanding of the organizational context that evolves from strategic thinking that continues to be relevant and guiding. With a sense of the *why* behind the *what* that drives the *how*, managers are able to react rapidly and consistently to change and the inevitable, unforeseen obstacles that often arise along the way.

Organizations are not led by written documents. Organizations are led by teams of individuals with different perspectives of the world (p.236).

For nurses and others, sharing those perspectives paves the way for effective organization-wide communication. As well, involvement in strategic thinking helps build commitment to the shared understanding that guides organizations.

Nurses collaborate with other health professionals in determining standards of patient care. Like professionals in other health care disciplines, nurses bring their unique perspective to patient care delivery. They expect to play a role in ensuring that this perspective is reflected in standards of patient care in their organizations. Those standards should be determined through a collaborative process involving professionals from other disciplines.

More and more, the knowledge nurses bring to standard setting draws from practice-based research. The value of such research and of nursing care was captured by Heater, Olson, and Becker (1990), who set out to measure the effect specific nursing actions had on patient outcomes. To this end, they analyzed data from 4,146 patients as reported in 84 studies published between 1977 and 1984 (Heater et al, 1988). Their conclusion: "that research-based nursing interventions can produce 28% better outcomes for 72% of patients."

Nurses determine the standards of nursing practice. As members of a self-regulating profession concerned with protection of the public, nurses in Canada are guided by standards of practice defined by national and provincial professional associations. An underlying belief of these standards is that they must be developed by members of the nursing profession.

The standards express what is desirable nursing practice and lend themselves to further development and refinement by nurses in their practice setting. Standards of nursing practice are seen as prerequisite to the evaluation of quality nursing care. To reflect new knowledge and the changing nature of nursing practice, they must be reviewed and revised on a regular basis.

Quality improvement activities are in place and considered fundamental to the organization's operation. In health care, as in business, quality improvement is a major focus of the 1990s. But whereas early efforts emphasized measurement and, occasionally, comparison with a standard, today they focus on outcomes management and continuous improvement. State Lemieux-Charles and Wylie (1992):

Outcomes management is generally characterized by a reliance on standards and guidelines, measurement of functioning and well-being of patients, pooling of clinical and outcome data on a massive scale, and analysis and dissemination of results. Continuous improvement stresses improvement of work processes and systems of service delivery. The belief is that quality problems generally result from inadequacies of the system and work processes rather than from specific individuals (p. 250).

In a June 1992 position statement, the Canadian Nurses Association articulated its belief that high standards of nursing care can best be achieved in organizational settings that are committed to a philosophy of continuous quality improvement. This philosophy should involve the governing body, management, health care providers, and consumers (CNA, 1992).

The organization analyzes the potential impact of all decisions relative to nursing. There are few decisions in health care organizations that do not have an impact on nursing. Decisions to introduce programs or buy a new piece of high-technology equipment can easily increase nursing resource requirements. Impact analysis of all decisions relative to nursing is important to ensure adequate and appropriate nursing resources for the uninterrupted delivery of quality patient care. This was a common theme in the recommendations of federal and provincial health care commissions and task forces conducted over the last 10 years (Angus, 1991, p.6).

Nurses actively participate in the selection and assessment of technologies. In the document *Technology and Health Policy*, published by the Canadian Hospital Association, Taylor (1989) notes that technology has become a central driving force in hospital structure and organization in recent decades (p. 3). But the technological imperative has its disadvantages. When Feeny and Wall (1989) surveyed technology assessment practices in Canada, they made three discoveries:

- adoption and utilization decisions are usually made prior to evaluation;
- levels of utilization for many technologies diverge from and often exceed those justified by need; and
- some technologies continue to be used even though there are more cost-effective alternatives.

As well, studies indicate that 10% to 20% of procedures performed in the health care system are unnecessary and inappropriate (Senate, 1990). This, according to Rachlis and Kushner (1989), helps explain the sorry financial state of the health care system.

Most biomedical technologies increase the need for nursing care (Baumgart & Larsen, 1992, p.224). And by virtue of their numbers alone, nurses tend to be the biggest users of medical devices. Despite this, staff nurse knowledge of technology utilization is an important but "currently under-exploited organizational resource" (Campbell, 1989, p.34). More than knowledge of utilization, however, nurses have firsthand knowledge of the complex ethical dilemmas posed by technology.

Assessment of health care technologies must be with a view to their effect on patient care and on health human resources. It must also include "finding a balance between social concerns such as the human/machine interaction and the economic effect of technology on nursing practice." (Baumgart & Larsen, 1992, p.224). Of particular concern to nurses is that the introduction and use of health care technologies be guided by the principles of primary health care.

Nurses contribute to the development of clinical and management information systems. Clinical and management information systems are transforming health care environments and helping shape the nurse's new role as knowledge worker. These systems have both advantages and disadvantages.

As Campbell (1989) points out in her CNA-commissioned paper *Technology and Nursing*, sophisticated management information systems allow nurse managers to "collect objective data to support their ideas, the authority and apparent neutrality of these data overcoming gender bias and nurses' traditional professional subordination" (p.72). On the other hand, she says,

...computerized information about nursing designed primarily to help nurse managers become more effective in their jobs is articulating nursing practice more and more securely to the framework of cost-efficiency being advanced by Canadian health care funders. The new managerial professionalism in nursing requires nurse managers to speak from the standpoint of cost efficiency which is structured into their jobs in budgeting and accountability objectives. Staff nurses, who might, in the past, speak from the standpoint of care, are increasingly bound to act in ways that are inconsistent with their caretaking role image. They are urged to accept a different ideal image—that of information provider and receiver. Their sanctioned behaviour is underwritten by the standpoint of cost-efficiency carried in the information systems they use (Campbell, 1989, p.72).

