Reluctant Managers: Nurses Surviving Despite the Bottom Line

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Abstract

Chronic hospital bed shortages and compromised patient care has dominated the media over the past decade. Restructure and change are the catch cries for the survival of a quality public health system. The majority of existing Australian research has focused on the impact of hospital restructuring and retrenchment from the perspectives of the non-professional staff, such as cleaners and kitchen hands. This research investigates the perceptions of middle management nurses in a major Victorian hospital. Unlike other managerial survivors of restructuring, this research reveals that this group of nurse managers have remained committed to their vocation and their workplace, despite the unrelenting pressures they have endured.

Introduction

This paper provides an analysis of the impact of restructuring on middle management nursing staff in a major Victorian catholic public hospital. During the first half of the 1990s the hospital moved from a traditional, functional and hierarchical model of nursing to one based on the development of decentralised multi-skilled teams of nursing and allied professionals focusing on patients with similar illnesses (Campbell and Breen, 1994). Informing, but not totally determining the organisational and nursing role aspect of these changes was a United States model of patient-focused nursing care (Brider, 1992; Schweikhart and Smith-Daniels, 1996). During this period, the downsizing of nurses as a result of a flatter, decentralised organisational structure, was limited to indirect administrative staff and some direct nurse mangers. In the second half of the 1990s closure of wards in the hospital and their reaggregation (integration) with remaining wards caused more major downsizing of nursing jobs. These changes were driven by health funding cuts by a National Liberal Coalition government. These cuts were achieved by the introduction of a new casemix based funding formula, which allocated resources according the type of clinical service delivered to patients. The impact of the formula was to proscribe duration of hospitalisation for different illnesses and increase throughput of patients. This casemix funding formula resulted in greater nursing workloads in Victorian

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4 Gough Fitzpatrick 9 Dec 04.indd 1 9/12/2004 6:11:54 p.m.

hospitals, and facilitated reductions in staffing (Duckett, 2000). In New South Wales' public hospital system during the 1990s, Bray and White (2002) note similar problems with increases in the number of patients serviced without matching increases in staffing levels, leading to an intensification of work for nurses and other hospital staff. These changes in New South Wales during this period occurred under a state Liberal government and also an Australian Labor Party government.

The development of a flatter and more decentralised structure in the hospital was accompanied by the creation of a new role for charge nurses. They were renamed "Nurse Unit Managers" (NUMs) and took on managerial duties such as staffing, monitoring of supplies and equipment, quality processes and procedures and coordination with other areas of the hospital on patient needs. These changes led not only to greater work pressures on NUMs but also required them to work considerable unpaid overtime. In the broader Victorian hospital sector, Considine and Buchanan (1999) found that unpaid overtime by nurses was equivalent to 750 extra positions a week. Based on their study on NUMs in a New South Wales hospital, Bray and White (2003) report a similar intensification of work and longer working hours.

Another important factor causing intensification of work for nurses has been technological change in health care, which has led to major increases in day surgery and increased levels of acutely ill patients staying in hospital (Bray and White 2002).

Analysis of similar processes of restructuring and downsizing in Australia across the whole labour market (Dawkins, Littler, Valenzuela and Jensen, 1999) reveal that the managers who survived had poor morale and commitment, low levels of job satisfaction and security and lacked motivation. With these problems in mind and also the greater work pressures referred to above, the aspirations and values of the nursing staff that have remained in the hospital throughout the changes are explored. In this paper the response of nurses to the changes in the second half of the 1990s will be examined. The impact of a role change from a mainly clinical role to a managerial one for nurses is also explored. Whilst increased work pressures and unpaid overtime similar to that of the research cited above are apparent in the hospital, its will be shown that the interaction between skills, technology and length of tenure of staff in different wards of the hospital led to varying levels of perceived stress by the nurses. Their willingness to remain in a difficult environment is also mediated by their professional commitment and concern for patients.

