

Increasing Nurse First-Line Leader (Manager) Positions to Improve Nurse Retention and Quality of Patient Care

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Abstract

Nurses' job action during the spring and summer 2001 taught us much in British Columbia. Post job action de-briefing with non-contract staff confirmed for the Capital Health Region in Victoria that the workload of patient care managers, along with their scope of responsibility was contributing to dissatisfaction, both on the part of patient care managers as well as nursing staff who they are intended to serve. Further, it was becoming increasingly apparent that the success of most of the organizational initiatives depended greatly on the presence, availability and support of patient care managers. Supported by the senior leadership team, the Chief Nursing Officer for the Capital Health Region agreed to have a look at unit based leadership - see what was being discussed across the country and in the literature and draw on her own experience in three provinces. The result would be a discussion paper that would circulate broadly throughout the organization and would provide the organization with broad input to help it decide collectively "What do we need to do? Where do we need to go from here? And how will we get there?" This article is an adaptation of that discussion paper.

Introduction

The purpose of this article is to draw attention to an important issue for the nursing profession – one that we need to face up to, before there is further deterioration of quality of care and practice. Health care organizations must develop effective strategies for improving nurse recruitment and retention in the workplace, as well as quality of care. One important strategy is *increasing nurse first-line leader (manager) positions*.

Increasing the numbers of nurse first-line leader (manager) positions is one of the most important recruitment/retention and quality of care 're-forming' initiatives that could be undertaken in our health care organizations. The reduction of nurse first-line leader (manager) positions coupled with the introduction of multi-

unit management – consequences of health care restructuring in the 1990's – must be revisited.

The Problem

The work environment of our health care system in the present and foreseeable future can be described as de-stabilized and always changing. Financial pressures, advances in technology, increased knowledge and professional staff shortages have changed and will continue to change our health care settings. One of the most significant actions of health care de-stabilization has been the reduction of nurse first-line leader (manager) positions. Titles for this position have included, but are not limited to, 'unit manager', 'nurse manager', 'patient care manager', 'patient care leader', or most traditionally, 'head nurse'.

The factors that stimulated health system reform across the country have not substantially changed. As our destabilized system continues to re-form itself, it must do so now with two imperatives:

- 1) Ensure quality patient outcomes through the delivery of safe, competent and ethical care and
- 2) Recruit and retain competent professional staff who are highly engaged with their organization.

Research demonstrates the importance of leadership and communication to staff satisfaction and quality of care. As well, much has been learned from our own experiences. The summer issue of *Hospital Quarterly* has an article on the Canadian nurse survey component of the International Hospital Outcomes Study, demonstrating very clearly the predictive value of executive and unit nurse leadership to nurses job satisfaction, nurses' intent to leave their current position and quality of patient care, as well as nurses' emotional exhaustion (Clarke et al., 2001). Nurse leaders best understand nurses' perspective and practice requirements and best speak as nurses when they are communicating staff nurses concerns to more senior staff. Nurse leaders can best put into nurse-relevant language issues and communications from senior staff.

Managers want and need to be leaders on the unit (the nursing community) not sporadic visitors. Intervening is what many managers do – it's all many can do in some of our current environments. Nursing units need continuous care and effective nurse leadership, not interventionist short-term cures. Nursing units need competent, engaged leaders (managers) who understand and lead the work of the unit and who can link that work to the broader system so that outcomes of care are continually improved and so that inspired practice and learning environments are collectively created.

Tempering the realities of cost containment with the priority of providing safe, competent and ethical care has been very difficult regardless of organization mission. However, reduction of nurse first-line management positions has resulted in a diminishment of:

- Communication links between staff nurses and administration contributing to lack of trust and allegiance by nurses to their employer and to lack of avenues in which to express concerns related to their professional practice;
- Nurse leadership at the practice level – leadership for clinical decision making, development of models of practice, commitment to a philosophy of practice and team building;
- Input by staff nurses in unit level and organizational decision-making and policy development; and
- Medical and interdisciplinary staff communication.

