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RM Publication ID: 2006008369

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Table of Contents: [Click here to view](#)

ISSN: 0813-0531

Title: Australian Journal of Advanced Nursing [Additional Title Information](#)

Publishing Body: Australian Nursing Federation

Country: Australia

Status: Active

Start Year: 1983

Frequency: Quarterly

Document Type: Journal; Academic/Scholarly

Refereed: Yes

Abstracted/Indexed: Yes

Media: Print

Alternate Edition [1447-4328](#)

ISSN:

RSS Availability: [Click here to view](#)

Language: Text in English

Price: AUD 110 subscription per year domestic to non-members
AUD 125 subscription per year foreign to non-members
AUD 99 subscription per year to members
AUD 297 subscription per year domestic to institutions
AUD 355 subscription per year foreign to institutions
(effective 2006)

Subject: [MEDICAL SCIENCES - NURSES AND NURSING](#)

Dewey #: 610.73

Circulation: 1000 unspecified

Editor(s): Margaret McMillan

Publisher(s): Jill Iliffe

E-Mail: ajan@anf.org.au

URL: http://www.anf.org.au/04_anf_ajan_publications/index_ajan.html

Description: Covers nursing research and allied philosophical study.

ADDITIONAL TITLE INFORMATION

Alternate Title: Medline Abbreviated title: Aust J Adv Nurs

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THE IMPACT OF HOSPITAL STRUCTURE AND RESTRUCTURING ON THE NURSING WORKFORCE

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Accepted for publication December 2006

Key words: hospital structure, restructuring, nursing, management

ABSTRACT

Objective:

Health systems throughout much of the world have been subject to 'reform' in recent years as countries have attempted to contain the rapidly rising costs of health care. Changes to hospital structures (restructuring) have been an important part of these reforms. A significant impact of current approaches to restructuring is the loss of, or changes to, nursing management roles and functions.

Setting:

Australian hospitals

Primary argument:

Little evaluation has been undertaken to determine the impact of hospital structure and organisational restructuring on the nursing workforce.

Conclusions:

There is some indication that nurses have experienced a loss of key management positions, which may impact on their capacity to ensure that adequate and safe care is provided at the ward level.

INTRODUCTION

The demand for efficiency in health care has resulted in significant and, too frequently, continuous changes to hospital structures. Mergers, downsizing and re-engineering, all of which may include changes in work assignments, modifications to clinical staffing and skill mix, and reductions in management positions, are commonplace. Often these strategies have been driven by factors external to the

health service itself such as decreased funding or the introduction of a new or expanded service. In the Australian context we can also add political imperatives such as: a strengthening of the federal government's influence in health; the need to better integrate and coordinate health services; increased expectations of consumers for accountability; and media coverage of adverse hospital outcomes such as occurred recently at Bundaberg Hospital (Queensland) or the Macarthur Health Service (New South Wales).

The impact of restructuring on staff is not necessarily accounted for in the process of change, which is unfortunate, as the pressures of cost containment usually lead to an emphasis on work redesign to deliver care in more efficient and cost effective ways. However as hospitals undergo restructuring there is little evidence that efficiency or outcomes actually improve (Fulop et al 2002; Braithwaite et al 2005). Despite this, restructuring can have significant implications for patients and the nursing workforce.

For patients, decreased bed numbers and 'bed block' have resulted in shorter stays in hospital, increased rates of day only admissions and longer waiting times. Patients are likely to be sicker on admission and as a consequence, require more care. It is now well established that patient outcomes are linked to appropriate nurse-patient ratios and the proportion of registered nurses (Aiken et al 2002). Hospitals in which the organisation of nursing promotes high levels of nurse autonomy, nurses' control over their work environment, and good relationships between nurses and doctors, have better patient outcomes (Sochalski and Aiken 1999). These factors are also associated with greater trust in management and a greater commitment from nurses to their work place (Laschinger et al 2000).

However nurses as the largest component of the workforce and thus the largest operating expenditure, are often faced with restructuring which involves reducing their labour costs through changes to skill mix and work practices and a reduction in management positions. Hospitals are now less likely to have enough registered nurses, adequate support services, supervisors who are supportive of nursing, an influential chief nurse executive, and other organisational characteristics associated with good patient outcomes (Upenieks 2003). It is timely therefore to consider in more detail the impact of restructuring, an almost constant occurrence in today's health care system, on nurses who ultimately provide the majority of patient care.