The method adopted in the research was qualitative. Individual interviews were conducted from September 1999 to April 2000 with fourteen nurses from three levels of managerial status at the hospital; two nursing clinical directors, seven Nurse Unit Managers and five Associate Nurse Unit managers. Interviews were also conducted with a former Clinical Director of Nursing Education, a former Hospital Services Delegate and an official from the Australian Nurses Federation covering the hospital. Transcripts of interviews were

analysed by topic and quotes are given to illustrate the predominant attitudes of those interviewed.

The paper begins by explaining the nature of the new funding formula introduced by the Kennett National Liberal Party government and nurses' perceptions of its impact on their work. It then looks at the repeated reaggregation of wards caused by resultant funding cuts and nurses' responses to the situation. This is followed an examination of the varying level of work pressure experienced by nurses in different wards. Finally, it explores how the professional commitment and the morale of the nurses who remained have been sustained despite changes to the role of their job, the repeated downsizing and growing work pressures.

The New Funding Formula

Prior to the introduction of a new method of funding hospitals major changes to the role of nursing managers had occurred at the hospital. The decentralised team-based structures put in place in the first half of the 1990s meant a major change in the role of ward charge nurses, who became Nurse Unit Managers (NUMs) in the new structure, and also shifted the emphasis from a clinical role to a more management oriented one. Nurse Unit Managers became involved in matters such as staff recruitment and selection, appraisal, rostering, patient discharge, planning, and budgeting. Nurse Unit Managers worked what could be deemed as regular 'office' hours, whereas Assistant Nurse Managers (the old assistant charge nurses) (ANUMs) had a patient load and worked both night shifts and weekends, deputising for the Nurse Unit Manager during those periods. A number of wards or units were grouped together to form care centres under a director so that the centres became almost mini hospitals.

These changes formed part of a coherent vision of improving efficiency and patient care, and the hospital soon became a state leader in these areas. However, concurrent with these major changes, a new method of funding was introduced, which created further pressure to reduce costs.

When the Kennett government gained office in 1992, it moved quickly to cut health funding by 14% over the following two years (Stoelwinder and Viney, 2000). The Victorian government also introduced Casemix funding in July 1993. The government, however, used the introduction of Casemix, not as a way to more effectively allocate resources but as a vehicle for cutting costs, rather than services, in hospitals (Duckett, 2000).

Casemix funding replaced block grants to hospitals, which was based on the number of patients treated, with funding based on Diagnosis Related Groups (DRGs). DRGs are a method of classifying hospital stays into various categories, and specifying cost of each of the stays or inputs required to treat the illness. As a result, complexity of treatment rather than numbers of patients became the basis of costing. One key aspect of the

measures associated with each of the DRG is the normal length of patient stay in the hospital. Nursing costs are treated as an overhead and allocated to DRGs according to length of stay. No successful attempt has been made in Victoria to accurately access actual nursing inputs associated with each DRG. In effect, nursing staffing levels were determined by the funding available to the hospital through the DRG based formula. This method of measuring nurse staffing levels in the context of the government cuts to health funding had a significant negative impact of the number of nurses in Victorian hospitals.

Casemix was used to increase efficiency by linking it to a funding formula called "Weighted Inlier Equivalent Separations" (WIES)[1]. This formula works by calculating an average cost across all DRG groups for patient treatment. This average cost then becomes a unit of measure against which all DRGs are compared (Auditor General's Report, 1998). Weights are created against this unit for different DRGs. The WIES system allows hospitals to choose the number of patients they will treat in each DRG within their limit of WIES units allocated by the department and the weighting given to each DRG.

Due to the prior restructuring, it was better placed than other hospitals to achieve efficiency improvements required under the new funding arrangements. However, further efficiencies could only be achieved by further cuts in services and staffing. Such reductions placed unreasonable and in the longer term unsustainable pressures on remaining nursing staff. As argued by Stoelwinder and Viney (2000:220), 'Massive funding reductions were achieved by obfuscating them in Casemix funding rhetoric of hospital competitiveness and complexity of formulation'.

