Hospital Restructuring and the Work of Registered Nurses

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EFFORTS TO RESTRUCTURE THE OPERATIONS OF U.S. hospitals have been under way for more than a decade (Pierson and Williams 1994; Walston, Burns, and Kimberly 2000). There is no universally accepted definition of organizational restructuring. However, internal restructuring of a hospital typically includes the redesign of patient care processes and changes in workforce composition, organizational structure, decision-making processes, and the responsibilities of management and patient-care staff. Although the scope of restructuring varies across hospitals, many restructuring efforts involve changes in each of these areas, redetermining where work is located, who does the work, and by what process or patterns the work will be done (Walston, Burns, and Kimberly 2000).

In many cases, hospital restructuring results in some change in the hospital's nursing staff, particularly in the use of registered nurses (RNs), who represent about 23 percent of the workforce in hospitals and are the single largest labor cost for hospitals (American Hospital Association 1996–97). Frequently, hospitals reduce their use of registered nurses by replacing RNs with unlicensed assistive personnel (Rosenthal 1996; Kunen 1996; Shuit 1996). This type of restructuring has been the subject of much discussion in both the public and professional literature.

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The debate has focused mainly on how much direct impact the growth of HMOs has had on the demand for hospital nurses (Aiken, Sochalski, and Anderson 1996; Buerhaus and Staiger 1996; 2000; Hall 1998; Spetz 1999) and whether restructuring the work of nurses has had a negative effect on the quality of patient care (McClure, Poulin, Sovie, and Wandelt 1983; Powers, Dickey, and Ford 1990; Bostrum and Zimmerman 1993; Wunderlich, Sloan, and Davis 1996; Aiken, Smith, and Lake 1994; Grillo-Peck and Risner 1995; Lengacher, Mabe, Heinemann, et al. 1993; Mularz, Maher, Johnson, et al. 1995; Blegen, Goode, and Reed 1998; Kovner and Gergen 1998). With respect to each of these issues, the studies produce mixed findings and are inconclusive when considered together (Spetz 1999; Buerhaus and Staiger 2000; Mitchell and Shortell 1997).

In this article, we take a different approach. We focus on the effects of hospital restructuring on the work of registered nurses. In particular, we review the relevant literature to describe the restructuring-related changes frequently reported with respect to three key characteristics: the work roles, workload, and control over work of registered nurses. Understanding the effects of restructuring on these aspects of nursing work is important for two reasons. First, work roles, workload, and control over work are key structural characteristics that define the nature of nursing in a given hospital. To understand nursing, and the impact of hospital restructuring on nursing and on the satisfaction of nurses with their work, we must pay particular attention to these characteristics. Second, these three structural characteristics of hospital nursing are key variables through which the effects of hospital restructuring on patient outcomes may be mediated. Hence, a better understanding of the effect of restructuring on these characteristics of nursing work may provide insights to guide future research on patient outcomes.

The Effect of Hospital Restructuring on Nurses' Work Roles, Workload, and Control over Work

Over the last 15 years, hospital leaders have proposed three different motives for restructuring. Early restructuring efforts in the mid-1980s were motivated by the desire to make better use of RN skills and time (AHA 1989). The next wave of restructuring was undertaken to meet

the needs of patients better by implementing patient-focused care (Lathrop 1993). More recently, restructuring efforts have been undertaken to improve operational efficiency (Greiner 1995). Although each of these motivations provided the dominant rationale for hospital restructuring during different eras since the mid-1980s, they are not mutually exclusive or time-bound. Even today, each of these motives is being espoused individually or in combination to justify hospital restructuring.

Restructuring to Improve the Use of RN Time

Early efforts to redesign the work of registered nurses were motivated by the desire to use RN time more appropriately. Many analysts of the nursing shortage in the mid-1980s attributed the shortage of nurses to an increased demand for RNs driven by a relatively low RN wage rate and the substitution of RNs for other types of workers (Aiken and Mullinix 1987). There were numerous reports of nurses being used to perform non-clinical functions, such as transporting patients, stocking supplies, and housekeeping (Prescott 1991; Roberts, Minnick, Ginzberg, et al. 1989). In response, many hospitals implemented nurse extender and other types of nonclinical support and assistive roles to relieve nurses of clerical and other administrative tasks (AHA 1989). In hospitals that implemented such changes, cost reduction was not a major goal. Indeed, in many cases, the goal was to implement changes that were budget-neutral (Brett and Tonges 1990). Generally well received by the professional nursing staff, these changes succeeded in their goal of optimizing the time spent by nurses in providing patient care (Donovan, Slack, Robertson, et al. 1988).

