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Reluctant Managers: Nurses Surviving Despite the Bottom Line

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Abstract

Chronic hospital bed shortages and compromised patient care has dominated the media over the past decade. Restructure and change are the catch cries for the survival of a quality public health system. The majority of existing Australian research has focussed on the impact of hospital restructures and retrenchment from the perspectives of the non-professional staff such as cleaners and kitchen hands. This research investigates the perceptions of middle management nurses in a major Victorian hospital. Unlike other managerial survivors of restructuring, this research reveals that this group of nurse managers have remained committed to their vocation and their workplace, despite the unrelenting pressures they have endured.

Introduction

This paper provides an analysis of the impact of restructuring on middle management nursing staff in a major Victorian urban public hospital.[1] Those studied were the survivors of both downsizing and also of their job roles with the move to a decentralised team based organization. The perceived state of crisis in Victorian public hospitals and shortages of trained nurses was the subject of public debate leading up to the Victorian State election in 1999 (Carson 1999) and the nursing shortage 'crisis' has again become a focal political and community issue receiving considerable press coverage (Toy 2000; Coffey, 2000). To understand the restructuring process merely in terms of budget cuts is an over simplification of a complex series of factors that have impacted on nurses and nursing practices in the past decade in Victoria.

The research was funded by an Australian Research Council Small Grant and unlike the majority of research on hospital restructures in Australia, which have reported on allied professionals and hospital support staff, O'Donnell (1997), and Allen (1998), the focus of this research was to examine the impact of restructure and retrenchment on those nurses holding managerial positions, who have lived through the changes within the hospital and patient care over the past decade.

Interviews conducted with nursing staff, a nursing educator, an Australian Nursing Federation (ANF) official and a former Health Workers Union representative indicated that a wide range of imposed changes had affected both

[1] Numerous people from the hospital participated in the research by providing information for the case study and the authors thank them sincerely. However, the research findings reported in the paper are those of the authors and should not be attributed to the views held by the hospital management.

work practices and the day to day operations of the hospital. Numerous and on going changes in both work systems and practices were revealed, and included: a shift to a technological based electronic internal communication; less intrusive forms of surgery; new funding mechanisms such as Casemix and Weighted Inlier Equivalent Separations (WIES),[2] hierarchical 'flattening' of the organisational structure and a decentralisation of responsibilities and a reorganisation of wards with a strategic approach to patient profiling. The aim of the decentralisation and restructure was to achieve a more efficient and cost effective method of processing and treating patients. Concurrent with these changes was also a shift in nurse training from hospitals to universities, the growth of the use of day surgery and extensive use of ambulatory care (treatment of patients outside the hospital). This move to a more modern purpose design hospital on the existing site with the above changes meant nursing staff cuts.

Informing, but not totally determining the organisational and nursing role aspect of these changes has been a United States model of patient focussed nursing care (Brider 1992). A key aspect of this model is the development of decentralised multi-skilled teams of nursing and allied professionals focussing on patients with similar illnesses. This model has been promoted by US consulting firms such as Arthur Andersen who assisted with the reorganisation of this Victorian hospital. One of the drivers of this model is the reduction of staffing costs (Ibid 1992) through the reduction of indirect staff and more effective utilisation of direct staff.

Such cost cutting and job intensification is not necessarily a feature of the team based approach. Even in US manufacturing industry where decentralisation of organizational structures and related changes to work roles have been promoted as Best Practice (Dertouzos, Lester and Solow 1989), research by Appelbaum and Batt (1994) indicates that lean production style teams, often associated with work intensification, are not the predominant model. They identify teams similar in style to Swedish semi-autonomous teams, which are not associated with work intensification, as having a significant presence in US workplaces. Hence, it is not possible to simply equate the shift to a new model at the hospital studied with the advent of extreme work intensification. Further, the extent of the adoption of the US model has been limited in the Australian context by local circumstances such as: the nature of the Australian health system, the policies of the ANF and the award structures covering nurses and allied professionals. Understanding the wider context of change outlined above and the reduction of funding by a state government pursuing a neo-liberal agenda are also necessary to explain the impact of restructuring at the hospital.

