Nurse Executives: Internal and External Influences in the Management of small Rural Hospitals

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Internal and external influences on the Nurse Executive in the management of small rural hospitals.

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Abstract

Small rural hospitals play a pivotal role in serving communities that would otherwise lack acute and community services. There is little research however into the internal and external influences on the nurse executive in the management of rural hospitals and in the provision of health service delivery. ***Aim/Objective:*** The aim of this study is directed towards developing an understanding of the internal and external influences on the nurse executive in the management of small rural hospitals. The objective of the analysis is to better inform the health service research agenda of the realities of managing a small rural hospital. ***Methods:*** Using a two staged approach this paper draws on a questionnaire in the first stage, and semi structured interviews with respondents in stage two. There were 11 eligible survey participants within a convenience sample of one area health service. Using a mail out questionnaire both demographic and qualitative data was sourced, to which 10 nurse executives responded. Responses to the Questionnaires were themed and ranked by frequency of response. The themes formed the conceptual framework for the 10 follow up interviews. ***Results:*** Themes from the content analysis of the interviews were grouped into 3 categories: external influences (community, Department of Health/influential bodies, general practitioners), internal influences - organisational (financial management, information technology, resources and support), internal influences - nursing (recognition and value, education, leadership, recruitment and retention). ***Conclusions:*** The study provides an understanding of influences from which nursing executives of small rural hospitals face distinctive challenges both operationally and professionally. The role is not simply one of health service delivery in a rural setting but rather a complex web of imperatives and relationships in balancing the profession with organisational goals and short-term performance. ***Implications:*** The study may

greatly benefit future research in examining the effects of the diversity of influences in formation of nursing workforce strategy and strategy development for rural health service delivery. Additionally, material derived from this study gives some indication of what should be incorporated into any framework for learning about rural health management.

Introduction

In response to rapid and sweeping changes in health care technology and resource scarcity, and as a means to improve quality and lower costs, health care industries across the nation have been restructuring, downsizing and streamlining.[1.2.3] Throughout this process, health services have moved to reduce nurse leadership roles, which has resulted in the demise of the key mechanism for connecting the hospitals mission with bedside nursing care.[2.3] This has impacted strongly on the practice and working environments of many nurses.[1.4]

Health professionals are being encouraged to turn to research to both inform and justify their service delivery. In these times of reorganisation and uncertainty it is timely to examine the effects of recent changes on the nursing executive of small rural hospitals.

Background

There have been vast changes in response to external forces, and internally health care has sought to increase efficiency, decrease waste and duplication, and reshape care delivery.[1.3]

In a common trend towards centralisation of governance at state health authority level, the New South Wales (NSW) public health services amalgamated and restructured into 8 ‘super regions’ in 2005.[5] The amalgamation saw stronger accountability measures, with greater emphasis placed on goals such as performance and efficiency, increased outputs for decreased inputs, quality assurance and financial accountability[6.7.8] – the ‘key drivers’ of health service delivery.[2]

The rise of managerialism in health care and the introduction of economic principles is indicative of the ‘market forces’ ideology in health care.[3.4.9] It is argued

however that this ideology is more than just cost containment, and that it changes the underlying principles of the health system, positioning health care as a 'commodity' and care recipients as consumers.[3] Additionally it is suggested that the changes brought about by a market model have often been inappropriate for the rural and remote area.[8]

It is presented throughout the literature that the amalgamation and reforms over recent years have posed a serious threat to the nursing profession.[3] The rise of managerialism has seen a demise of nursing career structures and the implementation of organisational structures which has left nursing managed and controlled outside of the profession.[1.4] Executive nursing management positions have been eliminated and front-line nurse manager positions cut.[1.2.3.4] Media reports and documented accounts of redundancies, resignations and redeployment of nurse managers and senior nurses around the State[10.11.12] has resulted in a perception among many nurses and aspiring nurse managers that they are not valued for their contribution to their organisation and the public health services.[1.10.11.12]

Studies of nursing turnover identify the importance of value and recognition, and also highlight the necessity for continuing education in empowering the nursing profession[13] and in reducing nurse attrition.[13.14] With the lack of recognition of the skills required to practice as a rural nurse, by employers; the profession; other professions and the community; nurses are dissuaded from seeking employment and staying in rural areas.[14.15] Additionally, much of the current literature centres on nursing career paths, the absence of career paths and perceived support or value, and their links to recruitment and retention.[16.17]

The relationship between nursing and patient outcomes has also continued to emerge within the literature,[1.3.4.5.6.10.18.19.20.21.22] with studies showing a link between nursing management and leadership as being critical for building the infrastructure to enhance the professional practice environment.[19] The literature also shows that nurse empowerment is critical to organisational effectiveness[20] and to the success of hospitals and health services.[3]

Against this background there is little research into the effects of the changing health care industry on the nurse executive in a small rural hospital. This study is therefore an essential element in developing knowledge and in providing evidence as

to the role of the nursing executive in the rural health setting. It is directed towards understanding the internal and external mechanisms that influence and impact on the nurse executive in their management of small rural hospitals.

Methods

- Procedure

Permission to undertake the study was obtained from the relevant Area Health Service Executive Director of Nursing and Midwifery. Ethics approval for the project was obtained from the applicable Area Health Service Ethics Committee.

- Sample and sampling design

Participants and Setting: A purposive sample was drawn from the one rural Area Health Service in NSW where participants were employed as nurse executives of small rural hospitals and Multi Purpose Services (MPSs). Participants were invited to partake in the project, and were informed of the aims of the study via a participant information sheet.

For the purpose of this study, rural hospitals by definition include all hospitals and MPSs within the Area Health Service that have fewer than 50 beds. Most provide access to emergency services, and general medical services. Some also perform general surgery (mostly day surgical), have low risk obstetrics and low risk paediatrics. Most provide aged care services for the frail aged, rehabilitation services or a degree of transitional care. All hospitals are supported to varying degrees by local General Practitioners (GPs) with weekend services covered by locums or GPs on call. All sites accommodate a range of primary care services for the local community however not all respondents were directly responsible for the management of those services.

