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CONCEPTS AND THEORIES GUIDING PROFESSIONAL PRACTICE

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LEARNING OBJECTIVES AND ACTIVITIES

- Describe the importance of having a theory for professional nursing practice.
- Identify the scope and standards for nurse administrators as a framework for practice.
- Discuss the linkages of theory, evidence-based nursing, and practice.
- Discuss the guiding principles and competencies for nurse administrative practice and how they crosswalk to the scope and standards of nurse administrators.
- Define the terms *executive*, *manager*, *managing*, *management*, and *nursing management*.
- Identify five essential management practices that promote patient safety.
- Differentiate among concepts, principles, and theory.
- Describe critical theory.
- Discuss general systems theory.
- Illustrate selected principles of nursing management.
- Describe roles for nurse managers and nurse executives, differentiating among levels.
- Distinguish between two cognitive styles: intuitive thinking and rational thinking.
- Discuss the use of nursing theory in managing a clinical practice.
- Discuss the responsibility of the nurse administrator for managing a clinical discipline.



CONCEPTS

Aim of health care, scope of practice, standards of practice for nurse administrators, management theory, nursing management theory, critical theory, general systems theory, nursing management, management principles, management development, nursing management roles, role development, cognitive styles, intuitive thinking, rational thinking, management levels, modalities of nursing

Q U O T E

Do not, I beg you, look for anything behind phenomena. They are themselves their own lessons.

—Goethe



NURSE MANAGER BEHAVIORS

Applies postmodern management theory to organizational operations; assesses the impact of various influences from ethnic, political, social, financial, economic, and ethical issues perspectives; networks with state, regional, national, and global peers to share ideas and conduct mutual problem solving; demonstrates a commitment to lifelong learning and on-going professional development through such activities as certification and participation in professional organizations



NURSE EXECUTIVE BEHAVIORS

Examines the application of a nursing and management theory by creating a business plan that incorporates a pilot study; works with representatives of the professional nursing staff to develop and test the pilot study; leads initiatives in innovative programs and new implementation alternatives; pursues continuing education, certification, professional development, and networking; seeks experiences to advance one's skills and knowledge base in areas of responsibilities, including the art and science of nursing, changes in health care systems, application of emerging technologies, and administrative practices

Introduction

Patient safety and quality initiatives as well as magnet status continue to mandate that nurses practice from a framework of professionalism. A sound evidence-based management practice advances the overall practice of nursing administration. Nurse leaders guided by a conceptualized practice have an opportunity to transform health care. In 1999 the Institute of Medicine released *To Err Is Human: Building a Safer Health System*, a disturbing report that brought significant public attention to the crisis of patient safety in the United States. *Crossing the Quality Chasm: A New Health System for the 21st Century* followed in 2002, which was a more detailed reporting of the widening gap between how good health care is defined and how health care is actually provided. The latter report calls the divide not just a gap but a chasm, and the difference between those two metaphors is quantitative as well as qualitative. Not only is the current health care system lagging behind the ideal in large and numerous ways, but the system is fundamentally and incurably unable to reach the ideal. To begin achieving real improvement in health care, the whole system has to change.

Looking at the other side of the chasm, the 2002 report outlined an ideal health care with six “aims for improvement”:

1. *Health care must be safe.* This means much more than the ancient maxim “First, do no harm,” which makes it the individual caregiver’s responsibility to somehow try extra hard to be more careful (a requirement modern human factors theory has shown to be unproductive). Instead, the aim means that safety must be a property of the system. No one should ever be harmed by health care again.

2. *Health care must be effective.* It should match science, with neither underuse nor overuse of the best available techniques—every elderly heart patient who would benefit from beta-blockers should get them, and no child with a simple ear infection should get advanced antibiotics.
3. *Health care should be patient centered.* The individual patient’s culture, social context, and specific needs deserve respect, and the patient should play an active role in making decisions about her or his own care. That concept is especially vital today, as more people require chronic rather than acute care.
4. *Health care should be timely.* Unintended waiting that doesn’t provide information or time to heal is a system defect. Prompt attention benefits both the patient and the caregiver.
5. *The health care system should be efficient,* constantly seeking to reduce the waste—and hence the cost—of supplies, equipment, space, capital, ideas, time, and opportunities.
6. *Health care should be equitable.* Race, ethnicity, gender, and income should not prevent anyone in the world from receiving high-quality care. We need advances in health care delivery to match the advances in medical science so the benefits of that science may reach everyone equally.

However, we cannot hope to cross the chasm and achieve these aims until we make fundamental changes to the whole health care system. All levels require dramatic improvement, from the patient’s experience—probably the most important level of all—up to the vast environment of policy, payment, regulation, accreditation, litigation, and professional training that ultimately shapes the behavior, interests, and opportunities of health care. In between are the microsystems that bring the care to the patients, the small caregiving teams and their procedures and work environments as well as all the hospitals, clinics, and other organizations that house those microsystems. “We’re trying to suggest actions for actors, whether you’re a congressman or the president or whether you’re a governor or a commissioner of public health, or whether you’re a hospital CEO or director of nursing in a clinic or chairman of medicine,” says Donald M. Berwick, MD, MPP, President and Chief Executive Officer of the Institute for Healthcare Improvement and one of the Chasm report’s architects. “No matter where you are, you can look at this list of aims and say that at the level of the system you house, the level you’re responsible for, you can organize improvements around those directions.”

A framework for nursing administrative practice necessitates a redesigning of the various functions, roles, and responsibilities of a nurse administrator. Changes in the landscape of health care, such as new technology, increased diversity in the workplace, greater accountability for practice, and a new spiritual focus on the mind and body connection, require creativity, innovative leadership, and management models. A roadmap, with its definitive lines of direction, is not enough. A more appropriate analogy is that of using a compass to find true north in this new age of health care delivery systems and nursing practice models. Productivity and cost concerns remain important; however, there is an equal if not greater focus on safety, quality relationships, and healing environments. Sound nursing and management theories, along with evidence-based management practices, equip the nurse administrator with the tools to foster a culture of collaborative decision making and positive patient and staff outcomes. Core competencies identified by the Institute of Medicine in its work on educating health care professionals further underscore the work that needs to be done¹:

1. Provide patient-centered care.
2. Work in interdisciplinary teams.
3. Use evidence-based practice.
4. Apply quality improvement.
5. Utilize informatics.

Core competencies apply to all health care professionals and emphasize greater integration of disciplines, creating a culture focused on improving safety outcomes in health care. Transformational lead-

ership and evidence-based management are necessary for redesigning our current health care system. Creating a professional practice model of nursing can serve to strengthen this agenda and advance a safe, quality health care system.

PROFESSIONAL PRACTICE MODEL OF NURSING

If nursing is truly to be a professional practice, an environment supporting professional practice must be created. Models of care delivery by professional nurses further advance this important work. The impact of increasing demand and decreasing supply of registered nurses and rapid aging of the nursing workforce means that by the year 2020 there will be a 20% shortage in the number of nurses needed in the U.S. health care system. This translates into an unprecedented shortage of more than 400,000 registered nurses.² Given the anticipated shortage as well as the increased demand for nursing as a professional practice, the American Nurses Association (ANA) notes work environments that support professional practice to enhance positive staff and patient outcomes³:

1. Magnet hospital recognition
2. Preceptorships and residencies
3. Differentiated nursing practice
4. Interdisciplinary collaboration

Magnet Recognition Programs

The foundation for the magnet nursing services program is the *Scope and Standards for Nurse Administrators*.⁴ The program provides a framework to recognize excellence in

1. Nursing services management, philosophy, and practices
2. Adherence to standards for improving the quality of patient care
3. Leadership of the chief nurse executive and competence of nursing staff
4. Attention to the cultural and ethnic diversity of patients, their significant others, and the care providers in the health care system

Nurse scientists continue to evaluate magnet hospitals. There have been substantial improvements in patient outcomes in organizational environments that support professional nursing practice. The magnet nursing services designation remains a valid marker of nursing care excellence.⁵

Preceptorships and Residencies

Clinical experiences facilitating students and graduates to make the transition to the work setting with more realistic expectations and maximal preparation are necessary.⁶ Academic and clinical partnerships are essential, taking such forms as summer internships, externships, and senior capstone preceptored experiences. These partnerships offer opportunities for role socialization and for increasing clinical skills, knowledge, competence, and confidence.⁷⁻⁹ Extended preceptorships serve as well-thought-out recruitment strategies to decrease costly, lengthy orientation programs and potentially reduce turnover rates.^{10,11}

Along with socializing students and new nursing graduates, postgraduate residencies or internships are innovative ways to transition new graduates into practice. The National League for Nursing defines residencies as formal contracts between the employer and the new graduate that outline clinical activities performed by the new nurse in exchange for additional educational offerings and experiences.¹² In a survey of chief nursing officers, 85% of responding chief nursing officers reported having an extended program of orientation for new graduates.¹³