[2] Inlier equivalent separation refers to a measure of the number of patients below the average length of stay for a Diagnostic Related Group adjusted back to average length of stay equivalent value.

Analysis of similar processes of restructuring and downsizing (Dawkins, Littler, Valenzuela and Jensen 1999) reveal that the managers who survived had poor morale and commitment, low levels of job satisfaction and security and lacked motivation. With these problems in mind the aspirations and values of the nursing staff that have remained in the hospital through the changes are explored. It would seem that their professional ethics has been the dominant culture throughout the series of changes and this too has also affected the emerging hospital model.

In the sections that follow, an historical and contemporary profile of the hospital will be presented along with the series of changes that have occurred over the decade. These include: major changes to health care, the nature of Casemix funding, the new model of patient focussed care and the changed roles and responsibilities of senior nursing staff. These issues will be explored and presented through the eyes of the nurses and the impact of the downsizing and restructuring at the hospital will be assessed.

Method

An ethnographic approach was used to conduct the qualitative interviews. That is, the researchers chose this methodology to, '…preserve the unitary character of the social object being studied' (p.33 Goode and Hatt 1952). This method was considered the most appropriate way in which to investigate the impact of the restructuring process on the professional, social and personnel levels and hence document and analyse the lived experience (Denzin 1989) as told by those directly impacted.

Individual interviews of approximately forty-five minutes duration were conducted with fourteen nurses from three levels of managerial status at the hospital; two nursing clinical directors, seven Nurse Unit Managers and five Associate Nurse Unit managers (refer Table 1). Each of these levels has direct managerial duties and responsibilities, including: staffing, rosters and the discharge of patients. The two nursing clinical directors do not have a clinical patient load. Nurse unit managers and associates share a clinical patient load with the other nurses on the floor. All but one of the interviews were conducted on site at the hospital. One of the participants chose to be interviewed at her home. The interviews occurred from September 1998 – April 2000. Three interviews were also conducted with individuals considered as both relevant to the study and a means of triangulation of the data. They included: a former Clinical Director of Nursing Education, an official from the Australian Nurses Federation and a former Hospital Services Delegate. All of the participants interviewed were employed at the hospital during the restructure.

Table 1: Profiles of Interviewees

No	Title	Area	Age
1	CDN: Special Medicine	SM (oncology, neurology/neurosurgery/ general medicine)	42
2	CDN: Special Services	SS(intensive care, cardiology, gastroenterology)	52
3	NUM	Plastics	42
4	NUM	Neurology/neurosurgery	41
5	NUM	General Medicine	44
6	NUM	Cardiology	44
7	NUM	Gastroenterology	28
8	NUM	Oncology	32
9	NUM	Intensive Care	32
10	ANUM	Gastroenterology	27
11	ANUM	Special Medicine	27
12	ANUM	Cardiology	31
13	ANUM	Oncology	34
14	ANUM	Neurology/neurosurgery	34
	Nursing Interviews =**14**	Average Age	36.4
* A	Academic/researcher		
* B	Former Health Workers Union Representative		
* C	Current ANF official		
		Total combined interviews = **17**	

Abbreviations & Acronyms used:
CDN = Clinical Director of Nursing
SM = Special Medicine
SS = Special Services
NUM = Nurse Unit Manager
ANUM = Associate Nurse Unit Manager

The interviews were individually transcribed and sent back to each of the participants for comment. Two of the participants were nominated as key informants. The researchers were able to contact them throughout the duration of the entire research for clarification or further discussion. Authorisation to conduct interviews was given by the Chief Nursing Director following ethics approval. None of the participants were identified by name to ensure that

confidentiality was maintained. There were no refusals to take part in the research. The researchers attempted to collect data from as many areas of the hospital as possible. Given the busy schedules of nurses, it was at times difficult to make appointments. However, all of the participants involved were eager to be involved and were prepared to make the time.