Restructuring for Patient-focused Care

A related but distinct motive underlying hospital restructuring in the 1980s and 1990s was the desire to redesign the hospital to meet the needs of patients better. Known as patient-focused care, this redesign strategy was intended to eliminate inefficiencies created by the departmentalization of hospital services and to focus hospital operations around patients rather than around departments or disciplines (Lathrop 1993). Implementation of patient-focused care included the development of multiskilled workers through extensive cross-training of caregivers. Typically, the goal was to provide 80 to 90 percent of the services required by patients at the bedside, including nursing, routine lab work, EKGs,

respiratory care, and basic radiology films (Lathrop 1991). Reports from individual hospitals often have been positive about the impact of patient-focused care on nursing staff, patients, and the overall quality of patient care (Tidikis and Strasen 1994; Weber 1991). However, implementing patient-focused care is costly. Hospital executives have reported spending as much as \$5 million to \$9 million dollars on this type of restructuring (Weber 1991). As one of its leading proponents notes (Lathrop, as cited in Weber 1991), patient-focused care should emphasize service enhancement rather than cost savings. The organization benefits from long-term operational efficiencies as well as from improved patient satisfaction, which should enable the hospital to compete successfully for market share. Nurses have generally accepted hospital restructuring to achieve patient-focused care well, frequently taking leadership roles in such efforts (Rundall, Starkweather, and Norrish 1998).

Restructuring to Improve Efficiency

In the 1990s, hospitals began to implement restructuring as a cost-saving mechanism. This rationale for restructuring emphasizes improving operational efficiency by reducing hospital costs through replacement of high-cost registered nursing staff with lower-cost licensed practical/vocational nurses and unlicensed assistive personnel (Greiner 1995). This type of restructuring specifically seeks to reduce the skill mix of RNs (the number of RNs providing patient care compared with the number of total patient-care givers) and to deploy substitutes for RN caregivers where possible. Hospitals experiencing operating losses due to lower Medicare and Medicaid reimbursements and the utilization controls and other effects of managed care in the commercial health insurance market commonly desire to lower costs through restructuring (Ayala and Fries 1993; Curtin 1994). The need to restructure to reduce operating expenses often results in rapid changes in organizational structures, work roles, and processes with little opportunity for staff involvement. One hospital reported planning, developing, training, and implementing organizational redesign in five months (Ayala and Fries 1993). As restructuring to improve operational efficiency gained momentum in the hospital industry, widespread reports of RN dissatisfaction with restructuring appeared in both the professional literature and public media (California Nurses Association 1994; Curtin 1994; McEachern 1995; Ventura 1996).

The Impact of Restructuring on Work Roles of Nurses

As hospitals began their efforts to redesign work roles in the 1980s, most hospitals delivered nursing care using a system known as primary nursing. Many hospitals implemented primary nursing in the 1970s in response to major dissatisfaction among nurses with the working conditions associated with the dominant model of hospital nursing at that time: team nursing (Joiner and Marram-van Servellen 1984; Manthey 1980). Primary nursing was viewed as a method of delivering nursing care that promoted professional nursing practice. The essential ingredient of primary nursing was the responsibility relationship established when one nurse was assigned responsibility for decision making about a patient's care throughout hospitalization (Manthey 1980). In most hospitals, in addition to planning the patient's care, the RN was also the sole provider of nursing care for the patient. Primary nursing was described as a method to improve the autonomy, authority, and accountability of the RN in patient care (Deiman, Noble, and Russell 1984; Manthey 1980; Marram 1976). In hospitals where the responsibility aspect of primary nursing was not successfully implemented, nursing care was delivered by a system called modified primary nursing or total patient care. In both primary nursing and total patient care, registered nurses provided direct patient care and were no longer responsible for supervising the work of other caregivers as was required by team nursing.

Nurses received primary nursing and total patient care more favorably than the system of team nursing that preceded it because of the emphasis on the nurse-patient relationship, which they have long espoused to be the essence of nursing (Trossman 1998). Brannon (1988, 1994) described the transition from team nursing to primary nursing as a reunification of nursing tasks that engendered a feeling of "professionalism" emanating from the nurse-patient relationship.

Nursing Work after Restructuring

Hospital restructuring often results in a return to team nursing and a de-emphasis of the nurse-patient relationship. In a recent study of hospital restructuring (Norrish 1999), nurses reported that after restructuring they spent less time providing care and comfort measures for patients and more time doing indirect care activities (such as care planning and

coordination) and more technical direct care activities (such as medication administration and patient monitoring). As a result, nurses believed that their role in patient care became less tangible and visible to patients. In other studies, nurses have reported a sense of loss and grief over their inability to provide the care they believe patients need (Rundall, Starkweather, and Norrish 1998), and high levels of dissatisfaction when working in systems that did not provide an opportunity for a meaningful nurse-patient relationship (Chambliss 1996).

These findings help to explain the opposition of many nurses to the increased use of unlicensed assistive personnel (UAPs) that accompanies many hospital restructuring efforts (Rosenthal 1996; Gillilan 1997). Without a doubt, UAPs have provided an extra pair of hands to help with patient care and to respond to patient requests when the RN is busy with another patient. However, for many nurses, accomplishing patient care through another person results in a qualitatively different, and less satisfying, nurse-patient relationship (Norrish 1999).