Closure and Reaggregation

The failure to increase throughput of patients to match the level of WIES available resulted in the closure of beds. This inability to keep within the budget raised concerns that the hospital might be closed. Pressures on the hospital to cut costs led to two major reaggregations, one in 1996 and another in October 1998.

The second reaggregation came about because of the gradual closure of beds across the wards, which led to an assessment by management that a whole floor should be closed to save costs. As a result many units within wards were reallocated throughout the hospital. These changes came on top of the several reshufflings of wards prior to the move to the new hospital. Inevitably, one would not expect to find the new ward structure to remain due to the impact of changes in technology and methods of treatment. However, the time and effort devoted in the planning of the structure of the new hospital was undermined by the piecemeal changes that followed.

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[1] Inlier equivalent separation refers to a measure of the number of patients below the average length of stay for a DRG adjusted back to average length of stay equivalent value.

Perceptions of nurse managers on the impact of the reaggregations were varied. Most had been subject to reaggregation, although several claimed that they had not been affected. Also on both occasions of the ward closures, Nurse Unit Managers were forced to reapply for their jobs creating considerable anxiety. ANUMs and other nurses were reallocated to different wards. The closures led to further redundancies amongst senior nursing staff and non-nursing support staff.

Nursing staff found themselves affected by either being placed in a new ward or having to integrate new staff from a different area of specialisation into their ward. In some cases specialist areas were allocated to a ward, taken off that ward and then returned again. One of the NUMs, who did not change wards ,but experienced a lot of upheaval, commented:

> *So we have had a few moves physically and downsizing of staff and totally splitting teams up and reconfiguring them again…We had a unit running well [after the first reaggregation] and then they reaggregated again. That soul destroyed staff.*

Another NUM observed that:

> *…what was across the whole floor [each floor has two wards] became one ward, that was a massive change for staff.*

The reaggregations had several effects on staff. The first effect impacted on staff who were dispersed to other wards and thus required to learn a new specialism. This also applied to remaining staff, who had another specialist group integrated into their ward. As one ANUM stated:

> *Each ward is a speciality unto themselves, so there is a learning curve as well*

Another ANUM noted that:

> *I was very worried about renal because I knew nothing about it.*

Seemingly, no formal training on how to cope with these changes was provided for staff and they were left to learn from other nurses and medical staff who were familiar with the area. Most claimed that this was stressful and placed an extra demand on their already diminished free time.

The second problem was that nurses had difficulties adapting to new unit managers and integrating into an effectively functioning teams again. One senior NUM noted that:

> *The staff became very unsettled because…most people got on well with their NUM and did not really want to change.*

There were also comments regarding the fact that more effort should have been made to ensure more cohesive teams. One ANUM remarked on the importance in taking time to build teamwork:

> *We built a lot of teamwork knowing each other.*

The third problem was the pressure placed upon NUMs to help integrate new staff into the ward and to orientate them on new specialisms. One NUM said that:

> *In the first six months I was doing this job after reaggregation, I think I was working from 7 a.m. to 6 p.m.*

The fourth major impact was that for some nurses the reaggregations increased the number of patients they nursed. The reduction in the number of beds and ward closures created constant pressure to find beds for patients and an increased nurse-patient ratio, as one NUM said:

> *When the ward went from 20 to 25 patients, I found it busier.*

Staff were also disconcerted how abruptly the changes occurred and the lack of communication, particularly with the first reaggregation. Examples of comments were:

- *They told us it was happening when it happened.*
- *Every time there is a reaggregation, it just depresses you the way they do it*…they don't take people aside and tell them solo before it is told to a big audience.

With regard to the second reaggregation in 1998, the current ANF job representative indicated that:

> *When the eight floor shut I did not find out until it was happening…[the ANF organiser] had been to see management a week before it happened and she couldn't believe they had not mentioned it.*

However, some communication did occur with NUMs who were directly affected. One of the senior NUMs, affected by the reaggregation, indicated:

> *With the last one there was quite a bit of communication with it all.*

Another senior NUM also commented:

> *Management walked around from top to bottom and said we should actually close another floor and think this through again.*

The ambivalence in the comments probably reflects the change in senior management at the time. The new management were more consultative compared to the previous management. The job representative believed that management were more approachable, but they still did not necessarily always communicate.