The transcripts were categorised using *Nvivo* to reveal emerging patterns in relations to the issues raised. Categories were identified using key words (refer Table 2)

Table 2: Key Words

Categories:

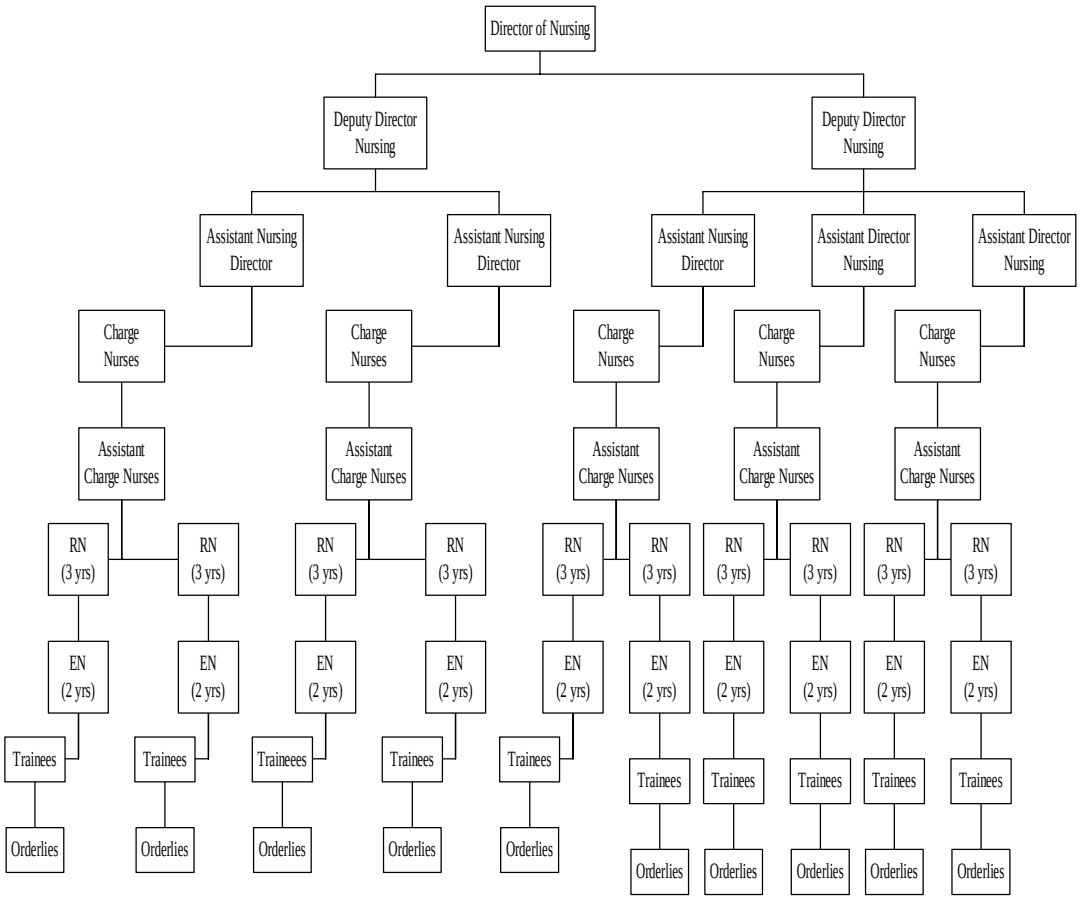
Term used (includes all forms)	Relating to:
Acuity	Level of sickness of patient/ increased pressure
Ambulatory care	Treatment of patients at home/ pressure to send home
Autonomy/autonomous	Position, decision making
Adaptability/adapt	Changes in work practices
Burn out	Work schedule/hours
Challenge/s/ed	Demands of position
Change/s/ed	Structure from old to new hospital. Role/duties
Commitment/ed (lack of)	To organisation. To job
Communication	Systems e.g computers email. Management
Downsize/d/ing	Reduction in staff numbers/work intensification
Career pathways	Options available
Decentralisation	Administration/decisions
Efficiency/ent	Patient care/work
empower	Through promotion, increased responsibilities
Flexible/ibility	Hours, type of work done
Morale (demoralised)	Within individual/with co-workers
Multi-skilling	Of work tasks/others taking on
overtime	Hours worked over and above working day
performance	Measurement, patient care
Promote/ed/ion	Opportunities through changes
Productive/ivity/	Evidence of increase in
Pressure/s	Of job, emotional
Stress/ed	work
Redundant/cy	When occurred/who/impact

