NURSING IN TROUBLE: BURNOUT LEADS TO NEGLIGENCE

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UNCLEAR ROLE EXPECTATIONS

The management style and attitudes of administration strongly affects the morale of nurses because these attitudes are carried on down the line (Bueno, 1973). Weak leadership usually causes employee turnover or employee apathy. If relationships between the nurse, coworkers and supervisors were better, the nurses would not leave the profession (McCloskey 1974).

This is a strong indication of the effect of leadership on administration-staff relationships, even in nursing. Goodall (1979) indicates that the situation had deteriorated so much that 47% of the nurses who had left nursing would not consider returning to the profession if it stayed the same.

The effect of managment skills is crucial to the productivity of the nursing staff. When the staff ceases to be productive research indicates that nurses may be on their way out of the profession. About 30 percent of responding nurses saw the nursing shortage due to poor nursing administration, and 25 percent attributed the shortage to poor communications between nursing staff themselves (GhignaHallas, 1980). Nursing administration includes the director, supervisor, and all levels of management including head nurses. Policies and attitudes filter down through these decision makers. Most employed nurses thought that communication between nursing administration and nursing staff was less than excellent.

Communication is crucial. If the nurse is not sure of boundaries of expectations, norms, and clear role definitions, she cannot function without confusion and anxiety.

One of the blocks to developing strong management skills in nursing administrators and supervisors is the value system and attitude pattern of the hospital administration.

Their ears are often closed to the needs expressed by nursing. Of hospital administrators asked what skills they were looking for in nurses, only 14% thought leadership ability was important, only 7% thought psychological assessment skills were important, and only 6% cared about bedside manner (Donovan, 1980a). A nurse is a manager and leader because she supervises other people, but administrators seem to overlook this important point. If nurses are hired more for technical skill than for leadership and management ability, we should expect this severe problem of unhappy nurses.

Only 3 percent of administrators thought the nursing shortage was from lack of support from administration (Sandroff, 1980). This contrasts sharply with 33 percent of working nurses who saw the shortage as directly due to poor hospital administrative support (Goodall, 1979). Lack of administrative support and poor leadership produces staff disharmony and loss of dedication. When dedication is gone, the nurse becomes apathetic and patient care is affected.

Nurses want clearly defined nursing policies, and see this as a constant problem. If there was good management practice, this would not even be an issue. This has become so much a problem that groups representing nurses are demanding change. The Michigan Nurses Association has formally recommended that nurses demand better hospital policies and procedures if they are inadequate.

The nurse is ultimately responsible for what happens to the patient. In a case of patient oversedation and death now in the courts (Wiley, 1981), the jury could define the nurse as murdering the patient even if the officially prescribed dose of morphine was too high because she should have used her professional judgment and refused to give it, even if other people on the staff knew and approved of her actions. "The way we always did it" is not a defense. If the hospital policies regarding verbal orders and clarification of orders was inadequate she should have demanded better policies or refused to practice under those circumstances. Inadequate management practies lead to poor decisions, and these decisions may have a direct impact on patient care.

Professional standards can only be maintained through appropriate management direction. Even if nurses have a good background in nursing knowledge, they cannot

"meet the nursing care needs of patients and maintain established standards of nursing practice" (JCAH, 1980) without a solid grounding in management principles.

Nurses, must have management skills because they work with team members with less authority, including aides and ward secretaries. There is a wide misconception that management skills are only for head nurses, and then on the need-to-know basis. Good management knowledge and application is a vital component in organizing an effective nursing unit, in establishing a productive communication team, and providing continuity of quality care.

In our role as management consultants in various types of hospitals we often assist in departmental reorganization, deal with employee morale and turnover issues, and develop systems for more effective productive systems. We have observed a trend which occurs very frequently in nursing departments, that people in positions of authority and responsibility throughout the hospital often do not have adequate preparation in management skills. Recurring problems include the following where there is lack of knowledge:

(1) issues of time management and time utilization

(2) dealing appropriately with employees who do not follow policies,

(3) awareness of established procedures

(4) knowledge and use of ranges of authority

(5) how and when to write incident reports

(6) awareness of management principles of assessment

(7) assessment of motivational needs and skill levels of staff

(8) ways to influence the organizational climate for the better

(9) awareness of "People skills" and productive communication patterns

(10) when to be assertive

(11) how to develop effective systems and organizational skills

Part of the responsibility for educating nurses in management skills lies with the nursing schools. Many nursing schools still do not provide management courses from the school of business built into the nursing program. The nursing students cannot be expected to become leaders if they have little or no leadership education.

