Impact of Organizational Restructuring on Nurses' Facilitation of Parental Participatory Care

McKiel, E.

Abstract

In a study to explore nurses' perceptions of their role as facilitators of parent participation in the care of hospitalized children and the factors that promoted or impeded their role, massive reform and downsizing of hospitals were noted to have created tension between the restructured health care system and the capacity of nurses to provide the optimal level of care they valued. Specifically, revised staffing patterns, (e.g., increased number of part-time and casual nurses) and workload issues (e.g., time constraints, early discharges) created concerns relative to job satisfaction and the quality of participatory care facilitated by nurses. Findings from this study support those reported in other literature.

Introduction

The role of nurses as facilitators of participatory care by parents of hospitalized children is significant to child health care outcomes. However, knowledge of nurses' understanding of their role has been identified as insufficient (Bruce & Ritchie, 1997; Coyne, 1995; Darbyshire, 1994; McKiel, 1996). In seeking to understand this deficit, a study using narrative inquiry was undertaken to explore nurses' perceptions of their role as facilitators of parent participation in the care of hospitalized children and the factors that promoted or impeded their role. One outcome of the study was the identification of impediments to participatory care as a result of restructured hospital systems in which massive reform and downsizing of hospitals created changes in staffing patterns and a surge of workload issues. Tension was generated between the restructured health care system and the capacity of nurses to provide the optimal level of care they valued. The changes and their consequences are described in this paper.

Research Method

Eight nurses who were engaged in bedside nursing in a children's hospital were interviewed. I, as the researcher, did all of the interviews. Each interview, which lasted from 1 1/2 to 2 1/2 hours, was recorded and then transcribed verbatim. In addition to the interview transcripts, data sources included field notes with descriptions about the characteristics of the participants, nature of the environment, interpretations that occurred to me during our interactions, my relationship with the participants, and conversations apart from the interviews. Prior to conducting the interviews, ethical approval for the study was received from a research ethics board, and each participant signed a consent form.

Participants

Criteria for inclusion of participants were adapted from those suggested by Morse (1991). Each participant: was a registered nurse employed on a standard, inpatient pediatric unit supportive of parent participation, was engaged in bedside nursing, was willing to critically examine her role in relation to parent participation, consented to participate, had time to talk with me, and was willing to read and provide feedback to the narrative accounts constructed from the interview transcripts. Participation in the study was voluntary. All nurses who fit the criteria were invited to participate.

Recruitment into the study was stopped at eight nurses because, at that point, the data seemed to be redundant; any differences across the stories were minor in relation to participatory care. All of the nurses were female. They were employed in an acute care, pediatric hospital in a Canadian city. They came from a variety of educational programs, i.e., hospital based, college, and university. Their nursing experience ranged from 1 1/2 years to 26 years. At the time of the study, two nurses worked permanent part-time by choice, one had a 0.7 line position and "picked up" extra shifts to equal full-time, one had a 0.6 line and "picked up" shifts to equal 0.8, one had casual employment by choice, and three had 0.9 positions which were classified as full-time. The three nurses who were employed full-time were initially in the casual pool because that was all that was available when they started; it had not been their personal preference.

Data Analysis

The process of data analysis consisted of two parts, narrative analysis and analysis of narratives (Polkinghorne, 1995). From the analyses, narrative accounts (stories) were constructed. To ensure trustworthiness, the individual narratives were sent to each corresponding participant who was asked to provide feedback regarding the comprehensiveness and accuracy of the story. Changes were made subsequently based on the feedback received. To further ensure rigour, two faculty colleagues reviewed the interpretation of the narratives and confirmed both accuracy and congruency. Prior assumptions about participatory care, which had been recorded as memos, were reviewed periodically during the writing to check that they were not shaping my interpretations.

Results

The data analysis led to the identification of themes which clustered into five categories: becoming a facilitator of participatory care, creating a context for participatory care, implementing the process of participatory care, downsides to participatory care, and impediments to participatory care. Within the latter category, organizational restructuring emerged as impeding the nurses' ability to facilitate participatory care by parents as a result of revised staffing patterns and ensuing workload issues.

Staffing Patterns
Excerpt from Laura's Story (All names are pseudonyms)

Laura was one of the participants in the study. The following excerpt depicts her experience as a casual employee who valued participatory care by parents.