In summarising the nurses' responses to the reaggregations and WIES driven cost reductions, one of the ANUMs said:

> *So we are placing too much emphasis on that budget by reducing, closing beds, wards and re-aggregating them so that we can provide the services just with less beds, a higher turnover and lesser work.*

Nurses' Attitudes to Casemix and WIES

In examining the effect of Casemix and WIES based funding on nurses, the impact of increased acuity (level of illness) needs to be taken into account. This issue was raised repeatedly in interviews. For example, the job delegate commented that:

> *Before on a ward you would have patients come in and they would be really sick and then they would get a little bit better…so you would have a balance of sick and a balance of ones nearly ready to go home, but now the patients are kicked out so quickly, they are sick all the time so there is no break so the graduates are burning out. So the pressure is more constant now…so their workload has increased but they have not changed the staffing numbers*

Therefore, irrespective of other changes the impact in the increase in acuity has added to the nurses' workload.

The perception of nurses regarding Casemix and WIES varied in two ways. Firstly, those ANUMs, who carried a patient load, tended to respond to the pressure created by the interaction between Casemix and WIES, as the examples of comments below testify:

- *I know because of the WIES targets it puts the pressure on…there is a set number of days a patient stays for a procedure*
- *We just have a higher turnover of patients coming through. Everyone is out of control, everyone is so busy and working so hard that you think well this is no good.*
- *It has created a lot of pressure for beds and…. then you have got the pressures of patients being admitted who have not got a bed and you are desperately trying to find a bed or facilitate a discharge to make that happen, so it has been very stressful.*

The responses of the NUMs reflect not only the pressure they were under, but also highlight the issue of efficiency. For instance:

- *In some ways I think it is a good thing, because it has meant that things are a lot more efficient, and we look at our practices.*
- *Now there is this constant demand and bean counting for us, but you are being more co-ordinated instead of putting a multitude of tests over five days you are doing them in two. There was a lot of waste.*

Both the ANUMs and NUMs who were in wards and where the pressure was greater, felt much more strongly about the impact of the need to juggle beds and the turnover of patients as well as the need to meet the Casemix DRG benchmarks of number of days stayed per patient. The following comments from NUMS in such areas are typical:

- *The ward just gets busier and busier…getting people in and out quickly or as quickly as we can.*

- *Alot of a Nurse Unit Manager's time is spent dealing with the bed disaster…We never have enough beds, it's a nightmare.*

In the discussion, concern was expressed about the nature of the Casemix system and the weighting inherent in WIES. Having to average the treatment costs for a DRG across a floor, even though nursing intensity (nurse patient ratio) differed, was a significant issue. Concern about the capacity of the hospital to accurately cost the nursing component of various DRG's was also raised by some of those interviewed. The weighting in the WIES system was seen as a source of mounting pressure and the following comments reflect the pressure most NUMs were under:

- *You have to achieve so many procedures including operations to get points… so the weight [changes] so the money goes down so we have to do more to achieve the same amount.*
- *Juggling the beds and the length of stay is dropping all the time.*

Another concern raised was that the incessant and increasing pressure had made it very difficult for ANUMs and nurses to provide emotional support for patients. For instance, one talked about this with compassion and concern:

I know I don't have time to sit down and talk to a patient

Generally, it was apparent that the emphasis on shortening bed stay and the pressure to discharge patients had become unduly onerous in some areas of the hospital. The improvements in efficiency in terms of working smarter and using resources better were recognised by the NUMs as valuable. Although quality improvement techniques to identify inefficiencies in existing procedures and protocols was inherent in the new structure, the remorseless pressure to continually revise WIES weights for particular DRGs went well beyond what seemed reasonable.