The Impact of Restructuring on RN Workload

As indicated above, hospital restructuring often reduces the number of RNs providing patient care and adds UAPs to perform some of the tasks previously done by RNs. However, it is difficult to assess the impact of work redesign and staffing changes on RN workload because the methodological problems of existing techniques for estimating patient-care staffing needs for care units are compounded by the addition of new categories of caregivers. Also, the dynamics of staffing the inpatient care unit are highly complex. It is important to understand the impact of the use of patient classification and acuity systems, the process of scheduling, the fluctuation in patient volumes, and other staffing practices on RN workload.

Patient Classification Systems

Efforts to measure nursing productivity have been ongoing since the 1930s (Georgetown University Hospital and Georgetown University School of Nursing 1986). The early studies focused on managing RN workload by designing systems to aid nurse staffing decisions. These

efforts resulted in the development of patient classification systems (PCSs) intended to serve as administrative tools to project or monitor staffing needs based on patient acuity (Prescott 1991). (Acuity, as used in PCSs, measures the amount of nursing time required to care for a patient over a given period of time rather than the patient's medical acuity or severity of illness. Nursing acuity and severity of illness may or may not be correlated in a given patient or patient population [Piper 1989]. For example, severely ill patients who are receiving only palliative care may require less nursing-care time than patients who are less acutely ill but require intensive education and discharge planning.) Most patient classification systems measure the nursing-care requirements of an individual patient to determine that patient's level of acuity. The individual patient requirements are summed to determine the total patient-care needs for the entire patient-care unit, and the staffing needs for the patient-care unit are thus based on the sum of the patient-care requirements of the individual patients (DeGroot 1994), adjusted for the unit census or patient volume. These staffing projections are based on predetermined time standards for each type of patient or patient-care task. The time standards are empirically derived for the institution either based on work sampling measures or based on standards inherent in the PCS.

During the 1980s, the emphasis on patient classification systems intensified as a result of the Joint Commission on Accreditation of Healthcare Organizations' nursing standards, which required nursing departments to have a system for determining nursing-care requirements based on the patient's needs (Piper 1989). The implementation of the Prospective Payment System and hospital reimbursement based on Diagnosis Related Groups (DRGs) further intensified efforts to define, measure, and manage nursing productivity (Altman, Goldberger, and Crane 1990; Bostrom 1992; Cleland, Marz, and Killeen 1985; Georgetown University Hospital and Georgetown University School of Nursing 1986; Harju and Sabatino 1984). However, patient classification systems have many shortcomings that are exacerbated when hospital restructuring alters the skill mix of patient-care staff. Estimates of the need for RNs may be invalid when restructuring introduces UAPs.

Methodology of PCSs. There are three problems with the methodology of PCSs for calculating the appropriate level of nurse staffing for a patient-care unit. First, the time standards incorporated in a PCS reflect the average time to perform a task for a typical patient. Variations related

to individual characteristics of either the patient or nurse that may influence the time required to perform the task or procedure are not captured. For example, a simple task like inserting an intravenous (IV) catheter into a patient to administer fluids will take longer for a patient who is confused and combative than for a patient who is alert and cooperative. Similarly, a nurse who is highly skilled in starting IVs will take less time to perform the task than a nurse who has less skill. In these situations, the acuity system may underestimate the time requirements. In situations where more than one task can be performed simultaneously, the acuity system may overestimate the time required for care (Piper 1989).

Second, staffing levels for the patient-care unit are determined by summing individual patients' care requirements, based on the assumption that standard times for performing patient care are linear and do not vary. According to DeGroot (1994), this methodology may lead to errors in determining staffing levels. As DeGroot notes, the standard times are actually measurements of the mean time and what is rarely known is the variation of the time standard, as measured by the standard deviation from the mean, for each level of care. Thus, as DeGroot notes, if the average nursing care required by a patient in a PCS category is 5.8 hours per patient per day (HPPD), it can make a significant difference to the total staff requirements whether the HPPD varies by a standard deviation of 0.3 HPPD or 2.2 HPPD. Obviously, in a care unit where the variability of patient-care requirements within a classification category is high, the resulting staffing levels may result in significant under- or overstaffing even though the staffing levels have been allocated according to the PCS.

Third, measuring the care requirements of individual patients to determine total staffing requirements fails to take into consideration the population dynamics of a group of patients on a patient-care unit (DeGroot 1994), including such factors as the volume of patient admissions and discharges and the total complexity of discharge planning needs. The overall activity level in a patient-care unit may be greater than the sum of individual patient acuity levels. Also, when the PCS is used to determine shift-to-shift or day-to-day staffing needs, patient-care needs must be projected based on the care anticipated rather than on the care actually delivered. Given the complexity of patients in hospitals today, it is reasonable to assume that there may be a discrepancy between projected and actual needs related to changing patient conditions.