BACKGROUND

Obviously the complexity of providing health services presents different challenges in structuring for the best results (effectiveness) and the greatest return on investment (unit cost) than in many other service industries. Health care administrators have been pressured to undertake almost constant organisational restructuring due to a range of dynamic external factors including: increasingly scarce resources; rapidly developing and costly technology; shifting consumer expectations; a changing workforce; new regulations and competition; and demands for greater efficiency (McConnell 1998; Keating 2000). In addition, as with other public sector organisations, governments' adoption of a market-based model has reinforced the need for more efficient ways of organising (Self 1993).

A range of contemporary managerial ideas including: total quality management; the use of teams; process re-engineering, patient focused care; decentralisation of services; and high performance work organisations; have impacted on the organisational design of hospitals and health services (Landsbergis et al 1999). While these generic business oriented approaches are persuasive, the extent to which they are effective in health is unknown.

Hospitals, which constitute a significant proportion of health services expenditure, have sought to increase efficiency, decrease duplication, and re-shape the way that care is delivered through whole systems restructuring (Urden and Walston 2001). Generally however there is widespread dissatisfaction with this market-based approach from nurses, with its strong emphasis on organisational management and efficiency, rather than on nursing practices that have been shown to lead to better patient outcomes (Urden and Walston 2001). Organisational change should result in a more patient-centred system emphasising goal alignment amongst all clinicians (not just nurses) and managers, and devolved decision making that supports improvement in satisfaction, quality, cost, innovation and growth (Miller et al 2001).

Indeed there are some who argue that the new, leaner, restructured health system has replaced earlier

models which were traditionally characterised by high job satisfaction; adequate staffing; clinical career ladders which fostered retention; a degree of autonomy, responsibility and control at a practice level; lower staff turnover; and superior patient and nurse safety outcomes (Aiken et al 2001).

A common market-based model for restructuring to increase efficiency has been downsizing. This process usually involves an overall reduction in staff numbers, centralisation of administrative functions to reduce overheads and duplication, and removal of middle layers of management (Roan et al 2002). The current target is white-collar professionals rather than blue-collar workers, making nursing staff especially vulnerable (Di Frances 2002). As Aiken et al (1996) report, a result of downsizing of hospitals in the USA was that the number of nurses declined while the number of non-clinical administrators increased. Hospitals continue to flatten their structures with fewer nurse management positions and wider spans of control in an ongoing effort to cut costs (Laschinger et al 2001).

Restructuring in Australia

Australia is not immune to the trend to restructure. For several years now there has been a shift toward an organisational structure that involves managing a network of inpatient, outpatient, community and support services at the hospital level. This grouping of 'related specialties' is commonly referred to as clinical divisions or directorates. More recently the trend in New South Wales has been to streams of care. Clinical streaming builds on the model of networking of services and focuses on the provision of services across the care continuum and across a number of settings and institutions with a senior clinician (usually medical) responsible for service delivery.

Streamed services usually encompass everything from health promotion, early intervention, community health and outpatient services, through to acute and intensive care. Clinical streams are meant to facilitate the participation by all clinicians as well as consumers in the planning, development and improvement of services and to assess the best way to use available resources (human, financial and infrastructure) to meet client needs (NSW Health 2004). Despite these intentions, the changes have not always united clinicians as specialist interests sometimes become even more strongly focused, leading to competition for resources and restricting integration (Braithwaite and Westbrook 2005). Nevertheless, it is being replicated in other Australian states (Sainsbury 1999; Western Australia Government 2001).

Another consequence of a clinical streaming structure is a lessening of focus on managing at the institutional level. As the management of these streams transcends institutional boundaries, the nursing unit manager of a surgical ward for example, may find her/his direct supervisor is off campus in a location that may be hundreds of kilometres away. As a consequence, their

role acquires more devolved administrative tasks because senior nurses and managers are no longer on site, are less familiar with the organisation and what is happening; and realistically, are unable to provide direct leadership. The result for nurses is that the first-line nurse manager, the position responsible for providing clinical leadership, has less time and capacity to do so. In addition, there are concerns about proposals to 'downgrade' nurse manager positions in this structure (NSW Health 2005). Not only does this send the wrong message about the importance of these roles in patient safety and the effective management of the largest component of the clinical service but also, the loss of nursing leaders or a nursing voice results in a demoralised nursing workforce and increased turnover (Fagin 2004).

