Organization of Nursing Care

a reader consisting of eight articles especially selected by The Journal of Nursing Administration Editorial Staff

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The Problem in Nursing's Middle Management

by
Barbara J. Stevens

Mrs. Stevens describes the need of nursing's middle management, i.e., nursing supervisors, for a job function with a nature different from that of an extended head nurse role. She also discusses the problems that arise with the usual nursing supervisory role and presents models of appropriate supervisory roles.

Barbara J. Stevens, R.N., A.A.N., Ph.B., M.A., is an assistant professor of nursing service administration, University of Illinois and a doctoral student, University of Chicago. This article is reprinted from JONA, September-October, 1973.

The role of the nursing supervisor, whatever the official title, is often the most ill-defined role in the hospital hierarchy. Inability to clarify the nursing supervisor's role has led many organizations to eliminate the position and to give the head nurse more authority. Unfortunately, this solution is not always practical in large institutions. Basic management principles for span of control indicate that no more than six to eight persons should report to one boss.* The director of nursing who tries to have twenty head nurses report directly to her will quickly confirm the validity of this rule. Thus, unless the director has an exceptionally experienced, capable, and self-directed group of head nurses, middle management becomes a necessity. Where middle management is needed, identifying a clear role for the nursing supervisor is a problem of first priority.

In most organizations the nursing supervisor has from two to eight head nurses (or key areas) under her supervision. This range satisifies the management principle concerning span of control and the director's need to limit contacts. Creation of a middle management layer merely to satisfy span on control, however, may create more problems than it solves.

*This principle is generally accepted in the literature on management. For example, see American Management Association: *Supervisory Management Course for Hospital Supervisors, Part I Management Principles,* American Management Association Publishers, pp. 3-11.

Granted that occasionally a remarkably adept and clever individual comes along and really makes a significant contribution in the supervisory role. Unfortunately, remarkable individuals are rare. More commonly, the nursing supervisor is a competent, industrious, intelligent, normal human being with problem-solving ability within the frame of the given policies of the institution. The nursing supervisor who has all these attributes, however, is still likely to do a mediocre job because of obstacles built into the supervisory role.

THE TERRITORIALITY OF THE HEAD NURSE

The head nurse has strategic advantages over the supervisor. The first advantage is quite simple; the head nurse knows where she works. She can physically "mark off" her territory, her patients, her staff. There is no question about what is hers. Consequently, when the supervisor appears, the head nurse reacts as if a "foreigner" had invaded her territory; she is immediately on the defensive. In spite of her knowledge of organization charts, job descriptions, or lines of authority, the head nurse responds much like a brood-hen defending her nest against an intruder.

The supervisor, on the other hand, often comes to feel that her only real territory consists of elevator shafts, back stairways, and halls between wards. She can periodically retreat to her office, of course, provided it is not in proximity to the office of the director. The director reasonably expects her to be on the patient wards.

The head nurse's second advantage is that she, unlike the supervisor, really knows what her job is. If she never gives her role a thought or never defines one work objective, she still can come to work, let the events of her ward direct her activity, and go home feeling that she has accomplished something. The supervisor, however, is usually forced to ask herself, "What is my role, and how do I go about fulfilling it?" The answer to this question is difficult, for the role of the supervisor is chiefly one of her own making. Her job is limited or productive, depending upon her ability to use creativity, insight, and to influence others. The supervisor "proves" her value by altering (interfering with) the domain of the head nurse. Even if the supervisor has good ideas, it is very difficult for a head nurse to accept these ideas from a person she regards as "competition."

Most of the recent attempts to alter the supervisor's role have been designed to soften the competitive response to this position. The title has been changed to that of coordinator, and job descriptions have been altered to define the nursing supervisor as a "resource person." Nevertheless, such attempts to change the image of the supervisor have minimal effect if the position retains line authority over the head nurse. Such alterations in image do not change the essential problem inherent in the supervisor's role. The problem, simply defined, is that the commonly assigned supervisory tasks are merely extensions of the head nurse's responsibilities rather than discrete, separate functions. For example, the supervisor might be expected to be more expert in patient care decisions or in planning for staffing, but these tasks can be handled by the head nurse. Thus, the supervisor is expected to do the same job as the head nurse, only bigger and better. The difference in jobs is simply qualitative or quantitative; essentially the supervisor and head nurse have the same job. The supervisor has a greater number of patients, but not different patients; she has greater knowledge, but she uses it to make the same kinds of decisions.

The lack of a clear job differentiation is demonstrated in the manner that the average supervisor deals with head nurses reporting to her. She usually relates to each head nurse separately, and whatever she does with the head nurse is only an extension of what is happening on that particular head nurse's ward. Thus, the supervisor has neither synthetic nor distinct function; her functional unit, similar to that of the head nurse, is the individual ward. This basic failure in role differentiation undoubtedly is the reason so many supervisors can be found spending excessive time in checking employee time cards, transferring employees from one ward to another, or in other trivial duties which they have managed to usurp as their own prerogative.

MIDDLE MANAGEMENT AS OBSTRUCTION

Middle management may also be the source of both upward and downward communication problems. In the first instance, the nursing supervisor may have the human tendency to minimize problems in her wards in order to prevent stressful relations with the nursing director. This tendency causes considerable frustration for the head nurse, as she must cope with the concrete work problems while awaiting higher level decisions. A director of nursing may face similar communication obstacles in trying to make changes at the patient care level. Theoretically the director should transmit objectives and plans through the defined lines of authority, i.e., she should communicate with the supervisory level. The supervisor, to support her position of authority, should be the person to interpret objectives and plans at the head nurse level.

Even if the supervisor tries to translate the director's intentions and plans, the head nurse, as previously noted, has a vested interest in complying only so far as necessary, and then reasserting her own ideas (protecting territorial rights). Frequently the director, in her need to produce results, is tempted to bypass the supervisors, either by holding meetings directly with the head nurses or by placing both supervisors and head nurses in one common group for meetings she conducts herself. Either of these methods err by confirming what the head nurse already suspects — the infirmity of the supervisor's role.