Differentiated Nursing Practice

Differentiated practice models are clinical nursing practice models defined or differentiated by level of education, expected clinical skills or competencies, job descriptions, pay scales, and participation in decision making.^{14–16} Differentiated models of practice support clinical “ladders” or defined steps for advancement within the organization. These steps or “rungs” on the ladder are based on experience, additional education, specialty certification, or other indicators of professional excellence. Evidence supports differentiated practice models that foster positive patient and nursing staff outcomes.^{17–20}

Interdisciplinary Collaboration

Interdisciplinary practice or collaboration is described as a joint decision-making and communication process among health care providers that is patient centered, focusing on the unique needs of the patient and the specialized abilities of those providing care. Characteristics of interdisciplinary collaboration include mutual respect, trust, good communication, cooperation, coordination, shared responsibility, and knowledge.²¹

Interdisciplinary practice emphasizes teamwork, conflict resolution, and the use of informatics, facilitating collaboration in patient care planning and implementation.²² Best integrated health delivery systems evolve toward a model of care in which complex patients are managed by interdisciplinary providers. The Pew Health Professions Commission study supports collaboration among physicians, nurses, and allied health professionals. There is evidence of improved outcomes for both acutely and chronically ill patients when cared for by interdisciplinary teams.²³

Professional nursing practice must be supported by an environment of professionalism, with exemplars of magnet recognition, preceptorships, residencies, differentiated practice, and interdisciplinary collaboration providing evidence that such an environment makes a difference. Using this as a backdrop, the ANA outlines components of a professional nursing practice environment²⁴:

1. Manifests a philosophy of clinical care emphasizing quality, safety, interdisciplinary collaboration, continuity of care, and professional accountability, in that nursing staff assume responsibility and accountability for their own practice and nurse staffing patterns have an adequate number of qualified nurses to meet patients’ needs, considering patient care complexity.
2. Recognizes contributions of nurses’ knowledge and expertise to clinical care quality and patient outcomes, in that the organization has a comprehensive reward system that recognizes role distinctions among staff nurses and other expert nurses based on clinical expertise, reflective practice, education, or advanced credentialing. Nurses are encouraged to be mentors to less experienced colleagues and to share their enthusiasm about professional nursing within the organization and the community.
3. Promotes executive level nursing leadership, in that the nurse executive participates on the governing body and has the authority and accountability for all nursing or patient care delivery, financial resources, and personnel.
4. Empowers nurses’ participation in clinical decision making and organization of clinical care systems, in that decentralized, unit-based programs or team organizational structure is used for decision making and review systems for nursing analysis and correction of clinical care errors and patient safety concerns are used.
5. Maintains clinical advancement programs based on education, certification, and advanced preparation, in that peer review, patient, collegial, and managerial input is available for performance evaluation on annual or routine basis and financial rewards are available for clinical advancement and education.
6. Demonstrates professional development support for nurses, in that professional continuing education opportunities are available and supported and long-term career support programs tar-

get specific populations of nurses, such as older individuals, home care or operating room nurses, or nurses from diverse ethnic backgrounds.

7. Creates collaborative relationships among members of the health care provider team, in that professional nurses, physicians, and other health care professionals practice collaboratively and participate in standing organizational committees, bioethics committees, the governing structure, and the institutional review processes.
8. Uses technological advances in clinical care and information systems, in that documentation is supported through appropriate application of technology to the patient care process and resource requirements are quantified and monitored to ensure appropriate resource allocation.

Professional nurse administrative practice considers the scope and standards for nurse administrators, providing a template for excellence in health care management.

SCOPE AND STANDARDS FOR NURSE ADMINISTRATORS: FRAMEWORK FOR PRACTICE

In a joint position statement on nursing administration education, the American Association of Colleges of Nursing and the American Nurses Association (ANA) outline core abilities necessary for nurses in administrative roles. These include the abilities to use management skills that enhance collaborative relationships and team-based learning to advocate for patients and community partners, to embrace change and innovation, to manage resources effectively, to negotiate and resolve conflict, and to communicate effectively using information technology. Content for specialty education in nursing administration includes such concepts and constructs as strategic management, policy development, financial management/cost analysis, leadership, organizational development and business planning, and interdisciplinary relationships. Being mentored by expert executive nurses, engaging in research, and enacting evidence-based management (such as the tracking of effectiveness of care, cost of care, and patient outcomes) are also critical to the education of nurse administrators.

The *Scope and Standards for Nurse Administrators* provides a conceptual model for educating and developing nurses in the professional practice of administrative nursing and health care. This document serves as a framework for this book, which focuses on the levels of nursing administration practice, the standards of practice, and the standards of professional performance for nurse administrators. Consideration of the scope and standards, the role of certification, magnet recognition, and best practice are also included from this frame of reference.²⁵ Management and leadership theory serves to further reinforce the concepts required for nursing administrative practice. Such concepts are essential to managing a clinical practice discipline.

THE NURSE ADMINISTRATOR

The nurse administrator has been described as a “registered nurse whose primary responsibility is the management of health care delivery services and who represents nursing service.”²⁶ Nurse administrators can be found in a wide variety of settings, with entrepreneurial opportunities available throughout the health care arena. In addition to hospitals, home health care, and skilled care, nurse administrators can also serve in such settings as assisted living, community health services, residential care, and adult day care. In these settings, the nurse administrator must be adequately prepared to face challenges in diverse fields such as information management, evidence-based care and management, legal and regulatory oversight, and ethical practices.

Level of Nursing Administrative Practice

The ANA conceptually divides nursing administration practice into two levels, nurse executive and nurse manager, each with a particular focus that makes a unique contribution to the management of

health care systems. The nurse executive's scope includes overall management of nursing practice, nursing education and professional development, nursing research, nursing administration, and nursing services. "The nurse executive holds the accountability to manage within the context of the organization as a whole, and to transform organizational values into daily operations yielding an efficient, effective, and caring organization."²⁷ Particular functions of the nurse executive include leadership, development, implementation, and evaluation of protocols, programs, and services that are evidence-based and congruent with professional standards.

Nurse managers are responsible to a nurse executive and have more defined areas of nursing service. Advocating and allocating for available resources to facilitate effective, efficient, safe, and compassionate care based on standards of practice are the cornerstone roles of the nurse manager. A nurse manager performs these management functions to deliver health care to patients. Nurse managers or administrators work at all levels to put into practice the concepts, principles, and theories of nursing management. They manage the organizational environment to provide a climate optimal to the provision of nursing care by clinical nurses and ancillary staff.

Management knowledge is universal; so is nursing management knowledge. It uses a systematic body of knowledge that includes concepts, principles, and theories applicable to all nursing management situations. A nurse manager who has applied this knowledge successfully in one situation can be expected to do so in new situations. Nursing management occurs at unit and executive levels. At the executive level, it is frequently termed administration; however, the theories, principles, and concepts remain the same.

With decentralization and participatory management, the supervisor, or middle management, level has been largely eliminated. Nurse managers of clinical units are being educated in management theory and skills at the master's level. Clinical nurses are being educated in management skills that empower them to take action in managing groups of employees as well as clients and families. Clinical nurse managers perform more of the coordinating duties among units, departments, and services. "Nurse managers are accountable for the environment in which clinical nursing is practiced."²⁸ Both the nurse executive and nurse manager use the standards of practice and standards of professional performance as priorities for nurse administrative practice.

The standards of practice (as framework for this edition) include the following²⁹:

- Standard 1: Assessment. Considers data collection systems and processes. Analyzes workflow in relation to effectiveness and efficiency of assessment processes. Evaluates assessment practices.
- Standard 2: Problems/diagnosis. Considers the identification and procurement of adequate resources for decision analysis. Promotes interdisciplinary collaboration. Promotes an organizational climate that supports the validation of problems and formulation of a diagnosis of the organization's environment, culture, and values that direct and support care delivery.
- Standard 3: Identification of outcomes. Considers the interdisciplinary identification of outcomes and the development and utilization of databases that include nursing measures. Promotes continuous improvement of outcome-related clinical guidelines that foster continuity of care.
- Standard 4: Planning. Considers development, maintenance, and evaluation of organizational systems that facilitate planning for care delivery. Creativity and innovation that promote organizational processes for desired patient-defined and cost-effective outcomes are also included in this standard. Collaborates and advocates for staff involvement in all levels of organizational planning and decision making.
- Standard 5: Implementation. Considers the appropriate personnel to implement the design and improvement of systems and processes that assure interventions. Considers the efficient documentation of interventions and patient responses.
- Standard 6: Evaluation. Considers support of participative decision making. Develops policies, procedures, and guidelines based on research findings and institutional measurement of quality

outcomes. Evaluation includes the integration of clinical, human resource, and financial data to adequately plan nursing and patient care.

