Organizational Culture and Health Care Providers Commitment

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INTRODUCTION

Many believe that quality improvement represents a promising strategy for improving hospital quality of care. Quality improvement (QI) is a systemic approach to planning and implementing continuous improvement in performance. QI emphasizes continuous examination and improvement of work processes by teams of organizational members trained in basic statistical techniques and problem solving tools and empowered to make decisions based on their analysis of the data. However, QI implementation is demanding on individuals and organizations. It requires sustained leadership, extensive training and support, robust measurement and data systems, realigned incentives and human resources practices, and cultural receptivity to change.[1]

The demands for high performance in health care are increasing. Clearly, a major challenge to the health care executive is to put together an organization that maximizes productivity, quality, and market share while not losing sight of the organization's mission to serve the health needs of the community.[2] More than anyone else, the manager is responsible for the performance of the organization. The successful manager needs to guide and oversee all of the subsystems of the organization, not just the maintenance or managerial subsystems, which have been traditionally emphasized in health administration.[3] Thus, the manager can improve performance not only through attending to productivity and maintenance of the human and capital infrastructure, but also, to boundary spanning activities, adapting the organization to its ever-changing environment and advances in medicine, and governing, or holding the organization accountable for its actions. The performance of health care organizations in the future may increasingly depend on ability of health care managers to truly lead not just steer through obstacle, that is, to mold and innovate within their environment rather than passively react to external changes.[4] However, we now know that by adopting appropriate principles of management,

organizations can increase quality and simultaneously reduce costs (by reducing waste, rework, staff attrition and litigation while increasing customer loyalty).[5]

The overall aim of quality in intensive care is to monitor process and outcomes, evaluate the effectiveness of critical care services and provide recommendations and advice to the area executive with regard to the improvement of critical care services. Improving quality is dependent on mechanisms to analyze performance and variance at the unit, hospital and service network level. [6]

Assessment of organizational performance is an important goal in ICUs because a significant percentage of health care resources are spent in ICUs and because of the specificities of this specialty, such as stressful and urgent situations with a high mortality rate, high workloads, use of sophisticated equipment, and teamwork. [7] Organizational practices of ICUs are related to patient-centered culture, strong medical and nursing leadership, effective communications and coordination and collaborative approaches to solving problems and managing conflicts. [8] Outcome measure in intensive care are numerous and varied. However, intensive care is a process that comprises numerous inter-related therapeutic and supportive pathways. [9]

Intensive care areas have been identified as highly complex areas with high levels of uncertainty and instability above other hospital care areas. It has, therefore, been highlighted that the nature of care provided to critically ill patients requires interdependent practice. [10] Today, the balance of evidence indicates that intensive care units (ICUs) are stressful work environment for nurses and medicines. In recent years, ICUs have been exposed to increased workloads because of rapidly expanding medical technology, increasing job complexity and ethical dilemmas associated with it. In addition, cost containment and re-structuring programmes restrict the resources staff has available. Finally, ICUs are confronted with new types of diseases, not only those of old age, but also new viral and infectious diseases.[11]

In terms of organizational theory, ICUs can be considered as complex organizations of services. This complexity has several causes, including a combination of great uncertainty in the process of care, the diversity of these processes, and the need for rapid decision making required by an urgent situation together with a reduction of ICU length of stay. The challenge can be described as managing individual differences on a large scale.[7]

A review of the literature shows, however, that ICU organization depends first, on cultural aspects and focuses on dimensions such as a **team satisfaction-oriented culture** (where unit norms emphasize self-expression, achievement, cooperation, and staff development); a **people security culture** (where norms emphasize approval, adherence to procedures and conventions, dependence, and avoidance of conflict); and **a task security-oriented culture (**where unit norms emphasize perfectionism, competition, opposition, and authoritarian control). Second, it includes ***managerial practices*** often described as coordination (including reaction to uncertainty), communication, problem-solving/ conflict management, organizational learning and capacity to change, and skills developed in relationships with patient and their families. Third, today's ***ICU workforce*** is experiencing job burnout in epidemic proportions, a phenomenon that appears to be a sign of major dysfunction within an organization. Intensive care unit organization can cause personal stress related to excessive workload and high rates of mortality. Finally, ***organizational factors and management styles*** are increasingly recognized as key variables for explaining differences in the efficiency and quality of health care.[7,12,13]

On the other hand, many researches were done that cover one or two of the organizational dimensions at the most in ICUs. Researches that have studied organizational culture including those by Shortell et al (1994) and Parker et al (1999) have demonstrated the relationship of leadership and organizational culture to aspects of unit performance in health care organizations.[4] Also Baker et al (2003) conducted a survey measuring aspects of organizational culture, and providing comparative data

on coordination, teamwork and leadership, conflict management, unit leadership and unit culture. [14] Other researchers have investigated the individual well-being in ICU as Le Blanc et al (2001) who have presented a validation study concerned with the stressful aspects of ICUs based on a systematic, theoretically based, job analysis, to offer good starting point for interventions aimed at improving ICU nurses' well-being at work.[11] Soderstrom et al (2005) studied interactions between family members and staff in intensive care units, this study can be a starting point for ICU staff to reflect on how family members are met, and offer opportunities for family members to express their fallings and experiences in a dialogue with the staff, and meeting family needs.[15] Maureen Coombs (2003) explored decision making between doctors and nurses in the intensive care environment in order to examine contemporary clinical roles in this clinical specialty. [10]

In Egypt, several researches have investigated some organizational performance aspects. Abd-El Rahman (2004) study has identified the relationship between health care organizational culture and nurses' commitment to the work [16]. Zakaria (2004) has presented ethical decision-making among nurses and physicians in critical care units.[17] and Abed El-Aal (1999) has explored nurses' perception of job empowerment and organizational commitment in critical care units. [18]

As a result, these single aspects of performance measures may not capture all aspects of performance. Most importantly single aspect measures can be significantly influenced by other factors that are either not considered simultaneously or not presented. Global measures of organizational performance may offer a clearer reflection of overall performance of critical care services and, most importantly, allow for the dependency of some aspects on other factors. [9] Hence, a multidimensional approach to the measurement of organizational performance in ICU should represent the most comprehensive interrelated set of organizational dimensions compiled to date. In particular, such measurement should cover every aspects of organizational performance such as shared cultural values, managerial

practices and individual well-being. Moreover, the interrelation between these former variables offers a complete overview of the different key points that should be considered in ICUs. [7] Thus, efforts to improve those processes must be guided by an overall framework for quality management and improvement activities in the organization. [19]

UNIT I

ORGANIZATIONAL CULTURE

Learning outcomes

On completion of this unit, reader will be able to:

- Define organizational culture concept
- List importance of organizational culture
- Describe dimension in organizational culture

Key words

organizational culture, team satisfaction, people security, task security

Over the last decades, concerns for efficiency, productivity, excellence and total quality have become increasingly widespread in health care organizations. The concept of organizational performance or effectiveness holds a central position in the management of private and public organizations as well as in the field of organizational research.[(20)] Organizational performance may be defined as the ability of the organization to use its resources efficiently, and to produce outputs that are consistent with its objectives and relevant for its users.[(21)]

Organizations view their performance in terms of "effectiveness" in achieving their mission, purpose or goals. Organizational effectiveness depends on many factors including; excellence, effective planning, and capability to understand and match context requirements [(22)]. At the same time, a majority of organizations also see their performance in terms of their "efficiency" in deploying resources. This relates to the optimal use of resources to obtain the results desired. Finally, in order for an organization to remain viable over time, it must be both “financially viable” and "relevant" to its stakeholders and their changing needs.[(23)] Moreover, organizational

performance cannot be just evaluated in or other global terms, but it should consider values of the participating agents, such as individual satisfaction.[22] Performance measurement is not easy in healthcare services because the measurement of efficiency of healthcare delivery is multifactorial, the metrics are highly variable and t to be defined accurately, and specially the intensive care unit.[24]

A tremendous increase in the knowledge, technology and skills required to treat critically ill patients. This has led to the development of intensive care units (ICUs) [25] Intensive care developed rapidly in the 1960s and an increasing number of hospitals units to care for patients requiring more detailed observation and treatment than words.[26] A significant portion of healthcare resources are spent in intensive with, historically, up to two-fold variation in risk-adjusted mortality[27] An intensive care unit is a specially staffed, and equipped, separate and self contained section of the hospital for the management of patients with life threatening or potential life threatening conditions.[6]

It provides special expertise and facilities for the support of vital functions, and utilizes the skills of medical, nursing and other staff with expertise in the management of r problems. [6] Over the last few years, there has been a tremendous increase in the knowledge, technology and skills required to treat critically ill patients.[25]

Technological, demographic, and social forces are likely to lead to an increased volume of intensive care in the future. Thus, it is important to identify ways of more efficiently managing intensive care units and reducing the variation in patient outcomes [27]. Therefore assessment of organizational performance is an important activity in ICUs.[7]

Minivielle et al (2004) developed an analytical framework for studying an ICU's organizational performance. They mentioned that intensive care organization depends on organizational culture aspects, managerial aspects, and individual well- being dimensions; the relationship between the different dimensions is represented in figure one, which demonstrate analytical framework for studying an ICU's organizational performance.[7]

Figure 1.