Differential Pressure on Nurses

Increased acuity (level of illness) of patients, the pressure to increase patient throughput because of the WIES based funding system, increased nurse-patient ratios and the new responsibilities added to the duties of ANUMs and NUMs, contributed significantly to the work pressures experienced by nurses. However, it was apparent from interviews that the nurses differed in their assessment of the extent to which they felt under pressure.

This can be attributed to the following factors. First, whether the ward was a general medical ward, in contrast to a specialist surgical ward with intensive patient monitoring, often made a significant difference to perceptions by nurses of their ability to cope. The specialised surgical areas often had lesser staff-patient ratio than general wards. One of the ANUMs in a surgical ward noted:

Our work is different. It is not as physically demanding.

Another noted:

> *I think we are pretty well staffed with one to four [patient ratio] but I know on the medical wards on the 9th floor they are one to five, they work a lot harder than we do.*

Surgical patients also tended to be very sick initially and then required less attention. They were also more likely to be ambulant in the recovery phase and did not need the continuous heavy lifting required by very sick medical patients. An ANUM said:

> *Because we are a medical ward we are very heavy [workload]…You can have five patients but four can be bed bound. We aren't a surgical floor, where, once you fix their problem, they can walk around and all that. The type of patients we have need 24 hour care.*

This was supported by one of the NUMs in a surgical ward:

> *If you are in medical, people don't stay because it is heavy and hard on your back.*

The challenging nature of the work in specialist surgical wards also made it attractive to nurses, enabling such wards to retain skilled staff. A senior NUM said:

> *So you have a better chance of maintaining staff if you are in a surgical area in preference to medical area because they have had holes in their roster as long as I can remember.*

An ANUM in a medical ward commented:

> *I think medical nursing needs a big uplift…we need more nurses…we can't get our just regular staffing filled because of the shortage.*

The ability to retain senior staff and as result have a relatively stable team was a second factor that affected the level of stress. One senior NUM in a largely surgical area noted that:

> *I have the luxury of having very senior staff and a very stable workforce…and five to one is adequate and if you have good regular staff, you manage.*

Higher turnover of staff plus the inability to fill vacancies meant there was a need to use the hospital's bank of casual staff and outside agency staff. These nurses required more supervision, were not necessarily as competent as permanent staff and did not form a close knit team. A skill mix, which included more experienced staff also, helped to take pressure off supervisory staff. An ANUM noted that:

> *I worked on a general [medical] ward and now I am in working in specialised area so we have less junior staff.*

The higher acuity also impacted on the skill mix. According to one of the senior NUMs in a surgical area the greater acuity meant that:

[There was a need] for more grade twos [experienced nurses] and less grade ones

A third factor differentiating wards and the level of pressure was the degree of focus required to do the work. General medical wards particularly with their variety of different types of patients meant that nurses do not develop the same level of skills and resultant efficiency. One senior NUM said:

Our ward is acute medical …,so we have a massive variety of patients.

The fourth factor that added emotional pressure on the nursing staff was the number of patient recoveries. A senior ANUM in oncology said:

We have always had high turnover in our area anyway. It is because of the type of nursing we do. Young people, serious illnesses, a lot of death and dying and people tend to burnout fairly quickly.

As noted previously, the high turnover of staff, in part because they are stressed, adversely affects the skill balance and increases pressure on senior staff.

The fifth factor was higher turnover of patients. Obviously the WIES/Casemix system had increased pressures to discharge patients, but some wards, especially surgical had a particularly high turnover of patients.

The final factor related to the mix of patients. If most patients in a ward were just back from surgery or treatment it could mean a very heavy workload, since they required constant attention. One NUM described this:

Sometimes when you might have a ward of twenty-two patients, they might be very independent, they can do a lot of things for themselves and there might be twenty two who can't and it just makes the workload a lot busier and heavier and that is hard to judge and plan for.

Therefore, although the overriding impact of the broader factors mentioned above, particularly the pressure to discharge patients, was felt by all participants, there were also the specific factors in the nature of the ward which were a source of stress for nurses. Variance in the capacity to cope obviously relates to the specific characteristics of wards and patients outlined above.