Standards of professional performance such as quality of care and administrative practice, performance appraisal, professional knowledge, professional environment, ethics, collaboration, research, and resource utilization are also integrated in the framework of this edition. These standards are woven within the chapters and provide continuity of processes and systems of nursing administration (Figure 2-1).

Magnet Recognition Program and Scope and Standards for Nurse Administrators

The American Nurses Credentialing Center provides guidelines for the magnet recognition program. This program's purpose is to recognize health care organizations that have demonstrated the very best in nursing care and professional nursing practice. Such programs have been recognized for having the best practices in nursing, and they also serve to attract and retain quality employees. A key objective of the program is to promote positive patient outcomes. This program also offers a vehicle for communicating best practices and strategies among nursing systems. "Magnet designation helps consumers locate health care organizations that have a proven level of nursing care."³⁰ Quality indicators and standards of nursing practice as identified by the ANA's Scope and Standards for Nurse Administrators are cornerstone to the magnet recognition program. Qualitative and quantitative factors in nursing are also included in the appraisal process. Certification of nurse administrators is also endorsed through the magnet recognition program.

Qualifications of Nurse Administrators

Attaining the license, education, and experience required for levels of nursing administrative practice is paramount to success in the role as well as to the organizational responsibilities accepted. The nurse

FIGURE 2-1

ANA SCOPE AND STANDARDS FOR NURSE ADMINISTRATORS

Standards of Practice	Standards of Professional Performance
Assessment	Quality of Care and Administrative Practice
Problem/diagnosis	Performance Appraisal
Appraisal	Identification of <i>Journal of Nursing Administration</i> , 97, <i>Journal of Nursing Administration</i> , 97, outcomes
Professional	Knowledge
Planning	
Professional	Environment
Implementation	Ethics
Evaluation	
Collaboration	
Research	
Resource	Utilization

manager and nurse executive must hold an active registered nurse license and meet the requirements in the state in which they practice. The nurse executive should hold a bachelor's degree and master's degree (or higher) with a major in nursing.

In the nurse manager's role, preparation should be a minimum of a bachelor's degree with a major in nursing. A master's degree with a focus in nursing is recommended along with nationally recognized certification in nursing administration with an appropriate specialty. "The experience backgrounds of professional nurses who serve as nurse administrators must include clinical and administrative practice, which enables these registered nurses to consistently fulfill the responsibilities inherent in their respective administrative roles."³¹

Certification of Nursing Administration

The American Nurses Credentialing Center offers two levels for nursing administration, including an advanced level. Both certification examinations include the following domains: organization and structure, economics, human resources, ethics, and legal and regulatory issues. The domain of organization and structure accounts for the highest percentage of questions for the advanced level. For the nurse manager level, the domain of human resources ranks highest. Both certification examinations include 175 questions with 150 questions scored. Review and resource materials for certification are available and can provide continuing education units for the certification examination.

Using management theory as an underlying framework supports the work of the nurse administrator through the Scope and Standards for Nurse Administrators.

MANAGEMENT: HISTORICAL PERSPECTIVES

Consideration of premodern, modern, and postmodern eras provides a broader perspective on management. The premodern era includes the concepts of work as craft, apprenticeship, journeyman artisan, fraternal organization of professions, and tradition. The modern management era considers pyramids, hierarchy, and systems of money, materials, manpower, inspection, distribution, and production in specialized cells that minimize interaction. The postmodern era includes networks, network stakeholders, and team planning.

Mary Parker Follett is credited with being the "mother of modern management." Taylor, Fayol, and Weber have had considerable influence on modern management and are called the "fathers of modern management." Scientific management (efficiency) provided information on standards, time/motion studies, task analysis, job simplification, and productivity incentives.

Modern management theory evolved from the work of Henri Fayol, who identified the activities or functions of the administrator as planning, organizing, coordinating, and controlling.³² His work has been called "process management." Fayol defined management in these words:

To manage is to forecast and plan, to organize, to command, to coordinate, and to control. To foresee and provide means [of] examining the future and drawing up the plan of action. To organize means building up the dual structure, material and human, of the undertaking. To command means binding together, unifying and harmonizing all activity and effort. To control means seeing that everything occurs in conformity with established rule and expressed demand.³³

Although some persons believed these were technical functions that could be learned only on the job, Fayol believed that they could be taught in an educational setting if a theory of administration could be formulated.³⁴ He also stated that the need for managerial ability increases in relative importance as an individual advances in the chain of command. The principles of management described by Fayol are listed in Figure 2-2.³⁵

FIGURE 2-2

FAYOL'S PRINCIPLES OF MANAGEMENT

1. Division of work
2. Authority
3. Discipline
4. Unity of command
5. Unity of direction
6. Subordination of individual interests to the general interests
7. Remuneration
8. Centralization
9. Scalar chain (line of authority)
10. Order
11. Equity
12. Stability or tenure of personnel
13. Initiative
14. Esprit de corps

Human relations management and behavioral science and management are also integrated into the modern management paradigm. The Hawthorne studies validated the influence of working conditions on employee efficiency and productivity. Labor and management relationships, communication, and democratization of the workplace are key aspects of human relations management. Maslow, Herzberg, MacGregor, Argyris, and Likert have been instrumental in developing behavioral science management theory. Additionally, Blake, Mouton, Fiedler, Hersey, and Blanchard are also noted for their work in this aspect of the modern era. Building on the work of human relations management, the behaviorists paid particular attention to leadership, participative management, personal motivation and hygiene factors, and hierarchy of workers' needs. During the modern management era, there was noted stability in the workforce, limited diversity in the workplace, and a better educated workforce.

Throughout management literature, the original functions of planning, organizing, directing (command and coordination), and controlling as defined by Fayol and others have been accepted as the principal functions of managers. Although linear structures, bureaucracy, rationality, and control define the modern era, the postmodern era considers a new universe of pattern, purpose, and process. Postmodern organizations are described as loosely coupled, fluid, organic, and "adhocratic." Organic, continuum-based, and living systems are inherent to this era. Wilson and Porter-O'Grady contrast linear integration with meta-integration, which focuses on long-term service orientation, systems design, and population/person-driven, continuum-based, and outcome-driven systems. According to the authors, the postmodern manager's role is accountability based, resource oriented, and service driven. The term "service driven" highlights the manager's role as facilitator, integrator, and coordinator.³⁶

Peter Drucker first applied the term *postmodern* to organization in 1957, identifying a shift from the Cartesian universe of mechanical cause and effect (subject/object duality) to this new order of pattern, purpose, and process. Knowledge workers were also included in this discussion with greater emphasis on providing management processes and systems that supported decision making at the point of service by those knowledgeable about the processes. Evidence-based management is viewed as critical to transforming work environments and providing safe and quality care.³⁷

Evidence-based management has particular significance in health care, because the work environment experiences greater turbulence, chaos, and instability than do those of other disciplines. Dated and untested management practices are no longer useful and may be detrimental to providing safe care. In *Keeping Patients Safe: Transforming the Work Environment of Nurses*, the importance of sound, evidence-based management practices are underscored. Using an evidence-based frame of reference, managers, like their clinical counterparts, are accountable for searching for, appraising, and applying empirical evidence from management research in their practices. Additionally, thoughtful reflection, decision making, and actions by managers should be systematically recorded and evaluated in ways that further add to the evidence base of effective management practice. The Committee identified five essential management practices.³⁸ These five practices have not been consistently applied, adding further evidence to their importance in today's health care environment:

1. *Balancing the tension between efficiency and effectiveness.* Best practices in this domain include putting redundancy into work design, which has proven effective in the air traffic control industry. Consideration of production efficiency, balance and alignment of organizational goals, accountability processes, rewards, incentives, and compensation are aspects of this practice, which can improve patient outcomes.
2. *Creating and sustaining trust.* Trust and honest, open communication are critical to successful organizational change. When there is openness and trust, individuals are more willing to make contributions to the organization without immediate payoffs. Trust in an organization's leaders and management practices has been linked to positive business outcomes such as increased productivity and greater profitability, whereas distrust has been linked to increased absenteeism, turnover, and risk aversion.
3. *Actively managing the process of change.* This management practice is related to human resource management and includes practices such as ongoing communication; training; designing mechanisms for feedback, measurement, and redesign; sustained attention; and worker involvement. The concept of investment in change as being good for the organization and individual is illuminated in this practice.
4. *Involving workers in work design and workflow decision making.* Hierarchically structured and highly controlled organizations lack the flexibility to respond to situations that are highly variable and associated with reduced safety. The concepts of shared governance, nursing empowerment, control over nursing practice, and clinical autonomy have been noted to improve patient outcomes as well as worker satisfaction. The key element in this practice is nurses' control over their practice. This influences care of the individual patient as well as organizational policies and practices carried out within nursing units, the effects of the health care organization as a whole on nursing care, and the control of resources in care provision. Magnet hospitals support these aspects of nurses' involvement. Studies reveal that both autonomy and control over nursing practice are consistent magnet characteristics. Additionally, nurses' autonomy and control over practice are positively related to trust in management.³⁹
5. *Creating a learning organization.* Learning organizations constantly manage the learning process and consider all sources of knowledge, the use of systematic experimentation to generate new knowledge within the organization, and the quick and efficient transfer of knowledge within the organization. Understanding the existing knowledge culture within the organization is important to the work of creating a learning organization with enough time to think, learn, and train. Incentives and reward systems must be aligned and must facilitate knowledge management practices in the creation of a learning environment.⁴⁰

These five essential management practices in nurses' work environment and health care at large are inconsistent at best and create barriers to positive patient outcomes. An understanding of management theory and practices provides a foundation for best practice.