- Data Collection

Data collection was undertaken as a two stage process. A questionnaire was conducted as the first stage, and a semi-structured interview was undertaken with respondents of the questionnaire as the second stage. These two methods were deemed the most appropriate for eliciting broad themes and patterns for the development of a theoretical framework.

- The Questionnaire

A structured questionnaire was developed and pre-tested on two former nurse executives of a small rural hospital. The participants were asked to examine all questions for relevance, content validity and potential for bias. This resulted in a slight modification, after which the revised questionnaire was mailed to all participants. The pilot responses were not included in the study.

The questionnaire contained two sections (refer Appendix 1). The first section elicited nominal and ordinal data concerning participant's demographic information and work history. The second section of the questionnaire asked open–ended exploratory questions relevant to the work and role of the nurse executive and their profession. Questions focussed on functions of the role in a typical day, challenges, barriers in providing safe quality care and, influential relationships. Participants were also asked to suggest abilities that their successor should posses and what they considered the greatest issues facing nursing in rural hospitals. Provision was made for additional comment.

After three weeks the non respondents were called to determine if they had received their questionnaire, and if not, whether they required a second copy. In total there were 10 out of the possible 11 nurse executives who completed and returned the questionnaires, each of which was used in this research.

To ensure the anonymity of the participants, codes were generated whereby individual participants could not be linked to responses. Qualitative data was coded using an inductive approach and thematically analysed so as to identify prominent themes and general concepts that arose from the questionnaires. These themes were adopted as the conceptual framework for the second stage of this study, the interviews.

- The Interviews

Each respondent to the questionnaire was interviewed. The interview process was explained to the participants, informing them of anonymity, confidentiality, and their rights as a participant, as explained in the Participant Information Sheet (refer Appendix 2). Written consent was obtained from all participants prior to the commencement of taping the face to face interviews. A digital recorder was used to record the hour long interviews, and field notes were taken. The recorded interviews

were transcribed into a text document. Two participants were interviewed over the telephone, with information recorded via in depth note taking.

The interview content reflected themes that were developed upon analysis of questionnaire responses. Open ended and non-directive questions were posed, with themes further explored. Although questions differed to reflect interviewee responses, there were three specific questions asked of all interviewees.

- How do you balance professional standards of quality care against more efficient use of resources?
- Why do you stay if you are not feeling valued in the workplace?
- Can you envision a non-nurse in the executive role?

A content analysis of the transcribed text documents was conducted using a coding system which reduced the responses into three major categories. The coding scheme was supplemented by emergent codes as analysis proceeded. A test-retest check on coding reliability was conducted near completion of the analytic process using a random sample of three transcripts. These major categories reflect the primary internal and external influences on nursing executives in the management of the small rural hospital.

Results and discussion sections combine the findings from the questionnaire and the interviews.

Results

Demographics

An important feature pertaining to the hospitals within this current study is that they all differed in physical structure and capacity. There is substantial variation in service provision between hospital site due to historical factors, physical structure, and distance from the nearest base hospital. Some of the participants managed more than one hospital. The bed occupancy rate of the hospitals ranged from 69% to greater than 86%.

All respondents in this study are Registered Nurses. There was a near equal ratio of females to males. Respondents indicated that their major roles and responsibilities

encompassed financial and human resource management, operational/executive management, clinical management, professional development of staff, quality assurance and leadership. Most respondents worked greater than a forty hour week with a few indicating that their average work week is between 50-55 hours. All of the respondents had worked within the nursing profession for greater than 20 years. The tenure in their current position ranged from two years to greater than ten years with a median of five years. Nearly all held tertiary level qualifications with half of the respondents having a Masters qualification.

Influences

Themes from the content analysis of the interviews were grouped into three categories: external influences (community, Department of Health / influential bodies, general practitioners), internal influences - organisational (financial management, information technology, resources and support), internal influences - nursing (recognition and value, education, leadership, recruitment and retention).

External Influences

1. Community

The community was found to be a major influence on the nurse executive. Although many of the interviewees lived outside of the geographic area of the hospital they managed, they regarded the community as a key stakeholder, seeking to work with them in a proactive and collaborative approach. As one interviewee relayed "the community is the essence of small hospitals – their support and the funds raised are the only way small hospitals survive".

All but a couple of interviewees discussed the historical importance of the hospital to the community, not just in health service delivery but in economic terms and the effects of recent changes. Many commented that the implementation of shared corporate services has impacted communities at a local level stating "this impact can't be underestimated - previously the small rural hospital was an important corporate citizen in most communities….the hospital use to be a major employer and purchaser of goods and services in town thereby contributing to the economic viability of the town".

Concern was expressed by most interviewees regarding the recent changes to a State driven shared corporate services model. They elaborated by stating that this change, plus the fact that some rural communities were being adversely affected by other factors, such as the drought and economic downturn, had compromised community participation and “their much relied upon fund raising activities”.

A few interviewees suggested that local communities had been marginalised, and that the link with the community had been diluted as a result of the abolition of local boards some years back. One of the interviewees had set up a local community consultation group to link the hospital and the community, and to act as a conduit in strengthening local relationships.

Only a couple of interviewees indicated that they did not “feel connected to the community”. One interviewee advised that “the community does not know how much work is involved at the local level to keep services going”. Others made comment that “community expectation can at times be unrealistic”. Most interviewees saw themselves as the interface between community and hospital/health services. Many stated that they are involved in fostering community participation and promoting a sense of ownership of the local health service. Most place great effort in supporting fund raising activities which they see as integral to the local hospital.

The majority of interviewees indicated that they market the hospital through positive stories in the local newspapers, through attendance at various service functions, local council meetings, and through participation in local fund raising events. Most stated that this led to a strengthening of network ties, and in this way the “local community supports the hospital”.