STRUCTURING MIDDLE MANAGEMENT

What then can be done to strengthen the supervisor's role when the director elects to maintain a middle management level? There is no single or simple answer. One guideline for the director is that the supervisory level must have a job function that is different from that of an extended head nurse.

One possibility for restructuring the supervisor's role is to analyze the nursing management components and to assign each supervisor to the management of a specific component.

For example, suppose a hospital has fifteen wards (fifteen head nurses) and three supervisors. The director might decide, on the basis of their number, to divide tasks into the following areas: (1) evaluation and improvement of patient care, (2) staffing and regulation of personnel, and (3) administrative processes and nursing systems. Each supervisor then would be responsible for guiding and directing her assigned specialty in each of the fifteen wards. With this chance to specialize, it is likely that each supervisor could become expert in her particular field.

The head nurse in such restructuring would be responsible to the appropriate supervisor for each area of function on her ward. For example, her ongoing patient care would be evaluated in consultation with supervisor A, while her staffing would be done in consultation with supervisor B.

There is psychological advantage to this scheme that should be examined. The head nurse is less likely to react negatively to the supervisor who has only a partial interest in her "territory." Thus it becomes easier for the head nurse to accept this person in the "expert" role and to take advantage of the guidance offered.

The system of divided function must be carefully structured for there is a danger that a primary management rule may be broken, i.e., the rule that each person should have to report to only one boss. The head nurse cannot be responsible to three supervisors who may conceivably give incompatible orders. In this system the supervisor must function in a staff position rather than with line authority. Thus, the head nurse has ultimate line responsibility to the director, but the director can handle this extension of numbers reporting to her by channeling most communication through the appropriate staff supervisor.

This system can work well if each supervisor has a clear understanding of her function and insists that problems outside of her range be referred to the proper supervisor. For example, with the theoretical division of function between three supervisors, one might frame job descriptions as such:

SUPERVISOR A (Coordinator of Patient Care Services)

1. Directs and implements patient care evaluation tools
   a. Nursing chart audit
   b. Nursing quality control
   c. Patient interview systems
2. Evaluates nursing care plans
   a. Checks nursing care plans for patients needing complex care
   b. Checks nursing care plans on other patients on a periodic basis
   c. Makes rounds on selected patients
   d. Suggests care improvements to head nurses
3. Daily follows the care progression of patients who are critical or require complex nursing care
4. Serves as a resource person and expert in nursing care
   a. Is available to head nurse at her request to assist in solving care problems
   b. Is available to head nurse at her request to set up care plans for complex patients
   c. Periodically assists in team conferences focusing on patient care problems
5. Participates in patient care research
   a. Helps head nurse identify needed areas of research
   b. Assists head nurse in constructing research test systems
   c. Assists in implementing and evaluating patient care research
6. Coordinates care problems as needed with physicians and allied health groups

SUPERVISOR B (Coordinator of Nursing Personnel and Staffing)

1. Directs and implements policies for hiring, promoting, transferring, and discharging personnel
   a. Coordinates vacancies with Personnel Department
   b. Arranges with head nurse for interviews for hiring, evaluating, and discharging personnel
   c. Assists the head nurse in developing interviewing skills
2. Evaluates daily staffing patterns
   a. Uses patient rating systems to evaluate staffing needs
   b. Confers with head nurse concerning needed changes in daily staffing
   c. Assigns float staff personnel
   d. Plans for evening and night staffing needs
3. Analyzes and recommends permanent staffing patterns
   a. Researches staffing needs
   b. Determines levels of nursing skill required
4. Serves as arbitrator for personnel grievances and problems that cannot be settled at the head nurse level.
5. Coordinates all payroll data
6. Serves as an assignment expert for the head nurse
   a. Teaches head nurse and team leaders appropriate means of developing team assignments
   b. Periodically evaluates staff assignments
   c. Makes recommendations to head nurse for improvements in assignment patterns
   d. Researches new concepts and patterns in assigning and staffing
   e. Assists head nurse in constructing, implementing, and evaluating new models for assignments
   f. Periodically evaluates staff responses to their assignments

SUPERVISOR C (Coordinator of Nursing Systems)

1. Evaluates systems by which care is delivered and recommends appropriate changes

a. Examines daily routines of care, such as bath schedules, medicine distribution, and linen changes
b. Evaluates emergency routines, such as cardiopulmonary resuscitation, and disaster plans
c. Examines accepted nursing procedures

2. Evaluates forms which record nursing data
   a. Chart forms
   b. Kardex forms
   c. Forms for staff assignments and notices
   d. Forms for patient data such as bedside signs and intake and output sheets
   e. Interdepartmental communication forms
3. Maintains expert and up-to-date knowledge of nursing and hospital policies
   a. Serves to communicate policy changes
   b. Serves as a resource to head nurse in policy issues
4. Coordinates nursing policies with others
   a. Communicates among nursing wards
   b. Communicates with other hospital divisions and individuals
   c. Participates in formulating policies that involve nursing plus other divisions
5. Serves as an expert resource in applying management techniques to nursing function

This example of job division is representative and not meant to be complete. No two hospitals would be likely to make the same task division structures. Job divisions would depend on many factors: number of wards, number of supervisors, abilities of supervisors, nursing objectives, to name a few.

In addition to giving each supervisor a job unlike that of the head nurse, the proposed system offers the director other advantages. Since the job division requires close coordination, the director has a real purpose for her staff meetings with supervisors. Too often meetings between the director and supervisors evolve into meaningless recitals of patient admissions, discharges, and deaths. With the proposed system, immediate in-house patient data is not the only focus, and proper attention will be given to relating patient data to delivery systems and policies. Thus staff meetings can become dynamic problem-solving, decision-making sessions rather than simply informational reports.