Managing means accomplishing the goals of the group through effective and efficient use of resources. Specifically, project management is considered a core competency for nurses and managers. Some organizations have adopted project management as their main management approach (management-by-project); other organizations superimpose project management on their current organizational structure and management practices. The manager creates and maintains an internal environment in an enterprise in which individuals work together as a group. Managing is the art of doing, and management is the body of organized knowledge underlying the art. In modern management, staffing is frequently separated from the planning function, directing is labeled leading, and controlling is used interchangeably with evaluating. The ANA's standards for nursing administration are based on these principles, which support the science of nursing administration.⁴¹

THEORY, CONCEPTS, AND PRINCIPLES

The knowledge base of management science includes theory, which in turn includes concepts, methods, and principles. The principles are related and can be observed and verified to some degree when they are translated into the art or practice of management. Concepts are thoughts, ideas, and general notions about a class of objects that form a basis for action or discussion. Concepts tend to be true but are not always true. Principles are fundamental truths, laws, or doctrines on which other notions are based. Principles provide guidance to concepts and to thought or action in a situation.⁴²

White explores a viewpoint on nursing theories in which she addresses prescriptive theories. She notes that their use as practice guidelines must be broad enough to provide a wide range of practice situations but not so broad as to be meaningless. A theory of decision making might be as beneficial in practice as a theory of nursing. If nursing is going to base its theory on laws, nurses need to validate principles through research—a difficult task, as theorists in the social sciences have discovered. It is not easy to reduce human behavior to laws. Nurses deal with human behavior in all roles but particularly in nursing management. Nurses believe that for nursing to be a real profession, it should have a scientific and theoretical base. Nursing is thus a practice profession based on the physical and social sciences.⁴³

Nurse managers learn to merge the disciplines of human relations, labor relations, personnel management, and industrial engineering into a unified force for effective management. Nurse managers would add the theory of nursing to this list. A successful synthesis of these disciplines can promote employee commitment, increased productivity, enhanced competency, good labor relations, and competitiveness in health care. The workforce is poorly managed when these goals are not achieved.

Critical Theory versus Critical Thinking

Steffy and Grimes note that a strict natural science approach to social science is naive, because subjective or qualitative analysis is important to quantitative research. This holds true for management and consequently for nursing management. Health care organizational models are not objective and value free. Steffy and Grimes suggest using a critical theory approach to organizational science rather than a phenomenological or hermeneutic approach.

A phenomenological approach uses second-order constructs, or “interpretations of interpretations.” This approach requires researchers to become participants in the organization and to suspend all judgments and preconceived ideas about possible meanings. The nurse manager interprets the meaning of nursing management experiences or observations and arrives at a nursing management theory from the aggregate of meanings.

Hermeneutics is the art of textual interpretation. In this approach, the nurse manager as researcher views self as a historically produced entity and recognizes personal biases in doing research. He or she considers the specific context and historic dimensions of data collected and reflect on the relationship between theory and history.⁴⁴

Critical theory is an empirical philosophy of social institutions. Decision makers, such as nurse managers, translate theories into practice. Theories in use are behavioral technologies that include organizational development, management by objectives or results, strategic planning, planned change, performance appraisal, and other practice-oriented activities performed by managers. Critical theory aims to do the following:

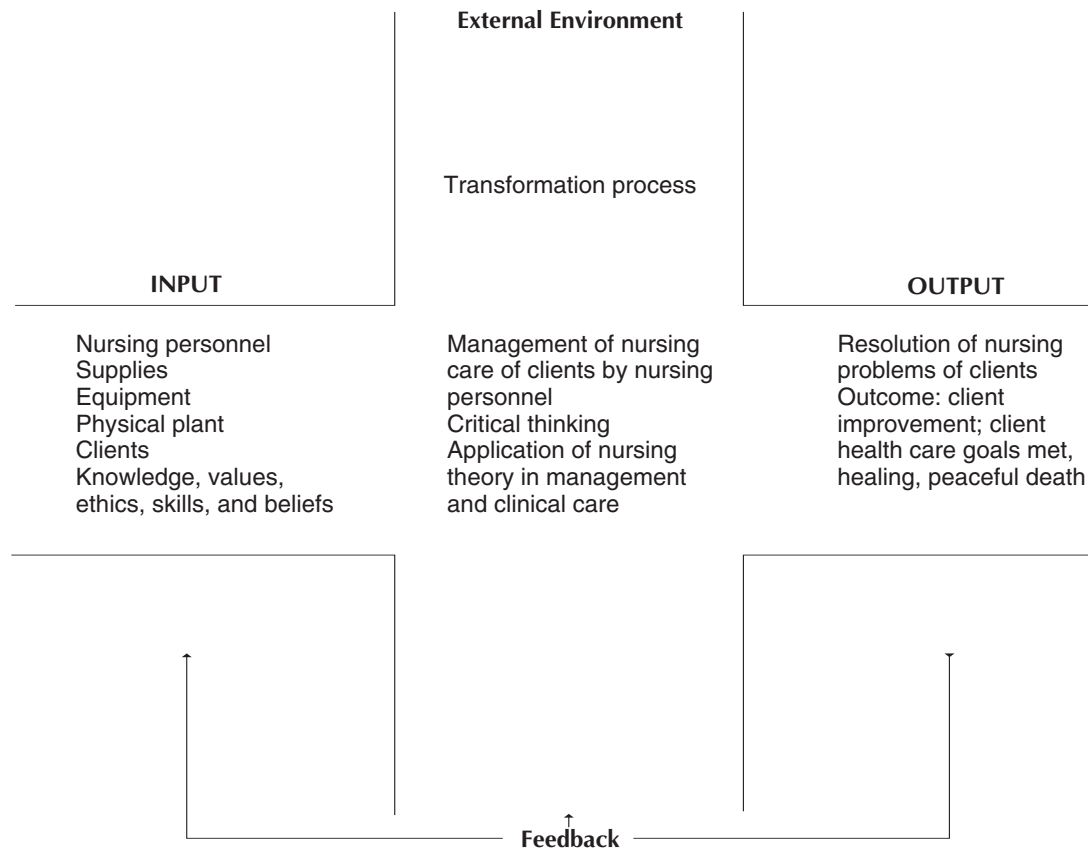
1. Critique the ideology of scientism, the institutionalized form of reasoning that accepts the idea that the meaning of knowledge is defined by what the sciences do and thus can be adequately explicated through analysis of scientific procedures
2. Develop an organizational science capable of changing organizational processes

These aims are compatible with a theory of nursing management. Nurses use science to legitimize the practice of clinical nursing and nursing management.⁴⁵

General Systems Theory

General systems theory is an organic approach to the study of the general relationships of the empirical universe of an organization and human thought. The theory comes from the field of biology and poses an analogy between an organism and a social organization. General systems concepts form the theoretical underpinnings for other leadership and management theories. Boulding describes nine levels of a general systems theory,⁴⁶ which are given here with nursing management applications:

1. *A static structure: the framework.* Nursing is a discipline with an aggregate population of registered nurses educated at several levels (including those with hospital diplomas and those with degrees from associate through doctoral levels), licensed practical nurses, and unlicensed assistive personnel (e.g., aides, orderlies, attendants, nursing assistants, and clerks). This population functions within a dynamic and flattening structure that may change frequently. Superior/subordinate relationships are giving way to decentralized, participatory, and transformational management at the practice level. Flat organizations usually have a top administrator, first-line managers, and practitioners. These nursing persons usually function in an environment in which the focus of attention is the client. One approach to a framework in nursing is that nursing persons apply the nursing process in giving care to patients. Many similarities exist between the nursing process and nursing management.
2. *A moving level of necessary predetermined motions: the clockwork.* Nurse managers process the knowledge and skills of management—planning, organizing, leading, and evaluating—to produce nursing care. The function of nursing management is the use of personnel, supplies, equipment, clinical knowledge, and skills to give nursing care to clients within varying environments. The nurse manager may also have other ancillary personnel to manage, such as therapists, housekeepers, and social workers, adding to the complexity of providing overall quality services for client care. One such environment is the hospital physical plant. Nursing planning + nursing organizing + nursing leading + nursing evaluating = nursing management. To this we may add that nursing management + nursing practice = nursing care of clients. The move is toward equilibrium of all forces that go into the nursing management equation.
3. *A control mechanism: the thermostat.* In nursing administration this thermostat could be the top administrator or any first-line manager. This person maintains a management information system that transmits and interprets information and communication to and from employees. Production of nursing care of satisfactory quality and quantity depends on the manager maintaining an environment satisfactory to employees.
4. *An open system or self-maintaining structure: the cell.* Nursing management will survive and maintain the nursing organization by being open to new ideas, new management techniques,

FIGURE 2-3 AN OPEN SYSTEM

and the input of human and material resources to produce the nursing care needed by clients. An open system reproduces itself by keeping up to date and by developing replacements. Keep up to date by adding nursing education: nursing management + nursing planning + nursing evaluation = nursing care of clients (see Figure 2-3).