2. Department of Health/Influential Bodies

Department of Health (DOH) Policy Directives and Legislation is viewed by most interviewees as being a major impact on the role of the nurse executive. They discussed interpretation of the principles of policy directives and legislation as “time consuming”. Most indicated that it isn’t just the time taken to read the documents but “making the time in the first instance”, “deciphering what does and doesn’t comply” and “having the knowledge to interpret whether a multitude of standards are met”. A

couple of interviewees gave the example of the legislative requirements related to operating theatres, and standards for sterilisation of equipment. Obstacles in applying the principles were outlined, such as difficulty in predicting or interpreting the legislation, and subsequent controls.

Significantly, some interviewees outlined the issues that arose at the local site when DOH initiatives were introduced without prior consultation with the general practitioners. They stated that often the initiatives were "metrocentric" and the ability of the nurse executive or nursing staff to implement or enforce such initiatives when there is "no or little buy-in" by the general practitioner is challenging and often futile.

The capacity of interviewees to deal with the speed and volume of changes, the directives, and observance of standards at their sites, new programs and systems was raised. A point noted by all interviewees is that in general they are "it" at small rural sites and "additional support would be beneficial when it came to addressing and planning for the concurrent health care changes and expectations".

Most interviewees discussed other influential bodies such as the Australian Council for Safety and Quality in Health Care and the Australian Council on Healthcare Standards, with their respective requirements and criterion, as "being a major impact on their role". Numerical Profile was also raised, with most interviewees indicating that achieving accreditation and numerical profile is a significant workload for their individual sites.

3. General Practitioners (GPs)

All interviewees identified that a key influence and aspect of the work environment was the nature of professional relationships with the visiting general practitioners. Interviewees emphasised the importance of general practitioner engagement with a couple stating "not only do they influence clinical practice, but also culture".

The general opinion is that physician support varies based on physician attitude. Nearly all interviewees indicated that some of the general practitioners will become involved with area and local initiatives if they can see the "value in it", or "if it is in their interest". Physician resistance to initiatives was stated as "not

uncommon". One interviewee indicated that "they try to get a physician 'champion' in order to get the process started and other physicians involved, resulting in some of the general practitioners being involved in clinical audit and morbidity and mortality reviews".

A point noted by a few interviewees was that "general practitioners are employees of the Commonwealth Government and as such are not directly employed through the State/Area Health Service or the hospital. Consequently, it is difficult to effect and implement State directives, hospital protocols/procedures and area policies".

Interviewees explained that medical governance is off site, and for the majority, Director of Medical Services support is limited. Several interviewees indicated that challenging practice and practice patterns was difficult, with a couple of interviewees indicating "they relied on evidence based information if there was a requirement to challenge 'unsafe' practice". Nearly all interviewees indicated "they make an effort to maintain harmonious working relationships with the general practitioners". Most stated that "whilst they promote compliance with initiatives such as the *National Inpatient Medication Chart*, or *Ensuring Correct Patient, Correct Site, Correct Procedure* protocols are implemented, there is only 'so much' they can do".

Many of the interviewees have initiated hospital medical staff councils in order to promote positive collegial relationships, improve communication flow, and discuss clinical issues. For some, relationships had been built up over many years with "a lot of hard work". Most participants commented that "rapport was possible with the local medical staff through building up trust, and due to the clinical background of the nurse executive and the commonalties around 'jargon', an understanding of what happens at the bedside, and of clinical conditions and treatments".

A couple of significant influences as highlighted by many of the interviewees include the decline in physician numbers and the fact that many physicians "do not want to carry out on-call anymore". There was a difference between the interviewees in how they are being influenced by the decline in physician availability, and how the shortage is being addressed. Some stated that they spend a large amount of time and

effort in recruiting locums and "enticing" physicians to the hospital. A couple of interviewees discussed alternative models when unable to obtain a physician, with the nurse practitioner becoming integral to the ongoing provision of services.

One of the interviewees summed up the influence of the general practitioner by saying "the scales are lopsided, as the Area Health Service needs general practitioners, but general practitioners don't necessarily need the health service".

Internal Influences - Organisational

1. Financial Management

All of the interviewees expressed varying levels of frustration in relation to financial imperatives and budget allocations. They spoke candidly about what they deemed to be a lack of "real world understanding by the corporate sector". Many interviewees commented that as the corporatisation of health care has escalated, strategy measures that were imposed externally were in many instances unrealistic. Significantly, a couple of interviewees noted "if strategies and goals were more realistic they would have a 'better go' of working towards achievement". Most interviewees acknowledged the importance of savings efficiencies but expressed targets and benchmarks in most instances had not been "adjusted /set appropriately for differences in hospital type".

Many interviewees commented on reporting requirements in relation to finance, stating "the expectations are too high, and timeframes unrealistic". There were many references by the interviewees to "cost containment" as being the major driver of health services. One interviewee stated that there is a "lack of reality, regarding savings strategies" and that "the circle of influence of a nurse executive on a day to day basis in relation to the amount of influence on resource utilisation can be very difficult". Others stated "there are too many outside factors beyond our control".

A question was asked of all participants as to how they balanced professional standards of quality of care against more efficient use of resources. Many noted that they have introduced new models of care, changed skill mix, reduced wastage where possible, and monitored use of resources on a daily basis. Most interviewees for example discussed the monitoring of sick leave, however they indicated that "in the

smaller sites it takes just one member of staff that has a serious illness to be on long term sick leave to reflect poorly against sick leave targets". One interviewee suggested "rather than talk cost cutting, let's work together in promotional activities that will reduce costs as a spin off, for example, an area promotional program to reduce electricity use".

Many interviewees emphasised that maintaining their professional standards of care to the patient was of paramount importance and "patient care would not be compromised in their decision making". All the interviewees expressed their commitment to the organisation in working towards cost containment and savings efficiencies, but they all emphasised "the need to put the patient at the centre of their decision making".

2. Information Technology (IT)

The rapid growth of information and technology systems within the Area Health Service was raised by all interviewees as a key influence. The benefits of new information systems were acknowledged, however capacity to use the available technology and the accuracy of much of the data was raised as a concern. Many interviewees expressed that increased computerisation of information and quick information transfer via e-mail has resulted in numerous requests with short turn around timeframes. One interviewee summed up by saying "they were becoming 'slaves' to IT systems".