A SECOND ALTERNATIVE

The previously described supervisory pattern is only one possible application of the basic principle of giving the supervisory role a job different in nature from that of the head nurse. As a second alternative, it would be possible to create a functional unit larger than the patient ward. For example, suppose a supervisor manages three wards, and some common basis for action can be identified in spite of their differentiated functions. Possibly all wards might serve surgical patients, or perhaps they all serve geriatric patients. If some unifying factor can be identified, then the wards can establish common goals and needs. The unity could be of a very broad nature and still serve the purpose.

The supervisor might then begin to wield her separate wards into a single functional team. She could hold staff meetings with all her head nurses to set common goals or to try common projects. Any transferring of personnel to meet daily variations in patient numbers and needs could be managed among these wards cooperatively rather than reaching outside the new functional unit. Indeed the head nurses could plan a methodic interchange of personnel so that each employee was properly oriented to the other two wards and to their special equipment and patient care needs. Necessary staff relocations, then, would not cause the usual employee protest and resistance, since workers would be prepared for such interchange.

Indeed, if an assistant head nurse role did not exist in the institution, the head nurses could also orient themselves to their partner wards in order to be available as resource persons during their coworkers' days off.

With this proposed structure, the job of the supervisor is clearly differentiated from that of the head nurse. She has a "territory" of her own, i.e., the larger (combined) unit. She functions with that unit as a whole rather than interfering in the everyday function of the head nurse. She helps the unit evolve group goals and long-range objectives. She is no longer trying to usurp the day to day head nurse functions. She maintains a broader objective and serves to coordinate the activities of the new functional unit. She now meets head nurse needs through the staff meetings more often than in individual conferences.

Consider the difference in response to these two situations: (1) the supervisor informs the individual head nurse that she is weak in interviewing techniques and makes learning suggestions, (2) the supervisor, in a staff meeting with the head nurses, proposes that the group work on building expertise in interviewing skills and proposes a study program. In the second situation the threat to the individual head nurse is removed. What would have appeared to be criticism now can be accepted as a group goal for increasing head nurse expertise. The head nurse no longer sees the supervisor as competition; the supervisor now has a job which is validly larger and more complex than that of the head nurse. The head nurse now can respond to the supervisor without being on the defensive, without taking each suggestion as a criticism of her performance.

In addition to the two alternatives described, many others could be identified which could give the supervisor a credible role. The answer for any one organization depends upon its individual needs and capabilities. In all cases, however, it seems logical that if the director of nursing needs a middle management, then she should use this group for more valuable purposes than the simple reduction in the number of her daily contacts. The director should evaluate the supervisor's role closely and determine what functions that role really serves. In addition, she should recognize that it is both unfair and unwise to take the best of head nurses in an organization and lose their contributions in that capacity by placing them in ill-defined supervisory jobs with built-in obstacles designed to reduce them to mediocrity.

The thesis of this article is that the key to institutional politics is an understanding of the basics of the informal organization as it affects the formal authority relationships inherent in the hospital's formal organizational pattern. Informal relationships are among the most important relationships that exist in any organization. They deserve the attention of everyone concerned with the effectiveness of the organization. As nursing service administrators become more involved with institutional politics, they must understand the critical part played by the informal organization.

Beaufort B. Longest, Jr., M.H.A., Ph.D., is assistant professor of hospital and health services management in the Graduate School of Management at Northwestern University, Evanston, Illinois. This article is reprinted from JONA, March-April 1975.

Institutional Politics

Beaufort B. Longest, Jr.

In April 1974, the American Society for Hospital Nursing Service Administrators, meeting in Boston, heard Richard D. Wittrup suggest that the successful performance of nursing service administration will increasingly require active participation in institutional politics. Mr. Wittrup attributed this development to changes in the formal organizational pattern and position of nursing service in the hospital. He supported his hypothesis by stating that the proliferation of specialty groups within the nursing profession; the removal, in some hospitals, of outpatient nursing from the central nursing department; the continuing development of supporting services such as physical therapy and social service; and the emerging organizational role of the physicians, which gives them a degree of authority which can dilute the authority of the nursing hierarchy, tend to limit the scope of the function of the nursing service and require that nursing service administrators play the institutional politics game.

These changes will surely mean a greater reliance on the informal aspects of the hospital's organizational pattern. The thesis of this article is that the key to institutional politics is an understanding of the basics of the informal organization as it affects the formal authority relationships inherent in the hospital's formal organizational pattern.

The formal organization is a planned structure representing the deliberate attempt to establish patterned relationships among participants in the organization. A great deal of management time and effort goes into the establishment and maintenance of the formal organization. These efforts include the development of an organization structure backed up by an organization chart, job descriptions, formal rules, operating policies, work procedures, control procedures, compensation arrangements, and many other devices to guide employee behavior. However, as people who have participated in an organization know, there are many interactions among members of an organization which are not prescribed by the formal structure. These relationships and interactions which occur spontaneously out of the activities and interactions of members of the organization, but which are not set forth in the formal structure, make up the informal organization.

The formal and informal organizations coexist and are inseparable. They are totally intermeshed. As pointed out by Blau and Scott:

> It is impossible to understand the nature of a formal organization without investigating the networks of informal relations and the unofficial norms as well as the formal hierarchy of authority and the official body of rules, since the formally instituted and the informally emerging patterns are inextricably intertwined. The distinction between the formal and the informal aspects of organization life is only an analytical one and should not be reified; there is only one actual organization [1].

NATURE OF INFORMAL ORGANIZATION

Real awareness and interest in the informal organization stemmed from the famous Hawthorne studies of the 1930s [2], which showed that informal organization is an integral part of the total work situation. Because the informal organization arises from the social interaction of participants in an organization, it has come to be synonymous with small groups and their patterns of behavior. Most of what managers know about the informal organization has come from the work of sociologists and social psychologists.