5. *The genetic–societal level.* There is a division of labor even within nursing management but especially among nursing personnel who produce the nursing care of patients. Further integrating multiple skill-level personnel into the mix offers more comprehensive complimentary care in meeting clients' health care needs. The raw materials—that is, the human and material resources—are input. These resources are processed as put through by a group of nursing personnel with varying knowledge and skills using a theory-based nursing care delivery system. The output is resolution of the nursing needs and problems of clients, with their improvement, accomplishment of health care goals, and healing, or their succumbing to a peaceful death.
6. *The “animal” level.* This level has increased mobility, teleological (designing or purposeful) behavior, and self-awareness. Some evidence indicates that nursing management is reaching this level. As nurse managers learn the knowledge and skills of the business and industrial world, they adapt these skills to the management of health care services. This gives nursing management and

nursing practice a more scientific basis, the result of which may be that nurses will be able to demonstrate empirically and theoretically that what they do affects client outcomes.

7. *The “human” level.* The nurse manager develops an increased awareness and knows that he or she can process the knowledge and skills of management to produce specific results.
8. *The level of social organization.* Nurse managers at this level distinguish themselves from other groups of managers. Nurse managers operate within complex roles; their functions are made effective by communication, relationships, and other interpersonal processes.
9. *Transcendental systems.* At this level nurse managers ask questions for which there are as yet no answers. Theoretical models of nursing management extend to level 4 (the cell), the level of application of most other models. Empirical knowledge is deficient at nearly all levels. Descriptive models are needed to catalogue events in nursing. The movement toward decentralization and participatory and service-line management, although still a very simple system, is growing each year as nurse scientists develop and apply new nursing administration models and theories of nursing. General systems theory is the skeleton of a science. Adding nursing research gives: nursing management + nursing planning + nursing evaluation + nursing research = nursing care of clients.

Disciplines and sciences have bodies of knowledge that grow with meaningful information. The empirical universe provides general phenomena relevant to many different disciplines; these phenomena can be built into theoretical models, including one for nursing management. Nursing as a discipline has varied populations (phenomena) that interact dynamically among themselves. These include professional nurses, technical nurses, practical nurses, and unlicensed assistive nursing personnel as well as professional nursing teachers, researchers, and managers. Individuals within the discipline interact with the environment (another phenomenon). Through knowledge and experience they grow. The media for growth are information, interpersonal processing, relationships, and communication, which are themselves phenomena.⁴⁷

With the emerging changes in health care systems, nurse leaders need to accelerate changes in nursing organizations. The goal may be nursing modules centered on closely related operations, such as differentiated practice delivery models matched with intensity of care or specialized services. Standardization and flexibility can be melded to develop systems based on a requirement for a theory of nursing practice as a foundation for all modules, but with different theories being used in different modules chosen by professional clinical nurses.⁴⁸

Full realization of systems theory is as far in the future for nursing as it is for manufacturing. Nursing is a “head, heart, and hands” discipline. Nursing management and practice tie the parts of the health care system together. Transformational nurse leaders will be fully knowledgeable about the work being done by their constituents because they will be coaches, mentors, and facilitators. Followers of the systems concept will also have to implement the integration of people, materials, machines, and time.⁴⁹

ROLES AND NURSING MANAGEMENT

Role Development

The nurse manager draws from the best and most applicable theories of management to create an individual management style and performance.⁵⁰ This requires knowledge and the skills to use it. The nurse manager continues to acquire and use management knowledge to solve managerial problems, which require a contingency approach because no single approach works for all situations.⁵¹ The nurse manager acts with the assumption that clinical nurses and other health care providers want to be competent and that with managerial support they will be motivated to achieve competence and greater levels of productivity. With achievement of competence and productivity goals, higher goals are set. Clinical nurses will seek out the organization that fits their needs.⁵²

Adding to the nurse manager's ever-expanding role is the need to increase knowledge of and sensitivity to other health care individuals providing clinical services. These services are integrated into the client's overall experience of health care, of which nursing is a critical component.

McClure points out that nurse managers manage a clinical discipline performed by professional nurses. Because most nurses are women, conflicts may arise between their professional and personal lives. The nurse manager devises strategies to deal with these conflicts. Some blue-collar nurses lack knowledge of nursing research and do not read to keep up to date; they want nurse managers to do everything. White-collar nurses often want to be treated differently; they want job enrichment, with primary nursing duties and professional autonomy, and they want to be organized like the medical staff, with staff appointments and peer review. The nurse manager manages these two groups differently.⁵³

Management Levels

Nurse managers perform at several levels in the health care organization. These include first-line patient care management at the unit level, middle management at the department level, and top management at the executive level. In some organizations decentralization has displaced the middle management level and redistributed department-level functions to staff functions under a matrix or another organizational structure. The middle management role is often reconsidered in work redesign effort, particularly as leadership moves further away from clinical care. The roles of managers are developmental, building on knowledge and skills as the scope of the nurse manager's role increases in breadth and depth. Middle nurse manager roles are frequently eliminated, and clinical nurses become empowered through management education.⁵⁴

First-Line Nurse Managers

The following are some of the knowledge and skills needed by nurses in first-line management roles:

- Financial management knowledge and skills to prepare and defend a budget for expenses of unit personnel, supplies, and capital equipment and for revenues to meet expenses; the ability to manage scarce and expensive resources for performance
- The ability to match moral and ethical choices with respect to human needs, moral principles for behavior, and individual feelings in making decisions
- Recognition of and advocacy for patients' rights
- Active and assertive effort to share power within the organization, including shared power for nursing's practitioners. This includes nursing autonomy, which is threatened by authoritarian management. In turn, practicing nurses are involved in solving managerial problems.
- The ability to communicate and to promote effective communication and interpersonal relationships among nursing staff and others; presentation skills
- Knowledge of internal factors related to purpose, tasks, people, technology, and structure
- Knowledge of external factors related to economy, political pressures, legal aspects, sociocultural characteristics, and technology
- The ability to study situations and use management concepts and techniques, analyze the situations correctly, make diagnoses of problems, and tie the processes together to arrive at decisions
- The ability to provide for staff development
- The ability to provide a climate in which nurses clearly perceive that they are pursuing meaningful and worthwhile goals through their individual efforts
- Knowledge of organizational culture and its impact on productivity and problem solving
- Ability to effect change through an orderly process
- Commitment to maintain self-development by reading and attending workshops and other educational programs

- Knowledge of how to empower clinical nurses through committee assignments, quality circles, primary nursing, and even assigning titles
- Knowledge of recruitment and retention strategies to promote and retain valued nursing and health care personnel

To these could be added staffing and scheduling, management reports, hiring, performance appraisal, job productivity and satisfaction, constructive discipline dealing with stress and conflict, personnel management, diversity, and awareness of culture, values, norms, and ways of doing things.⁵⁵ Although these skills and this knowledge may be obtained through staff development, master's level management preparation is essential.

In no way are these lists complete. They are a beginning, however, and are built on in succeeding chapters.