'Invisible' Overtime

One way of coping with the increasing work pressures was the increase in unpaid overtime. Overwhelming the majority acknowledged that overtime was worked in terms of working longer hours than their shifts, not only as managers, but the other nursing staff not only worked overtime, but often missed lunch and tea breaks in order to get through the work.

The statement below was a common sentiment amongst most of the interviewees:

> *... but the girls are still doing quite a bit of overtime or not getting to tea breaks, which is something new, that never used to happen as well… Lunch often gets busy… so it's often difficult to get staff off for half an hour they're often run off for fifteen minutes.*

Three of the participants held slightly different views and one interviewee in particular stated that it was more of a give and take between management and staff and making sure that when he was in charge he would let people off earlier when he could or have longer breaks to make up for the overtime.

> *I feel that it's a two way street and there are times, a lot of the time when we get off ten minutes late, so I try and get people off early, especially on the weekend.*

One of the participants regarded the issue as a status quo, in that she regarded that the problem existed previously in the old structure.

> *Much the same, even in the old unit, the problem shift is always the evening shift going over to night shift and the night shift leaving in the morning, being organised enough because there's lots of unforeseen things that can come up and you can be as organised as you possibly can and something can hit the fan so to speak and can put you half an hour behind and we try and we always have done, its very unusual for people to get off late on an early shift.*

Nonetheless, overtime was described as a major issue that affected not only this hospital but all nurses in Victoria:

> *It is a major issue. They work it because they have always been refused. The managers have never paid it and they'll turn it around and put it back on the people and say its just that you are inefficient… It's not just at ……., it's state-wide.*

It would seem that the majority of nurses at all levels work overtime, with those in management roles accepting that they needed to work longer in order to get their work completed. This is consistent with the research done by ACCIRT (1999:104), which found that most people working in managerial positions in most occupations worked overtime:

> *…the big difference, however, between white collar and blue collar jobs is that white collar don't get paid for their overtime.*

The nurses in management positions indicated that overtime had become invisible and part of the organisational culture, in that there was an expectation by management that doing overtime was part of the job. Some of the nurses saw this as a deterrent from applying for more senior roles and for recruiting young nurses.

Survivors and Reluctant Managers

The participants in this study were survivors of dramatic changes to their work environment that had lasted for almost a decade. Analysis of similar processes of restructuring and downsizing (Dawkins, et al. 1999) revealed that managers who remain in downsized organisations tended to suffer from poor morale, lack of commitment and motivation, job dissatisfaction and insecurity. These symptoms were clearly not evident with the participants in this organisation.

The process of restructuring and downsizing outlined in this study can be divided into two phases. Phase one included the major changes in job roles, organisational structures and downsizing that occurred with the move to the new hospital in the first half of the 1990s. These changes did cause anxiety amongst the nurses and the loss of some senior and experienced nurses who did not want to change the way they worked. The downsizing was also handled with short- term contract appointments filling most promotional positions in the year leading up to the move to the new hospital, thus avoiding further redundancies. The restructuring was also accompanied by extensive consultation about the new model for running the hospital. This model of downsizing fits the criteria of what Dawkins et al. (1999) have described as 'good downsizing'. Nurses views of the results of the change process show a relatively positive response.

The second phase of change, which led to further downsizing with the reaggregations and the growing pressures of the WIES/Casemix system present all the features of bad downsizing; repeated job cuts, increased pressure on remaining staff and likelihood of further cuts. In effect this second phase was driven by economics, bottom line considerations and did not appear to have any of the positive benefits like the previous phase.