The basic distinction between the formal organization and the informal organization is that the formal organization emphasizes *positions* in terms of authority and functions, whereas the emphasis in informal organization is on *people* and their relationships. It follows that informal organization is not subject to management control in the way that formal organization is.

There are three facts about informal organization which the manager should accept from the outset:

1. The informal organization is inevitable. Management can eliminate any aspect of the formal organization because it is created by management. The informal organization is not created by management and it cannot be canceled by management. As long as there are people in an organization, there will be an informal organization.

2. Small groups are the central component of the informal organization, and group membership strongly influences the overall behavior and performance of members. Many sociologists now believe that the social unit (group), rather than the individual, is the basic component of the human organization.

3. Informal organization has both positive and negative consequences for the organization which we shall examine later. To capitalize on the advantages and to minimize the disadvantages, the manager must understand the informal organization, and to do this he must understand groups in the organization.

WHY PEOPLE FORM GROUPS

When one considers why another human being does anything, the obvious starting point is motivation. Motivation theory has taught us that humans are motivated by things which satisfy their needs. If the formal organization satisfied all the needs of all organizational participants, then there would be no informal organization. Informal groups come into being primarily in response to the needs of its members which cannot be fully met in the context of the formal organization alone. The interpersonal contacts within the small group provide some relief from the boredom, monotony, and pressures of the formal organization. The individual in a group is usually surrounded by others who share similar values, thus reinforcing the individual's own value system.

A second reason why people join small groups is the fact that a form of status—which may be nothing more than the fact that one belongs to a distinct little unit which is more or less exclusive—can be accorded by the group.

Third, group membership provides a degree of personal security; the group member knows that he is accepted by his peers as an equal. Group membership permits the individual to express himself before generally sympathetic listeners. The individual gains satisfaction for his recognition, participation, and communication needs, and may even find an outlet for his leadership drives. These important forms of satisfaction are available in the group usually to a greater degree than the formal organization permits.

A fourth very important reason for group membership is to secure information. The grapevine is a phenomenon familiar to all organizational participants. Technically, it is the informal communication channel of the organization. It is important to note here that informal group membership provides the member an inside track on the flow of informal communication in the organization; access to this information flow is one of the important reasons for group membership.

The element shared by all these reasons for group membership is that they meet specific needs of members which cannot be fully met by the formal organization. Informal groups arise and persist in the organization because they perform desired functions for their members.

Edwin B. Flippo has suggested that informal groups tend to possess the following characteristics: (1) a tendency to remain small; (2) the satisfaction of group member wants; (3) the development of unofficial leadership; (4) a highly complex structure of relationships; and (5) a tendency toward stability [3].

POSITIVE ASPECTS OF INFORMAL ORGANIZATION

1. A Complement to the Formal Organization

The key benefit of the informal organization is that it blends with the formal organization to generate a workable system for the accomplishment of work. The formal plans and policies of the organization tend to be too inflexible to meet all the needs of a dynamic situation. Thus, the flexible and spontaneous characteristics of the informal organization can be of great advantage if they permit or even encourage deviations in the interest of material contributions toward the goals of the organization. Dubin was among the first to recognize the necessary complementarity of the formal and informal organization when he stated, "Informal relations in the organization serve to preserve the organization from the self-destruction that would result from literal obedience to the formal policies, rules, regulations, and procedures" [4].

2. The Provision of Necessary Social Values and Stability to Work Groups

Turnover may be caused by a poor matching of man and job, or for such pragmatic reasons as a better job or a necessary move. However, research has shown that many resignations occur because the new employee is unable to become a primary member of one or more informal groups. Group membership is a basic means by which employees achieve a sense of belonging and security. If an organization is so cold and impersonal that informal, interpersonal contacts are not encouraged—or even, in some cases, permitted—then many new employees will seek employment elsewhere. Of course, informal group membership can be carried to such an extreme that the work place becomes merely a social circle, resulting in a detrimental effect on work output. Good management can avoid this extreme and provide an atmosphere where workers, through informal relationships, can meet their human needs of acceptance and gregariousness.

3. The Simplification of the Manager's Job

In a very real sense the informal organization can make things easier for the manager if he remains in control of the situation. It has been shown that when the manager can obtain informal group support, he can supervise in a much more general way than when such support is not available. The manager can delegate and decentralize when the informal group is cooperative. The task of the manager is to understand the informal organization and use it to his advantage. In Flippo's words:

> Awareness of the nature and impact of informal organization often leads to better management decisions. Acceptance of the fact that formal relationships will not enable full accomplishment of organization tasks stimulates management to seek other means of motivation. If most of the work is done informally, the manager will seek to improve his knowledge of the nature of people in general and his subordinates in particular. If he realizes that organization performance can be affected by the granting or withholding of cooperation and enthusiasm, he will seek other means than

the formal to develop desirable attitudes. He will not depend solely upon the authority of his position [5].

4. The Provision of an Additional Channel of Communication

A well-known benefit of informal organization is that it provides an additional channel of communication for the organization. The grapevine can add to management's effectiveness if it will study and use it. The grapevine can serve to get certain information to employees as well as to determine the feelings and attitudes of employees on various issues, but it can cause problems if it is not understood by management.

NEGATIVE ASPECTS OF INFORMAL ORGANIZATION

In a very real sense, all the advantages of the informal organization also carry the seeds of trouble. Anyone who has had to deal with an informal organization realizes that these advantages are not always realized—indeed, that in many cases the disadvantages far outweigh the potential advantages. In truth, the formal organization deals with human behavior as management would like it to occur in the organization, while the informal organization deals with human behavior as it actually does occur.

The most clear-cut disadvantage is that in many situations the individuals and groups that comprise the informal organization can and on occasion do work at cross purposes to the goals and objectives of the formal organization. It is a basic fact of organizational life that what is good for the employee is not always good for the employer, and vice-versa. The employee may want to meet the requirements of both his group and his employer, but often these requirements are in conflict. What results is known as role conflict.