The Nurse Executive

Executive nurse managers increase their knowledge and skills by building on what they learned as lower level managers. Executive nurse managers should be able to do the following:

- Apply financial management principles to costing and pricing nursing care and convey this knowledge to the nurses providing care
- Coordinate the division budget
- Empower lower level nurse managers
- Undertake corporate self-analysis of what nursing can do (skills, capabilities, weaknesses, the work of nursing) and its assumptions about itself, its environment, and its beliefs and convey results to employees
- Specify, weigh, interrelate, and simultaneously accomplish multiple goals
- Abandon obsolete principles of standardization, centralization, specialization, and concentration
- Decentralize and share authority and power through participatory management and transformational leadership, shared governance, professional nursing models, employee involvement, and programs on the quality of work life
- Establish a matrix organization using task forces and project teams with project leaders
- Set the stage for clinical nursing practice. This does not necessarily require that the nurse executive be clinically competent.
- Promote application of a theory of nursing within a nursing care delivery system
- Advise nursing educators on content of nursing administration programs
- Set depth and breadth of nursing research programs
- Anticipate the future of health care and of nursing
- Manage strategic planning
- Serve as mentor, role model, and preceptor to lower level managers, graduate students, and others
- Recognize and use authority and the potential for power

Evidence from research indicates that executive nurses prepared at the doctoral level need courses in ethical and accountable decision making, including missions and goals, policies, human resources, financial and material resources, databases, and communication management. These courses would be organized into organizational structure and governance, resources, and information management.⁵⁶

With major changes in business practices, lessons learned from Japan offer meaningful strategies to American business, including the business of health care. For example, the Japanese have found that less variety is best when it comes to cutting costs and saving time. Consensus decision making does not always work. With the help of high-tech information systems, lone decisions based on multiple data

sources and data points may be the best decisions.⁵⁷ The understanding of theories, roles and responsibilities, and evidence-based management provides the foundational work for the nurse administrator to manage a clinical practice.

MANAGING A CLINICAL PRACTICE

Nursing is a clinical practice discipline. Professional nurses want autonomy and control of their practice. They want to apply their nursing knowledge and skills without interference from nurse managers, physicians, or persons in other disciplines. The effective nurse manager trusts the professional nurse to apply knowledge and skills correctly in caring for a group of patients. In turn, the clinical nurse trusts the nurse manager to coordinate supplies, equipment, and support systems with personnel in other departments. Clinical nurses trust a human relations management in which they participate rather than one in which they have rules and regulations imposed on them. They use the body of nursing knowledge (theory) gained in nursing school and maintained through continuing education and staff development to practice nursing as they determine it should be practiced. In doing so, they adhere to management policies regarding such issues as documentation or quality improvement, because these requirements are also part of clinical nursing practice.

Use of Nursing Theory in Professional Practice

In developing nursing as a professional scientific discipline, nursing educators and researchers have developed theoretical frameworks for the clinical practice of nursing that are used by clinical nurses as models for testing and validating applications of nursing knowledge and skills. The results are added to the body of knowledge commonly called the theory of nursing. Theory gives practicing nurses a professional identity. It is based on scientific inquiry: nursing research. Each result of nursing research adds tested facts to nursing theory that can be learned by nursing students and active practitioners.

Watson's Theory of Caring

Caring is central to nursing, and most persons choosing nursing as a profession do so because they desire to care for others. Caring as a science has been defined by Jean Watson. She describes science of caring as one that encompasses a humanitarian, human science orientation, human caring processes, phenomena, and experiences. Watson outlines caring from a science perspective, grounded in a relational ontology of being-in-relation and a world view of unity and connectedness. Transpersonal caring, as Watson notes, acknowledges unity of life and connections that move in concentric circles of caring—from individual, to others, to community, to world, and to the universe. Caring science embraces inquiry that is reflective, subjective, and interpretative as well as objective-empirical. Caring science inquiry includes ontological, philosophical, ethical, historical inquiry, and studies.⁵⁸

An example of how Watson's theory of caring can serve as a framework is illustrated in the Attending Nursing Caring Model (ANCM). ANCM is an exemplar for advancing and transforming nursing practice within a reflective, theoretical, and evidence-based context. The ANCM serves as a program for stimulating the profession and its professional practices of caring—healing arts and science, when nursing is experiencing decline, shortages, and crises in care, safety, and hospital and health reform. With the ANCM, Watson's theory of human caring is used as a guide for integrating theory, evidence, and advanced therapeutics in the area of children's pain. The ANCM raises contemporary nursing's caring values, relationships, therapeutics, and responsibilities to a higher level of caring science and professionalism, interacting with other professions, while sustaining the finest of its heritage and traditions of healing.⁵⁹

Orem's Theory

Orem's theory of self-care is composed of three related theories: the theory of self-care, the theory of self-care deficit, and the theory of nursing systems. She viewed each person as a self-care agent who possesses capabilities, termed *self-care agency*, essential to performing self-care actions. Deliberate action is taken to meet the therapeutic self-care demand arising out of known needs for care. Self-care needs and demands vary throughout the lifespan. If the demand is not met, a self-care deficit exists, which creates the need for nursing. In the nurse–patient experience, a joint decision is made between the nurse and the patient. The role of the nurse is to facilitate and increase the self-care abilities of the individual. Self-care is not instinctive or reflexive but is performed rationally in response to a known need, which is learned through the individual's interpersonal relations and communication. Self-care agency is the power to engage in action. This is a complex developed capability that enables adults and maturing adolescents to recognize and understand factors that must be controlled and managed to regulate functioning and developing as well as the capability to decide about and perform proper care measures. This capability is dependent on lifelong experiences and values related to culture. This is aided by intellectual curiosity and by instruction and supervision from other persons.⁶⁰

Parissopoulos and Kotzabassaki describe Orem's self-care theory in the management of elderly rehabilitation. Orem's theory provides common language in self-care leading to improved communication and enhances consistency in care delivery and building consensus of goals and outcomes of nursing. Nurses are in key positions to facilitate the achievement of self-care that requires sophisticated communication skills, teaching skills, specialized knowledge, and an awareness of the multiple factors affecting nurse–patient relationships during the provision of care.⁶¹

Roy's Theory

Roy advocates adaptation level theory to nursing intervention. She notes that a person adapts to the environment through four modes: physiologic needs and processes, self-concept (beliefs and feelings about oneself), role mastery (behavior among people who occupy different positions within society), and interdependence (giving and receiving nurturance).⁶² Just as the individual patient adapts to changes in the environment, so does the nursing worker.

According to Roy, the goal of nursing is to assist the patient to adapt to illness so as to be able to respond to other stimuli. The patient is assessed for positive or negative behavior in the four adaptive modes. Once the assessment is made at the necessary (first or second) level, intervention is established by a nursing care plan of goals and approaches. The approach is selected to match the goal.⁶³ According to Mastal and Hammond, Roy's views are "that the developing body of nursing knowledge now contains verifiable theories and general laws related to: (1) persons as holistic beings, and (2) the role of nursing in promoting the person's maximum potential health and harmonious interaction with the environment."⁶⁴

Frederickson illustrates application of the Roy adaptation model to the nursing diagnosis of anxiety. He describes or defines anxiety from the nursing perspective as exhibited by "poor nutritional status, reduction in usual physical activity, and lowered self-esteem, in addition to concern for job security." The nurse diagnoses the symptoms of anxiety through assessment of the four modes and then designs and implements an intervention that promotes client adaptation.⁶⁵

Evaluation criteria for empirical testing of nursing theory were developed by Silva and expanded by others. Theory testing includes processes of verifying whether what was purported or experienced is true or solves problems in one's discipline or practice. Silva and Sorrell define nursing theory as "a tentative body of diverse but purposeful, creative, and logically interrelated perspectives that help nurses to redefine nursing and to understand, explain, raise questions about, and seek clarification of nursing phenomena in their research and practice."⁶⁶ They list three alternative approaches of testing to verify nursing theory:

1. Through critical reasoning
2. Through description of personal experiences
3. Through application to nursing practice (This concept has been applied at the National Hospital for Orthopedics and Rehabilitation, Arlington, Virginia, where the Roy adaptation model has been implemented throughout the hospital.)

Newman's Theory

Margaret Newman's theory of health as expanding consciousness emphasizes the whole pattern of the person in interaction with the environment and the process of nursing practice as the content of nursing research.⁶⁷ Newman's theory is grounded in Martha Rogers' science of unitary human beings and is consistent with the unitary transformative paradigm of nursing. Newman describes her model as the process of nursing intervention from the unitary–transformative paradigm. The outline of this intervention process can be applied to research and takes into account the following steps:

- Step 1: Determining the mutuality of the process of inquiry
- Step 2: Zeroing in during the interview on the most meaningful persons and events in the participant's life
- Step 3: Sharing the researcher's depiction of the participant's life pattern, which has been translated from the interview data into a diagram as sequential patterns over time
- Step 4: Determining evidence of pattern recognition and concomitant insight into the meanings of the client's life pattern

According to Newman, this process is the unitary–transformative nursing intervention via pattern recognition. It is the dynamic flow of patterning through the researcher and the researched interaction within the larger dynamic context. Newman's theory has been used in working with cancer patients and provides a conceptualization of intervening in a meaningful way.