When nurses use information systems, argues Menzies (1989), their thinking and decision making focus less on human beings in the wards and increasingly on how the computer system sees the human beings: "as composites of standardized patient-task requirements" (p. 88). The nursing challenge is to help design information systems that support nurses in achieving cost-efficiency yet articulate the human values on which nursing practice is based.

This will be difficult. As Milio (1986) notes, "digital thinking is not compatible with the world of human experience...." But though machines will never see patients quite as nurses do, nursing involvement in the design of information systems makes sense for another reason: It helps ensure that information for decision making is relevant and based on both nursing research and theory-based practice.

Nurses have a key say in resource utilization. State Baumgart and Larsen (1992): "The common future thread is accountability for use of resources, especially because resources affect outcomes of care" (p.252). But to be accountable for resource use means having a *say* in resource use. In having a say, nurses need relevant data.

Today, nurse managers need a wide range of data. State Giovannetti and Johnson (1990):

Information related to productivity monitoring, long range planning, budgeted staff tracking, trend analysis, costing, charging, and the linking of patient classification data such as quality criteria, length of stay, nursing diagnoses and medical care data are among the frequent demands. (p.33).

Recognizing the need for relevant nursing data for decision making by nurses and others, the Canadian Nurses Association held the Nursing Minimum Data Set Conference in Edmonton, Alberta in October 1992. The main objective of the event was to develop a nursing minimum data set in Canada to ensure both the availability of, and accessibility to, standardized nursing data. Recently, the name nursing minimum data set was replaced by Health Information: Nursing Components to incorporate nursing components into the broader data base of multidisciplinary, national health information.

Nurses shape their own staff development and professional education programming. Increased acuity of patients, the rapid diffusion of technology and changing demographics are placing new demands on nurses in all settings. To meet their professional obligation to deliver safe, cost-effective, quality care nurses need discipline-specific staff development and professional education programming.

As a study by the Ontario Nurses' Association (1989) showed, technology is one area where such programming is particularly needed. Nurses surveyed for the study indicated that they often had to fill in the gaps in training, service, and resources, teaching themselves how to operate and maintain new equipment.

When the Canadian Nurses Association and the Canadian Hospital Association reviewed 23 nursing work life studies in 1990, education emerged as a major factor in job satisfaction. Stated the resulting report: "Education provides nurses with a challenge and stimulation, instills confidence and competence, and affords status" (p.22).

The organization fosters and supports nursing linkages with educational institutions. Whether in the business world or in health care, strategic partnerships are the way of the Nineties. But they are not a new idea. In the magnet hospitals study mentioned earlier, all 41 institutions identified for their ability to attract and retain nurses were associated with a school of nursing. Such linkages foster joint appointments for faculty and staff nurses; collaboration on clinical research and on curriculum development and evaluation; and new clinical learning opportunities for nursing students. Particularly needed today are learning experiences in the community setting.

PART IV

In the excitement and challenge of change it is easy to convince ourselves that the changes we make, and experience, are for the better....The final most important question should be—is this difference better? For whom do we do things differently, think differently, feel differently and see things differently? Ultimately we must ask, have we improved patient care?

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Guest editorial in the Canadian Journal of Nursing Administration,
March/April 1993**

QUESTIONING CHANGE: SOME TOOLS

Like all changes, organizational restructuring and new models of patient care delivery engender a mix of excitement and concern. The excitement is a product of promise: the promise of new paths, fresh approaches, and that things will surely be better. The concern is a product of reason: the measured voice that asks what is behind the promise, what is the true meaning of change?

Given their responsibility to create environments and provide leadership that result in quality nursing service, nurse administrators are listening to reason. They welcome change, but they want the *right* change: change that ensures cost-effective quality care for patients. Ensuring it means asking the right questions of the organizations they work for. Some questions:

- Where is the research supporting claims that the new approach will be more efficient, more cost-effective, and result in high-quality care?
- How will promised gains in these areas be measured in this organization? What mechanism will be used to report them to the board, to health care professionals, and to the public the organization serves?
- Does the new approach to patient care delivery support the current directions of health care reform; that is, multidisciplinary decision making and shared power among health professionals and consumers?
- How does the new model or structure of patient care delivery support the professional practice environment fundamental to the delivery of quality patient care?
- Does the reorganization or restructuring respect the Canadian Nurses Association's Principles for a Professional Practice Environment? (See previous chapter, "Supporting Professional Nursing Practice".)

Specifically:

- Is leadership provided by a chief executive nurse?
- Are nurses actively involved in decision making at the board and executive levels?
- Do nurses participate in strategic planning at the organizational level?
- Do nurses collaborate with other health professionals in determining standards of patient care?
- Do nurses determine the standards of nursing practice?
- Are quality improvement activities in place and considered fundamental to the organization's operation?

- Does the organization analyze the potential impact of all decisions relative to nursing?
- Do nurses actively participate in the selection and assessment of technologies?
- Do nurses contribute to the development of clinical and management information systems?
- Do nurses have a key say in resource utilization?
- Do nurses shape their own staff development and professional education programming?
- Does the organization foster and support nursing linkages with educational institutions?

There is a popular expression in the business world these days: *Do the right thing. Do things right.* By asking the right questions about new care delivery approaches, nurse administrators will not only help ensure that health care organizations do the right thing and do things right. They will help ensure that change occurs for the right reason: To ensure the protection and improved health of the Canadian public at a cost society can afford.

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