Student nurses are often taught conflicting messages. They may be encouraged by today's nursing faculty to question the physicians, but are not given ample opportunities to question their instructors of nursing or have input in their nursing curriculum. People learn by instruction and by doing, so when student nurses are not taught appropriate organizational and leadership skills and are not given opportunities to practice or learn such skills, they cannot become effective managers.

DEMOTIVATION FROM SYSTEM PROBLEMS:

The five most sought after goals in nursing are achievement, helping, stimulation, education and fellowship. Achievement is related to recognition. In a survey of nurses 37% rated as crucial the problem of lack of recognition of nurses in the health care field by hospital administration, and 45% indicated they received very little recognition or appreciation from management in their own places of work (Donovan, 1980b). These nurses were on the road of demotivation that leads to apathy. Hospital administrators were asked why there was a nursing shortage and why nurses were unhappy in their profession; only 3 percent said it was from lack of professional recognition (Sandroff, 1980). They do not listen to nurses. Our study indicates some of the behaviors of nurses in the hospital units are a direct result of this frustration.

Although 92 percent of nurses surveyed rated a sense of achievement very important, but only 32 percent felt very satisfied in that respect; 17% rated the opportunities for their achievement as poor. Nurses are faced with increasing frustrations. Many take the option, which to many seems like the only alternative, of forgetting about the principles of good nursing practice to focus on salary. Demanding higher salaries becomes a psychological defense against frustration with the more crucial issues on the job. Nurses need to have control over their practice. They did not go into nursing to only follow orders in a routine job. In a study of nurses 55 percent indicated a problem of no input on matters concerning their practice. They perceived this as crucial and severe. (Donovan, 1980b).

Nurses perceive a lack of control over their work, and this leads to iob dissatisfaction

(Weisman, 1981). Another major reason for the lack of implementation of good management skills in nursing relates to motivational needs and drives. People may not feel comfortable utilizing skills they have learned. What they practice must be congruent with their motivational needs. For nurses to be consistantly concerned with maintaining high professional standards of conduct, they must have high level of achievement need. We found nurses more motivated by needs for control and/or social approval than by needs for achievement (Clavreul, Caviness, 1981). We suspected these needs changed from achievement needs after these nurses had been frustrated in their profession for some time. However, a longitudinal study could determine when these changes occur. Nurses with the higher need for achievement may be more likely to give up nursing as other studies suggest.

If nurses with higher control and social needs are staying in the profession, and nurses with higher achievement needs are leaving, problems could develop which would further enhance the current problems in nursing. For the nurses with the higher social needs, to be liked and accepted by the work group is more important than the need to achieve excellence of performance. Therefore, they are less likely to enforce nursing standards than would nurses with the higher achievement needs. Nurses with high social needs would have difficulty in leadership positions. They would be more likely to make assignments based on pressures from the group members like complaints and expectations, than based on good management principles. On the other hand, nurses with higher needs for control would tend to spend more time exerting power over employees and focusing on minor structural issues when they did not have to appropriate management skills to understand the overall system. They would spend time asserting their authority in minor concerns, while overlooking major problems they did not understand.

A nurse with higher social needs and inadequate management skills runs a risk of making decisions based more on the desire to gain approval from the work group then the desire to maintain professional standards and provide high quality care. A nurse with higher control needs and inadequate management skills runs the risk of being a "junior general", appearing to be in control of the situation, but in reality is not in control at all.

Without appropriate managment tools, nurses cannot achieve excellence in their profession. Even if they started with high needs for achievement, this motivational pattern may have been thwarted if they were placed in positions for which they were not prepared. Frustration and feelings of helplessness are potent demotivators. The next step in this chain of feelings is apathy, a "don't care" attitude. When this happens in nursing, professional standards are not kept.

Nurses who have given up on getting their needs for achievement met often fall into the routine of working without questioning anything. They have "dropped out"; going through the motions without considering contingencies or consequences of decisions. They only focus on repeating routine behavior. The situation may deteriorate to such a degree that they display poor judgment and show a marked loss of interest. This syndrom of "burnout" occurs when people feel drained and overwhelmed (Rosenberg, 1981).

Hospitals are in the business of taking care of patients. When there are management problems, and errors of decision making, the patient could be affected. Goodall (1979) found nurses indicating problems with lack of job gratification, staff disharmony, and loss of dedication to patient well being. These nurses admitted the situation had deteriorated to the point where they no longer cared that much about the patients. When patients feel dehumanized and demoralized, they sue the hospital. When nurses feel dehumanized and demoralized by the management philosophy and practices present in the hospital, they have no redress.