Despite the experiences of the second phase of change, the nurses' morale, commitment, motivation and job satisfaction remained relatively good. One important reason for this was that, despite being put in managerial positions, most of them remained reluctant managers. That is, they remained committed to their vocation. Concern for patients and attachment to specialist areas of nursing were prominent themes in the interviews. Many spoke with passion about their work and this was illustrated in the following comments:

- *I stay here because I want to be a nurse and I still see myself as a clinical nurse a well as a manager.*
- *The reason I am here is because of the patient contact and I love what I do, so that gets you over everything else most times, even having a bad day.*
- *We are torn between the increased managerial role [and clinical nursing].*
- *My passion is surgery, [but] all I feel I am doing at the moment is managing beds and staff allocation.*

- *If I move into management I would like to stay in an area I know something about*
- *I started of in plastics, which is my main passion in life.*
- *I love haematology.*

Thus, while most interviewees expressed some frustration with the managerial side of the job, the positive attachment to the clinical role was very important in maintaining morale and job satisfaction. The inability to give what they considered an appropriate level of emotional support to patients due to work pressure was the only other source of job dissatisfaction expressed.

Besides their commitment to clinical nursing, strong commitment to the hospital was also apparent. This was despite the negative views of previous senior management who were seen as only interested in cost-cutting and lacking the ability to communicate. Typical comments about the hospital included:

- *It is a very supportive organization…It has done an enormous amount of work to review our priorities and be efficient and good at what we do.*
- *It has always been very caring and like a big family.*
- *People who stayed through the second re-aggregation were dedicated and working very hard to keep the place afloat.*

The character of the employees who remained after all the restructuring was another important factor in the positive attitudes expressed. First, they were a relatively young group with an average age of 31, which made them more receptive to change and able to cope with pressures they faced. Second, most of those interviewed showed a capacity to deal with change, despite expressing initial misgivings about changes to their work routines. Some commented about how they liked change:

- *I have really learned to like change.*
- *It was a total revelation to me that I turned out to be an early mover and a change agent.*
- *Then you think about it [change] and think about it as a challenge, something new and different and so it is a positive thing.*

The third factor was an ability to cope with what were often unreasonable pressures and to think positively. Comments such as the following from a NUM in one of the more stressed wards illustrate this strength:

> *But you have to try and get on with it keeping everyone positive and I guess that is the way you run the ward… We could not survive if we had a heap of negativity here. Because I was an associate it was important to keep positive with everyone because otherwise it reflects badly with everyone down the line.*

The ability to cope was also aligned with the love of clinical nursing. For instance an ANUM in a very stressful ward explained:

- *The reason I am here is because of the patient contact and I love what I do, so that gets you over everything else most times even having a bad day.*
- *Maybe I am a survivor, I love my job and I think that helps.*
- *The reward comes from knowing you have done your absolute best for people.*
- *Then you realise you are a good nurse and I know what I can do and I do it for that.*

Several interviewees also commented that they were surprised at the ability of the nurses to cope with the pressures.

- *Nurses just seem to cope with it all.*
- *I thought we will never function with this number of beds but we have managed.*
- *I believe everyone has all these things happening and all these deadlines and maybe not enough staff to help out, but it works out, it works out.*
- *But we got through it all and people made excellent adjustments.*

A fourth factor was the perception that senior NUMs and Care Centre Directors communicated well to staff and were supportive in so far as they could be, given the budget contraints. Meetings at Care Centre level were viewed as good vehicles for discussions and decisions about operational issues. The ability of NUMs, in many cases, to be hands-on at work while arguing for more resources for staff, was seen as a positive feature. Previously senior managers were viewed as uncaring and non-communicative but the recent more open approach of senior management of the hospital was appreciated.

- *It's more open now than it was.*
- *We are well consulted with and communicated with by management of the hospital.*

There was some ambivalence about senior management communication. In the area of professional nursing practice issues, such as work practices, however, the revivification of a consultative forum called the Professional Nurse Practice Council, was favourably viewed. It was seen as a mechanism for tackling issues through the hospital and actually implementing agreed changes.

However, with some policy issues there seemed to be little dialogue. For instance, one NUM noted:

> *But there are still decisions made they go to executive and they get passed and we hear later or you hear about it the day before it goes to the executive, there is nothing you can do. It upsets people.*

The job delegate indicated that communication had improved with the new senior management, but said:

> *They will only let you know what they want you to know.*

There was also a feeling amongst some of the participants that there was not enough appreciation by some senior management of the pressure staff were under.