Johnson's Theory

Johnson incorporated the nursing process (assessment, diagnosis planning, intervention, and evaluation) into a general systems model. Rawls applied this model to care of a patient for the purpose of testing, evaluating, and determining its utility for predicting the effect of nursing care on a patient. Rawls indicates that the model has disadvantages but is a tool that can be used “to accurately predict the results of nursing interventions prior to care, formulate standards of care, and most importantly, administer truly holistic empathic nursing care.”⁶⁸

Derdiarian sampled 223 cancer patients to verify the relationship among the eight subsystems of Johnson's behavioral system model. These eight subsystems (achievement, affiliative, aggressive/protective, dependence, eliminative, ingestive, sexual, and restorative) function through behavior to meet a person's demands. Illness disrupts and changes behavior sustained in the subsystems, resulting in negative effects on the behavioral systems. Changes in one subsystem initiate changes in others. Findings of this research indicated “fairly large, statistically significant ($P < .001$) direct relationships between the aggressive/protective subsystems and each of the other subsystems.” The research presents a model for continued research of Johnson's behavioral system model with “implications for comprehensive assessment, early intervention, prevention of patients' potential problems, and ultimately for efficient care.”⁶⁹

Peplau's Theory

Peplau's theory defines nursing as a “significant, therapeutic, interpersonal process.”⁷⁰ Peplau's theory involves such concepts as communication techniques, assessment, definition of problems and goals, direction, and role clarification.

Peplau states that four components make up the main elements of the nurse–patient relationship: nurse, patient, professional expertise, and client need. The nurse–patient relationship has three phases: the orientation phase, the working phase, and the resolution phase. During encounters with patients, the nurse observes, interprets what he or she observes, and then decides what needs to be done.

Interpersonal relations use the theoretical constructs of concepts, processes, and patterns:

- A concept is a small, circumscribed set of behaviors pertaining to a particular phenomenon such as conflict.
- A process is more complicated, more comprehensive, and longer lasting.
- A pattern is made up of separate acts that may have variations but share a common theme, aim, or intention.

Interpersonal theory is especially useful in psychiatric nursing and is useful in relation to psychosocial problems and nurse–patient relationships in all clinical areas of nursing. The joint effort of the nurse–patient relationship “includes identification of the presenting problems, understanding the problems and their variation in pattern, and appreciating, applying, and testing remedial measures in order to produce beneficial outcomes for patients.”⁷¹

Case Management: An Example of a Nursing Practice Modality

Case management is more than a modality of nursing. It has been described as all of the following: clinical system that focuses on the accountability of an identified individual or group for conditioning care for a patient or a group of patients across a continuum of care; ensuring and facilitating the achievement of quality and clinical and cost outcomes; negotiating, procuring, and coordinating services and resources needed by the patient or family; intervening at busy points (and/or when significant variance occurs) for individual patients; addressing and resolving patterns in aggregate variances that have a negative quality/cost impact; and creating opportunities and systems to enhance outcomes.⁷² Simply stated, case management is a process of coordinating services, and the case manager is the person who does the coordinating.⁷³

The Center for Case Management’s model of case management was designed as a clinical one. The model’s underlying assumption was that caregivers of each discipline needed to have management skills, better patient care management tools, and more responsible administrative support to create quality clinical outcomes within a new cost-conscious milieu. The organizational structure is flat, with attending-level physician and “selected primary care nurses expanded into case managers to produce the integration of processes, aided by critical paths.”⁷⁴ Critical paths have been integrated into CareMaps®. The CareMap® is used as the nursing care plan and for documentation.

A collaborative team approach is used when integration of care occurs across geographical care units such as the emergency room, the coronary care unit, the step-down unit, and the ambulatory clinic. Primary nurses from these units who have undergone formal orientation join the team.⁷⁵

Personnel at the Center for Case Management believe that 100% of patients need their care managed by a CareMap®. The CareMaps® provide the documented standards for specific patient populations and disease states. With this infrastructure of care delivery, only 20% believe that patients need a case manager in addition to a CareMap® system.⁷⁶

Quality improvement is an integral part of the case management system. Quality management is operationalized by the use of critical paths, CareMaps®, and case management, all of which provide the tools for accomplishing the nursing process.⁷⁷ CareMaps® present problems by defining quality as a product.⁷⁸ When interventions and goals are recorded that are different from those planned, they are termed *variances*. A variance indicates deviations from a norm or standard. Variance indicates intervention that works or does not work. Variances alter discharge dates, expected costs, and expected outcomes.

Variations show how the CareMap® and reality differ both positively and negatively. Variance that shows negative outcomes requires action to improve quality. Variance data are collected, totaled, analyzed, and reported; they then result in decisions that revise CareMaps® critical paths, procedures, and other elements of the plan–do–check–act cycle.⁷⁹ Because CareMaps® can be used to document nursing care, are outcome based, and have been found to be effective and efficient, nurses may want to use a computerized version for documentation.

Other Models of Case Management

University of Kentucky Hospital Model The University of Kentucky Hospital model of case management uses a problem-solving process. Case managers are master’s-prepared nurses to whom cases are referred by quality-monitoring groups. Case managers verify problems, design strategies to fix them, and evaluate outcomes.

The priority in this model is efficient movement through the health care system. Case managers consult with finance personnel, administrators, and health care providers; they collaborate with physicians, primary nurses, and other health care providers; and they establish therapeutic relationships with patients and families. A case management advisory board meeting takes place quarterly. Members perform prospective or retrospective surveys for clinical problems. Case managers follow up with diagnoses and procedure codes specific to the cases with verified problems. Sample problems of outcomes include poor continuity in patient’s care, inadequate discharge planning, inadequate patient teaching, extended preoperative and postoperative stays, and poor nutritional status of patients.

Among the results were the following:

- Reduced glucose levels in diabetic, adult, open-heart surgery patients (which resulted in a savings of \$11,585 in room charges during a 6-month period)
- Decreased arterial blood gas charges in cardiovascular patients
- Intensive care newborn patients home 218 days earlier than comparable patients during the previous year (a savings of \$82,731 for Medicaid patients alone)

Management will pay for performance when hiring case managers in the future.⁸⁰

Carondelet/St. Mary’s Hospital and Health Center Model Another model of case management is the Carondelet/St. Mary’s Hospital and Health Center in Tucson, Arizona. In this model, nurse case managers work in partnership with high-risk individuals in the hospital (30%) and in the community (70%). Reports of applications of this model of nursing case management indicate that it results in financial savings and liability defenses. It is case management in which the nurse manages and coordinates the entire spectrum of a patient’s care in all settings, hospital and community. Effective case management wins the confidence of all team members, including social workers and physicians. Nursing case management supports the highest use of clinical nursing skills. Rogers, Riordan, and Swindle report that case management reduced total admissions, mean admissions per patient, mean length of stay per patient, and net reimbursement. The authors recommend mandating Bachelor of Science in nursing qualifications for case managers and 5 years of clinical experience. They worked out comparable arrangements with social workers.⁸¹

Other Factors Related to Case Management

Bower reported that case managers at Hennepin County Medical Center in Minneapolis were responsible for the following⁸²:

- Over \$1 million in direct cost savings
- Readmission rates for patients having major bowel procedures reduced from 67% to 26%

- Readmission rates for patients with cerebrovascular disorders (except transitory ischemic attacks) reduced from 43% to 31%
- Compliance with antibiotic protocols in patients having hip and femur procedures increased from 38% to 89%

Nurses have been at the forefront of case management as it relates to moving patients through the hospital efficiently. There may be conflicts between nurse case managers and other providers within the community. Professional nurses should become educated about case management programs, interagency groups, use of interdisciplinary teams, and legal issues and should keep respect for clients' wishes and rights continually in mind.⁸⁴

Strong indicates that clinical nurse specialists have the expert clinical and management skills to enhance planning, clinical decision making, and evaluation of resource use. The case management system has been applied to promote cost-effective, long-term wellness in migrant children by addressing cultural, nutritional, and dental care needs and by using available resources. This has also been done with homeless families. Case management identifies the clients' needs and makes and implements plans to meet those needs efficiently and effectively. Case management may be performed by a group practice of primary nurses.⁸⁵

Discussing clients with learning disabilities, Thomas describes case management applied to clients in their local communities as managing a team of field workers who assess clients' needs and make action plans with them.⁸⁶ These plans address assessment, action planning, package development, and financial management. Case managers draw up contracts for clients' services.

These packages include an estimate of hours required for 1 month's care and residential versus home care costs, and they break down costs into those for such workers as community care assistant, respite care home outreach worker, physiotherapist, and occupational therapist and for transportation. Contracts involving groups of clients may obtain discounts. Third-party payers usually approve contracts. Thomas states that caseworkers are frequently social workers, and case management may develop into a new autonomous profession.