The causual sequence leads to three options, 1) to resist; 2) to surrender, and 3) to quit, as shown in Figure 1.

VARIABLES IN NURSING PRACTICE

Nurses are leaving the profession in record numbers. This trend started on the west coast and has spread across the country. Therefore, people in health care look to California to determine what will be the future for the industry. In interviews with California nurses who either

left nursing, were working in some other form of health care, or who were working in nursing registries, we asked their reasons for their own burnout. No matter what range of variables we discussed, the issue of management skills in their head nurses, supervisors and peers, arose along with problems of administration not willing to listen to needs of nursing service. These nurses perceived the deterioration of (1) nursing care, (2) organizational climate on the unit, and (3) nursing professionalism in practice. Many of these nurses said they could no longer work in an environment where they were repeatedly placed in positions where there was poor patient care and practices adversly affecting patient safety.

We realized that many studies brought up these same concerns, but they were expressed in more general terms in a questionnaire. In most of these the nurse would respond to answers ranging from "strongly agree" to "strongly disagree" on questions about patient care in general. We wanted to know the specific happenings on nursing units that these nurses were referring to when they would state "patient care has deteriorated." We knew such subjective evaluations could be given in response to one occurance of behavior or when it happened frequently across the hospital. Therefore, we asked the nurses to list in specific terms the behaviors they observed which would be indicators of poor management policy or poor decision making that either directly affected patient care or had the potential to do so. Our intent was to determine if the nurses who were unhappy with the situation had made their evaluations based on fact.

We developed a list of variables with these nurses for nursing practices that could be observed by any well-qualified nurse in the normal course of her work. We deliberately chose practices which, if they took place, should have been noticed and stopped or forestalled by the average well-qualified nurse.

By choosing variables of behaviors that would be blatant violations of good nursing practice or good management decisions, we assumed the result would place most of the hospitals in the ideal range or close to it, with only occasional lapses.

We decided to conduct a field study to determine if the practice of nursing had deteriorated due to lack of appropriate leadership and management and if this was affecting patient care and safety. We had already conducted interviews for a study in progress on the nursing shortage, but realized interviews may be biased in either the direction of omitted information or exaggerated information. Questionnaires present the same potential problem. Not all people respond, and those who do may be likely to have extreme responses.

NURSES' PARTICIPANT OBSERVATION

The nature of the problem suggested a field study of participant observation. We would have nurses working in the units at the same time they were assessing the situration for specific behavioral events — variables. This type of study is recommended when (1) the variables under consideration are behavioral and may be non-conventional, (2) the situation involves avoidance behaviors, (3) the study involves physical arrangements and manipulation of objects, and (4) the situation involves observing manipulative or defensive behavior (Doby, 1967).

To protect the privacy of the people and hospitals observed, their names were transferred to code numbers when the data was tabulated. The person organizing the data did not know the identity of the nurses or the hospitals. The nurses who were acting as participant observers were not aware of the identity of any of the other nurses collecting data for the study, or the names of any of the hospitals, other than where they were working.

The source of the data was the behavior of the members of the work group and the patients' charts. The variables under observation were designed as things that ideally any nurse would notice or make herself aware of in the expected practice of her profession. Therefore, there was no ethical problems of the participant observers having to be in a position to gather information that would not usually be available to nurses in the routine course of their work.

The data reported here was collected over a period of 50 weeks from July 1980 to July 1981. The group of nurses collecting the data and making the observations were in the hospitals on the average of 23 shifts a week, resulting in 1150 shifts. This means there were 1150 occasions where the behaviors were observed.

Clavreul was the major investigator with a team of 25 nurses who agreed to participate in the data gathering throughout the year. Of the 25 nurses collecting data, 19 were registry nurses. A registry is an agency that provides nurses on a temporary or semi-permanent basis to hospitals when they need extra help. Most hospitals in this area used nursing registries. We made the choice to utilize more registry nurses because they would have the opportunity to be in more facilities, with a minimum of five shifts each, and would be more likely to notice specific behaviors. People who have become familiar with a routine or surroundings tend to overlook details. The nurses were selected because they (1) were concerned about the future of nursing, (2) were motivated to collect the data in detail over a year, (3) displayed strong nursing skills and awareness of good nursing practice so they would know what they were looking for, and (4) could be trusted to maintain confidentiality and not reveal to others, findings which could jeopardize the hospital.

We trained the nurses in what specific behaviors to record. This reduced the element of subjectivity. At the end of each shift they would compile a table of frequency for the occurrence of each variable. These were later compiled into percentage tables for all hospitals indicating the percentage of the occurrences for the percentage of the hospitals.