> *Some managers are really good they will do their best to get you more staff when you need it, but there are other managers who say, "It's not in the budget, it is just the way you work, your skills, that is why you are not coping".*

Overall, despite the ongoing pressures faced by the management nursing staff to achieve bottom line targets, it is evident that their morale, commitment and motivation remained positive. Those who instigated and implemented the restructuring and changes experienced by the nurse managers was in stark contrast to Dawkins et al (1999) 'bad downsizers' which was described as those who engaged in repeated downsizing, did not have a positive strategy for the future and failed to consult employees about the changes.

Conclusion

This paper set out to explore the response of nurse managers to the continuous change experienced by public sector hospitals in the 1990s. These changes occurred in the context of increasing acuity of patients and technological change affecting nursing care. The hospital chosen was a leader in understanding the need to change and acting on it. According to the interviewees, it was a better place to work in terms of workload than other major public hospitals.

The organisational changes of the first half of the 1990s provided a new more patient -focused model of nursing in an environment of decentralised, decision making. Those interviewed were largely positive about these changes, having chosen to remain, while others who did not like the changes had left. Those who remained expressed some regret about colleagues who had left and were critical of senior nursing management. There were also adjustment problems with the initial reaggregation of wards prior to the transfer to the new hospital. Consultation about these changes was extensive, even though there were criticisms of it. The levels of redundancies of nurses were considerably less than those experienced by support staff and allied professionals. Generally, morale of nurses on entering the new hospital was positive, despite major changes to their work roles to encompass managerial responsibilities.

Subsequent changes brought about by State Government policy through the application of the WIES funding formula in interaction with Casemix put great pressure on nurse mangers. Each reaggregation and related cost cutting made the situation more intolerable. However, as the findings revealed, the impact of this pressure was unevenly felt by the nurses. Some wards were harder hit than others due to the nature of the wards, treatment measures and the type of patients.

Research by Dawkins et al. (1999) indicates that managers in organizations suffering repeated downsizings and increasing work pressures would show poor morale, low commitment and motivation. However, this research has shown that, to a large extent, the nurses interviewed were reluctant mangers, whose overriding concern for their work and patients largely counteracted such negative feelings. Further, they were a self-selected group in that they remained while had others left. They were also a relatively young group of managers with considerable energy. These factors assisted them to absorb a great deal of pressure, whereas, with a group of people less dedicated this would not have been possible.

However, the broader labour market consequences of this situation were to render acute care nursing unattractive to potential nurses, as the hospital found it difficult to fill positions in key wards where the pressure were felt most. This outcome raises a key issue: the inability of politicians, health department officials and in some cases hospital management to see when an equilibrium point of reform had been reached beyond which further change and cost cutting became counter productive. By the time labour market pressure demonstrated by a nurse shortage became apparent, considerable damage had been done to the hospital and to the community it serves. Recent decisions by the Australian Industrial Relations Commission (AIRC) in August 2000 and April 2001 have set a ratio for nurses in acute care hospitals at one nurse to every four patients in areas other than intensive care and day surgery. In agreeing to the AIRC decisions the Brach's Australian Labor Party government made budget costings, which failed to take into account the inability of hospitals to staff to these levels. The need to staff to this level has led to extensive use of highly expensive agency nurses, which, in turn, has caused overruns in hospital budgets. The current government has initiated a ban on use of agency staff in order to restrain costs. As a result some hospitals have been forced to seek alternative arrangements such as building their own nurse banks and closing beds due to their inability to attract full time staff. These changes have occurred in the context of an international nurse shortage.

Innovation, better quality and efficiency are admirable, but this research indicates that there is a need to recognise when the equilibrium point has been reached beyond which damage is done to the organization, its employees and clients. More effective understanding by management of the situation faced by employees is critical to stop the need for crude responses such as labour market pressures being the only warning sign. Bodies such as the Auditor-General in his report did highlight the issues. However, there is need for an independent body such as the Auditor-General to develop a methodology to assess these issues to improve public policy making.

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