A good bit of this role conflict can be avoided by recognizing that the more compatible the interests, goals, methods, and evaluation systems of the formal and informal organizations can be made, the more productivity and satisfaction can be expected. However, as Keith Davis has pointed out, "there must always be some formal and informal differences. This is not an area where perfect harmony is feasible" [6].

It should be noted that even the potentially negative impact of conflict should be weighed against the constructive and positive function of conflict in fostering creativity and innovation. A relatively conflict-free organization tends to be static. Thus, some conflict should exist as a condition for the generation of fresh ideas.

LIVING WITH THE INFORMAL ORGANIZATION

The existence of the informal organization within the formal structure is a fact of organizational life. The formal and informal aspects of the organization must be balanced if optimum performance and goal attainment, both for individuals and for the organization, are to be achieved.

If management tries to suppress the informal organization, it creates a situation in which the informal organization gains strength to counteract the autocratic administration in order to protect the employees and to make the work situation acceptable in their view. The opposing forces clash, and the result is reduced organizational effectiveness. On the other hand, if the formal organization is too weak to accomplish its objectives, the informal organization can grow in strength, leading to such undesirable abuses of power as work restriction, insubordination, disloyalty, and other manifestations of a generally anti-institution attitude.

The optimum situation is one in which the formal organization is strong enough to attain the objectives of the organization and at the same time permit a well-developed informal organization to maintain group cohesiveness and teamwork. In the words of one authority, "The informal organization needs to be strong enough to be supportive, but not strong enough to dominate [7].

A relationship such as the one described above is, at best, difficult to achieve. There are, however, two steps which can be taken to move the organization in the direction of a properly balanced formal and informal relationship:

1. Management must convince employees that it does in fact understand and accept the informal organization. Of paramount importance here is that management consider the impact on, and the resulting implications for, the informal organization of any action taken by it.

2. To the maximum extent possible, management must integrate the interests of the informal organization with those of the formal organization. In so doing, management should attempt to keep its actions taken through the formal organization from unnecessarily threatening the informal pattern of relationships.

It must be remembered that informal relationships are among the most important relationships that exist in any organization. They deserve the attention of everyone concerned with the effectiveness of the organization. As nursing service administrators become more involved with institutional politics, they must remember the critical part played by the informal organization.

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Decentralization of Nursing Service

By Casmira Marciniszyn

The 700-bed hospital described in this article is part of a major university health center located in the heart of a poverty area. This health center conducted a major reevaluation of its teaching and service programs and concluded that it existed to serve the needs of society. It also concluded that traditional roles filled by traditional manpower armed with traditional knowledge could no longer meet the needs society required.

Five years were spent in developing goals and objectives, philosophies and policies, and in conceptualizing alternative organizational and physical patterns. The end product of these efforts was not only a new teaching hospital, but a program—a working guide for the trustees, the staff, the administration, and the architect. The hospital was to become a special kind of hospital through which new approaches in the delivery of quality care would, through service, be demonstrated to health professionals and institutions.

A traditional nursing structure and its philosophy were changed to permit emphasis on good patient care. Decentralization of nursing service, to parallel the clinical management division, allowed for the application of principles of good unit management and human relations.

Patient Care Coordinators were assigned to divisions with autonomy to direct and control nursing activities within the division. As the scope of authority and responsibility were broadened, problems emanated from inadequate coordination in the operational component. Tensions developed, and resistance to change was evidenced despite careful planning. Attitudes toward change were gradually modified through group discussions and work shops.

There is merit in decentralizing nursing service, for the patient emerges as the focus of activity and employees develop a strong identification with the organizational unit.

Over the years the hospital had developed a vertical organization, with much of the authority and decision-making held at the top. In this type of organization it is difficult to retain the patient as a central figure. Authority generally is highly centralized, which tends to destroy initiative. Typically, when confronted with the need to make even the smallest decisions the administration tends to forget the need for long-range planning, procedural improvement, and policy development. This organizational pattern tends to impede the development of horizontal communications at lower levels.