Because these nurses were also working as regular staff nurses at the same time they were collecting data, they would not spend all their time making observations. This would cause an undercount of occurences which means that our results are conservative.

The nurses on the units under observation were not told of the study because it could bias their behavior. However, if they inquired they were informed. Trust was developed between them and the researcher-nurse if they discovered the nature of the study. Trust was important because the nurses feared they might be reported to the administration or nursing service for their poor practices. After this trust was established, these nurses volunteered to share more information about how the units were organized, how nursing was practiced in that unit or hospital, and how this affected patients. Responses from these nurses were very positive and indicated they were glad something is going to be done about nursing. As a professional courtesy, the nurse-researchers talked to the supervisors in the hospital or directors of nursing about the study. These people agreed not to let the staff nurses know about the study, and they were often very pleased that they could be part of the study. Many hoped the results would provide a vehicle for the administration to be aware of what is going on in nursing.

LOW MORALE ENDANGERS PATIENTS

Our research findings indicate many practices that endanger the safety of patients. These practices, did not occur because the nurse was cruel or deliberately wished to harm the patient. In most cases where the undesirable behaviors were observed it was noted that the nurses in question were either (1) unprepared in basic management principles and how to apply them in decision making, or (2) were so frustrated in the work situation that their only coping mechanism was to withdraw and go through the motions of the work—burnout syndrome. This apathy had its origins in the nurses' own inadequate preparation for the situation or in lack of supportive systems for nursing they perceived in the hospital. They had become demotivated.

This demotivation was also related to (1) increased work load because of the nurse shortage, resulting in part because many nurses have left the profession, (2) perception of decreased support from supervisors, (3) unclear limits of professional responsibilities, and (4) disappointment over unmet expectations. The use of poor judgment, is a common outcome in this situation.

In our discussion of the findings we applied the assumptions of our theoretical base to label findings as "dangerous" if they happened in hospitals over 50% of the time. Our determination of what is serious and what is not is based on our principles of management and humanist orientation.

If a practice that is dangerous for patients, or has the potential for such danger is consistently happening to someone in the hospital, it is a direct violation of the principles of good nursing and medical practice.

The variables were organized into four major categories: (1) Medication Management, (2) Management System Effects on the

Nurse-Patient Relationship, (3) Change of Shift Report and Assignment Issues, and (4) Procedures in Utilizing Registry Nurses. The variables under these categories were selected because they could be easily observed and tabulated.

The ideal result was to have 0% on the reported variables because these were behaviors that were contrary to good nursing practice. The most severely negative result was to have an occurrance in 90-100% of the shifts under observation as shown in Table 1.

MEDICATION MANAGEMENT

In all the hospitals under observation, in at least one unit, narcotics were given after the orders for that narcotic were expired. Sometimes the patients received the narcotic for many days after it should have been stopped. The patient risks becomming addicted to narcotics that are given routinely. In these cases the nurse administering the narcotic either did not think to verify that the order was still in effect, or was not aware narcotic orders had to be renewed for limited periods in order to protect the patient.

In this situation the hospital is liable because the nurse is prescribing narcotics without a license for doing so if she continues to give it with expired orders. The situations observed were not ones in which the nurse, out of concern for the pain of the patient, made a conscious decision to go ahead and give a narcotic with an expired order. That is a different issue. The problems observed in this study were repeated events of nurses just going through the motions and engaging in habitual behavior, not utilizing their authority and responsibility of nursing and management assessment along with decision making abilities.

The data indicate a frequent occurrence of mismanagement of intravenous (IV) fluids. The IV fluids may be started in the emergency room or operating room. But when the patient gets to the unit, no orders are written by the physician to continue them because they may no longer be needed. However, sometimes patients continued to receive IV fluids, often for many days, that they did not need. The patient may have received the wrong IV fluid because the person starting it made a mistake, but the problem is often enhanced when the nurse on the next shift continues to give the wrong fluid without checking the orders. This same type of issue is present when antibiotics are continued and not checked against orders. It is the responsibility of the nurse to be aware of the expiration time of orders for specific medications, and to have the knowledge base to know the side effects otherwise.

A major problem in medication management occurs when the patient does not receive medications as prescribed. When hospitals use the unit-dose system, there is a great potential for this type of problem. In this case the delay is likely to arise in the pharmacy. Then the nurse spends her time trying to get the medication, repeatedly contacting pharmacy, and not attending to the patients. Then she gets behind in her duties and makes mistakes. If stronger management systems were instituted with clear expectations spelled out across departmental lines, nursing departments would not have this problem. This occurred in 37% of the hospitals 90-100% of the time. This means that patients often do not get the vital medications when needed due to a systems management problem.