Interviewees explained "with the lack of 'depth' of staff, it is difficult to respond to all the competing demands that IT systems have generated". A number of interviewees identified that their staff are not computer literate, whilst other interviewees questioned the appropriateness of the data for small hospitals, with an example given of volume measures. Nearly all interviewees raised the workload implications of an electronic rostering system stating "nursing staff have being given the function of inputting award codes and allowance codes – payroll duties".

3. Resources and Support

Resources and support - how much, how little and what type was raised by every interviewee as a key influence in the management of their hospitals. The

majority of interviewees identified that the most recent State Health amalgamation/restructure has led to a reduction in human resource support, business management support and has created an increase in workload. For example, an interviewee stated “clinical hours have to support the infrastructure – and they are now using clinical hours to fulfil clerical roles”. One interviewee stated “the support has gone, but the work hasn’t – it has come down to the nurse executive”. Another stated “with the administrative support centralised – the workload still flows down to the coal face”.

A few interviewees identified that the influence of the amalgamation and the formation of networks was to give more back to clinical at the bedside. It was stated however that “what has actually happened is all support services have been shrinking for example, human resources - with clinicians undertaking administrative work”.

Improved access to support services such as human resources was identified as crucial by most interviewees, with an example given of time spent resolving staff issues and the lack of consistent resource to facilitate problem resolution. Business management support was also identified by many as “lacking”.

The level of support given by the local geographical Network was seen as important to most interviewees. Some indicated that service development between/within their relevant Network has occurred to a degree whereby they felt supported. Others stated that their Network did not deliver services to the small rural hospitals. Examples were given of little support in relation to competency assessment such as occupational health and safety, and manual handling, and nil sharing of resources such as educators, and limited Director of Medical Services support.

A few interviewees stated “their Network was not a cohesive team” and “their opinion was not sought”. This was not the experience of all interviewees, with a few having the view that the Network structure “is helpful for the small sites and there is some sharing of resources across Networks”. The lack of support from ‘area management’ was also raised, but interestingly one interviewee said “area support at times can create more work”.

All of the interviewees identified that their main support is predominantly internal, with support from “nurse managers, nurse unit managers and the goodwill of

the nurses off the floor". Internal administration support where available was also acknowledged. Interviewees discussed that "very few staff wear many hats" and "sometimes getting work done is difficult". All indicated "there is a lack of depth" to call upon in their hospitals, stating "larger hospitals have a better infrastructure with more expert senior teams". Others commented "just because you are a nurse executive of a small site does not mean the workload is any different to that of larger sites".

Internal Influences - Nursing

1. Recognition and Value

All of the interviewees discussed recognition and value as being extremely important. Workplace communication was significant in whether recognition/value was perceived.

Responses were recorded regarding the interviewees perceptions of the value placed upon their work by the organisation. Most of the interviewees expressed that they did not believe they are valued by the organisation for what they do, and the contribution they make to health service delivery. In general they perceived their skills and experience as unrewarded. When asked directly do they feel valued, many indicated that their opinion did not seem to count, and whilst all considered they had a degree of autonomy in their role, most considered that they could not act accordingly because of unfavourable environmental factors.

Most interviewees discussed that their work was not rated highly with five interviewees indicating the perception of many within the organisation is "small hospital/small workload" with minimal understanding of the complexities. Unlike the larger sites it was identified by most interviewees that they do not have an executive team and therefore they are responsible for committee development, community consultation, site management, and facilitation of medical staff councils – "everything".

Upon probing as to what would make interviewees feel valued similar responses were given. For example, they would like to see more support "come from above" in relation to larger issues, and "work at solving issues together". The level of delegation was identified as "extremely frustrating", with one interviewee stating

"restrictive delegations compromised their ability to have a voice in strategic planning". Some of the other interviewees identified that they felt "delegations was seen as the worth of their value". Most interviewees stated "they didn't expect too much - return of phone calls or responses to e-mails" to make them feel valued. Yet another interviewee indicated "it takes time to write submissions and briefs that detail things that could be beneficial to the workplace and often there is nil response, or little support for endeavours – some acknowledgement would help in demonstrating that we are valued".

Some of the interviewees indicated that they wanted to be more involved in strategic planning, to be asked "their opinion on things", asked "what they think" – and stated that whilst "they were seen as managing small sites most had years of experience in health, were knowledgeable and capable, and had a lot to offer".

The interviewer further explored the issue of value and asked all of the interviewees "why they stay if they are not feeling valued in the workplace?" There was a large degree of similarity with most indicating that they stayed due to "their commitment to patient care and the community". Most stated that they received positive feedback from the community and "felt they made a valuable difference". A few interviewees discussed a "sense of team, seeing the difference they make to community, staff and patients, and a feeling of personal satisfaction and achievement". One interviewee explained "they loved the variety and challenge of the position" with another commenting "they went into the nursing profession because they wanted to care for people and contribute to the community". Most stated "they could not imagine working outside of health".

2. Education

The importance of education, up-skilling and competency for rural nurses was emphasised by all interviewees with concurrence that the professional development of nurses is critical to ensuring safe nursing practice. Many interviewees stated that education support was "the biggest thing" for ensuring safe quality care. Insufficient clinical experience was deemed a huge risk to the delivery of safe services within participant hospitals, with interviewees identifying that nurses have less support and back up than the larger hospitals.

One of the interviewees stated “until becoming a nurse executive of a small hospital I did not appreciate or understand the complexity of the role of the nurse or doctor at the small site”. It was explained that “they ‘stand alone’ and therefore they are, and need to be more skilled, and more advanced than their large hospital counterparts”. The view of the majority of interviewees was that they work with physicians who provide high quality care and nurses who are clinically competent.