Analytic framework for studying an ICU's organizational performance

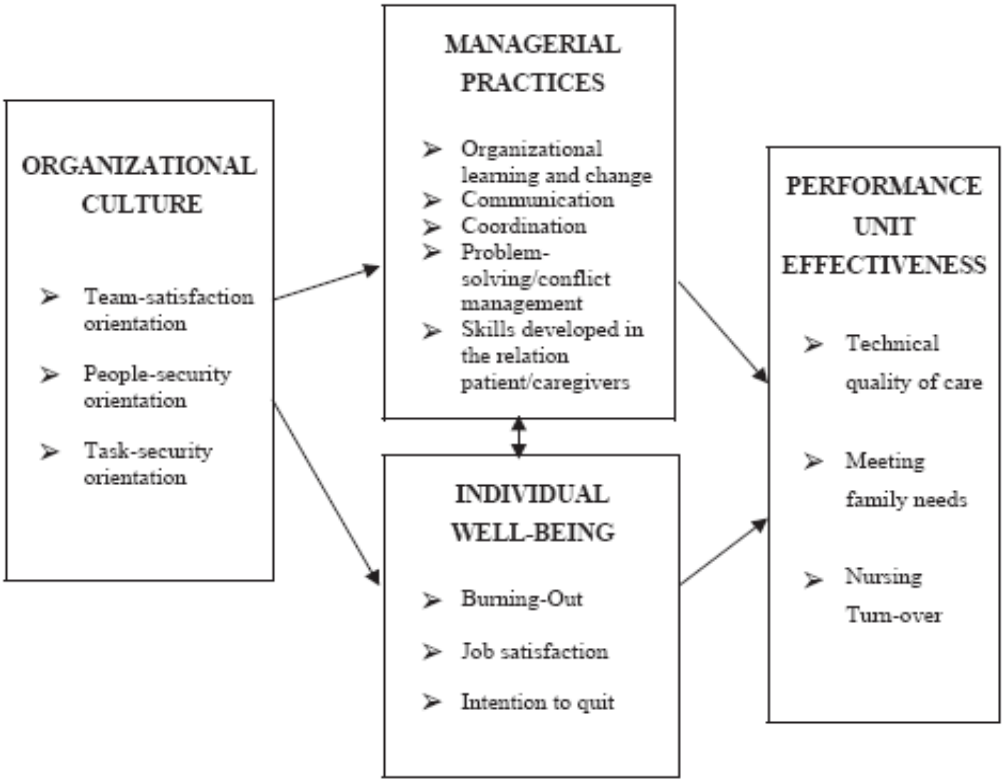

Fig. 1 Analytic framework for studying an ICU's organizational performance.

1. Organizational culture

Multiple definitions of organizational culture are existing and many of them centering on enduring attributes of culture such as values, assumptions and beliefs. Organizational culture gives a sense of what is valued and how things should be done within the organization. It can be thought of as the 'normative glue' in organizations that preserves and strengthens the group through maintaining equilibrium. Also it is a sense-making

and control mechanism that guides and shapes the behavior and attitudes of an organization's members.[28] The culture of an organization consists of its norms, values, and beliefs, and is reflected by its stories, rituals and rites, symbols, and language. Recent interest in the culture of healthcare organizations has begun to address the importance of culture for key organizational outcomes.[29]

There is general agreement that culture embodies the norms and expectations for behavior within an organization that are related to organizational behavior in general and organizational success in particular. A group should have stability, shared experience, and history to form a culture. [30]

The concept of organizational culture might best be described as the collective personality of an organization. It is a complex tapestry woven from the assumptions, attitudes, values, beliefs, collective memories and customs of an organization and upon these assumptions the individuals base the daily behaviors that become habitual, patterned and integrated.[31]

Cooke and Szumal (1993), and Verbeke et al (1998) described the organizational culture as the way things are done around here. [32,33] Whereas, on the other hand O'Reilly and Chatman (1996) referred that it as the shared norms, beliefs, and behavioral expectations that drive behavior and communicate what is valued in organizations. These beliefs and expectations are the basis for socializing coworkers in how to behave within an organization and create a social milieu that shapes the tone, content, and objectives of the work accomplished within the organization.[34]

A variety of theoretical models, including social-learning theory, expectancy theories, cognitive processing models, are useful in understanding acculturation into a new as well

as ongoing behavior guided by an organization's expectations and norms. These models succinctly described how new organizational members are taught through observation, modeling, and personal experiences the i.e. "way things are done around the organization," as well as the rewards, punishments, and expected outcomes that follow from one's work behavior. Mental representations (schemas) are developed and aid new organizational members in gaining meaningful representations of how their work. Conversely, these schemas guide how organizational members work within these organizations. As a result, workers are acculturated to a set of organizational and expectations that help in guiding their interpretation of organizational stimuli, they make, and the behaviors in which they engage. These beliefs and (norms) are the basis for many of the quantitative scales employed to measure culture. The approaches of measuring culture often consist of items normative behaviors and expectations within organizations. These items are to all organizational members and then aggregated to derive an organizational-level indicator of culture. Also qualitative approaches are used for organizational culture.[35]

Organizational culture strives to describe and explain activity in the organization as a whole. An integrated organizational culture reduces the uncertainty and ambiguity experience in an environment and maintains an organization's operating capacity.[36] Moreover, the healthcare environment, organizational culture has been associated with several elements of organizational experience that contribute to quality, such as nursing care, job satisfaction, and patient safety.[30]

Thus, a healthcare organization can benefit from a widely shared culture in a variety of ways. First, it can provide employees with a clear sense of direction, managing, and guidance which can obviate the need for extensive or restrictive systems of bureaucratic control. Second, cultures can allow healthcare organizations and their employees to achieve valued outcomes. Third, a culture is Imperative for the establishment and perpetuation of high technical and patient-perceived service quality. Also, culture is

likely to improve decision making and communication, as well as to facilitate succession planning.[37]

So, the concept of organizational culture is an important one for healthcare managers to consider because of its ability to influence organizational and individual performance. [37] Organizational culture is important for the new administrator; also it is important in change, innovation, and mergers, and in rewards and other practical matters.[37]

The Organizational Culture Inventory (OCI) is a 120-item scale, and it is the most widely used tool for measuring these cultural aspects. It includes 12 styles. These 12 basic culture styles compose the following 3 dimensions: (1) a team satisfaction-oriented culture (constructive), (2) a people security culture (passive/defensive), and (3) a task security-oriented culture (aggressive/defensive [7, 39]

1.1 *Team satisfaction*

A team satisfaction-oriented culture (constructive) is a positive culture in which, members are encouraged to interact with others and to approach tasks in proactive ways that will help them to meet their higher order satisfaction needs, where unit norms emphasize: a) Self-expression: this characterizes organizations that value creativity, quality over quantity, and both task accomplishment and individual growth. Members of these organizations are encouraged to gain enjoyment from their work, develop themselves, and take on new and interesting activities. While self-expression organizations can be somewhat difficult to understand and control, they tend to be innovative, offer high quality services, and attract and develop outstanding employees, b) Achievement: which characterizes organizations that do things well and value members who set and accomplish their own goals.