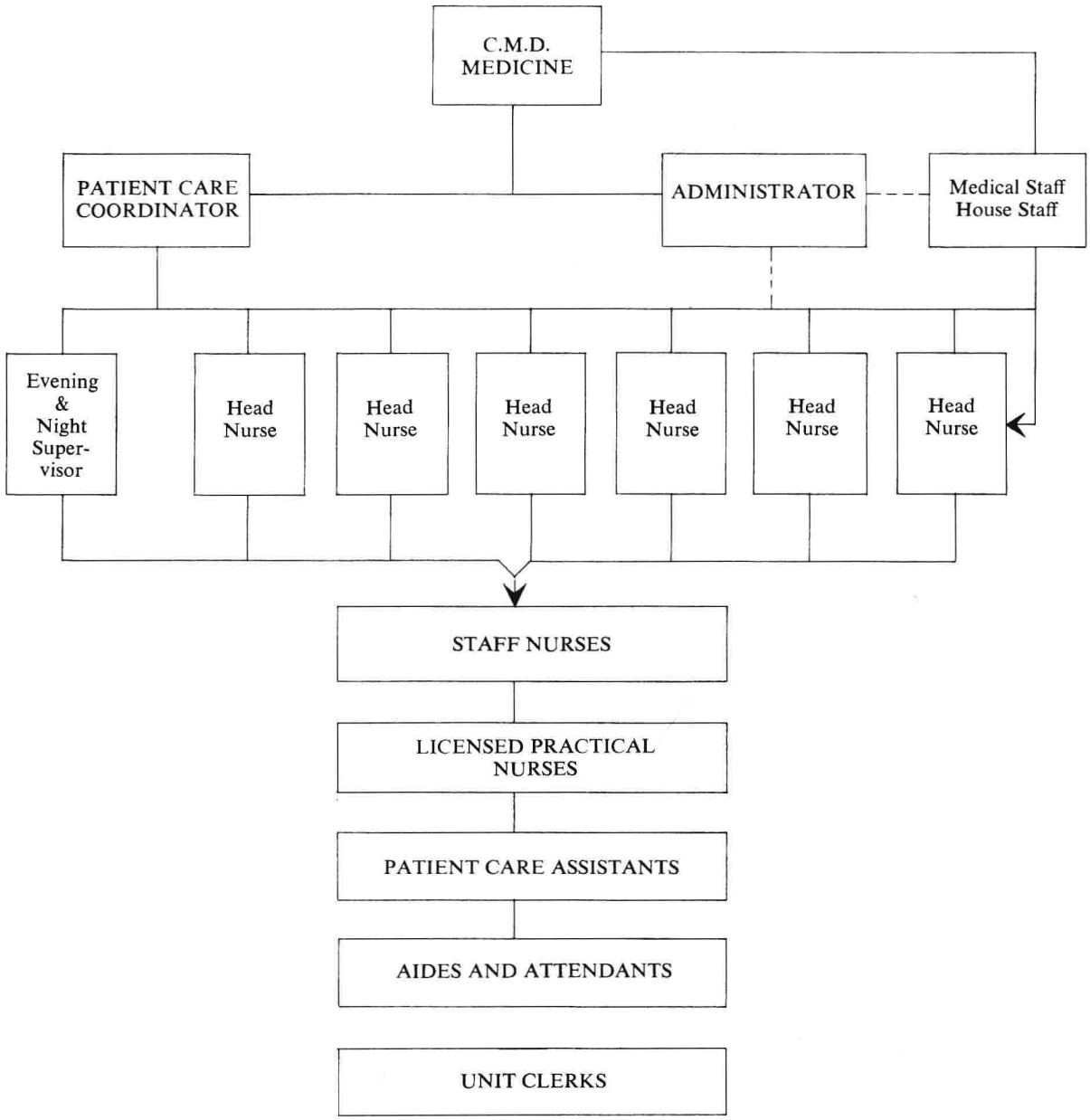
The hospital, in preparation for the new clinical teaching building, was challenged to implement the established forward-looking commitments of the health center. The executive director of the hospital, recognizing that implementation of broad and sweeping planning requires flexible administration, appointed a new hospital administrator.

Under his direction a horizontal structure was designed to bring decision-making, responsibility, authority, and accountability to the operational level. The new organizational pattern could flexibly encompass both ongoing and experimental programs of health service, research, and teaching. It accommodated the complex pattern of human relationships and communications necessary for the efficient delivery of hospital services.

Casmira Marciniszyn, B.S.N.Ed., M.P.H., is assistant administrator/nursing services at Mercy Hospital, Charlotte, North Carolina. At the time this article was written, Miss Marciniszyn was assistant administrator of the Patient Care System at Temple University Hospital and associate professor of nursing, Temple University, Philadelphia, Pennsylvania. This article is reprinted from JONA, July-August 1971.

FIGURE 1

CLINICAL MANAGEMENT DIVISION ORGANIZATIONAL CHART FOR MEDICINE



A key part of the new organization was the creation of clinical management divisions, a new idea involving clinical activities and, perhaps, one of the most innovative of all approaches to the delivery of health care. In this concept clinical programs were grouped into divisions related to the curriculum interests of the school of medicine and the interests of the hospital and its research programs (see Fig. 1). In addition to the traditional medical and surgical programs, four other major clinical management divisions were defined and established: (1) musculoskeletal, (2) neurosensory, (3) human growth and development, and (4) cardiopulmonary.

Each clinical management division is headed by a physician who is responsible for the entire direction and operation of the division. He is aided by an administrative assistant who has responsibility for day-to-day management and policy implementation.

The *clinical management division* is an administrative unit designed to function in a cooperative and cohesive way and to apply management to all activities that happen on patient units. Each division is administratively independent of the other divisions, yet it is so composed as to allow necessary patient care interaction. To support the clinical management divisions, hospital service departments with common characteristics were organized into groups called *resource systems* (see Table 1 and Fig. 2).

TABLE 1

RESOURCE SYSTEMS

Patient Care
- Nursing Department
- School of Nursing
- Social Service Department
- Volunteers
- Patient Relations Representatives
- Nurses Registry

Transportation, Supply and Logistics
- Central Supply Department
- Dietary Department
- Laundry Department
- Purchasing Department
- Storeroom Department
- Transportation Department

Environmental Services
- Housekeeping Department
- Plant, Grounds and Maintenance Department