All interviewees stated that they encouraged the professional development of staff, and whilst release for education was supported, lack of suitable staff to backfill, and funding imperatives created barriers. Competency issues arose with interviewees indicating that it is very difficult to maintain competently trained staff. Most interviewees were particularly concerned regarding competencies required for effective rural nursing into the future.

Interviewees identified that education plans had been established for their staff and competencies were often assessed by area clinical nurse consultants. Two interviewees had developed a reciprocal placement program for staff to spend time and gain experience in large facilities, however had found it difficult to progress, and success was limited.

3. Leadership

Interviewees displayed a high degree of similarity regarding comments on leadership, and all identified leadership as a significant influence in hospital management and service delivery. Most interviewees identified leadership as the means for fostering a positive approach to the work place and a key quality for any successor.

One interviewee identified “leadership as integral to successful change, and in exploring and implementing different services or models of care”. A few interviewees discussed leadership in “linking quality improvement to strategic direction, and facility strategy to organisational strategy”. Others discussed that nursing leadership is pivotal to recruitment and retention of staff.

Leadership was given many qualities by the interviewees such as making staff feel valued, delegation of responsibility, working as part of a team with a common

vision, good communication skills, good management skills, resilience and commitment. Facilitation of team work as distinct from working as part of a team was also raised as an important aspect of leadership. When asked how they demonstrate leadership, interviewees described motivating staff, being visible, role modelling, acknowledging staff and giving constructive feedback. Some identified having a vision, developing a cohesive culture, and stating and supporting the direction of the Area Health Service.

All interviewees were asked a similar question around the leadership of their hospital and whether they could envision a non-nurse in the executive role. Responses were comparable with the majority commenting that a non nurse would not be able to carry out many of the functions within the position that they currently undertake. Some of the interviewees for example stated they were actively involved in addressing clinical issues, clinical audits, clinical reviews, identifying gaps in care, and would undertake patient rounds on occasions. Other interviewees advised that the 'GP' regularly drew on their clinical experience and there was a trust and respect in relation to clinical knowledge, and this trust would not be present if a non-nurse held the executive position. A few stated that they can draw on their clinical experience and judgement in assessing appropriate length of stay, patient transfer, and review of skill mix in time of shortages. This was similar to other interviewee responses that highlighted the importance of understanding clinical implications and clinical risk. Others advised that they 'take on' the role of pharmacist, one or two days per week in dispensing medication, and give clinical 'hands on' support in times of staff shortages and in clinical emergency situations.

Some of the interviewees commented that sites would require another layer of management if the nurse executive position was to become a non-nurse executive position due to the lack of depth of nursing resource and the requirement for clinical leadership and guidance. Another interviewee indicated "a second layer of management would only work if the relationship was of equal standing, for example, administrator and nurse manager", but added "it would be difficult".

One interviewee responded in the following words "facilities need leaders with clinical knowledge so as to maintain clinical standards, integration and strong relationships between medical, nursing and allied health staff, environmental decisions around clinical equipment purchases, and a working knowledge of clinical

standards". The interviewee further commented "construct is important in the delivery of holistic and diverse services. Nursing has the knowledge to know what is safe and acceptable and not acceptable in managing a small hospital".

4. Recruitment

The challenge of successfully recruiting nurses, allied health staff and medical officers to rural practice settings was raised by all interviewees. For some, the ongoing provision of services, such as maternity services, was identified as particularly difficult with many highlighting shortages in the midwifery workforce.

The interviewees identified recruitment and retention as a major influence on how they provide services, will continue to maintain and provide services, and for future planning. One interviewee in particular discussed the issue of recruitment and retention and the fact that the future will be about "providing models of care that fit the workforce, not a workforce that fits the models of care".

Many discussed the biggest impact on recruitment and retention as being workplace culture, which they believed affected recruitment and retention, stability of workforce and the overall working environment. They discussed that a positive culture was necessary in the facilitation of "buy-in from clinicians in quality improvement activities, and in achieving efficiencies such as a reduction in sick leave and turnover of staff".

The aging workforce was raised on numerous occasions by most interviewees. Some indentifying their staff have "done their time and just want to do a good job and go home – they do not want to wear many hats". One interviewee stated that the issue is not about the aging workforce but the "challenge is modelling care to what our workforce will be, and the shift of resources to the community". The interviewee stated that "models of care will be the biggest challenge". The decline of the generalist nurse was also raised by most interviewees. Some of the interviewees discussed that there are quite a few hospitals within reasonably close proximity, and therefore staff shortages are exacerbated as hospitals compete for the same pool of staff.

Many interviewees advised that in times of nursing or pharmacy staff shortages they undertake “hands on clinical”, that is, ‘step in’ for a day or a few hours and do a clinical operational role whilst still overseeing the hospital as the nurse executive. Most indicated that their services are experiencing recruitment difficulties of appropriate skilled registered nurses and allied health staff such as social workers, physiotherapists and pharmacists.

Discussion

This research is exploratory in nature, and provides a foundation for beginning to understand the experience of the complexity of managing small rural hospitals. It has provided a profile of the operational and professional needs of the nurse executive in small rural hospitals, which in this climate of change is imperative. Additionally it highlights potential sources of learning for future consideration relative to the changing demands on the nurse executive role.

Nursing influences that impact upon the management of small rural hospitals included leadership, recruitment and retention, education, value and recognition. These factors have been considered in various studies as elements that are relevant to the future of the nursing profession.[16]

Of significance within this study is that many comments were made by the nurse executives in regard to the perception of the value placed on their positions. The majority perceived that their opinion and the work they undertook was not valued by management. Whilst, morale issues were not mentioned in the discussion of value and recognition, research is plentiful in relation to amalgamations and restructures[1.10.11.12] and the interrelatedness of value and recognition of nurses, the effects on morale, recruitment, retention and productivity.