Members of these organizations set challenging but realistic goals, and pursue them with enthusiasm. Achievement organizations are effective, problems are solved appropriately,

clients are served well, and the orientation of members is healthy, c) Cooperation: this characterizes organizations that place a high priority on constructive interpersonal relationships. Members are expected to be friendly, open, and sensitive to the satisfaction of their work group. A cooperation culture can enhance organizational performance by promoting open communication, good cooperation, and the effective coordination of activities, d) Staff development: this characterizes organizations that are managed in a participative and person-centered way. Members are expected to be supportive, constructive, and open to influence in their dealing with one another. A staff development culture leads to effective organizational performance by providing for the growth and active involvement of members who, in turn, report high satisfaction with and commitment to the organization.(39)

1.2 *People security*

In contrast, in people security culture (passive/defensive), members believe that they must interact with people in ways that will not threaten their own security, where norms emphasize: a) approval: which describes organizations in which conflicts are avoided and interpersonal relationships are pleasant at least superficially. Members feel that they must agree with, gain the approval and be liked by others. This type of work environment can limit organizational effectiveness by minimizing constructive and the expression of ideas on. b) **Adherence to procedures and conventions**: this is descriptive of organization that are conservative, traditional, and bureaucratically controlled. Members to conform, follow the rules, and make a good impression. Too conventional a in interfere with effectiveness by suppressing innovation and preventing the *am* from adapting to changes in its environment, c) **Dependence**: this is e of organizations that are hierarchically controlled and non participative. Centralized decision making in such organizations leads members to do only what they're told and clear all decisions with superiors. Poor performance results from the lack of initiative, spontaneity, flexibility, and timely decision making, d) **Avoidance of conflict:** this characterizes organizations that fail to reward success but nevertheless punish

mistakes. This negative reward system leads, members to shift responsibilities to others; and to avoid any possibility of being blamed for a mistake. The survival of this type of organization is in question since members are unwilling to make decisions, take actions, or accept risks.(39)

1.3 Task Security

Task security-oriented culture (aggressive/defensive), members are expected to approach tasks in forceful ways to protect their status and security, where unit norms emphasize: a) **Perfectionism:** this characterizes organizations in which perfectionism, and hard work are valued. Members feel they must avoid all mistakes, keep track of everything, and work long hours to attain narrowly defined objectives. While some ; of this orientation might be useful, too much emphasis on perfectionism can lead to lose sight of the goal, get lost in details, and develop symptom of strain, **b) Competition**: this is one in which winning is valued and members are rewarded for out one another. People in such organizations operate in a win-lose framework and : they must work against their peers to be noticed. An overly competitive culture can effectiveness by reducing cooperation and promoting unrealistic standards of **c) Opposition:** which describes organizations in which confrontation and negativism is rewarded, members gain status and influence by being critical AND THUS are reinforced to oppose the ideas of others and to make safe decisions. While some questioning is functional, a highly oppositional culture can lead to unnecessary poor group problem solving, and watered down solutions to problems, **d) Authoritarian control:** this is descriptive of non participative organizations structured on the authority inherent in members' position. Members believe they will be for taking charge and controlling subordinates. Authoritarian oriented are less effective than their members might think; subordinates resist this type of control, hold back information, and reduce their contributions to the minimal acceptable level. (39)

UNIT II

MANAGERIAL PRACTICES

Learning outcomes

On completion of this unit, reader will be able to:

- State components of managerial practices
- Define concept of: change, coordination and conflict management

Keywords

change, coordination, conflict management

Shortellet al (1991) and Minivielle et al (2004) noted that managerial practices *organizational learning and change,* where organizational learning is defined as to learn the know-how that enables each actor not only to do what is asked of but also to be ready to respond to what has not been anticipated and to the consequences of this unforeseen event for his or her colleagues, while change is defined as the staffs capacity to accept new organizational rules *communication* refers to openness, accuracy of information conveyed to nurses and physicians by other parties, and time lapse, and understanding (the extent to which nurses and physicians find information in the unit easy to understand and appropriate), also satisfaction with communication; *coordination,* it is distinguishing within-unit coordination between nurses and physicians and between-unit coordination, in addition to coordination in situations of high uncertainty, where these situations require information exchange and feedback among staff to adapt to unforeseen circumstances; *problem solving/conflict management* refers to the extent to which nurses and physicians tend not to avoid problems but to cooperate with trust or compromise with each other or among themselves whenever problems occur; as well as *skills developed in the relation patient/care givers*[40,7]

2.1 Organizational learning and change

Continuous professional development is an essential component within the healthcare organizations.[41] The learning organization and the concept of organizational learning had become indispensable core ideas for managers, consultants and researchers since the end of the 1990s. The ability to learn better and faster than its competitors is an essential core competency. A learning organization can be recognized from the outside by its agility in changing, how it relates to the external world and how it conducts its internal operations. It can be recognized from the inside by an ethos in which learning from challenges and mistakes is central. While successful results are very important to learning organizations. Typically these organizations set very high standards, and recognize that success is achieved after initial mistakes. Employees must learn from everyone's mistakes, not just their own. It is too costly to have those repeating mistakes that have already been made by others. A learning organization is good at two kinds of learning: good at creating new solutions and good at sharing knowledge with other members who may need it. So, there should be openness to new ideas, and share knowledge for the good of the business. It is important to avoid the embarrassment over sharing one's mistakes and the reluctance to ask for help or to borrow someone else's solution.[42]

Learning is the process of acquiring new behaviors, skills, knowledge, and worldviews. Also it is a process in which the system is triggered by something it notices in the environment while working toward a goal.[43] Learning and development are essential to improve the quality of patient care delivered within the healthcare organization. This can be achieved through a framework of lifelong learning. One of the core areas identified within this framework is the need for the maintenance and extension of skills post-registration. Continuing education and training are also essential to maintain good practice. Updating knowledge and skills in response to the increasing amount of technology in the workplace and changing work practices is essential to deliver evidence-based care. Nurses have to be able to respond to these changes

especially within the intensive care environment where the majority of patients are critically ill, suffering from a wide variety of conditions, and will need some form of ventilation and monitoring. Moreover, these changes require a vast array of knowledge and skills on behalf of the carriers, nursing and medical, in order to deliver effective, evidence-based patient care. It is identified that a community, such as the intensive care environment, is not a static environment, but an ever moving and improving area and it is understandable that newcomers to an environment will need to learn new knowledge and skills.[44] As a response, the system can be Purposeful pro-active, or radically re-create itself as needed. The result is some sort of change from the unconscious and un-noticeable to a complete transformation. Unless the cycle includes feedback, the system has no way of knowing whether to repeat the change under similar circumstances or not. Thus, change does not always imply that learning has taken place. Groups and organizations exchange members with old ones leaving and new one entering with no group or organizational learning necessarily taking place. Learning some change, however subtle.

Learning also requires feedback such that the system knows whether to repeat the change, refine it, or revert to previous states and habits. At the individual level, learning is in new behaviors (that are perhaps observable) and new awareness. At the team level, learning is evident in changing structures, communications between team members, operating procedures, and behavioral routines. At the organizational level, is demonstrated through changes in such areas as vision, strategy, policies, regulations, structure, culture, and products or services.[43] However, nurses who are experienced within the intensive care unit also have a need to learn due to the constantly changing environment. Therefore, continuing professional development must be part of the process of life-long learning for all healthcare professionals.[44]

Change is persuading massive numbers of people to stop what they have been doing and start doing something that they probably don't want to do. [45] An effective process is key to changing service delivery practices in health. Five factors facilitate effective change in health services: a dedicated internal change agent; clear purpose, benefit and expected results; clear responsibilities assigned; long-term support for staff; and an organizational environment open to change. A well defined process has five phases: recognizing a challenge; identifying promising practices; adapting and testing a set of practices; implement the new practices; and scaling up the new practices.[46]

Change management is crucial to the success of any change effort. It is a structured to helping an organization and its people smoothly transition from a current state [able desired state. Change occurs in two dimensions, people and technology, management of people dimension of change requires managing five key phases: of the need for change, desire to make the change happen, knowledge about change, ability to implement new skills and behaviors, and reinforcement to retain once it has been made. [47-48]

Change can also be understood in relation to its extent and scope. Eynde and Hoy distinguished between three types of change: developmental, transitional and transformational. 1) Developmental change may be either planned or emergent; it is first or incremental. It is change that enhances or corrects existing aspects of an often focusing on the improvement of a skill or process. 2) Transitional change seeks to achieve a known desired state that is different from the existing one. It isepisodic, planned and second order, or radical. The model of transitional change is the basis of much of the organizational change literature.[49] It has its foundations in the work of Lewin (1951) who conceptualized change as a three-stage process involving: unfreezing the existing organizational equilibrium, moving to a new position, and refreezing in a new equilibrium position. Schein

(1987) further explored these three stages. He suggested that unfreezing involves: disconfirmation of expectations, creation of guilt or anxiety,and provision of psychological safety that converts anxiety into motivation to change. Moving to a new position is achieved through cognitive restructuring, through: identifying with a new role model or mentor, and scanning the environment for new relevant information. Refreezing occurs when the new point of view is integrated into: the total personality and concept of self and significant relationships. 3) Transformational change is radical or second order in nature. It requires a shift in assumptions made by the organization and its members. Transformation can result in an organization that differs significantly in terms of structure, processes, culture and strategy. It may, therefore, result in the creation of an organization that operates in developmental mode one that continuously learns, adapts and improves. [50',51]

Elements of change process are: define methodology, identification of activities, back-out process documented, prioritization of change tasks, agreed upon service levels, develop project plan, identify documentation requirements, list training needs, and produce implementation plan[47] When change affects everyone in an organization, personnel need to participate in the details of the change and must engage in some kind of learning to cope with change. As changes in the healthcare organization environment occur, role expectations of employees are likely to be modified. Individuals tend to have different requirements regarding the impact of organizational change than the organization itself.[52]