The narcotic key is often left where any person, staff or visitor, could have access to it. It may be left on the nurses station desk or in a drawer. An assigned nurse should have it on her person at all times. In 27% of the hospitals this happened 50-89% of the time. These issues of poor judgment also occur when the medication cart is left unlocked and unattended in the hallway. This was observed in 20% of the hospitals 90-100% of the time. Nurses do not deliberately leave the medication cart opened to entice people to take medication that is not prescribed for them. They often are just thinking about the task at hand, taking medications into a particular patient's room, and not thinking about contingencies.

Sometimes medication errors are accidental and sometimes they reflect an attitude of not caring. In either case, incident reports should be made. Otherwise the nursing staff participates in a cover up. Incident reports were not done when appropriate because the nurses were either not aware a problem had occurred, or their burnout had become so severe that their behavior was defensive and their judgment was impaired. In either case this represents a lack of management knowledge and appropriate utilization of manage-

ment skills.

Some nurses had such a high need to be liked by the group that they did not want to report a member of their team for making a mistake. In 45% of the hospitals incident reports were not done when reportable incidents occurred in 90-100% of the shifts observed. In some cases the patients' charts were falsified to cover the mistakes. Only 10% of the hospitals consistently made incident reports when appropriate.

TABLE 1: INCIDENCE OF VIOLATION OF GOOD NURSING STAFF MANAGEMENT
(Observations in 100 hospitals, percent of 1150 duty shifts)

	0	*1-40*	*50-89*	*90-100*
Violations observed in 1 + units of hospitals	*Ideal*		*Dangerous*	
Medication Management				
Narcotic given after orders expired			55	45
IV kept running without orders	17	47	36	
Antibiotics continued after order expired	7	29	36	28
Unit dose medicine not given due pharmacy delay	10	8	45	37
Cardex not current; potential medication error	11		26	63
Narcotic key unsecured on desk or in drawer	18	46	27	9
Medication cart left open, unattended in hall	10	25	45	20
Incident report omitted for reportable accidents	10		35	45
Nurse Patient Relation Affected by Management				
Hostile nurse response, ignore patients needs		17	18	64
Mixing systems; team leader assigned patients or management people included in staffing			45	55
Mixed shift lengths on one unit (8, 10, 12 hours)	27	18	27	28
Patients admitted, assigned, medicated much later	8		56	36
Initial rounds omitted by charge nurse or team leader	11	8	44	37
Change of shift report & assignment issues				
Report omitting vital information			28	72
At Report, vital terms undefined, responsibility unclear				100
Report 30 + minutes late; patients unattended	10	59	14	17
Patients assigned less qualified nurses when more qualified nurses available	8		65	27
Qualifications of float & registry RN's not checked	10		27	63
Staff, registry RN's pulled to other units though not prepared for such patients			18	82
Assignments not explained, lack information for good care	7		57	36
Assignment changes interrupt or delay patient care.	10		43	47
Procedures for Utilizing Registry Nurses				
No proof of RN license asked as registry RN reports	18		17	65
No proof of identity from temporary nurses	8		10	82
Inadequate orientation to registry RN on first day			28	72
Over half of registry RN's do not know patients or hospital routine	10		54	36
Some units entirely staffed by registry RN's	64	8	28	
Registry nurse as charge nurse in some units	10	9	43	38

NURSE-PATIENT RELATIONS

Sometimes the situation had so deteriorated that the nurse, was rude or hostile to patients or deliberately ignored their requests. This was not done because the nurses did not like patients. Instead, the patients have become the targets of the results of other stress. Our study indicated such inappropriate comments like the following: patient request a glass of juice—nurse responds, "What do you think this is, a hotel?"; or patient requests something for a headache—nurse responds, "How about a hammer?" What was observed more commonly was signs of boredom or disgust from the nurse when answering a patient, or putting off having to deal with the patients' needs. These needs were not always minor. In 64% of the hospitals this type of behavior was observed in one or more units 90-100% of the time. In *none* of the hospitals in this study were the nurses consistantly polite and caring toward the patients.