Part of the problem of keeping nurses is the “lingering perception of many that their role in health care remains undervalued”. [2] Work undertaken by the Harvard Nursing Research Institute indicates that without recognition of the value of nursing from within the profession, other professions, management and government, the capacity to attract young people to the profession and retain those nurses currently practising is limited.[17] With the aging workforce, particularly within the rural areas,

there is an urgent need to recruit and retain younger and more skilled nursing staff to ensure the viability of rural hospitals.[14]

The discussion of value and recognition, and potential impacts on recruitment and retention is significant in the context of the study results. The merit in focussing on improving communication feedback loops, appropriate delegations to the level of responsibility and accountability, and the engagement of the nurse executive in strategy formation should not be underestimated.

It was presented by the nurse executives that nurses who practice in rural environments are by necessity required to have a broad range of well developed generalist skills, underpinned by a sound knowledge base. Support for ongoing education for their staff and in creating a learning environment that ensured safe care to their patient's was unanimous.

Education is interrelated to value and recognition and recruitment and retention, and is paramount for professional development and the key to empowering the nursing profession.[13.14] Demands of the changing health environment make ongoing professional education necessary for practice as well as professional accountability. Barriers which may lead to attrition were highlighted within the study, which potentially could compromise the capacity of the rural hospitals to continue to provide nursing services. These barriers to education must be minimised. They need to be further explored not only in the context of patient care but also recruitment and retention within the rural setting.

Most nurse executives discussed a range of key qualities and experiences that were required in order to fulfil their position. Responses around leadership were of particular relevance as rural areas, possibly more than anywhere else, need good leadership that engages employees, key community leaders and other stakeholders.[8] In order to implement change, hospitals need to have skilled staff and dynamic leaders. Without effective leaders an organisation is limited in its ability to improve quality of patient care and reduce costs. Nurse executive leadership in fostering a positive work environment is critical for influencing employee commitment to the organisation and in building an infrastructure to ensure quality of care.[19]

There is evidence from this study that small hospitals are particularly reliant on key individuals, most notably the nurse executive. The nurse executives identified that they generally do not have depth of structure underneath them capable of delegating decision making or higher level problem solving. Strategies to foster the development of leadership such as clinical leadership and mentoring programs, and management development programs provide an opportunity to foster incremental positive change for the individual and the organisation.

Based on the findings of the literature[2.4] there were few surprises in responses from nurse executives regarding internal organisational influences, financial management, information technology, resources and support. The nurse executives in this study were unanimous in that financial imperatives are a major influence in the management of hospital services. Greater emphasis has been placed on goals such as performance and efficiency, increased outputs for decreased inputs, quality assurance and financial accountability.[6.7] Lack of involvement of the nurse executives in determining suitable targets for their sites results in limited power to influence achievement. For example, targets such as volume measures are viewed as inappropriate for many rural hospitals, as small fluctuations in volume are likely to result in large differences in volume based performance measures.[18] This type of health care market approach is reported as having limited success in terms of retaining nurses or improving patient outcomes.[2]

The informatics industry explosion has forced an increasing reliance on computer systems and programs within health services. IT systems are being designed to reduce inefficiency, enhance patient safety and facilitate instant access to test results. It should be recognised however that these systems are being introduced to staff that are facing great work place changes, and with many lacking in organised computer skills. How to convert to a computerised workplace, where there is a lack of 'human resource capacity' is challenging. Additionally, the dilemma of making sure systems that are introduced can be accessed in a timely manner, are 'user friendly' and have valid and accurate data also presents as a challenge for both the organisation and the nursing executive.

The delivery of acute care in small rural communities with shrinking hospital resources such as human resource support and other reduced support systems, whereby nurses are increasingly undertaking administrative work, was one of the

main discussion points raised by the nurse executives. The devolution of administrative work to nurse managers and nurses within the public health system has been an increasing trend over recent years.[1] The lack of say on these matters is demoralising[20] and results in nurses feeling disenfranchised - neither valued or feeling valued in the systems in which they work. Unless addressed, this trend will significantly impact on both recruitment and retention of nurses.

The Network structures were influential in how support was perceived. To manage small hospitals in constrained circumstances requires support, not only by key individuals on site but also from area management and the network structures. It is argued that adequate support and resources encourages commitment in accomplishing organisation goals[21] and the Network support approach could be viewed as one strategy to provide effective support within a geographical area. Additionally, the strategy is meant to facilitate a sharing of resources where hospitals co-operate rather than compete with each other. To date however there has been limited to no evaluation of the effectiveness of the Network structures across the State, nor of their contribution to the health practice environment.

The main external influences on the role of the nurse executive relate to the local community, general practitioners and DOH legislative/influential bodies. Complying with policy directives, legislative requirements and accreditation criteria with few resources was identified as a major workload influence on the nurse executive in their management. It is imperative for the regulatory bodies, accrediting bodies and the organisation to understand that compliance with some of the criteria is unrealistic and difficult from a practical standpoint. Small rural hospitals generally are not at the forefront of these policy initiatives and criteria, and therefore not enough attention has focussed on these concerns and the practicalities of the requirements.

The nurse executives discussed DOH led initiatives and Area Health Service innovations as being particularly difficult to implement in their hospitals, where input by the general practitioner/physician is required. The interrelationship of the nurse executive, general practitioner and success of such initiatives is rarely noted in the literature. As the results indicate the most sophisticated information systems and accountability structures can be in place to support and promote initiatives, but unless there is strong buy-in from the medical staff and medical leadership the chances of management initiatives succeeding are slim.[18] The issue of medical buy-in and lack of

medical leadership is further identified as a concern given physicians are largely outside the direct control of hospital management.

Whilst nurse executives promoted positive collegial relationships, this research suggests that more emphasis needs to be placed on the physician as a facilitator or medical leader in support of changes. Until this occurs the effectiveness of initiatives will be reduced, and cost management by nurse executives will continue to be an exercise whereby they internally work around external influences.

Community was emphasised within the themes as being a significant influence, yet the consequences of the restructure and the introduction of shared corporate service model on the community has received little acknowledgement within the literature. Most of the nurse executives in this study have focussed on the development of relationships to support, sustain, and maintain community links. Many have placed themselves in a position where they are known to the community. This is a benefit in terms of fostering strong linkages and creating funding opportunities between the hospital and the community. Gaining the trust of the community and managing change in situations where community expectations differ, for example, where services are unsustainable, is paramount to the work of the nurse executive of the small rural hospital.[8] Larger hospitals have an executive team to share the load and help look after the community interface.