Casuals are always having a first day and it's always a bit more scattered. You never ever get to meet parents or spend time with them because it's your first day. When I was a casual, I felt limited as a facilitator of participatory care because I didn't know the parents. But later, when I got a long-term appointment, I found that I got a lot more involved in the working of things, learning how to take care of trachs (tracheostomies) and progs (progressive care infants) and all that kind of stuff. So I really expanded my knowledge which made me more useful to teach parents. Because if you're there for a short time, then you don't have to know all these things because you never take care of them, then you can't teach it either. Casuals aren't allowed to take care of trachs and progs and they never, very seldom, get a long-term case. That's a big difference. When I got a permanent position, I became part of a team. We knew each other's strengths and drew on them, like, some might know a lot more about this, so you try and hook up the parent with that (person). And I think that's the value... You can compliment each other...and I find when it comes to teaching, it sure works; it sure works well.

Changing Work Environment

Laura's experiences were reflective of a decade in Canadian health care systems characterized by massive reform and downsizing of hospitals. As a result, there was a significant impact on nursing human resource planning (Donner, 1997; Rogers, 2000; Spence Laschinger & Sabiston, 2000; Working With Limited Resources, 2000), and consequently on job satisfaction for nurses and quality of care for patients (Fletcher, 2000a; McGirr & Bakker, 2000).

Job Satisfaction

Staffing patterns are a component of nursing human resource planning which has undergone notable change as a result of restructuring. Modifications are apparent in the increased number of part-time, float, and casual nurses (Buerhaus & Staiger, 1997; Burke & Greenglass, 1999; Carnevale, 1997; Fletcher, 2000a; Sibbald, 1998; The Nursing Strategy, 2000; Willard, 2000). In some centres, cross-training has been implemented as a means of staffing diagnosis related patient care units, (e.g., in a regional health authority comprised of several hospitals, neonatal nurses may be required to work across the hospitals as staffing needs change from one site to another (Altimier & Sanders, 1999; Donner, 1997).

Whether the patterns are positive or negative is being debated (Armstrong-Stassen, Cameron, & Horsburgh, 1996; Burke & Greenglass, 1999; Fletcher, 2000a, 2000b; McGirr & Bakker, 2000; Sibbald, 1998). Some people argue that job sharing and/or permanent part-time employment with more flexible schedules are attractive factors which favour recruitment and retention of nurses who have children, as well as aging nurses who comprise a growing group in nursing. Indeed, this was the case for three of the nurses in the study reported in this paper. Working part-time fit well with their lifestyles. From another perspective, however, such staffing patterns are viewed as contributing to a diminishing workforce of nurses. One study participant reported that she was uncertain as to whether she would stay in nursing. The other participants did not talk about leaving nursing, but they did express frustration with hiring and staffing practices. The nurses in this study were not required to work across hospital sites although the possibility had been discussed and rejected.

In Laura's story, the practices were not presented as being positive. Support for her views is also evident in the literature. Leppa (1996) described acute care nursing as a co-operative effort based on teamwork and trust with nursing work group cohesion being the most important element of job satisfaction. She noted that research outcomes herald the importance of protecting day-to-day work group structure and identity, that the practice of employing float and casual nurses, and to a lesser extent, part-time staff place group structure and identity at risk. Other reports (Burke & Greenglass, 1999; Chaboyer, Williams, Corkill & Creamer, 1999) support elements of this view which, in turn, are consistent with Laura's account. Although an individual nurse's experience of the work group is by nature a personal one, members of the group can contribute to or detract from the quality of the experience in terms of learning, confidence building, and subsequent patient care.

All of the nursing personnel employed in the hospital where this study was done were registered nurses. Regardless of that qualification, as Laura indicated, casual nurses were restricted from caring for children with complex conditions. As a consequence, these "heavier" children were assigned consistently to full-time nurses who, in time, grew tired of the relentless level of responsibility. Norma, another participant, described a situation, saying, "I

remember this little girl…she's now gone…she passed away. She had lost her I.V…I still remember, we poked her so many times trying to get an I.V. started. And I remember holding her and saying, 'I can't do this anymore.'" At the same time, the casual nurses experienced a sense of frustration because, by not being allowed to care for more complex children, they felt deprived of learning opportunities and professional growth. They also felt guilty because they were felt unable to share the workload equally. The workload allocation was a divisive factor in terms of group cohesion in that, as one participant said: "full-time can, casuals can't". There was lack of choice and little or no input regarding the patient assignments. According to Attridge (1996), Davidhizar, Dowd, and Brownson (1998), and Spence Laschinger and Sabiston (2000), an environment like that can engender a sense of lack of control, lack of autonomy, and powerlessness. Over time, such feelings give rise to diminished job satisfaction and a staff who feel less committed to the organization which, consequently, threatens retention.