As reflected in the literature, these losses are significant factors in job dissatisfaction, intent to leave one's current job, decreased quality of care, and lack of "best practices" reflected in unit and organizational level decision-making (Aiken et al, 2001).

Background

Traditionally, the first-line managers or 'head nurses' functioned as figures of authority and supervision – they were the "boss" in a typical nursing hierarchy. *Overt* management activities such as planning, directing, supervising and controlling were hallmarks of the role. If we accept the premise that nurses of today are "knowledge workers" as health care professionals and ought not to require much 'management' or *overt* leadership, then reducing the numbers of 'head nurses' or moving to structures of multi-unit management resulting in an overall reduction of middle management positions, might make some sense economically and structurally.

But if, as Mintzberg (1998) suggests, the significant or most meaningful leadership activities of a manager are *covert* (communication, leadership for decision-making, team-building, developing supportive work environments), then we need to re-visit the links between 'quality of the work environment, retention and recruitment, outcomes of care and the economic bottom line' and the role and numbers of first line managers in our organizations. As a result of our restructuring activities, have we in fact, negatively impacted the economic bottom-line?

In addition to being unhealthy work environments for nurses, health organizations have over-burdened some first-line managers with untenable workloads in systems constantly engaged in change. Our organizations are failing

first-line leaders and first-line managers are the first to tell us this. In various forums, managers in the Capital Health Region have expressed feelings of isolation and lack of support. Many are overwhelmed with their workloads, increasing complexity and expectations. Some have described feeling like visitors to their units. They are particularly distressed at being unable to provide front-line staff with the resources and support necessary to provide the quality of patient care expected.

Let's acknowledge *some* of the realities of today's work environment for many nurses and their line managers:

- Increased complexity of nursing roles and patient acuity
- First line management positions with broad scopes of responsibility, which may include multiple patient care areas or services, multiple work sites and multiple direct reports
- Management job descriptions that focus primarily on traditional management functions versus leadership and clinical outcomes
- One-size-fits-all rules
- Constant system transformation as a result of new information, technology, changing expectations of patients/client/consumers, capital projects and 'clever strategies' of organizational leaders
- Complex labor relations environments
- Increased roles in educating students and staff
- A need to support professional regeneration; compliance with professional, accreditation and regulatory standards.

Importance - Significance of the reduction of nurse first-line leader (manager) positions

Two decades of research across Canada (and beyond) has demonstrated clear links among quality of work life, the health, recruitment and retention of nurses and outcomes for patients during and after hospitalization (Health Canada 2001, Lee, Chang, Pearson, Kahn, & Rubenstein, 1999, McNeese-Smith, 2001).

The voices of nurses across Canada and elsewhere have echoed loudly and repeatedly the message that being with patient/clients is their highest source of satisfaction. At the same time it is clear that job satisfaction, health and recruitment and retention relate consistently to:

- Reasonable workloads and nurse patient ratios
- Job security
- Feeling appreciated, valued and recognized
- Feeling safe from abuse in the workplace

- Having access to safe equipment and sufficient supplies to carry out the work – as well as human resource supports such as administrative support and cleaners that allow nurses to focus on patient care
- Reasonable and flexible work schedules
- The calibre of leadership in the environment, as well as the nurse's personal relationship with a visible, accessible, credible supervisor
- Positive relationships with physicians
- Tangible, ongoing support for education and professional development. (Healthy Nurses, Healthy Workplaces – Health Canada, 2001).

One of the most effective strategies to address the factors related to nurses' satisfaction and retention, as well as the quality of patient care, is to have nurse first-line leaders (managers).

Maintaining a healthy workforce – valued, optimistic and engaged is a strategic imperative for any quality effort. Nurse leaders across Canada believe that means nurses need more support on the job, from nurse first-line leaders (managers) who understand their work, respect their expertise and can offer a sense of security and team/community. It means rebuilding an approach to nursing where the focus can be on the patient; it means ensuring a manageable workload; it means supporting professional development with time and resources. Organizational commitment used to be a given in many health care organizations. It's now becoming rare and endangered.