Application of PCSs. How the PCS is applied within an organization can affect its utility in determining optimal staffing levels. While they

were originally designed for equitable allocation of the nursing workload, PCSs may also provide a mechanism for organizational leaders to justify predetermined staffing levels. As Van Slyck (1991) noted, it is important to determine whether the acuity level is driven by preestablished staffing levels or whether patient acuity levels drive staffing allocations. In some organizations, the PCS has been used to reduce staffing costs by manipulating either the acuity measures or the staffing allowances to reflect lower staffing levels (Shaha and Bush 1996). On the other hand, the staff can easily learn to manipulate the patient's classification to reflect a higher acuity, a phenomenon termed "acuity creep," in an effort to increase staffing levels.

Another problem with the application of a PCS is that while it is frequently used to determine staffing needs for the macro unit level, it is rarely used to determine the patient-care assignment for the individual nurse. Rather, patient-care assignments for the individual nurse are often based on geography. That is, the nurse is assigned a group of patients based on their location in the care unit. Thus, nursing staff often do not see any direct application of the acuity system in their day-to-day workload.

Measuring nursing workload using PCSs is at best imprecise, and the difficulties are compounded when restructuring results in the introduction of additional types of staff. As UAPs and other categories of caregivers were added to nursing staffs, hospitals have often failed to consider the impact of changes in the skill mix on the resulting workload for RNs. When the system to measure RN workload lacks precision even before the skill mix changes, the ability to determine an appropriate RN workload after such changes is even less precise.

The Process of Staffing and Scheduling

The process of staffing the hospital patient-care unit has become incredibly complex, and measuring the nursing workload is only the first step. Numerous other factors must be considered, including the changing demand for staff driven by patient volume, the competency of the nursing staff in relation to the nursing-care needs of the patients, additional staffing practices that may be mandated by hospital policy, union contract, and state regulations, and the personal preferences of the nursing staff reflected in organizational scheduling practices. It is important to examine each of these factors in order to assess the impact of staffing the patient-care unit and the resulting nursing workload.

Changes in Patient Volume. Compounding the problems with measuring patient acuity are the problems related to projecting patient volume. Over the past five to ten years, hospitals have been experiencing tremendous variation in the hospital census, making it difficult to predict the demand for nursing care. Hospitals in northern California, for example, may experience as much as an 80 to 100 percent variation from the projected average daily census. (Thus, in a hospital with a projected average daily census of 100 patients, the actual daily census may range from a low of 80 patients to a high of 160 to 200 patients.) The impact of an erratic patient census affects nurse staffing at both an organizational and unit level.

At the *organizational level*, a volatile census results in the need to obtain additional staff rapidly to meet the needs of an increased census or to reduce staffing levels rapidly when the census drops (Lawrenz 1995). Given the extreme census fluctuations experienced by hospitals, the resulting change in demand for nursing staff is significant. As Lawrenz (1995) indicates, a census fluctuation of 50 additional patients will require a minimum of 30 additional nurses over a 24-hour period, depending on the staffing standards of the patient-care unit. (For example, if a hospital provides an average of five hours of nursing care per 24 hours for the typical medical-surgical patient, then $5 \text{ HPPD} \times 50 \text{ patients} = 250 \text{ hours}$ of additional nursing care. If each nurse works an eight-hour shift, that translates to 30 additional nurses over a 24-hour period. If some of the additional patients are admitted to critical-care units, the number of nurses required will be even greater.)

Because these changes in volume frequently occur in the short run, staffing adjustments in response to volume changes rely on short-term methods. When the patient volume increases, typical staffing adjustments—which tend to be high-cost—include requesting part-time nurses to work additional shifts, requesting or mandating both part-time and full-time staff to work overtime, paying staff a monetary bonus to work additional shifts, and supplementing regular hospital staff with nurses who work for registries. When the patient volume drops below the budgeted level, staff are assigned a day off (either voluntarily or mandated) and endure a loss of pay. Repeated episodes of extremely low patient volumes that last for more than a day or two may result in turnover of nursing staff who desire more predictable work conditions. Another staffing option, if circumstances permit, is to “float” staff—that is, temporarily reassign nursing staff from a unit with a low census

or high staffing level to a unit with a higher census or lower staffing level—an option that many nurses resist because of concerns for patient safety due to lack of knowledge and skills to care for a different patient population.

Constant adjustment of staffing levels to meet increased or decreased patient volume results in high levels of unpredictability regarding the staff assigned to care for patients. Thus, in times of high volumes, the nursing staff are frequently required to work with staff who do not know the routines of the hospital or the patient-care unit, and may be unfamiliar with the typical care requirements of the patients. When the volume is low, the predictability of nursing work declines as staffing levels are adjusted downward, usually based on seniority. The end result is a staff mix that may not have the appropriate combination of skills to care for the patient population and may lack familiarity with the organization.