Personnel and Training

Security and Medical-Legal

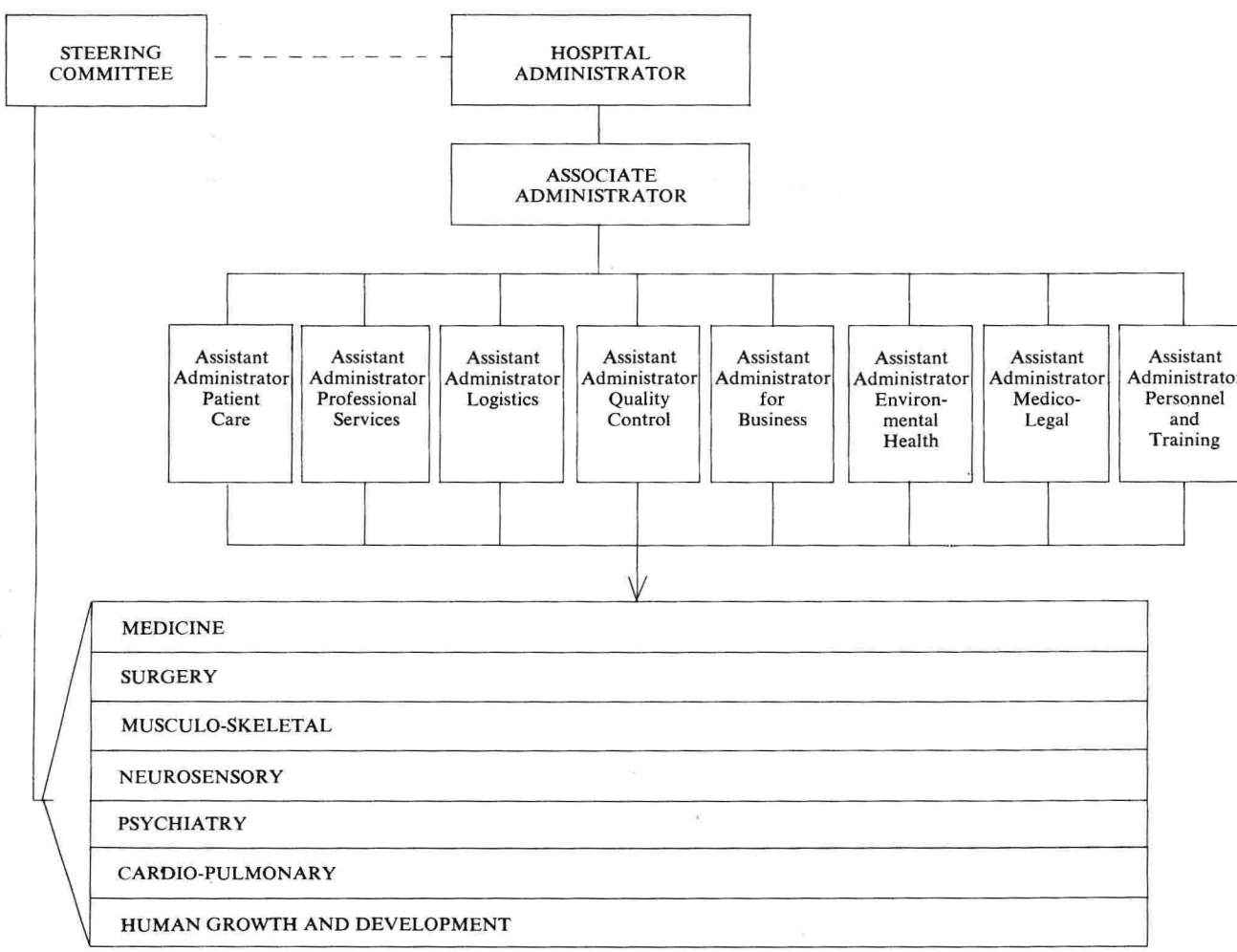
Professional and Clinics
- Anesthesiology Department
- Cardiology Department
- Inhalation Therapy Department
- Laboratories Department
- Pharmacy Department
- X-ray Department

Quality Control
- Admitting Department
- Duplicating Area
- Information Desk
- Mail Room
- Medical Records Department
- Switchboard
- Systems and Procedures

Business
- All Department Business Systems
- Inpatient and Outpatient Business Offices
- Payroll Department
- Accounts Payable Department

FIGURE 2

HOSPITAL ORGANIZATIONAL CHART



rigid hierarchical structure has a tendency to reduce the opportunity for creative nursing practice

An assistant administrator for the patient care system was appointed with the responsibility to improve both the quality of patient care and the job satisfaction of system employees.

The Nursing Department had been organized according to the traditional pattern, with the director of nursing responsible for education and service. This type of rigid hierarchical structure has a tendency to reduce the opportunity for creative nursing practice. The medical staff looked upon nursing as merely ancillary to medicine—there to do and not to think. Both patients and nurses were caught up in a system of routines and tasks which were seldom modified to meet individual patient care needs. The hospital had a shortage of graduate nurses which was complicated because the organization had become decidedly inbred. Outside graduate nurses were not made to feel welcome so that their stay was short.

In another traditional pattern, appointments to head nurse positions were made more on the basis of seniority than on leadership skill or excellent nursing practice. Many head nurses, having no other guide, used their predecessors as management role-models. There was no provision to teach them management skills or the psychology of handling people, and this had a definite impact on the quality of patient care.

Overall supervision was provided by assistant directors of nursing service. None had been prepared beyond the diploma school level; however, all were enrolled in courses at the university's school of education.

Of the five assistant directors of nursing service, only two were assigned to patient care areas. The others were assigned to employment and training of ancillary personnel, purchase and repair of specialized equipment, and the exchange-nurse-visitor program. Even though each assistant was assigned an administrative responsibility, authority for decision-making was not completely delegated.

Supervision in the patient care areas consisted largely of daily visits to the nursing units and discussions with each head nurse about the problems in her unit. The limited academic preparation of the assistant directors of nursing proved to be a barrier to problem solving.

From this reevaluation it was evident that if the quality and quantity of patient care was to be improved, the nursing structure and its philosophy had to change to permit emphasis on good patient care and the maximum use of new concepts and approaches in the delivery of nursing service. The structure would have to provide a setting in which all nursing personnel could function to the maximum of their abilities and which would reflect commitment to the patient. It would also have to allow practitioners to function as professionals "with peer" rather than "under" administrative control of performance.

A decentralized structure (see Fig. 3) seemed to make possible a proper environment for flexibility and fluidity in role, for creativity and innovation in patient care, for the use of a nurse's education and intellect in making judgments and decisions, and for the development of leaders in nursing.

While large nursing organizations must establish standards and policies, they tend to limit the freedom of professional nurses to make independent judgments and to be innovative, especially if these standards are rigidly enforced.