Until recently there has been limited evaluation in this country of the effectiveness of divisional structures and clinical streaming and certainly none in-depth. In particular, no analysis has been undertaken of the cost of supporting an additional organisational layer, nor even more importantly, whether this structure has had a positive impact on patient outcomes, organisational efficiency or enhanced service delivery. Braithwaite et al (Braithwaite et al 2005; Braithwaite and Westbrook 2005) maintain that the anticipated improved efficiency of services structured as clinical directorates was not realised in practice. Although clinical directorates were designed to promote team approaches and to improve patient care delivery, clinicians and managers have different perspectives. Their research found that change in hospitals requires deep-seated adjustments to the enduring sub-cultures of doctors, nurses and allied health professionals, so that each group can work better together. A new structure will not automatically achieve this.

Many years ago the NSW Nurses Association undertook a limited evaluation of clinical divisions at Johns Hopkins Hospital in the USA (NSW Nurses' Association 1991). Although dated, this report outlines some of the issues associated with this model and provides a number of ideas that are still relevant today when contemplating the introduction of this or any other structure. First, to enhance collaboration clinical divisions need management structures that ensure doctors and nurses are 'equals'. Second, the allocation of human and financial resources needs to remain flexible across structures with a nurse executive overseeing the appropriateness of the allocation for the entire organisation. Third, senior nurses require appropriate infrastructure support (administratively) and delegated authority for strategic and operational management of the nursing services. Fourth, the Director of Nursing must continue to represent nursing at a corporate level, speaking for nursing in administrative, financial and professional activities. Finally, senior nurses within any structure must maintain a line relationship with the Director of Nursing (NSW Nurses' Association 1991). At the end of the day, structures should facilitate, not impede, the provision of patient care.

The impact of restructuring on nurses

Despite the size of their workforce, nurses have had relatively limited input into the way restructuring has occurred, but conversely, have been most affected over the years. Yet each time structure is changed, the consequences and costs to nursing and patient services are often unacknowledged. While restructuring often focuses on increased efficiency, factors affecting the quality of care and the work life of nurses are often neglected. Downsizing potentially deskills the workforce, reduces collective corporate knowledge and the number of available mentors, and disturbs established organisational-client relationships. As Di Frances (2002) indicates, the whole process of downsizing can create distrust and low morale, especially when junior staff perceive that the reward for long and dedicated service is retrenchment. Such effects are exacerbated if the downsizing is top-down and takes place without employee consultation and participation in the process (Roan et al 2002).

In Canada, drastic financial cuts in public funding to the health care system led to widespread closures of beds, wards and even hospitals. Greenglass and Burke (2001) found the most significant predictor of stress in nurses working in downsized hospitals was workload. Decreased job satisfaction and professional effectiveness were also related to increased workload. In addition, restructuring was found to have negative consequences on more junior nurses, affecting recruitment and retention (Burke and Greenglass 2000).

Another consequence of hospital restructuring often is that lesser-trained or untrained staff replace registered nurses, resulting in additional stress on those remaining in the workforce (Burke 2005). With fewer qualified staff available to care for patients, higher patient acuity and shorter length of stay significantly increase nursing workloads, which has been shown to result in more adverse patient outcomes (Duffield and O'Brien-Pallas 2002), and high levels of absenteeism among nurses, with rates two to three times greater after a major as opposed to minor downsizing (Kivimaki et al 2000). The negative effects of restructuring on patient care and nurses' working conditions now are widely accepted (Baumann et al 2001; Burke 2003; Laschinger et al 2001).

A significant impact of current approaches to restructuring is the loss of, or changes to, the nurse executive role. Frequently these positions take on responsibility for a larger and more diverse range of staff and services, resulting in some cases with less direct representation of nurses and their issues at both institutional and policy levels (Institute of Medicine 2004). Unfortunately, this lack of involvement of nurse executives in organisational decision making has left nurses with limited power to influence change or create positive nursing work environments, both of which are critical in ensuring patient safety (Patrick and Laschinger 2006).

However it is the reduction in the number of first-line and middle management positions that may prove to have the greatest impact on the nursing workforce in the long-term. As middle management roles have disappeared, nursing unit managers (NUMs) now spend more time on administrative work and as a consequence, they are unavailable to supervise, mentor and support their staff (Duffield and Franks 2001). This has resulted in junior nurses and new graduates being relatively isolated, leading to dissatisfaction and frustration (Duffield et al 2001). With changes to skill mix, nurses are increasingly supervising less qualified or inexperienced staff, a task that they report as very time-consuming (McKenna 1995; McIntosh et al 2000). In addition, the number of first-line nurse managers has decreased as the trend for them to manage multiple units and more staff continues, resulting in less direct management support and clinical leadership for nursing staff (Sovie and Jawad 2001). Moreover, these redefined roles may come with little additional support.