The patient care is affected when the nurse is overworked. This may not be due to shortage of personnel, but a mix of systems which results in inadequate use of personnel. This is a common problem when hospitals try to mix functional nursing, team nursing, and primary nursing in the same unit. Lines of authority and responsibility become confusing. For example, when a team leader is assigned total patient care it becomes impossible for this person to function adequately as a team leader and take total care of acutely ill patients at the same time. Utilization of this pattern contributes to burnout. All of the hospitals did this mixing of systems 50-100% of the time. This is a clear indication of a lack of awareness of sound management principles for productivity.

Patient care is likely to suffer when nurses on the same unit are working 8, 10, and 12 hour shifts at the same time. The 10 and 12 hour shifts were intended to provide more coverage during changes of shift and result in better patient care. However, the management implications of mixing the shifts on the same unit have not always been thought out by nursing managers trying to use them. When there is this mix of systems the nurses spend more time giving and taking report. This preempts time from patient care. It also becomes confusing who has what patient. The patients may get lost in the shuffle and not be assigned to anyone. This is a problem on the 3-11 shift when the 10 and 12 hour people go off duty. We were glad to find that 27% of the hospitals did not mix these scheduling systems on the same unit. However, over half of the hospitals did so 50-100% of the time. It results in confusion and frustration.

Patients may be admitted and not taken care of until much later. This is a problem at change of shift and with the coming and going of the nurses on the 10 and 12 hour shifts. In 36% of the hospitals it was observed that one or more patients were not immediately cared for 90-100% of the time. These patients had increased anxiety as they sat in their rooms with no vital signs taken, no care and no food for a prolonged period of time.

Charge nurses or team leaders as part of their management responsibilities should make round at the start of the shift on all the patients under their ultimate care. They often leave this responsibility to the staff nurse who had been assigned patient care. This abdication of responsibility is a sign of unawareness of management functions and of boundaries of the leadership position. In only 11% of the hospitals was this done consistently, with the charge nurses and team leaders willing to take on their responsbilities of assessment of patients.

CHANGE OF SHIFT REPORT

The function of report at the change of shifts is to give the oncomming nurses appropriate information so they can take care of the patients adequately. Often vital information is not covered as the offgoing nurse either rushes through the report or spends time talking about things that are not important, or expressing her hostile feelings towared the hospital, other departments, physicians, patients, other nursing staff members, and even visitors.

The report should cover vital information such as new orders, lab work results which affect treatment plans, changes in condition, and special treatments for that day. When this information is not given in report, the patient care may suffer due to lack of appropriate information flow. Our study indicated all the hospitals under observation had units where report was not adequate 50-100% of the time.

This same issue comes up when vital terms are not defined and responsibility is not made

clear. Terminology has different meaning in different hospitals, units, shifts especially terminology relating to management practices. Duties of the nurse assigned for total patient care may not be clear. Does she indeed have total patient care including giving medications? If there is role confusion the team leader and the person assigned to medications may both medicate the patient, resulting in an overdose. Terminology needs to be well defined so lines of authority and responsibility are understood. This is critical when hospitals use many float, per-diem, or registry nurses who may not be familiar with the particular practices of certain units. In no hospital were those terms adequately defined at report time.

Report between shifts should last no longer than one half hour. When report starts late and ends late the patients are likely to receive their medications and treatments late. This is a serious problem when the report is thirty or more minutes late. In 17% of the hospitals this was observed 90-100% of the time. Only 10% of the hospitals consistently completed report on time.

Patient assignments are often made randomly. Our study indicated little assessment by the persons making the assignments to try to match the patients' need with the nurse who was best suited to care for that type patient. Often the nurse better qualified for a specific patient was assigned to someone else. The nurses making assignments need not only good nursing assessment skills but also good management skills and the ability to be in a leadership position. We observed situations where more acutely ill patients or those requiring more care were assigned to the nurse who did not complain about such a work load. Nurses who complained were given lighter assignments. Often the nurses for the registry, who were assumed to be there only for the day, were given patients who required more care.

With more and more hospitals utilizing nurses from the per-diem pool working by the day, as needed, float nurses who go from unit to unit in the same hospital, or nurses from the registry, the issue of how to make assignments becomes crucial. The person making assignments needs to have the skills to assess the nursing skills of these temporary nurses and their qualifications. Our study indicated most frequently even a basic inquiry about their field of nursing expertise was not made. The issue here is not the qualifications of registry nurses vs. staff nurses, but the responsibility of the hospital and nurse on the unit making assignments to have some awareness of how to match the patient with the most appropriate nurse. Only 10% of the hospitals consistently did assess the skill level of these nurses at the time of assignment.