In addition to unpredictability of the total patient volume, patient volume fluctuates markedly at the *unit level*, resulting in unpredictable patient-care requirements during the shift and over the course of the day, even though the total volume may remain unchanged at the end of the day. In a sampling of 20 medical-surgical care units in five hospitals nationwide, the number of admissions, discharges, and transfers averaged anywhere from 25 to 70 percent of the midnight census (Lawrenz 1992). In another study (Norrish 1999), nurses reported turnover rates as high as 40 to 50 percent of the patients on the unit at the beginning of the day during an eight- to 12-hour period of time. The unpredictability of admissions and discharges brings about the need to vary staffing levels during the shift to meet increased patient-care requirements, either through the use of supplemental staff or overtime. The total number of patients cared for by a RN in any given shift thus increases, which the RNs perceive as an increased workload. Multiple discharges and admissions also increase the overall level of unit activity and may not be reflected in patient acuity systems (Lawrenz 1992). In Norrish's study (1999), RNs reported that caring for an increasing number of patients during the shift has a cumulative effect on their workload. Even if an RN cares for no more than six or seven patients at any one time, the fact that the RN has been responsible for 10 to 12 patients over the course of the shift markedly increases the RN's workload.

The overall impact of fluctuating patient volumes is that nurse staffing levels are a constantly moving target. The demand for nursing staff becomes nearly impossible to predict on a shift-to-shift basis, and the

mechanisms to adjust staffing levels are limited, may be costly, and rarely consider the preferences of individual nurses. Census fluctuations and the resulting unpredictability of staffing affect nurses in two significant ways. First, there may be little consistency and continuity of the staff with whom nurses work on a daily basis. Thus, the much-praised benefits of having a consistent team of staff who works as a cohesive unit may be undermined by the realities of daily staffing adjustments. Second, fluctuating patient volumes undermine the stability and predictability of nursing work. Nurses frequently do not know from one day to another whether there will be sufficient work or whether they will be called and told to stay home. Both impacts have serious implications for the professional nursing staff. One major implication is the ability to develop a committed, cohesive working group in the face of uncertain work and uncertain work-team members. The constantly shifting work team can result in inefficiencies as staff adjust daily to the skills and competencies of the other staff with whom they are working, and can potentially affect the quality of nursing care provided.

Competency of the Nursing Staff. The competency of the nursing staff to meet the care requirements of patients has become a major staffing concern, as well. As patient-care units have become more specialized and technologically complex, the competency requirements of staff have become more detailed and complex and nurses have become more specialized in their knowledge and skills. Most patient-care units have identified basic and advanced skills that a nurse must have in order to provide competent and safe patient care for a specific patient population. When staffing needs must be adjusted in response to increased or decreased staffing demands, it becomes more difficult to fill the staffing needs with a group of nurses who have the appropriate set of competencies.

Mandated Staffing Practices. Adding to the complexity of staffing decisions are policies and procedures dictated by hospital policy, union contract, and even state regulations that mandate staffing practices. When hospital staffs are represented by a collective bargaining agreement, the contract may dictate how staff are given time off in the event of a temporary layoff, or how staff are assigned extra work during times of peak volume. Contracts for different categories of personnel may dictate different practices. For example, in one hospital in northern California, the RN staff is represented by the California Nurses Association (CNA), and the licensed vocational nurse (LVN) staff is represented by the Service

Employees International Union, Local 250. The CNA contract mandates that during periods of low census, temporary layoff of RNs be based on the seniority staff assigned to a specific patient-care unit. In contrast, the LVN contract specifies that temporary layoffs be based on hospital-wide seniority of the staff assigned to work that shift.

Hospital policies may also determine how staffing decisions are made, for example, by dictating when staffing levels may be increased or decreased, and when holiday and overtime benefits are paid. Staffing decisions can also be dictated by state law, such as in California, where state regulations mandate a 1:2 nurse-patient ratio in critical-care units.

Personal Preferences of the Nursing Staff. Compounding the staffing adjustments that are made each shift are the complexities of hospital scheduling practices. Many hospitals have implemented flexible scheduling policies, such as 12-hour shifts, part-time work, and self-scheduling in an effort to attract and retain nursing staff. However, when multiple staffing criteria are present, the optimal number and mix of nursing staff becomes very difficult to schedule, causing dissatisfaction among the nursing staff. The identification of numerous criteria for optimal staffing raises the expectations of nursing staff that all criteria can and will be consistently met. Because staffing needs frequently change at the last minute due to changes in patient volume or acuity, or due to staff absenteeism related to illness, it is impossible to meet the staffing demands and fulfill all the staffing criteria. Unfulfilled staffing criteria set the stage for staff dissatisfaction due to unmet staffing expectations (DeGroot 1994).