In summary, restructuring has tended to result in fewer middle management positions and greater demands on unit-based nurses for the management of the clinical work force. At the same time, nurse executive positions have lost responsibility, but not accountability, for the strategic direction of nursing services and/or have acquired administrative authority for functions in addition to nursing. The net result, in the view of leading nurse executives, has been a diminished influence of nursing in institutional priorities and operational decisions and weakened ties between clinical staff and administrators (Institute of Medicine 2004). Restructuring may lead to unintended voluntary resignations because of high dissatisfaction with the process. The surviving nursing staff may experience low morale and motivation prompted by reactions such as insecurity, distrust and anger, which can result in poorer patient outcomes (Duffield and O'Brien-Pallas 2002). At a time of global and worsening nurse shortages, anything that exacerbates the loss of nurses from the system must be redressed.

Is there an appropriate structure for hospitals?

Many health services have endeavoured to strategically renew their organisations through large scale restructuring of work processes and organisational structures in response to the pressures outlined earlier. Yet there is uncertainty about whether there is a best way, or even a particular way, to structure a health service. Frequently administrators and managers have relied on industrial and business models with an emphasis on decreasing costs and improving productivity rather than improvements in outcomes and quality of care.

The almost constant restructuring of health services suggests that while it is fairly easy to determine a broad strategy, such as downsizing or re-engineering, it is clearly more difficult to define the exact organisational structure necessary to support the overall strategy. There

is no consensus or widely accepted empirical evidence to indicate which form of structure suits which health care system or professional group, or whether indeed, there is a more universal and strategic approach to restructuring that can be applied to health care services generally (Rondeau et al 2002). Downsizing or re-engineering may simply be the first step with little detail provided on the allocation of authority, responsibility and accountability within the structure. Clearly, this clarification is important as part of the process.

While the ideal restructuring model remains elusive, there are clearly a number of important factors to include in order to minimise the impact on the nursing workforce. As Aiken et al (2002) show, hospitals with strongly supportive nursing work environments have significantly lower mortality rates than others. This suggests a strong correlation between organisational structure, and nurse empowerment and control which are significant for organisational effectiveness (Laschinger et al 2001).

Sainsbury (1999) confirms that some of the critical factors to consider include: organisational size because it impacts on the range of services provided; the skills and expertise of existing staff; personalities and loyalties of staff in the current structure; interpersonal relationships; reasonable workload; and the capacity for bureaucratic rationality. It is also important to ensure that professional links are maintained to prevent the individual loss of professional identity that can occur through restructuring (Wynn 1997). Furthermore, research suggests that nurses have improved job satisfaction when staffing levels remain high enough for reasonable time to be spent with their patients (Landsbergis et al 1999); job control is not limited, otherwise high physiological stress can result (Edwards and Harrison 1999); and upper management and medical staff are strong enough to implement changes.

There is some evidence that hospitals are returning to previous structures where divisions have disappeared, there are no sub-structures and the nurse executive is responsible for all nursing activity. In the UK the role of 'modern matron' was 'reconstituted' in 2001 under the Government's NHS Plan to provide strong clinical leadership at the ward level. This position has the authority and organisational support to resolve clinical issues and ensure that the standards of care are met if not exceeded (United Kingdom Department of Health 2001). Evaluation has indicated that these new matrons have a positive impact on improving standards of nursing care, the environment, skill mix and staff retention, encouraging staff development and reducing the number of formal complaints from patients (Scott et al 2005); and the potential to make a positive contribution to patient safety (Keeley et al 2005).

CONCLUSION

This paper has questioned the reliance on industrial and business oriented approaches to restructuring in health care and the effects these models have on nursing. It is evident that more research needs to take place before any claims about the cost and benefit of one restructuring approach being significantly better than another can be evaluated at face value. Evaluation of structural reform will always be problematic in hospitals due to the inability to judge outcomes in a timely fashion but one measure of success is the impact on people working within the system. The health care environment is highly dependent on its clinicians' knowledge and expertise. Downsizing and re-engineering, while sometimes inevitable, needs to be carefully considered in terms of their potentially negative impact on nursing and patient outcomes.

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