Restructuring and Quality of Care

Time

Effective participatory care requires time; time for nurses to come to know the parents, help them feel comfortable, negotiate their role with them, teach them, and provide feedback. This was the standard of care that the study participants wanted to achieve. However, they described a working environment in which they were taking on more and more in response to cutbacks in the health care system. Consequently, if involving parents required time "up front", the nurses often chose to do the care themselves because they could do it much faster and thereby get more "work" done, even though that was not what they preferred. Ita, one of the participants, commented that it was helpful to both the children and staff when parents provided care, but "it can be easier and faster to do it oneself. The teaching can take a lot of time, a lot of explanations, a lot of questions – depending on the family, of course. (But) you can't do that anymore. You're too busy. I wish we could." Cara, one of the participants, echoed the time constraint, when she expressed regret that "…when things get very busy, we all get very task orientated so you do, you do, and you do." For her, the tasks controlled the work to the point that the tasks were the work. There was no opportunity for quiet times with parents when she could talk with them about the hospitalization; how they thought their child was doing, how they were managing. Consistent with the stories reported by Attridge (1996), Cara was powerless to provide the scope of care that she valued, which to her was family-centred care; care that involved parents. The other participants echoed these frustrations as well.

Reduced time with parents was not only a consequence of heavy workloads. It was also an outcome of casualization, which involved scattered shifts and scattered placements. By not working consecutive shifts on one unit, a nurse's interactions with a particular family were often limited to one shift. As a result, she was unable to know the family well enough to identify needs and respond to them other than to make referrals. Although she might teach parents, there often was no opportunity to follow through to evaluate the parents' learning. One participant referred to it as assembly-line nursing saying, "You do a piece and pass it on."

Length of Stay

Another change, which has influenced the quality of care, is reduced lengths of stay. In an effort to contain costs, shorter hospitalizations have become a norm (Blegen, Goode, & Reed, 1998; Working With Limited Resources, 2000). However, although shorter lengths of stay may help to balance a budget, it does not follow that they contribute to an optimal level of care. To quote Laura: "Short hospitalizations interfere with participatory care… it isn't always possible to involve parents as much as you'd like to, or as much as they'd like to be, and that's because of short hospitalizations." This has particular significance when a child has a health problem that will require continuing care by the family at home following discharge. For example, Cara cited an occasion when she found herself rushing in to a parent and announcing: "Okay, your child's going home on NG (nasogastric) feeds; this is what you need to know." She explained her action, saying: "We don't have time, so we rush parents, wanting them to move ahead faster than they are able to do."

The change has also served to alter workloads because, "…as the length of stay decreases, the average nursing care needs of the patients in the hospital increase" (Blegen, Goode, & Reed, 1998, p. 49). Then, in order to manage the work as Cara pointed out, the focus of nursing care becomes the tasks, not the whole patient and definitely not the family. That which is visible and tangible is attended to; that which is less visible is moved aside hoping that, eventually, there will be time.

Conclusion

Cost containment has been purported to be essential in order to sustain the health care system in Canada. However, the massive reform and downsizing within regional health authorities has resulted in tension between the restructured health care system and the capacity of nurses to provide the optimal level of care they value. One sector which has been impeded is participatory care by parents, deemed to be crucial to a hospitalized child's wellbeing, and subsequently viewed by nurses as an essential component of care. Without it, job satisfaction for nurses and quality of patient care are at issue. Without resolution of the issues, recruitment and retention are at stake, burnout for those staying in the system is a reality,

and patient care is compromized (Working With Limited Resources, 2000). Solutions require that those who are "living" the issues be heard, that the issues be understood in their entirety, and that responses involve those stake-holders who are most affected by the issues.

Author

Elaine McKiel, RN, PhD is Associate Professor, Faculty of Nursing, University of Calgary, Calgary, AB.

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