When hospitals are short handed they try to operate at full capacity anyway. Units should be closed when there is inadequate nursing coverage, but this is not done. Short-sighted plans are made which cause even more problems in the long-run. This occurs when nurses are pulled from one unit to cover shortages on another. The problem is compounded because these nurses are merely ordered to go, with no assessment of their skills for the new unit. Nurses become more burned out and frustrated when they are pulled, especially if they have no control over the situation. In 82% of the hospitals in our study nurses were pulled in this manner somewhere in the hospital 90-100% of the time.

Not only should the change of shift report contain important information, but the person making the assignment should make sure the person receiving the assignment has information needed for good patient care. Assignments may be posted and without explanation or elaboration of patient care issues. Important information may not be communicated. In 36% of the hospitals this was a problem 90-100% of the time. In only 7% of the hospitals was the assignment clearly explained consistently.

The nurse cannot give good patient care if she is unclear for which patients she is responsible. This is a problem when assignments are changed after they are made. The result is often in interruption or delay in patient care, as well as frustration on the part of the nurse who may have already started planning the daily care for the patients she was formerly assigned. This results in confusion and frustration and contributes to nursing burnout. In 47% of the hospitals this occurred 90-100% of the time somewhere in the hospital.

UTILIZING REGISTRY NURSES

The use of nursing registries has increased in hospitals. However, hospitals do not always

utilize appropriate management practices in staffing with these nurses. Even though in the last two years the quality of registry nurses had increased as more of the better nurses want to leave affiliations with hospitals where they do not agree with management decisions and nursing practices, the hospitals still have the responsibility of determining the qualifications of these registry nurses. This is not being done. In 65% of the hospitals in our study, proof of RN licensure of registry nurses was not requested 90-100% of the time. Only 18% of the hospitals consistantly inquired about proof of licensure. Not only is this practice in violation of appropriate hospital practice, it could put the patient in severe jeopardy.

Hospitals should request a drivers license or other proof of identity of nurses who come from the registry. Since these people are not regular employees of the hospital and may only work one day at a time, it is important that the hospital establish that they are hiring the intended professional. A person may come in with a nursing license of another person and pretend to be that person. In 82% of the hospitals no drivers license or proof of identity was requested 90-100% of the time. This is not to say hospitals are run by non-licensed people, or by those pretending to be nurses. But when the hospital gives up its responsibility to check for such things, this could easily happen. When nurses are not thought of as people, or professionals, their credentials will not be checked. This attitude is evident when people from a hospital's nursing service call up a registry and ask for so many "warm bodies" to fill so many slots.

When nurses from the registry go to work in a hospital it is expected on their first day to have adequate orientation so they understand the functioning of that particular hospital, know the location of supplies, location of emergency equipment, and know the procedures. The orientation of registry nurses is also supported by JCAH guidelines, an organization that surveys hospitals nationwide for appropriate practices. This orientation was not taking place in 72% of the hospitals 90-100% of the time.

When hospitals are staffed with a great proportion of registry nurses, there is a lack of continuity of care and lack of information flow. This could affect patient care. Our study found in 36% of the hospitals there were some units with over half registry personnel 90-100% of the time, and units were entirely staffed by registry personnel in 28% of the hospitals 50-89% of the time. This raises serious ethical issues related to patient safety. This does not mean the registry nurses are not qualified. That is not the issue. They may even be more qualified than the staff nurse at their side. Even the most qualified people cannot give the best care if nearly everyone on any given unit is there only for the day.

This issue is compounded when the staff does not wish to be cooperative with the nurses for the registry. They may be perceived as outsiders, and therefore receive inadequate information from the regular staff. Staff nurses have expressed resentment of the registry nurses because they are paid higher salaries and have more control over their own practice of nursing than does the staff nurse who may be bound to a demotivating management system in a particular hospital. The registry nurse can more easily work where she wishes.