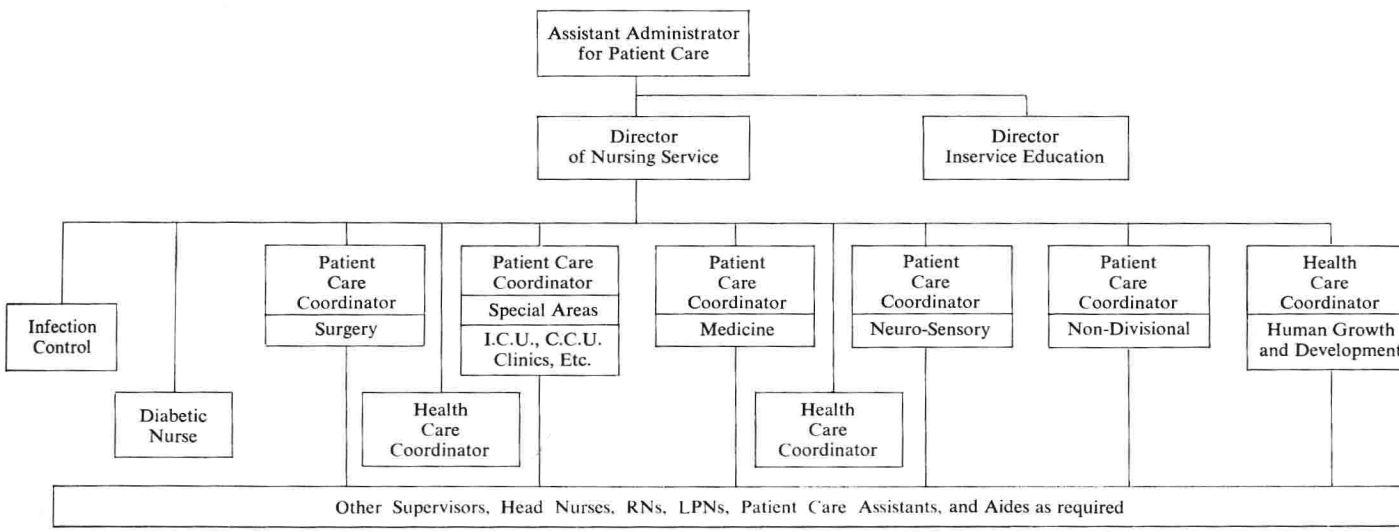
Decentralized units have the potential for adapting established standards to their special needs without creating confusion. Smaller and more cohesive, the span of control in a decentralized unit is more manageable. Moreover nursing leaders of decentralized units have greater opportunity to establish close working relationships with employees, to know them as individuals rather than as names. They become thoroughly familiar with each of their nursing stations with increased understanding of head nurse and staff needs and are able to act on these needs. Staff frustrations are reduced signficantly because the channels of communication are less complex and problems receive attention more quickly. This close-working relationship helps to promote staff involvement and participation; it permits some latitude for making judgments and decisions; and it encourages innovation. Employees develop a strong identification to the organizational unit for they have a better understanding of the goals and objectives and they work to attain these goals.

Before the nursing organization was decentralized, the nursing administrative staff, head nurses, and nursing practitioners were fully informed of the proposed changes in philosophy, goals, and objectives set by the university. The staff was also exposed to the evaluation of the nursing department and its three basic needs: a definition of nursing office responsibilities, a clarification of various nursing programs overlapping or cutting across the department, and an analysis of specific functional procedures followed by the department. Since these areas were recognized as problems by many, initial resistance to change was less than anticipated. Change was accomplished gradually. In the first stages, each nursing office position was discussed with the individual involved. The director of nursing was to concentrate on the broad picture, thereby providing the resources which make it possible for nurses to get their job done.

The day-to-day activities at the operational level were delegated to the assistants, who were charged with creating a working environment which would permit and encourage creativity and which would motivate practitioners to render good patient care by permitting flexibility in standards and

FIGURE 3

DEPARTMENT OF NURSING ORGANIZATION CHART



by allowing decisions to be made at the working level. The assistant directors of nursing service responsible for patient care areas were to help head nurses improve their management skills, assist in establishing staffing patterns, and identify staff needs for inservice education, with the ultimate goal to improve patient care. Each assistant director had full authority for nonprofessional employees, recruitment (through personnel), training, and staffing.

One assistant director was given total responsibility for the administration of the exchange visitor program, including student scheduling and assignment. It was emphasized that the service experience presented to each exchange nurse-visitor should help her gain new knowledge and develop new or improved nursing skills. At no point was the visitor to be used to plug holes where the nursing department had been unable to provide graduate nurse service coverage.

A staffing study of each nursing unit clearly showed the need for a nursing recruitment program. The institution had been unable to attract sufficient registered and licensed practical nurses. Salary, often a factor, is not always the most important need for professional nurses. Nurses seek a challenging atmosphere which is receptive to innovation, independent thinking, and creative leadership. This alone was sufficient reason to redouble efforts to create such an environment.

One of the contributing factors was poor utilization of available personnel. The nursing administrative staff participated in evaluating activities and reassigned some of the less-demanding, less-skilled tasks to less-skilled employees.

The head nurse was relieved from nonnursing functions so that she could devote her time to supervising her staff. Because head nurses lacked preparation or experience in management, a three-day workshop in supervision was conducted for all head nurses, followed by monthly, one-day sessions designed to help improve their management skills.

Nursing personnel participated in structuring a planned orientation program, part general and centralized and part specific and decentralized. New employees, regardless of position, educational background, or experience, have a right to expect an orientation to the hospital and to their specific job.

Nursing had been represented on all hospital committees by nursing office personnel. It is important for a few committees to have someone who knows the total nursing situation, but most committees do not demand such breadth of knowledge and would benefit from the participation of a head nurse or someone else who functions at the operational level. This would not only make the head nurse more of an integral part of hospital planning and operation but it would help them develop their leadership potential and give them greater exposure to other disciplines. Nursing is now represented by head nurses on the following committees: utilization, safety, medical records, infection, and material and supplies evaluation. They submit minutes of the meetings to nursing administration and give an oral report to head nurses at their monthly meetings.

The existing procedure manual had become outdated