Dowling states that nursing case management makes the patient's nurse the central decision hub for the entire spectrum of patient care requirements and services.⁸⁷ He calls this matrix management. The common results of nursing case management fall into five primary areas:

1. Early, or appropriate, patient discharges
2. Expected, or standardized, clinical outcomes
3. Promotion of collaborative practice, coordinated patient care, and true continuity of care
4. Promotion of nurses' professional development and job satisfaction
5. Use of appropriate, or reduced, resources

The model is the critical path forecasting physician intervention, diagnostic testing, ancillary department patient care, support department input, and supply and equipment requirements. The individual critical path is a communication tool for all care given. It is a production schedule. The critical path provides the hospital material manager with a dynamic distribution of patient care supplies and equipment needed in advance of any requests. Hospital information supplements provide the information needed for supplies and equipment planning to be case specific. Just-in-time programs can provide patient-specific supplies for multiple supply-retention locations on a nursing unit.

Research indicates that using the critical path technique for assessing the postoperative recovery of coronary artery bypass graft patients prevents complications, reduces lengths of stay, and reduces hospital costs. Nursing interventions such as use of inspirometers, resumption of activity, and patient education support this finding. Critical paths may be used by nurses to identify appropriate nursing interventions and their costs.⁸⁸

Case management is outcome based and supports evidence-based practices. The Medical Center of Central Georgia in Macon used outcome-based nursing practice. Researchers studied a population of stable cardiovascular patients receiving specialty infusions. By treating these patients on the telemetry unit rather than in the coronary care unit, the center realized cost avoidance of \$46,121.83 in 1 year. Patient classification systems estimate caregiver time and caregiver costs. The weighted salary of caregivers was \$14.34 per hour in the coronary care unit and \$10.00 per hour in the telemetry unit. Cost per patient day was \$102.45 versus \$49.23, for a cost avoidance of \$53.22 per patient day.⁸⁹

Zander states that the complete results of case management must include length of stay statistics, readmission rates, and some tally of patient satisfaction.⁹⁰

Bower catalogues the reasons for implementing case management⁹¹:

1. A client/family focus on the full spectrum of needs
2. Outcome orientation to care
3. Coordination of care by team collaboration
4. Cost management through facilitation through the health care system
5. Response to insurers and payers
6. A merger of clinical and financial interests, systems, and outcomes
7. Inclusion for marketing strategies

PATIENT OUTCOMES

Outcomes and their relation to productivity are a major concern in human relations management. At the University of Iowa College of Nursing, nurse researchers and practitioners have developed the nursing outcomes classification. At the College of Nursing, the nursing outcomes classification has been integrated with the nursing diagnoses classification, the nursing interventions classification, and the nursing management minimum data set.⁹² Patient outcomes are the outcomes resulting from care of patients by nurses or an interdisciplinary care team. Patient outcomes include those related to patient satisfaction and health status, nosocomial infection control, and risk events and adverse outcomes. Activities related to patient outcomes are directed toward improving organizational performance continually over time.⁹³

SUMMARY

The Scope and Standards for Nurse Administrators provides a conceptualization for practice. Levels of nursing administration further delineate the roles of nurse manager and nurse executive.

A theory of nursing management evolves from a general theory of management that governs effective use of human and material resources. The four major functions of management are planning, organizing, directing (or leading), and controlling (or evaluating). All management activities—cognitive, affective, and psychomotor—fall within one or more of these major functions, which operate simultaneously.

Nursing management focuses on human behavior. Nurse managers with knowledge and skills in human behavior manage professional nurses and nonprofessional assistive nursing workers to achieve the highest level of productivity of patient care services. To do this, nurse managers must become competent leaders to stimulate motivation through relationships and interpersonal processes and communication with the workforce.

The primary role of the nurse manager is that of managing a clinical practice discipline. To accomplish this requires numerous competencies supported by a theory of nursing management.

Nurse managers work with staff consisting of clinical practitioners. Educated in nursing management, they can assist these practitioners in their work according to the models of such theorists as Watson, Orem, Roy, Newman, Johnson, and Peplau.

Several modalities of nursing have evolved over the past 50 years. Functional nursing, the oldest nursing practice modality, is a method in which each staff member is assigned a particular nursing function, such as administering medications, admitting and discharging patients, and making beds and serving meals. Later, team nursing became the modality of choice for many hospital nursing services. Under the leadership of a professional nurse, a group of nurses works together to provide patient care. Team nursing rests on theoretical knowledge related to philosophy, planning, leadership, interpersonal relationships, and nursing process.

Since the 1970s the modality of total patient care through primary nursing has evolved. With primary nursing, the total care of a patient and a case load is the responsibility of one primary nurse. Joint or collaborative practice by a physician–nurse team has developed as a modality of nursing in a few hospitals. A more recent development is case management, a method of practicing nursing that incorporates any modality and in which the knowledgeable nurse becomes the case manager, making or facilitating all clinical nursing decisions about a case load of patients during an entire episode of illness.

As new technologies of patient treatment develop and the health care delivery system evolves around managed care, nurses need avenues to pursue the ensuing ethical dilemmas. Nursing practice is further complicated by the need for multicultural assessments as part of the nursing process and its outcomes.

Evidence-Based Practice 2-1

Professional nursing practice makes a difference in care delivery by empowering nurses. A study describing the experiences of work empowerment among nurses engaged in elderly care in southern Finland found that education and work experience related to behavioral empowerment. The data were collected with a questionnaire that included items on verbal, behavioral, and outcome empowerment. A response rate of 80.8% (252) was received with nurses experiencing strong verbal and behavioral empowerment. Nurses reported that they were less confident about outcome empowerment than in the two other fields of empowerment. “All fields of empowerment showed a statistically significant correlation with each other. Education and work experience were also related to behavioral empowerment. The results provide important clues for the development of elderly care.”⁹⁴

APPLICATION EXERCISES

Exercise 2-1

Define nursing management as it relates to your job. If you are a student, observe the work of a nurse manager and define management in terms of your observations.

Exercise 2-2

Describe a belief you have about nursing management in the organization in which you work or are doing clinical practice. Discuss your belief with your peers in clinical practice or students and with your nurse manager or instructor.

Summarize the conclusions. Is your belief valid? Totally? Partly? Not at all? Validity can be established by comparing your conclusions with viewpoints found in publications or by obtaining agreement from practicing nurse managers. You will codify selected theory of nursing management.

Exercise 2-3

Translate the management of time into nursing management theory with examples such as: “A nurse who practices good management will know how to use time effectively.” The example may be one that applies to you as manager or to the observed behavior of another nurse manager. Keep a log for a day, making entries at 15-minute intervals on a separate sheet of paper. Use the following format:

Time	Activity	Delays and Bottlenecks
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Analyze your log. How much of your day was productive? How much was unproductive? What can be done to increase productive time? Using the following format, make a management plan to make better use of your time.

Management Plan

Goal:

Actions	Target Dates	Assigned to	Accomplishments
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Based on your observations from this exercise, write a theory statement that describes management as the effective use of time.

Exercise 2-4

The following functions originate from a theory of the institution or organization and the division of nursing:

- Plans for accomplishing objectives are made.
- Strategies for accomplishing objectives are formulated.
- Activities are organized by priority.
- Work is assigned.
- Managerial jobs are designed.
- An organizational structure evolves.

Describe how each of these activities is evident in your place of practice as a student or a practicing professional nurse.

Exercise 2-5

Write a short theory of nursing management based on information presented in this chapter. Remember that a theory of nursing management is an accumulation of concepts, methods, and principles that can be or have been observed and verified to some degree and translated into the art or practice of nursing management.

Exercise 2-6

Examine the periodicals listed for the last 12-month period:

The Journal of Nursing Administration
Nursing Administration Quarterly
Nursing Management
Nursing Research

Note the following:

- The number of articles on nursing theory versus nursing management theory.
- Theories of nursing that could be incorporated into a theory of nursing management. Did the research indicate that the theory fulfilled its claim? Explain.

- According to these periodicals, what theory of nursing management is being used in the organization in which you are gaining clinical experience as a student or in which you are employed?
- According to these periodicals, what theory of nursing management could be used in the organization in which you are gaining clinical experience as a student or in which you are employed? Consider the value the research has for meeting the goals of the organization, the division of nursing, and the nursing unit.
- Make a management plan for putting the research results into practice.

Exercise 2-7

Use your student group or form an ad-hoc committee of nurses to plan for needed implementation of nursing theory in a nursing unit. Make a management plan using the following format. To help make a decision, access the Internet and find applications of theories of Watson, Orem, Roy, Newman, Johnson, and Peplau.

Management Plan

Problem:

Objective:

Actions	Target Dates	Assigned to	Accomplishments
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Exercise 2-8

Evaluate case management as practiced in the agency in which you are employed or to which you are assigned as a student. Do this by gathering and analyzing data that do the following:

1. Describe the model of case management being used.
2. Identify the standards used to trigger the case management process.
3. Trace the continuum of case management from patient's entry through discharge.
4. Measure the achievement of stated outcomes.
5. Relate the nursing modality to case management.

Exercise 2-9

Consider the *Scope and Standards for Nurse Administration*. Interview a nurse executive to determine how this individual meets the standards.

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