Strengths and Limitations

The strength of this study comes from the richness of the descriptive data derived from the in-depth interviews with the nurse executives. Discussion of the findings is with the acknowledgement of a number of study limitations. Firstly, the researcher is from the Area Health Service in which the study was conducted and has had previous and existing work relationships with some of the participants in the study. This could also be deemed as a strength in ease of rapport for interviews. The working relationships are not, and have not been of unequal balance of power, that is employee and manager. Secondly, the researcher has a background in nursing and business management and has worked in hospital management and on the executive of an Area Health Service. Again the researcher's history in health services could also be viewed as a strength. Thirdly, the study focuses on one Area Health Service within

NSW and it should therefore be emphasised that the samples used in this study are not necessarily representative of all nurse executives in rural NSW.

The researcher has endeavoured to reduce bias, and to eliminate potential weaknesses through method triangulation, pre-testing the questionnaire with two former nurse executives of a small rural hospital, and a test-retest check on coding reliability using a random sample of three transcripts. The researcher is therefore able to declare the research and the researcher's employment background, and any bias, to be minimal.

Conclusion

Some of the influences and challenges faced by the nurse executive of the small rural hospital are faced by all health service managers.[8] Dealing with structural changes, ongoing pressures on organisational efficiency and effectiveness, and implementing new models of care is not uncommon. This research however has presented distinctive influences and specific challenges that nurse executives of small rural hospitals face.

The perceived lack of professional recognition of the work of the nurse executive, and the findings that nurse executives within this study did not feel valued by the systems within which they work cannot be underestimated. It is suggested by the researcher that the perceptions could be reflective of fundamental differences that exist between corporate and professional modes of work within a hospital/health service. Further it is suggested that these perceptions are not necessarily confined to this group of nursing executives as there is much in the literature suggesting that the 'feeling' of devaluation by nurses is widespread. Nevertheless when there is already a nursing workforce shortage nationwide the impact on the future of nursing is profound. The implications for recruitment and retention and the subsequent long term future of the small rural hospitals and rural health services cannot be underrated.

This study also provides evidence that rural hospital nurse executives with their ability to interface with the community and physicians are a group whose perceptions and opinions need to be continually acknowledged and incorporated into organisational planning initiatives. Without nursing executive input at a strategic

level a significant component of local population health knowledge is missing from health care planning.

In summary, the findings demonstrate the importance of understanding the construct of the small rural hospital, the resources and support required, and the influences on the nurse executive, managing in a complex web of imperatives and relationships. It highlights that the small rural hospital is highly dependent on the expertise, clinical knowledge and leadership capability of the nurse executive. Additionally, it emphases the challenges that are involved with balancing profession with organisational goals and short-term performance. Significantly, the fact that those in the study look for new ways of doing things to achieve efficiencies, yet do not take their eyes off the delivery of safe quality care for their patients and community, demonstrates that their underlying professional nursing ethos remains - regardless of considerable internal and external influences.

Recommendations

The purpose of this study was not to produce solutions or recommendations for the myriad of challenges that are faced by the nurse executive in the management of rural hospitals. Instead the aim of this study was to raise an understanding of the internal and external influences on the nurse executives in the management of small rural hospitals, and to better inform the health service research agenda of the realities of managing a small rural hospital.

The future of small rural hospitals however needs to be understood in the formation of strategy, and therefore further research relative to the management of rural hospitals will add to the 'body of knowledge'. Additionally, it is suggested that the following research should be further considered:-

1. Examining the effects and benefits of clinical leadership and management development programs relative to the rural nursing workforce.
2. Evaluation of the effectiveness of the Network structures in rural NSW.
3. Preparation of nurses for the rural setting, relative to new models of care and changes in skill mix.

Finally, material derived from this study gives some indication of what should be included in a nursing workforce development plan for rural NSW, and incorporated into any framework for learning about rural health management.

Acknowledgements

The researcher thanks the NSW Institute of Rural Clinical Services and Teaching for funding this study and for their valuable support during the research process. Thank you also to the nurse executives for their input and openness throughout the study project. It is hoped the time that they expended in completing the questionnaire and attending the interview will result in positive outcomes for nurse executives, staff of small rural hospitals and rural communities into the future.

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NORTH COAST
AREA HEALTH SERVICE
NSW HEALTH

Exploring how the Nurse Executive in a small rural hospital integrates internal and external influences in the management of rural hospitals and in the provision of health service delivery.

You are making a decision whether to participate or not to participate in the above research study. Your signature indicates that, having read the information provided in the Participant Information Sheet, you have decided to participate.

…… Signature of Participant

…… (Please PRINT name)

…… Signature of Witness

…… (Please PRINT name)

…… Date

Instructions:

You are invited to complete the following questions relating to your role as an Executive Officer/Director of Nursing by ticking or circling your response, or by providing comments. There are two sections to the questionnaire.

- Section 1 contains demographic questions.
- Section 2 involves questions about your role as the Executive Officer / Director of Nursing.

NORTH COAST AREA HEALTH SERVICE NSW HEALTH

Study Questionnaire

GENERAL QUESTIONS - Circle, tick or **bold** one answer for questions 1-9.