Learning organizations and adaptive workers are becoming more important for organizational performance. Theory and research suggest that in the presence of global competition and rapid technological advancements, modern organizations must be flexible, efficient, and continually adapt to changing environments to sustain a competitive advantage and survive. Organizations with the strongest

learning environments also tended to exhibit the strongest overall organizational performance. Such learning enables organizational members to detect performance deviations and make incremental changes to enhance organizational performance. [53] Positive changes in the way people act (behavioral changes) and perceive their internal and external environments (cognitive changes) are expected to have a positive impact on organizational performance. [54]

2.2 Relations and communications

Communication establishes relationships and makes organization possible. Communication is the process of passing information and understanding from one person to another.[55]

Effective communication between healthcare professionals is necessary for the delivery of quality patient care and has been shown to be associated with greater job satisfaction. However, a lack of understanding of the roles, responsibilities, and skills of other team members can interfere with effective communication.[56] Qualitative studies have indicated that communication is associated with organizational performance and patient care. For example, high quality of care, as **measured by fewer** deficiencies, has leaders that foster teamwork across and within disciplines and create multiple and effective communication channels for staff. In high quality of care, staff members are involved in communication and decision making regarding Staff members are well aware that communication is essential.[57]

According **to** Mikanowicz and Shank (2007), communication is a key tool that s must use to elicit cooperation among individuals in the delivery of It is an integral part of socialization and imperative in establishing the relationships. In the healthcare community, it can be described as process for sharing information through utilization of a set of common rules. These rules vary with circumstances**,**, the

transfer of information can be interrupted by situational pressure; differences between the professionals' perspectives can interfere with shared meaning and the rules of process of communication can be changed with inappropriate responses Communication among health professionals can: increase awareness of health issues, problems **or** solution; affect attitudes to create support for individual or collective or illustrate skills; increase demand for health services; inform , attitudes, or behavior.(58)

The discipline of medicine and nursing are working in close proximity, and they are interacting to achieve a common goal: the health and well-being of patients. Human is a subset of communication. It refers to the interaction between people through the use of symbolic language.(58)

Mikanowicz and Shank (2007), identified five types of basic human communication these are; intrapersonal communication: refers to inner thoughts, beliefs, and feelings, and health issues that influence the individual's health-directed behaviors; interpersonal communication: includes those variables that directly affect professional-professional professional-client interaction; small group communication: includes treatment planning meetings, staff reports, and health team interactions; organizational communication : includes hospital administration, staff relations, and organizational communication public communication: refers to presentations, speeches, and public addresses by individuals on health-related topics; Finally, mass communication: refers to areas such as as national and world health programs, health promotion, and public health planning.(58)

Mikanowicz and Shank (2007), presented some basic assumptions about human communication, first assumption; it is a process, that human communication is an ongoing, and ever-changing process. The assumption that human communication is a process that forces one to recognize the complexity of human communication and the many relationships that it involves. In healthcare, the process directs one’s attention to

professional-professional and professional-client communications as ongoing dynamic processes rather than one-way, fixed sequences of events. The process not only direct us to review the factors that affect the client, but also to analyze factors that affect individual involved in the case. A second assumption is that human communication transactional, which means that both individuals in an interaction are affected by and effect each others. A transaction force one to view the simultaneous Interplay between the sender and receiver of a message. It features the relationships between individuals that are developed and maintained through their mutual influence on one another. A third assumption is that human communication occurs on two levels: content dimension and relationship dimension. The content dimension refers to language, words, and information in a message; the relationship dimension defines how participants in an interaction are connected to each other. Both content and relationship dimensions influence the development of meaning in human interaction.(58)

Staff relationships are an important element in healthcare delivery, since having the right number of staff members, the optimal staff mix, and strong communication and collaboration between nursing and medicine can have a profound effect on workplace environment and patient care and its outcome.(59,60) Burk et al (2004) and Evanoff et al (2006) confirmed that deficient communication among providers creates the conditions for acrimony, frustration, and distrust that can lead to inferior care and a greater risk of error and poor quality of patient care. On the other hand improving these processes in healthcare may reduce errors, adverse events, and length of stay.[61,62]

Jansky (2004) stated that the current nursing shortage is directly affected by nurse physician relationships. When those relationships are positive, nurses are more likely to feel satisfied with then- work place and remain in their current positions. This satisfaction in turn maintains the nurses' equilibrium, and prevents burnout. There is evidence that communication and collaboration are central elements of good nurse-physician relationships.[63]

Leatt and Schneck (1981) identified ICUs as highly complex areas, with levels of uncertainty and instability above those of other hospital care units. They identified the need in such areas for excellence in communication skills, for independent judgment by nurses, and frequent communication between nurses and physicians, all of which are related to collaboration.[64]

Shortell et al (1991) mentioned that communication in ICU is measured along a number of dimensions including openness, accuracy, timeliness, understanding and satisfaction. Openness involves the extent to which nurses and physicians are able to say what they mean when speaking with each other without fear of repercussions or misunderstanding. Accuracy involves the degree to which nurses and physicians believe in the accuracy of the information conveyed to them by the other party. Timeliness involves the degree to which patient care information is related promptly to the people who need to be informed. Understanding involves the extent to which nurses and physicians believe communication on the unit is comprehensive and effective. Satisfaction involves the degree of satisfaction with nurse or physician communication with patients, patients' families, and other nurses or other physicians.[40]

2.3 Coordination

Coordination, as a means of effectively linking together the various parts of an organization or of linking together organizations and dealing with interdependence, is one of the most important functions of management. Shortell and Kaluzny (1994) found that Coordinating interdependent groups was rated highly important by middle managers and executive and increased in the importance as one moved into higher management positions.[4] Conceptually and historically, coordination has been defined as the conscious activity and synchronizing differentiated work efforts so that they function harmoniously in attainment of organization objectives. Sometime use the term "integration "for this concept. [4]

Providing safe, timely, assistance to medical patients requires optimal coordination of staff, resources, equipment, schedules, and tasks. In intensive care units, this is a difficult because the workload is constantly changing. The arrival of new cases and changes in the criticalness of existing cases often necessitates last minute juggling of ICU and personnel schedules.[65]

Shortell et al (1991) defined the coordination in ICU as coordination within-unit and coordination. Within -unit coordination is defined as the degree to which work activities are coordinated within the nursing and physician groups and between the two groups within the unit. Between units coordination is defined as coordination between the ICU and other units in the hospital such as the emergency room, operating room, the ancillary support services and the patient floors. [40]

2.4 Problem solving / conflict management

Each of us brings different experiences, beliefs, values, and habits to work. These differences are natural part of our being unique individuals and members of different segments of our society. Pressures and demands in the workplace generate problems and conflict among people at work. These can interfere with the ability to work together.[66]

Conflict can be defined as a disagreement within oneself or between people that cause harm or have the potential to cause harm. There is some confusion between the definitions of conflict and disagreement. Disagreement may be a precursor to conflict.[67] However, expressing a different opinion always leads to a situation where damage can occur. Underlying factors usually precipitate the transition from a disagreement to a conflict. Theses can include differences in: ideas, perspectives, priorities, preferences, beliefs, values, goals, and organizational structures.[67] A range of misconceptions about conflict exist. They centre on the notion that conflict is immutable.[67] Conflicts are a daily occurrence in the life of healthcare providers, and they can interfere with getting

work done. Serious conflicts can be very stressful for the healthcare providers involved.[66]

Stress symptoms, such as difficulty concentrating, anxiety, sleep disorders, and Withdrawal or other interpersonal relationship problems can occur. Bitterness, anger, and even violence can erupt in the workplace if conflicts are not handled well. However, conflict also has a positive side. They can begin to see each other as people with similar needs, concerns, and dreams instead of as competitors or blocks in the way of progress. Being involved in successful conflict resolution can be an empowering experience. The goal in dealing with conflict is to create an environment in which conflicts are dealt with in as cooperative and constructive a manner as possible rather than in a competitive and destructive manner.[66]

A conflict goes through at least four phases in which thoughts and emotions interact with actions. Li the first phase, one or more parties involved in the conflict will experience frustration. Frustration is a strong, imperative, and yet undirected emotion that almost always demands our rapid attention. Second phase, conceptualization of the cause takes place. This rationalization is usually rapid and may not be accurate. The main purpose of the process is crystallizing our painful thoughts and feelings into a plan of action. Third phase represents the expression. A series of behaviors will be at our constructed "cause". Fourth phase, the conflict situation is formalized when these behaviors result in a series of destructive outcomes.[67]

Healthcare brings together people of different ages, genders, income levels, ethnic groups, educational levels, lifestyles, and professions for the purpose of restoring or maintaining people's health. Differences of opinion over how to best accomplish this goal are a normal part of working with people of various skill levels and backgrounds. In addition, the workplace itself can be a generator of conflict such as:

Competition between groups: Disagreements over professional "territory" can occur in any setting. *Increased workload:* Emphasis on cost reductions has resulted in increased pressure to get as much work as possible out of each employee, sometimes more work than a person can reasonably do in a day. This leaves many healthcare workers believing that their employers are taking advantage of them and causes conflict if these workers believe others are not working as hard as they are. *Multiple role demands:* Inappropriate task assignments, often the result of cost control efforts, can lead to disagreements about who does what task and who is responsible for the outcome. *Threats to professional identity and territory:* When role boundaries are blurred (sometimes even erased), professional identities are threatened, and people may react in defense of them. *Threats to safety and security: When* roles are blurred, cost saving is emphasized, and staff members face layoffs. People's economic security is threatened. This can be a source of considerable stress and tension. *Scarce resources:* Inadequate money for pay raises, equipment, supplies, or additional help can increase competition between or among departments and individuals as they scramble to grab their share of the little there is to distribute. *Cultural differences:* Different beliefs about how hard a person should work, what constitutes productivity, and even what it means to arrive at work "on time" can lead to problems if they are not reconciled. Nursing and medicine reflects two different cultures with contradictory visions. In this, medicine emphasizes the status quo of its authority within an inherently hierarchical organization and function, whilst nursing stresses a more egalitarian vision of power relations with collaboration and peer cooperation prerequisites for team care provision.[(1)] *Invasion of personal space:* Crowded conditions and the constant interactions that occur at a busy nurses' station can increase interpersonal tension and lead to battles over scarce work space.[(66)]

Nurses are equally vital to understand conflict in order to improve their working relationships with colleagues and managers and in turn making their working lives more Pleasant and productive. Decreasing stress has a clear connection to improved

performance and increased job satisfaction- However, improving their working relationships is not only a good thing for **their own** wellbeing and but also that of their colleagues. Recent research into patient safety and medical error indicates that positive working relationships within healthcare teams has a significant effect on the safety and efficacy of the care they give to patients. [68]

There are a number of characteristics unique to healthcare environment that help to generate misunderstandings and conflict. Therefore, it is important for nurses and other healthcare professionals to understand the origins of conflict and to develop strategies to manage the conflicts. Marshall (2006) suggested strategies to prevent and manage conflict, these were: first, get education and training in conflict and conflict management. Conflict resolution education and skills training should be part of all healthcare professional programs and all healthcare facilities continuing education programs. Training should include an overview of basic conflict principles and approaches, as well as practical skills training in negotiation, mediation and facilitation. In addition, there are numerous publications on conflict resolution skills and techniques that are easily accessible. Second improve the communication skills. Seek first to understand, then to be understood. Third, recognize that men and women have different communications styles and responses to conflict. [68]

According to Shortell et al (1991), there is a great need for physicians, nurses, and other care givers to solve problems and resolve conflicts. There are four different approaches to problem solving and conflict resolution including: *open, collaborative problem-solving approach:* involves the extent to which physicians and nurses work actively to make sure that all available expertise is brought to bear on a problem with the goal of arriving at the best possible solution; *arbitration approach:* involves the degree to which disagreements among nurses and physicians are brought to superiors for resolution; *avoidance approach:* involves the extent to which disagreements among nurses and physicians are ignored or are not directly discussed, instead, emphasis is

placed on maintaining friendly relationships; and *forcing approach:* involves the degree to which uncompromising positions and aggressive tactics are used in disagreements among physicians and nurses in order to force the submission of one party, it is a win-lose approach to problem-solving. (40)

Furthermore, problem-solving process can be used when staff problems occur. The goal is to find a solution to a given problem that satisfies everyone involved. The process includes identifying the issue, generating solutions, evaluating the suggested solutions, choosing what appears to be the best solution, implementing that solution, evaluating the extent to which the problem has been resolved, and, finally, concluding either that the problem is resolved or that it will be necessary to repeat the process to find a better solution. (66)

2.5 Skills developed in the relation patient / care givers

The patient-centered approach to interactions between health providers and patients has been gaining prominence in recent years. This approach includes such key communication strategies as eliciting patient perspectives, responding to patient concerns, giving information, partnership building, engaging the patient in participatory decision making and developing a follow-up healthcare plan together. Studies have demonstrated positive associations between elements of the patient-centered approach and patient satisfaction, patient recall of the content of the healthcare visit, patient compliance, and patient health outcome, as well as provider satisfaction. (69)

Nurse-patient relationships. Major nursing tasks, such as assessing the specific needs of patients, delivering physical care, providing socio-emotional support, negotiating and exchanging information, all have to do with communication and are subject to the rules of interaction. Li this light, communication is recognized as an important aspect of high-quality nursing care. As a consequence, nurses need to have

skills to create good interpersonal relationships, which allow them to share in the patient's experience and concerns, in addition to achieving the goals and upholding values of healthcare. [70]

The professional standards of acute and critical care nurses, define the scope and the responsibility of nurses as practitioners who practice in settings where patients require complex assessment, high-intensity therapies and interventions, and continuous nursing vigilance. Critical care nurses rely on a specialized body of knowledge, skills, and experience to provide care to patients and families and to create environments that are healing, humane, and caring. The scope of the practice and standards of critical care nurses includes patient advocacy.[71] The American Association of Critical-Care Nurses (AACN) defines advocacy as respecting and supporting the basic values, rights, and beliefs of the critically ill patient. In this role, critical care nurses will do the following:

- Respect and support the right of the patient or the patient's designated surrogate to autonomous informed decision making;
- Intervene when the best interest of the patient is in question;
- Help the patient to obtain necessary care;
- Respect the values, beliefs, and rights of the patient;
- Provide education and support to help the patient or the patient's designated surrogate make decisions;
- Represent the patient in accordance with the patient's choices;
- Support the decisions of the patient or his/her designated surrogate or transfer care to an equally qualified critical care nurse;
- Intercede for patients who cannot speak for themselves in situations that require immediate action;
- Monitor and safeguard the quality of care that the patient receives; and
- Act as a liaison among the patient, the patient's family, and other health-care professionals.[72]

The quality of the nurse-patient relationship is significant for how information is interpreted and understood. Patients depend on information and need to know what goes on and why, since they are not in charge of their own health and care. Therefore adequate information is an important aspect of nursing care quality. It is also important to involve patients in the decision-making to give them a feeling of power. Thus nurses must strive to understand the needs and thoughts of the patients they serve and continually improve the structure, process and outcome of their care. Patients expect healthcare services, including technical treatment and nursing care, to be of consistently high quality. The nurse-patient relationship may have some impact on patients' recovery, satisfaction and intention to participate in the treatment programme and its quality depends on nurse's ability to perceive and react to patients' verbal and nonverbal communication. It has been found that if nurses show an interested and caring attitude to patients, they reduce anxiety, and also the need for postoperative medicine.[73]

Doctor-patient relationships. Communication between physicians and patients is crucial to quality healthcare. It has been found that understanding patients' perspectives and cultural values enables physicians to tailor treatment plans more effectively in accordance with their patient's particular needs. [74]

Effective communication is an essential component of patient-centered care. [75]Studies have shown that effective communication within the physician patient relationship has therapeutic value. It can increase patient satisfaction with care, lead to greater adherence to treatments, increase diagnostic accuracy, lead to fewer malpractice lawsuits, improve the use of health resources, and lead to a more favorable clinical outcome. [76, 77]

Effective clinical communication is related to the doctor's ability to grasp their patient's communicative style and adjust his/her own to it in order to improve efficiency

and satisfaction for both. This means doctors should be committed; show respect, empathy and interest in their patients' ideas, fears, expectations and opinions; accept their wish to share decisions, and provide information that is clear and adequate to their needs and education. [77]

UNIT III

INDIVIDUAL WELL-BEING

Learning outcomes

On completion of this unit, reader will be able to:

- Describe variables of well-being
- Explain concept of: job stress, burnout, job satisfaction and intention to quit

Keywords

job stress, burnout, job satisfaction, intention to quit

Healthcare providers are working under considerable pressure to do more with less, resulted in an increased danger of raising staff workloads to a level at which their performance suffer. Staffs ability to focus on treatment may be impaired if competing demands for their attention and cognitive energy are too high i.e. undesirable high levels of staff job stress would lead to diminished quality of care, and indeed an association between stress and performance has been demonstrated in social service settings.[78]

Minvielle et al (2004) subdivided individual well-being into the following variables: *job stress and burnout, general job satisfaction,* and *intention to quit.*[7]

3.1 Job stress and burnout

Burnout is a major problem in the helping professions such as nursing, medicine, social work, law enforcement and education. Nursing staff face work places with blood and urine, disturbed sleeping pattern, frequent emergency situations, inappropriate expectations from patients and their relatives, insufficient nursing staff and lack of authority in decision-making, all of which can cause job burnout for nurses. Some of

the factors that have been reported to be associated with job burnout are: individual characteristics, threats to job control, hardness of training, workload, interpersonal relationships with colleagues, knowledge of nursing, bureaucratic-political constraints, level of education, night shifts, being hospital-based, working on medical and surgical wards and negative work-home interference. Stress management had a pivotal role in controlling job-induced stress and burnout.[79]