The combination of imprecise productivity standards, misapplication of the PCS in determining staffing requirements, the unpredictability of the demand for nursing care, the complexity of optimal staffing criteria, and the increasing number of sources that dictate scheduling practices makes optimal staffing levels for nursing difficult to achieve. Thus, a hospital's best efforts to provide an optimal number and mix of nursing staff may fall far short of the expectations of the nursing staff, leading to the nurses' perception that the staffing practices are not adequate. The complexity and difficulty in achieving an optimal staffing level may result in an unfavorable workload for the RNs, leading to job dissatisfaction and a perceived degradation in the quality of work life.

Nurses often couch their concern about the quality of their work life in the claim that the quality of patient care is suffering, without necessarily being able to support this claim with data. This observation

is based on numerous discussions one of the authors had with graduate nursing students who worked in California hospitals during the period when many were being restructured. When pressed to detail the actual harm to patients, most were unable to relate even anecdotal instances of adverse patient outcomes. When the question was posed in terms of job satisfaction and the quality of work life in nursing, there was general agreement that this had been markedly affected by many of these changes. Often the real issue may be that the quality of nurses' work life has declined. However, they frame the argument as a concern with the quality of the patient care to present a more legitimate claim for redress.

The Impact of Restructuring on the Control of Nursing Work

The struggle over control of the work of professionals in organizations is typically characterized as a clash between bureaucratic hierarchical control and professional colleague control (Kornhauser 1962, p. 13). At issue is whether the autonomy accorded professionals by virtue of their expert knowledge will become subordinated to the demands of the organizational bureaucracy, thereby limiting the effectiveness of professionals (Maas, Specht, and Ramler 1997). For many years, nurses have sought recognition as professionals within the bureaucratic structure of the hospital. These efforts have centered on gaining control over the performance of nursing tasks and the environment in which the tasks are performed (Clifford 1982). At issue when hospitals restructure is who should determine the conditions of RN work. In recent years, RNs have gained significant control over their work through their efforts to increase the managerial responsibility of the head nurse and efforts to improve the participation of nursing staff in decision making, including the implementation of shared governance. These gains are vulnerable to change when a hospital restructures.

The Role of the Chief Nurse Executive

The nursing leader within hospitals has only recently been promoted to the executive level. Growing out of the role of the superintendent of the nursing school, the role of the hospital nursing leader evolved into

the director of nursing and eventually, in the 1980s, into the role of the chief nurse executive (CNE) (Clifford 1998). The crucial role of nursing leaders in organizational policy development and decision making was recognized by the National Commission on Nursing, whose recommendation that nursing leadership be involved in decision making was important in elevating the role of the CNE to the executive management team (Clifford 1998).

Clifford noted that the nursing leader in the hospital must balance two sets of responsibilities: the role of a senior member of the administrative and executive team and the role of the recognized leader of the professional nursing staff. These two roles may be a source of conflict for the nursing leader. In the role of senior executive, the CNE must help the hospital meet its strategic goals, which are often financially driven and focused on the business side. As a member of the nursing profession, the CNE provides clinical leadership to the hospital and helps the organization meet the primary organizational objective of high-quality patient care (Clifford 1998).

It is important to understand how the CNE balances these two responsibilities, especially when hospitals restructure. The nurse executive's role on the executive management team and the need to demonstrate sensitivity to cost pressures may, at times, take precedence over the commitment to the profession of nursing. Can the nurse executive refuse to participate in redesign efforts or to implement changes in the skill mix? Not only would such refusal place his or her job at risk, but the nurse executive may also see little choice in the matter, thinking that "If I don't do this, someone else will."

However, the role of the CNE may change as a result of hospital restructuring. Clifford (1998) examined the role of the senior nursing leader in three hospital systems that implemented large-scale organizational change. She found that the senior nursing leadership role in the organizations she studied was moving to a staff role within the hospital. Clifford saw potentially "deleterious effects on nursing practice and, subsequently, patient care" (p. 120) as this senior nursing leader moves away from the professional domain of clinical nursing.

Decentralized Decision Making

The decentralization of decision making that occurred in hospital nursing departments during the 1980s was attributable partly to the

implementation of primary nursing, as well as to the promotion of the senior nursing leader to the executive management team, and may also reflect the desire of hospital nursing departments to emulate the magnet hospitals. As Manthey (1980) noted, one of the four major design elements of primary nursing was the role of the head nurse as manager. This individual was operationally responsible for the quality of patient care 24 hours a day, seven days a week. To fulfill this responsibility, the head nurse was given the authority to hire personnel, allocate resources, evaluate performance, set standards of practice, and discipline staff who did not meet standards and competency expectations. However, the responsibility for patient-care decisions remained the province of the clinical nurse.