Role expectations of nurse first-line leaders (Managers)

Staff nurses value leaders, including those closest to them in the practice setting, who understand the challenges of their work, can provide direction, support, information and resources and who can engage them in the personal and professional challenge they seek. With the significant nursing shortage upon us, yet not having peaked, it is critical that supportive practice environments that enhance the recruitment and retention of professional staff, promote autonomy in practice and seek quality patient outcomes are organizational priorities. If we believe that the environment in which they practice impacts nurses significantly, then the nurse first-line manager is the central player in building a healthy workplace (Frederick, 2001). How often have we heard the saying “ People join organizations, but leave managers and supervisors”? In other words, productivity, length of stay and patient outcome is related to an employee's relationship with his or her immediate manager.

The first-line manager's major responsibility is to facilitate quality patient care through nurses and their

colleagues. The manager has 24-hour accountability for the delivery of safe, competent, ethical and coordinated care by all nursing and other staff (care providers and support workers) on the unit or in the patient care area for positive patient outcomes. As the link between the organization's goals and nurses and their practice, the manager enables nurses and other professional staff to carry out their complex roles while fostering their professional growth and continuing competence through education. The nurse first-line leader/manager is in the key position to ensure that nurses are effective individually, as well as to create a practice environment that supports staff to interact in ways that deepen collegial relationships and create a strong sense of team.

The responsibility of the first-line leader (manager) to create a practice environment that is responsive to the *new nurse* employee is becoming particularly relevant. During the first 6 to 12 months, entry level nurses function as novices – with a beginning level of practical experience and knowledge application. The fact that experienced nurses continue to serve the patient and system well in today's environment is a credit to them and to the knowledge and skill they have acquired from years of professional practice. However, it is also true that many of those nurses began practice in a health care system that had seasoned, expert nurses to guide them – head nurses, clinical nurse specialists, clinical educators and directors of nursing departments. Technological change was slower, hospitalizations were longer and there was more balance between patients who were acutely ill and those who were convalescing. Unlike the new nurse employee, or new graduate, most nurses in practice today had a chance to hone their skills before they had to step up to the enormous challenges they now face in practice (RNABC, 2001).

I believe our ability to recapture community (including nurses' involvement in decision-making), and to support practice, autonomy and recognition at the unit level will be a key determinant of our success at recruitment/retention and the achievement of quality patient outcomes. I also believe it will help dispel the myth that interpersonal relationships have little to do with the economic bottom line.

We know our organizations need to abandon old hierarchical ways of managing in favour of models that rely more on de-centralized decision-making, information sharing and informal networking. Investing in the transformational leadership of first line managers in order to optimize an organization's performance is essential. We need nurse first-line managers, and we need them to act in simple, but profoundly different ways.

Conclusion

Let me conclude by acknowledging again, the reality of the work environment. Recent, relevant research demonstrates clearly a relationship between professional nursing and patient outcomes (Clarke et al., 2001). The quality of the work environment affects job satisfaction and retention and recruitment of nurses, which affects patient outcomes.

The nurse first-line leader (manager) is the link between the organization's goals and nurses and the care they provide which in turn, impacts patient outcomes. We can't make systems change with any success unless there are nurse first-line leaders (managers) in place who can make the connections for nursing staff about the relevancy of change to their work. Sure, we can continue to go through the mechanics....

Health care reform, regardless of its original intent, evolved into a cost cutting exercise. Yes, efficiency is important, but not at the cost of human connections, the connections that at the end of the day, impact the bottom line more than we ever considered.

Maintaining a healthy workforce is a strategic imperative for any quality effort. For those of us who are responsible for planning and implementing organizational change – are we getting the results that we want? Should we continue to spend money on a management design that fertilizes job dissatisfaction, breeds lack of organizational commitment, makes nurse recruitment/retention difficult and contributes to poor patient outcomes? Or, can we make a deliberate investment in quality patient outcomes by increasing nurse first-line leader (manager) positions? The answer is a secret in plain sight.

Author

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