Burnout is a state of physical, emotional, and mental exhaustion. It results from intense involvement with people over long periods of time in situations that are motionally demanding.[80] Burnout could be considered as a type of professional stress, which results from the social interaction between the person who provides help, and the person who receives that help. Nurses are particularly susceptible to the development of burnout, mainly because of the nature and the emotional demands of their profession.[81]

Job burnout is increasingly recognized as one of the most serious occupational health hazards, resulting in job dissatisfaction, lowered productivity, absenteeism, high turnover, and a state of disequilibrium. Work-related factors such as work pressure without support, ever-changing expectations, new job requirements, role conflict, and role ambiguity comprise some of the stressors which can cause job burnout syndrome. Personality traits such as idealism and a need for self-affirmation and work orientation can increase the risk of job burnout.[79]

Burnout is related to the deterioration of the relationships between the nurse and the patients, the coworkers, the family and the social environment Finally, nursing burnout results in poor patient care. Among the reasons contributing to the development of burnout are the following: 1) the time that nurses spend for patients care, 2) the contact with patients having a poor prognosis, 3) the contact with patients having increased emotional demands, 4) the work load, 5) the ambiguity and

the role conflict, 6) the lack of support on the part of the supervisor and colleagues, 7) lack of job satisfaction and 8) fear of death. Moreover the development of burnout depends on the personality characteristics of the individual such as motivations for having chosen a humanistic profession, expectations from himself and the others, his values and self-esteem, his ability to express his feelings, the control he exerts over the events and the others, and his personal style. All these factors influence the way of handling an emotional strain.[81]

Maslach and Jackson (1981) view job burnout as a response to chronic interpersonal and emotional stressors on the job, resulting in negative feelings such as incompetence, lack of achievement and productivity at work. Emotional exhaustion ranging from mild boredom to severe depression, depersonalization and treating people in an unfeeling way and poor sense of personal accomplishment are viewed as the key elements of job burnout. As a result of burnout people develop negative self-concept and become detached, apathetic, angry or hostile in their work place. Job burnout has cumulative effects on mental health, quality of life, family life and on productivity.[82]

Occupational stress has occupied the minds of business managers for many years. Additionally, burnout has been closely related to both the absenteeism of nurses from work and abandoning nursing. [81] It has been estimated that most absenteeism from work is attributable to stress-related disorders. Recently, it has become an issue in the National Health Service. The clinical aspects of healthcare are, however, almost absent from lists of major stresses reported by nurses and doctors; organizational and interpersonal factors are consistently cited as most stressful aspects of working in the health service. Studies of ICU nurses have demonstrated that stresses they experience are similar to those faced by non ICU nurses.[83]

The environment of ICU's has been recognized as stressful since their inception in the 1960's. [84] Stress is usually defined from a 'demand-perception response' perspective. The relationship between stressful work situations and stress-related outcomes, or strains, is not simple because each individual personality will mediate stress in a slightly different way. Work stressors constitute a satisfying challenge rather than a cause of distress, particularly in moderation, and unemployment and retirement are frequently associated with increased rates of stress-related problems. Health workers appear to suffer particular strains from occupational stress. There is a perception that health workers face unusually high levels of stress at work, particularly related to clinical duties, death and dying, and that the intensive care unit environment is especially stressful. [83] Lazarus and Folkman (1984) integrated this view into a cognitive theory of stress that has become the most widely applied theory in the study of occupational stress and stress management. [86] The basic concept is that stress relates both to an individual's perception of the demands being made on them and to their perception of their capability to meet those demands. A mismatch will mean that an individual's stress threshold is exceeded, triggering a stress response. An individual's stress threshold, sometimes referred to as stress hardiness, is likely to be dependent upon their characteristics, experiences and coping mechanisms, and also on the circumstances under which demands are being made. A single event, therefore, may not necessarily constitute a source of stress (i.e. be a stressor) for all nurses, or for a particular individual at all times, and may have a variable impact depending upon the extent of the mismatch. Assessing stress is likely to be very difficult in an occupation as diverse and challenging as healthcare, yet the effectiveness of organizational interventions to reduce or eliminate sources of stress depends upon a sound understanding of the stress phenomenon for nurses.[85]

The theoretical framework of Roy's Adaptation Model: The researchers examined the way in which critical care nurses adapt to stress and burnout in their environment and how they integrate the use of coping skills to effectively manage stress. It has been

found that when critical care nurses are unable to adapt to their environmental stressors, their levels of stress and burnout will almost rise as well. The use of effective coping skills to manage stress is a common way of adapting to the environment.[87]

Sawatzky (1996) examined the specific stressors that related to critical care nursing. He found that the highest stress levels were related to patient care and management issues. He added that if the origins of stress in the ICU can be identified and controlled, improved nursing performance will lead to a consistent level of optimal patient care.[88]

Stressors of ICU involve death and dying, conflict, as well as staffing and working conditions.[84] Foxall et al (1990) indicated that ICU nurses experienced significantly more stress related to death and dying than did medical surgical nurses. Li fact nurses in all clinical practice areas of the hospital consistently rank death and dying issues as problematic, especially issues concerning unexpected deaths, removal of life support equipment, and moral dilemmas.[88]

Conflict is inevitable in stressful settings such as intensive care. It exists at many different levels between doctors, nurses, families, and ancillary staff.[84] Greenfield (1999) explained that the tension between doctors and nurses can be related to the historical dominant role of the physician and the subservient role of the nurse. In other words the nursing profession that-as predominately female is undervalued by the patriarchal and hierarchical healthcare culture. [89] Authoritative workplaces are mismatch for contemporary nursing professionals that value autonomy, patient advocacy and holistic practice. This is particularly true in critical care areas, where nurses must be able to think critically, and respond emergently to life threatening situations. [84]

Nurses attempt to advocate for their patients in non-supportive environments become discouraged and may choose to leave. Disparities in treatment goals may be another reason that nurses and doctors are conflicted concerning treatment practices. The nursing profession values are centered on care versus the medical focus of cure. Nurses may fear lack of support from colleagues, or medical backlash at expressing their opinion about patient issues. [84] Erlen and Sereike (1997) found that it was important for the nurse to establish a good relationship with families in order to fulfill their nursing responsibilities. Nevertheless, families that require so much time and communication can be very taxing to busy ICU nurses. [90]

Pierce (2001) believes that working short-staffed in the unit increases the pressures enormously for ICU nurses. Amid the technological chaos of ventilator alarms, vasoactive drug administration, and cardiac monitoring, intensive care nurses are interrupted frequently by doctors, families, and patients that require their immediate attention. [91] Nurses are performing secretarial duties, due to lack of ancillary support. Making beds, and picking up meal trays. Many nurses are skipping breaks, and staying beyond there 12 hour shifts just to complete their work. Mandatory overtime and increased staffing ratios have increased the stress. The risk of errors is increased significantly for ICU nurses as they struggle to stay abreast of the newest medications, and use of high tech equipment. Unable to provide professional standards of quality of care that nurses believe their patients deserve, results in guilt and feelings of incompetence. [84]

3.2 Job satisfaction

Job satisfaction is defined as all the feelings that an individual has about his/her job. Job satisfaction among nurses has been defined as representing the degree of positive affective orientation toward one's job or how well one likes his or her job. [92] Job satisfaction is a multifaceted construct with a variety of definitions and

related concepts. Although the consensus among researchers is that job satisfaction consists of a positive attitude toward the job. Positive job attitudes among nurses are key elements in maintaining organizational effectiveness. [93]

Most of the studies of job satisfaction suggest that an important component of job satisfaction is the relationship a nurse develops with co-workers. Pay, benefits, and advancement opportunities quickly follow on the list of satisfiers. Conversely, job dissatisfaction is reflected in rising financial costs resulting from turnover, absenteeism, problems of low morale, and employee conflicts in the workplace. [93]

Examining healthcare providers' job satisfaction is important from the perspective of the healthcare providers and the patient. On the one hand, dissatisfaction leads to increased absenteeism, lower productivity, and increased turnover, each of which raises costs to the healthcare system. On the other hand, job satisfaction is correlated with patient satisfaction with the services they receive, patient compliance, and continuity of care. [94] The concepts of loyalty, commitment, and retention are outcomes of job satisfaction: if individuals have high job satisfaction then they do not want to leave their organization (i.e. loyalty), they are devoted to the job (i.e. commitment), and do not want to abandon their profession (i.e. retention).[95]

3.3 Motivation theories and job satisfaction

The study of job satisfaction grew out of several schools of management theory dating back to Frederck Taylor's early applications of scientific method to factory problems in the first part of previous century.[96]