1. What is your gender? Male or Female

2. What is your age? 22-30 31-40 41-50 50+

3. How many years have you worked in health care (since you gained your initial qualification)?

   2-5years 6-10years 11-15years 16-20years >21years

4. How long have you worked in your current position of EO/DON?

   < 2years 2-5years 5-10years >10years

5. What is your highest academic qualification?

   Certificate Diploma

   Bachelor Degree Graduate Certificate

   Graduate Diploma Master

   Other

   Please specify _____

6. Where do you work?

   Hospital Multi Purpose Service Both

7. What are your Hospital/Facility bed numbers? (*Note for EO/DONs that manage more than one Facility complete both a & b)*

   a) 10-20 21-30 31-40 41-50 51-60

   b) 10-20 21-30 31-40 41-50 51-60

8. What is the average occupancy of your Hospital/Facility? (*Note for EO/DONs that manage more than one Facility complete both a & b)*

   a) <50% 51-65% 66-75% 76-85% >86%

   b) <50% 51-65% 66-75% 76-85% >86%

9. Which term best describes the patients that are admitted to your Hospital/Facility?

   Acute Medical & Surgical Acute Medical Non-acute Medical

   Nursing Home

   Other (specify)_____

MANAGEMENT QUESTIONS

10. List the five most common functions of your role in a typical day.

    1. _____
    2. _____
    3. _____
    4. _____
    5. _____

11. State the three most difficult problems that you regularly face.

    1. _____
    2. _____
    3. _____

12. State the three most critical issues facing your workplace.

    1. _____
    2. _____
    3. _____

13. List the three most significant barriers to providing safe, quality care within your Hospital/Facility.

    1. _____
    2. _____
    3. _____

14. List the five most influential external relationships re - strategy development for service delivery within your Hospital/Facility.

    1. _____
    2. _____
    3. _____
    4. _____
    5. _____

15. List three key internal relationships that are most influential re - strategy development for service delivery within your Hospital/Facility.

    1. _____

    2. _____

    3. _____

16. How many hours per week do you spend on management duties?
    _____

17. How many hours per week do you spend on clinical duties?
    _____

18. What are three key abilities you would suggest your successor possess?

    1. _____

    2. _____

    3. _____

19. In your opinion what are three greatest issues facing nursing in rural hospitals?

    1. _____

    2. _____

    3. _____

Are there any other comments you wish to make?

Thank you for your cooperation.

Debbie Schwebel

Please return the questionnaire to:
Debbie Schwebel
Nurse Manager Policy & Evidence Based Practice
C/- Port Macquarie Community Health Centre
Port Macquarie NSW 2444
or Email to **Debbie.schwebel@ncahs.health.nsw.gov.au**

APPENDIX 2

NORTH COAST AREA HEALTH SERVICE NSW HEALTH

PARTICIPANT INFORMATION SHEET

Dear Executive Officer / Director of Nursing

You are invited to participate in a Research Project being conducted by Debbie Schwebel – Nurse Manager Policy & Evidence Based Practice – North Coast Area Health Service.

Title of the Study

To explore how the Nurse Executive in a small rural hospital integrates internal and external influences in the management of rural hospitals and the provision of health service delivery.

Aim of the Study

Small hospitals make up a significant force of health care delivery in the North Coast Area Health Service (NCAHS) – NSW. They provide access to health care that many of their communities, especially in isolated areas would otherwise lack. The situation for smaller hospitals as distinct from larger District Hospitals and Base Hospitals differ in that they usually have less than 50-60 beds, a smaller patient base and fewer economies of scale. The management also differs in that it is the Executive Officer / Director of Nursing (EO/DON) who often shoulders the responsibility of legislative, economic and strategy decision whilst working in an environment that is generally physically isolated from other hospitals and supports.

This research project is directed towards understanding the internal and external mechanisms that influence and impact on the role of the EO/DON in the management of rural hospitals and in the provision of health service delivery.

Who will be invited to enter the Study?

All Executive Officer/Directors of Nursing of Multi Purpose Services and small rural hospitals, defined as less than 60 beds, within the NCAHS, will be invited to partake in the study Project.

What will happen in the Study?

The data collection will be a two staged approach. A questionnaire will be the first stage, and face to face semi-structured interviews will be conducted as a second stage. It is expected that the questionnaire will take up to 40 minutes to complete.

After three weeks any non respondents will be called to determine if they had received the questionnaire, along with a request to complete and return the original, or to ascertain if a second copy needs to be forwarded.

Participants will be asked to consent to their participation in the research project by completing the consent section on the front of the questionnaire.

The interviews will be based on themes relevant to analysis of the questionnaire responses.

Interview times and venues will be arranged by telephone and will be relevant to EO/DON schedules and availability. Permission will be sought to tape interviews upon arrangement of the interview schedule. It is expected that the interviews will take up to 60 minutes.

Written consent for the face to face interviews will be obtained prior to the commencement of the interview. The consent form will include the advice that interviews will be audio taped.

What are the possible benefits?

The results of the research will be reported to the HREC-NCAHS and the Executive Director of Nursing & Midwifery NCAHS. If in the opinion of the Researcher the results of the study offer a significant contribution to the body of Nursing Research and/or the development of Rural Health Policy the research will be submitted to a relevant journal for publication.

Privacy, Confidentiality and Disclosure of Information

Information collected is strictly confidential. Only the researcher will have access to the information provided by you, and about you. Confidentiality of the participants will be protected in the dissemination of the research results as analysis and reporting of the research data will be deindentified and undertaken in a group context.

The results of this study will be written up however individual participants will not be identified in any publication of this study.

Consent to Participation

Participation in any research project is voluntary. If you do not wish to take part you are not under any obligation to consent. You have been given the opportunity to complete this questionnaire. If you do decide to take part and later change your mind, you are free to withdraw from the project at any stage.

Complaints

This study has been reviewed by the NCAHS Human Research Ethics Committee. Should you wish to discuss the project with someone not directly involved, in particular in relation to matters concerning your rights as a participant, or should you wish to make a confidential complaint, you can contact the NCAHS Human Research Ethics Committee through the Research Ethics Officer as follows:

Research Ethics Officer
NCAHS Human Research Ethics Committee
PO Box 126
Port Macquarie NSW 2444
Tel: (02) 65882941 Fax: (02) 65882942
Email: EthicsNCAHS@ncahs.health.nsw.gov.au

Contact details
If you wish to find out more about the study either before during or after the study, you can contact Debbie Schwebel on 0265882924 or
Debbie.schwebel@ncahs.health.nsw.gov.au

Thank you for your interest in this research project.