The decentralization of decision making in hospitals marked a distinct change in the organization of nursing. The organization of nursing departments was traditionally based on hierarchical concepts derived from military and religious organizations where command and control resided at the top of the organization. Decentralization represented a radical departure in structuring the nursing organization. It was implemented to improve communication and encourage participatory decision making in order to enhance the autonomy, accountability, and authority of the clinical nursing staff (Althaus, Hardyck, Pierce, et al. 1981). Key to decentralization was the elevation of the head nurse's role from that of shift charge nurse to nurse manager, who functioned as the department head of a unit with 24-hour operational responsibility. The role of the nurse manager was important for translating into action the goals and objectives of the organization as well as for developing professional nursing practice at the unit level (Clifford 1982). A study of the magnet hospitals found that one of the work environment characteristics that predicted magnet hospital status was the opportunity for nursing staff to consult with nurse managers on daily problems and procedures (Sochalski, Boulis, Shamian, et al. 1997).

However, the role of the nurse manager is also undergoing significant change as part of hospital restructuring. In many hospitals, the nurse manager has assumed supervision of more than one patient-care unit (Clifford 1998). This added responsibility has resulted in less time for the nurse manager to work directly with clinical nursing staff and provide ongoing nurturing and mentoring. Also lost with the change in the nurse manager role is the expertise of the on-site clinical manager, a role essential to achieving desired patient outcomes (Clifford 1998).

Shared Governance

Under shared governance, the control of nursing practice is placed in the hands of the nursing staff. In this system of management, the nursing staff and the organization work in partnership to meet the goals of the organization. Essential elements of shared governance in nursing include organizational structures and processes that provide the opportunity for nurses to make decisions about their work, to be accountable for the quality of that work, and to share decisions with the administration about the utilization and management of resources (Maas, Specht, and Ramler 1997). According to Maas, Specht, and Ramler (1997), "nurse-shared governance in organizations is synonymous with professional nursing practice in organizations that employ nurses" (p. 389). Shared governance has been identified as a management system that enables professional nursing autonomy and accountability through structures such as bylaws and committees or councils that provide the opportunity to define nursing practice and participate in decision making. Porter-O'Grady (1994) has estimated that more than 1,000 hospitals in the United States have implemented shared governance of nursing.

Shared governance provides a mechanism to reconcile the conflict between bureaucracy and professional values in achieving organizational goals. In an evaluation of the Strengthening Hospital Nursing Program, Rundall, Starkweather, and Norrish (1998) found shared governance to be a key facilitator of successful organizational change. Shared governance provided a mechanism for ensuring staff participation in planning and designing the changes as well as a mechanism for continual reevaluation and redesign in response to feedback from nurses and patients and in response to continuing environmental changes.

However, proponents of shared governance of nursing have expressed concern about the effect of hospital restructuring on shared governance. Some hospitals have bypassed the existing governance structures when restructuring, resulting in decreased support by nurses for shared governance (Lepler 1994). In other organizations, when redesign has resulted in the implementation of patient-focused care, the organization has found it necessary to expand the concept of shared governance beyond nursing to include all members of the patient-care team (Porter-O'Grady 1994). Finally, redesign efforts aimed at cost containment have resulted in the budgeting of less money to support the activities of shared governance (Lepler 1994).

Conclusion

Hospital restructuring affects the work of registered nurses in many ways. Restructuring often entails the adoption of the team-nursing model of patient care, which incorporates a nursing role significantly different from that found in primary nursing. After restructuring, nurses typically spend less time providing care and comfort measures for patients and more time doing care planning and administration, activities that many nurses find less rewarding than direct patient care.

It is unclear to what extent hospital restructuring affects nurses' workload, primarily because decision making with regard to nurse staffing is complex under any circumstances. Imprecise productivity standards, the misuse of patient classification systems in determining staffing requirements, the unpredictable demand for nursing care, and the increasing number of sources that dictate scheduling practices makes it difficult to establish an optimal nurse staffing level. When restructuring introduces new workers, such as unlicensed assistive personnel, to the staffing mix, the problem of setting optimal staffing—hence optimal workload per staff member—is compounded.

The effect of hospital restructuring on control of nursing work is less ambiguous. Restructuring often results in the nurse executive's leadership role being downgraded to a staff position. The role of the nurse manager also frequently changes as a result of restructuring, for example, assuming responsibility for more than one patient-care unit. These additional duties leave the nurse manager with less time to provide clinical expertise or to mentor nursing staff members. Finally, restructuring affects the control of nursing work by undermining established shared-governance arrangements.

Much of the public policy discussion about hospital restructuring and nursing focuses on whether to regulate hospital employment of nurses by mandating RN staffing ratios. Legislation has been introduced in several states, including California (where such legislation has been signed into law), Massachusetts, Nevada, and Florida (Spetz 1999). Our analysis of the effects of restructuring on nursing work suggests that state regulation of nurse staffing ratios may neither effectively protect patients' interests as hospitals restructure patient care nor result in better working conditions for nurses.