Vroom's (1964) Expectancy Theory of human motivation is a significant contributor to the field which goes beyond the simple behavioral concept of stimulus-response and reinforcement of behavioral psychology; it explains motivation as the perceived value of

probably outcomes of actions, and the probability that actions will bring about outcomes which are highly desired. The theory thus takes into account the intrinsic values that affect satisfaction and work.[97]

Abraham Maslow's (1943) theory of Hierarchy of Needs examines human motivation in terms of levels of met or unmet needs. At the lowest level of Maslow's Hierarchy of Needs are Physical Needs (food, clothing, shelter, and comfort), followed by Safety Needs (security for self and possessions, and avoidance of risk, harm, and pain). Social Needs comprise the level, and include companionship acceptance, love and affection, and group membership. Higher levels include esteem needs (responsibility, self-respect, recognition, and sense of accomplishment), and self-actualization needs (reaching one's potential, independence, creativity, and self-expression). His premises include that only an unsatisfied need can influence behavior, that a person will minimally satisfy each level of need before feeling the need at the next level, and that if need-satisfaction is not maintained at any level it will become a priority again. [98]) According to Plunkett and Attner (1994) an unmet need frustrates an employee and will continue to influence his or her behavior until it is satisfied; managers can therefore effectively work with an employee by identifying the level of need which he or she is trying to satisfy, and by attempting to build into the work environment opportunities that will allow the individual to satisfy his or her needs.[99]

Frederck Herzberg's (1975) Motivation-Hygiene Theory directly addresses the issues of satisfaction and dissatisfaction on the job. His theory suggests that job dissatisfaction is caused by the absence of or deficits in "hygiene" factors such as salary, job security, working conditions, status, company policies, quality of supervision, and quality of interpersonal relationships. These factors, although they can cause job dissatisfaction if deficient, do not result in job satisfaction if present. Rather, according to Herzberg, it is the "motivation" factors intrinsic to a job and related to job content that have the power to

increase job satisfaction. Motivation factors include achievement, recognition, responsibility, advancement, the work itself, and possibility of growth.[100]

Job satisfaction is affected by various factors such as workload, and staff support. Workload involves: clinical load (patient case-mix, complexity), contribution of healthcare assistants, skill mix of intensive care unit team members, staffing levels, and other duties (clinical, administrative, academic). Staff support-includes: leadership (nursing, medical), team culture, intensive care unit image, working relationships, flexibility of scheduling, supervision, definition of roles and skill requirements, autonomy of decision-making for frontline staff, intensive care unit policies, clinical guidelines, protocols, stress management, intensive care unit environment (e.g. equipment, facilities, physical layout), continuing professional development (e.g. education, training, appraisal), salary, and social and other benefits.[13]

3.4 Intention to quit

Intention to quit takes place when an employee decides to leave the organization at some unspecified point in the future. [101] Nurses' intention to quit has a strong effect on their actual action of turnover, which might lead to certain amount of decrease in the quality and increase in the cost for patient care. Managerial factors affected employees' attitudes, job satisfaction, organizational commitment, and motivation to perform well, and these factors, in turn, influenced organizational outcomes. Organizational outcomes included patient satisfaction and employees' intention to quit. The nurses, who had intention to quit, perceived themselves as less satisfied with several aspects related to job dimensions of cooperation, job complexity, help received from superiors, and sufficient time for nursing care delivery. Furthermore, occupational stressors, lack of professional latitude, and role of problems, predicted nurses' intention to quit their working healthcare organizations.[I02]

Recruiting and keeping the right staff are key challenges for health policy-makers. The performance and quality of a health system ultimately depend on the quality and motivation of health human resources. Therefore, recruitment and retention problems should be appropriately addressed, as nursing staff shortages and low motivation are likely to have adverse effects on the delivery of health services and the outcome of care. Motivation at work is widely believed to be a key factor for performance of individuals and organizations and is also a significant predictor of intention to quit the workplace. There is empirical support for the link between job dissatisfaction, lack of motivation and intention to quit. Health managers need to understand the crucial importance of motivation for the performance of health workers in the context of scarce resources.[I03]

Factors affecting intention to quit include individual factors, and work-related factors.[I04] Intention to leave and individual related factors, include common characteristics among nurses planning to leave nursing. Nurses between 21- 40 years are found to be the most eager to exit their profession. Moreover, newly qualified nurses often tend to leave the profession at an earlier stage than their experienced colleagues. Nurses with less than 15 years of employment are also amongst the most eager to leave. Male nurses and nurses with higher qualification levels or graduate nurses also reported to consider resigning more often. Nurses reporting burnout or stress often want to leave, as do those who have reported work-related exhaustion and job strain. Inadequate staffing and lack of support were also found to be significant factors in the decisions of the nurses to change their career. Also, there is an association between work-family conflicts, family commitments and the intentions of nurses to leave their profession. Some nurses have reported leaving nursing because they found the demands of work to be incompatible with a fulfilling home life. On the other hand, nurses whose families are dependent on them for their income are less likely to leave nursing.[104]

Intention to leave and work-related factors include: nurses working under a temporary contract, non-flexible shift work and obligatory rotation of night duty, lack of financial reward and dissatisfaction with salary, poor opportunities for development, the demands of nursing work such as (excessive workload, insufficient time for patient care and too much responsibility), unsafe work environment and high patient-nurse ratios, weak affective organizational and affective professional commitment are factors that linked to stronger intention to leave the profession.[104]

UNIT IV

PERFORMANCE AND UNIT EFFECTIVENESS

Learning outcomes

On completion of this unit, reader will be able to:

- Describe concept of performance and unit effectiveness
- List components of performance unit effectiveness

Keywords

quality of care, family needs, turnover

The last set of terms to assess organizational performance is consistent with a broader, open-system perspective of what the organization is trying to accomplish. Organizational effectiveness means the degree to which organizational goals and objectives are successfully met. Assessing organizational effectiveness is complicated because of the problems associated with defining and measuring organizational goals.(4)

Shortell et al (1991) described three "outcome" measures of organizational effectiveness, the first involves nurse and physician perceptions of the absolute *technical quality of care* provided in the unit, the second involves their judgment of the ability of the unit to *meet family member needs*, and the third involves the use of data on *nursing turnover* in the unit. (40)

4.1 Technical quality of care

Quality of healthcare and intensive care unit (ICU) has become a national and international policy issue.(1 5) Interest in measuring the quality of healthcare is increasing among both healthcare professionals as well as managers. To quantify the desired

(positive) and undesired (negative) consequences of activities in heath care, measurement of outcome is essential. Indicators may provide insight in the structure and process aspects of care that are related to outcome. [106]

Quality is meeting or exceeding the needs of our customers. The Institute of Medicine (IOM) defines quality of healthcare as the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.[107]

Quality of care can be measured from multiple domains and varying domains of quality are important to patients, providers, purchasers, and insurers. The recent IOM report, a new health system for the 21st century identified six aims of healthcare: care should be safe, effective, patient centered, timely, efficient, and equitable. These aims provide a framework for considering the domains of quality and for evaluating the impact of quality-improvement initiatives. The ability to measure" the quality of care has advanced considerably, laying the groundwork for improving care. As such, it is imperative that quality measures are meaningful, scientifically sound, generalizable, and interpretable. Despite evidence supporting specific practices in critical care, rigorously developed measures to evaluate the quality of ICU outside of risk-adjusted mortality are lacking.[108]

As consumers, payers, and regulatory agencies require evidence regarding quality of care, the demand for ICU quality measures will likely grow, i.e. critical care providers must be able to evaluate the quality of care they provide. [105] Providers must develop measures of quality, create data collection instruments, collect and analyze data, and then use these results to improve performance.[108]

The effectiveness of critical care units has traditionally been evaluated by examining severity-adjusted measures of mortality, length of stay, and other measures of administrative efficiency. Increasingly, patient- and family-centered outcomes are being recognized as important outcome measures. Satisfaction with care is an important domain, from a quality care perspective, especially for critically ill patients because desirable health status outcomes may not be attainable. As the public demands more accountability for the use of public funds and assurance that the healthcare system is performing effectively, hospitals and other healthcare organizations are actively engaged in measuring their performance, including the measurement of patients' satisfaction with care. [109]

4.2 Meeting family needs

The traditional nurse-patient relationship in intensive care units is often replaced by a nurse—family member relationship, due to the critical state of the adult patient. ICU nurses are responsible for supporting family members in various ways, including being aware of the family members' uniqueness and different ways of coping, as family members suffer when the survival of the patient is uncertain. The state of the patient and a positive relationship between nurses and family members is important and benefits patients, family members and nurses.[110] Hence family members are not only biologically related, but also socially and emotionally involved in every aspect of life. It is now widely recognized that hospitalization of a family member in a critical care unit results in a number of psychological and emotional problems, not only for patients but also for the family.[111]