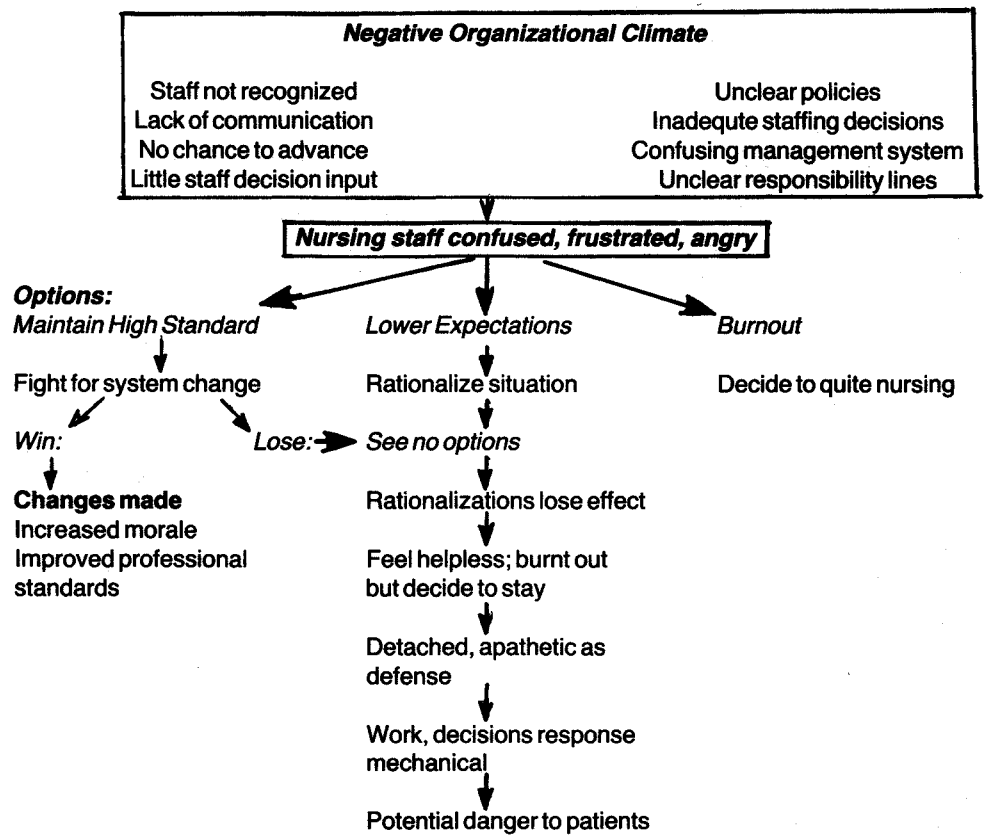
MANAGEMENT ISSUES AND NURSING PROFESSIONALISM

Our research has indicated a severe problem with ethical issues in nursing practice and nursing management. We examined issues of medication management, nurse-patient relationships, reports and assignments, and registry nurse utilization. From our data gathering, it was plain these four issues were only the tip of the problem of the nursing shortage.

Of the hospitals under observation, in those with a high percentage of these inappropriate practices we noticed a high degree of turnover in the nursing department. Nurses who were in leadership positions but with inadequate grounding in management skills and leadership knowledge did not know how to deal with the situation, so they ignored it. Avoidance of a problem is no solution. These nurses became frustrated, felt helpless, began to withdraw from the situation, and started showing lack of good judgment in decision making.

During the year's time the data was being collected several of the hospitals had JCAH surveys. The hospitals with severe problems would "clean up their act" for the survey, and

FIGURE 1: NURSING STAFF MANAGEMENT EFFECT ON PATIENT CARE



as soon as it was over they would revert to the previous behavior patterns. This indicates they were aware of the difference between professional and unprofessional behavior, but had become too apathetic to care.

What we propose is not a "policing action" and more authoritarian enforcers of good practice, but a revamping of management in nursing and throughout the hospitals in terms of management skills levels. Punitive actions are not motivators for change in the long run. Behavior may change with this approach, but resentments build to explode on other problems of a passive-aggressive nature at a later date.

As management consultants to the health care industry, we have been able to change the organizational climate in units and hospitals by providing a system of personnel support and education. People cannot practice what they do not know. In this capacity we have witnessed radical changes in the style of nursing practice, which of course benefited the patients.

These changes took place after the staff had become more secure in their management skills and were also encouraged and supported by the administration in these changes. In these facilities where a systems approach was taken to include all departments and medical staff, we were able to make changes that increased the professional level of nursing practice. Some of these hospitals formerly displayed the types of undesirable behavior patterns that were variables in this study. After the management changes and systems changes were made, morale increased, people became more motivated, communication pattern across departments increased along with cooperation for the common good.

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passage of the amendment. Just as they were heterogeneous in their religious and political beliefs, the pro-ERA women were also heterogeneous in their reasons for supporting the ERA. A labor union representative put forth some quite practical needs for the support of equal rights, others expressed concern for the concomitance of pro-abortion and pro-lesbian interests, the League of Women Voters represented an intellectual approach, activity from religious groups was apparent, and a small but obvious faction was there to enjoy, and add to, a controversial issue. These diverging interests and expectations, coupled with rumors of infiltration from the group opposing the amendment, made it difficult for the women to agree on objectives, coordinate activities and present the united front that would be necessary for an effective campaign.

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