Nursing workload is affected by many factors, including some that are unaffected by nurse staffing regulations, such as the use of patient

classification systems and the preferences of the nursing staff. Determining the demand for nursing care in a patient-care unit is so complex it is extraordinarily difficult to establish a regulatory approach that assures effective and efficient patient care across all hospitals. Also, it appears that many regions of the country are experiencing a shortage of nurses, making mandatory nurse staffing levels virtually impossible to meet in some cases. Hospitals need some flexibility to reduce nurse staffing ratios in the context of redesigning patient-care processes and redeploying other patient-care personnel. Moreover, the evidence base for regulating nurse staffing levels is inadequate.

Eight federally funded studies of the impact of hospital restructuring on nurse staffing and patient outcomes are currently being conducted. Buerhaus and Needleman (2000) recently reviewed this group of studies, concluding: "We believe the results of the eight federally funded studies will greatly influence the public and private policy-making environment in ways that support improvements in the quality of patient care. . . . We anticipate, however, that more research will be needed to develop better data on nurses and staffing practices, organizational influences, patient severity, nursing processes and clinical interventions, models of nursing care and practice patterns" (pp. 13–14).

We agree completely. Our review of the relevant literature suggests that hospital restructuring has the potential to affect many aspects of nursing beyond reducing RN staffing ratios. Restructuring-induced changes in nurses' work roles, workload, and control over nursing work are not easily visible to the public or to hospital regulators, but may significantly affect the quality of patient care. Further research is called for to increase our understanding of how restructuring changes these structural characteristics of nursing work and what impact these changes will have on patient outcomes.

We believe there are three strategies that hospital and nursing leaders can pursue to lessen the potentially harmful effects of restructuring on the work of nurses and on the quality of patient care. First, good change-management practices should be followed in any hospital restructuring effort. There is a substantial body of knowledge on organizational change processes generally and hospital restructuring in particular. Best practices for leading hospitals through the stages of restructuring have been identified. These practices include:

- Establishing and maintaining a clear focus on the patients throughout the change process

- Involving staff throughout the organization (including nurses) in planning and implementing changes
- Increasing the responsibility and accountability of individuals through shared governance and other techniques for decentralizing decision-making
- Evaluating frequently the effects of changes on patients and employees

Organizational restructuring carried out with these and related change-management practices will require more time and effort than with quick, top-down approaches, but the likelihood of successful change is much greater (Rundall, Starkweather, and Norrish 1998).

Second, a substantial effort must be undertaken in many hospitals to rebuild trust between managers and nurses. When reducing hospital costs became the underlying purpose of hospital restructuring, conflicts between nurses and managers increased greatly. The conflicts often centered on a reduction of hospital nursing positions and on many of the nursing work issues discussed in this article. In many hospitals, as each side challenged the motives of the other—including their commitment to patient care—interpersonal trust diminished along with individuals' trust in the institution. Explicit efforts must be undertaken to rebuild trust between nurses and hospital managers. While there is not enough space here to deal with this topic adequately, it should be noted that values clarification, communication, participatory decision-making, and competent work performance are often mentioned as important building blocks for trusting relationships.

Third, we recommend that large reductions in a hospital's nurse staffing ratio be implemented only after a *patient impact statement* (PIS) has been prepared. While the threshold for activating this requirement is debatable, for the purposes of this discussion we suggest that whenever the RN staffing mix in a patient-care unit is reduced by 10 percent or more, the hospital be required to prepare a PIS that describes the potential impact of such changes. The purpose of the patient impact statement is to ensure that the hospital management and patient-care staff fully think through the implications of such reductions in nursing personnel by identifying all likely harmful effects to patients and then identifying changes in patient-care practices and deployment of other personnel that may be required to eliminate those harmful effects. Elements to be included in the PIS could be based on the American

Nurses Association Report Card for Acute Care Nursing (American Nurses Association 1995) or an equivalent set of guidelines. The PIS should also include a plan for evaluating the effect of the restructuring on patients and hospital staff.

Although we envision the patient impact statement to be a voluntary activity carried out by hospitals, it could also provide regulatory and accrediting agencies with a statement of intent that fully describes the extent of planned changes and the anticipated consequences. One option might be to require that the patient impact statement be filed with the state health department 30 days before the restructuring is implemented. Alternatively, the PIS could be placed on file in the hospital for review during accreditation and licensing site visits. At the very least, the hospital's board should approve the PIS prior to implementation. Preparation of the PIS would require multidisciplinary participation of all stakeholders affected by the proposed changes.

No one should underestimate the difficulty of meeting the competing demands of all hospital stakeholders. However, the strategies identified above offer hospital managers and nurses constructive ways of working collaboratively on hospital restructuring, and, most importantly, of maintaining the focus of all concerned on the patient.

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