The hospitalization of a family member in the intensive care unit results in a number of psychological and social problems, not only for the patient but also for their family. Families act as buffers for patient stress and serve as valuable resources for patient care. However, when families have high levels of stress, they may be unable to provide support and may transfer their stress to the patient. Unmitigated family

stress can manifest itself as distrust of hospital staff, noncompliance with the treatment regimen, and even lawsuits. The stresses produced by critical illness vary in intensity and duration but undeniably can create a heavy burden for families. The sources of this stress include fear of death, uncertain outcome, emotional turmoil, financial concerns, role changes, disruption of routines, and unfamiliar hospital environments. Stress can interfere with the ability of family members to receive and comprehend information, maintain patterns of family functioning, use effective coping skills, and provide positive support. As family members struggle to cope with the stresses, the critical nature of the illness may lead to changes within the family unit. Whether these family changes are beneficial or adverse depend, in part, on the type of help the family receives from health-care professionals.[71]

The family may play a critical function in the course of an intensive care patient's acute illness. Role alterations, uncertainty, loss of control, being in an unfamiliar environment, financial constraints and fear of loss are just some of the factors that have been shown to cause family crisis and disorganization. The four-stages a family may go through when a relative is admitted to intensive care: hovering; information seeking; tracking; and garnering of resources. Hovering is the first stage, where families experience uncertainty, emotional turmoil and stress. As the initial shock subsides and families begin to refocus, they begin to seek information about their patient. Next, families will track the patient's progress, and then finally family members' energies are directed towards garnering resources, both for themselves and the patients. Nursing interventions for each stage were described, both for the individual and the organization. To move them out of the initial hovering stage, information needs should be anticipated and provided. The organization must provide sufficient staff and resources to meet family needs. During the information-seeking stage, message boards or information booklets should be available. Flexible and open communication is vital during the tracking stage, and when garnering resources there must be a suitable environment where families may wait, with food

and drinks available. The family described as an extension of the patient and insisted that nurses should consider the patient as part of the larger family unit.[112]

Intensive care unit caregivers should develop collaborative relationships with their patients' family members, based on an open exchange of information and aimed at helping family members cope with their distress and allowing them to speak for the patient if necessary.[113] Meeting the needs of their patients' family members is an essential part of the responsibilities of intensive care unit physicians and nurses, who are committed to easing the pain and suffering of those who have a critically ill relative or close friend. A major task of ICU physicians is to provide family members with the appropriate, clear, and compassionate information they need to participate in making decisions about patients who are unable to speak for themselves. Evaluations of family needs supply valuable information for improving the comprehension, satisfaction, and decision-making capacity of families. [113]

Intensive care nursing focused on the critically ill patient, with close assessment, observation and monitoring for complications. Most nurses devoted their time for giving care to the patient, leaving little time to deal with the families' needs, also relatives of intensive care patients expect care to be patient-centered, rather than family-centered. A body of nursing knowledge had developed with regard to patients in intensive care, but that the same level of knowledge concerning the psychological needs and welfare of the family did not exist. However, a holistic approach to patient care involving families is recognized as appropriate, especially in intensive care areas, where the patient can benefit from a supportive family network.[112]

The concept of holistic care is to be followed by the nurses cannot separate the needs of patients from those of patients' families. [112] The nursing goal focused

intentionally on the physiological and psychological impact of life-threatening illnesses on the sick, including the patient's family in the concept of total patient care.[111]

Also, the extent to which family needs are met may determine their ability to cope, which in turn may affect the patient's health outcome. Nurses are usually the first-line care providers that the family encounters on admission. They are responsible for the patient's day-to-day care in the ward and are intimately involved in meeting the patient's and family's immediate needs. Before critical care nurses can effectively intervene with the critically ill patient's family, knowledge of the family's immediate needs is essential.[111]

In the critical care environment, the care of the patient often requires the use of all of the resources available to nurses to assure positive outcomes, and it is the lack of time or coordination of other support services that is lacking or nonexistent. It is this focus of the Critical Care Family Assistance Program (CCFAP) that completes the accountability of the system to making sure that those patients and families have an advocate and have their needs met. Li hospitals where successful advocacy efforts have evolved, it is usually two or three physicians and a couple of nurses who have led the efforts. [71] The functions of the family as a supportive system to its individual members have been reflected in changes in nursing care. The concept of family involvement in patient care is an area that has evolved over time.[111] Any illness severe enough to require admission to an ICU is life-threatening and can precipitate severe stress within the family system. Because the responses of families to critical illness and psychological stress have implications for the family, the patient, and the health-care staff, it is advantageous for everyone to provide family-focused care so that optimal levels of family functioning are supported. Nurses who support a family-focused practice model report higher autonomy and job satisfaction. This is especially critical for the nurse who cares for these most vulnerable patients and

families. The family remains the most important social context for health-care professionals to positively influence patient outcomes. Family-focused care means that nurses assess the needs of each family and devise interventions to beneficially affect the outcomes of the patient and the patient's family. All nurses should develop competency in assessing the needs of families and in intervening to address those needs. Family assessment and intervention demand expertise and theoretical knowledge. Acquiring this expertise and knowledge requires active listening and observing of the interactions between patients and their family members. Nurses must have good interviewing techniques to generate family interventions in a professional manner. Almost all nurses benefit from education on understanding the nurse-family relationship, coping with the situations that evolve from family interactions, and improving the satisfaction of families with care delivery.[71] Inclusion of the patient's family in nursing care planning is not only within the scope of nursing practice, but also within the expectation for which the nurse is accountable. Therefore, it is helpful to consider the family as a group of people with shared past events, who experience emotional attachments and bonding, and who participate in every member's present and future goal planning.[111]

Numerous studies determined the various needs of the family members when one member is hospitalized in a critical care unit. The results of these studies suggest that the family members of critically ill patients have a well-defined predictable set of needs. These needs are grouped into the five major areas and are universally experienced by most family members they are: receiving assurance; remaining near the patient; receiving information; being comfortable; and having support available.[71]

4.3 Nursing turnover

Jones (1990) defined nursing turnover as the process whereby nursing staff leave or transfer within the hospital environment. This definition encompasses voluntary and involuntary, as well as internal and external turnovers [114] Some studies define turnover

as any job move while others consider nurse turnover as leaving the organization or even from the nursing profession. [115] Negrin et al (1999) suggest that turnover reflects the effect of the balance between organizational benefits (pull factors) and a careeristic attitude to work (push factors). [116] Turnover behavior may be counteracted by career aspiration if expectations for advancement kept them in organization, added to by fear of unemployment [115]

Staff turnover in health facilities reduces both the effectiveness and the productivity of delivering care and adds to labor costs of operating facilities. Inefficiencies of incoming employees, of co-workers, of the position while vacant, and of the departing employee, while difficult to estimate, are detrimental to the quality and cost-effectiveness of patient care. [114]

High nurse turnover can impact negatively on an organization's capacity to meet patient needs and provide quality care. At the nursing unit level, high turnover affects the morale of nurses and the productivity of those who remain to provide care while new staff members are hired and orientated. [117] Turnover has a negative impact on the cohesiveness of the work unit. Also, the additional burden put on the remaining staff during the transition period until a new nurse is hired and trained may create a stressful climate fostering further turnover [114]

Turnover predictors were identified in a literature review by Tai et al (1998) as age, tenure, job satisfaction, organizational commitment, perceived job possibilities and supervisor's behavior. [118] Similarly, Yin and Yang (2002) analysis revealed that internal environmental factors such as stress resulting from staffing shortages, leadership style, supervisory relations, advancement opportunities and inflexible administrative policies were significantly related to turnover [119]

The critical care workplace has traditionally been described as turbulent and unpredictable, this leading to high turnover rates amongst ICU nurses. The strongest determinants of turnover were younger age, lower perceived autonomy and lower educational level.[120] Factors that influenced nurses to leave have been found to be: stress too high; workloads inhibit the care; underfunded resources; bad atmosphere; petty regulations; poor promotion prospects; management style; to widen experience; wanting a new challenge; pregnancy, and hours of work. The factors that might have influenced nurses to stay included; realistic staffing levels; better pay; counseling support for nurses; part-time hours and crèche facilities.[120]

Turnover of specially trained staff can be expensive for employers in terms of finances, time and training. Uncontrolled turnover can quickly affect the sense of cohesion and morale of a unit. Most nurses want to work with colleagues they know and trust but turnover undermines familiarity and trust. There are many reasons why turnover occurs, one being the problem of role conflict. It is beneficial to patients to have a stable and skilled work-force to take care of them; effective communication and collaboration have been identified as key variables influencing morbidity and mortality outcomes in the ICUs. There is evidence to suggest that staff turnover can be detrimental to the quality of patient care. The length of patient stay was increased when staff turnover was high, and the quality of patient care is likely to deteriorate when staff retention is difficult.[120]

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