Restructure/d	Of positions
Retrenchment/ed	When occurred/who/impact
reaggregate/d/ion	When/where/why/impact
Technology	Electronic equipment for medicine/office
Train/ed/ing	Pre and post qualifications/(technology)
teams	Who is in them/tasks/how they work
Trust	In management
Security/secure/insecurity	Own perceptions/others perception's
union	Involvement/impact

The Hospital

During the late 1980s, there were approximately 2300 employees at this major Melbourne hospital. The traditional hierarchical nursing structure during this period included: a Director of Nursing, two Deputy Directors of Nursing, five Assistant Directors of Nursing, charge nurses for each of the different units or wards, assistant charge nurses, registered nurses with three years training, enrolled nurses with two years training, trainee nurses and orderlies (refer Table 3). The Director of Nursing controlled a large budget which represented almost one third of the hospital's total recurrent budget. Nurse education was the responsibility of one of the Deputy Directors of Nursing, with 400 trainee nurses undertaking a three year course and completing a graduate year. All training during this period took place at the hospital.

Table 3: Nursing Structure:Old Hospital



The physical structure of the old hospital was broadly divided into surgical and medical wards, with separate wards for males and females. Each ward was controlled from a central station. Under this system patients could be shifted around the hospital and may have up to thirty different persons handling them during their stay. That is, they were physically transported from floor to floor for each procedure. Nurses were allocated to wards, not to specific patients. Neither registered nurses nor assistant charge nurses had a patient load. They supervised enrolled nurses and trainees.

Under this system, nursing administration was run from a separate building and promotion to management positions was largely on seniority. Allied health professionals worked in separate functional areas and support staff were divided into cleaning, catering and orderlies who moved patients around the hospital. Administrative staff were centralised and controlled matters such as admissions, medical records and finance. Medical staff who either worked at the hospital or were there as consultants were the dominant group in the hospital.

Funding was provided by the State government on a block grant basis with no attempt to effectively audit expenditure. Some attempts were made to rationalise resource usage. Research undertaken by the *Committee of Enquiry into Nursing in Victoria* 1985, examined the issue of appropriate nurse staffing levels in different types of nursing care environments. In the late 1980s nurses in specialised acute care areas of the hospital looked after two to three patients per shift.

Rapid advancement in technology during the 1980s meant major changes to medical practice. With the advent of imaging machines, advanced and less obtrusive surgical techniques, improved anaesthetics and more specialised medication, the time spent on patient diagnosis and treatment was greatly reduced. For example in the 1970's common surgery such as the removal of a gall bladder required a post operation stay of up to ten days. Today the same surgery could be reduced to a total of three days hospital care. Pre admission clinics were also introduced, where the patient could be admitted on the actual day of the procedure, rather than a pre operative overnight stay. The design of the old hospital building became inadequate and could not embrace the wonders of this new technology.

The New Model of Patient Care and Restructuring

The process of organisational review and restructure commenced with the appointment of a new Chief Executive Officer, who commissioned Arthur Andersen, the management consultants, to undertake a major consultancy report

on the running and management structure of the hospital. The essence of the approach that emerged from that process had several strands that included the:

- development of patient focussed care or primary nursing
- elimination of administrative hierarchy and decentralisation of decision making to care centres
- multi-skilling of clerical staff and their relocation to care centres
- creation of semi-autonomous teams in the units (wards) within the care centres
- multi-skilling of support staff (cleaners, kitchen staff, and orderlies)
- introduction of information technology to assist the new structure
- reorganisation of existing wards in the hospital into care centres for patients with similar needs
- building of a new $146 million hospital on the site (Campbell and Breen 1994).

The concept of primary care involved each nurse having an ongoing relationship with a patient whilst in hospital and a focus of services more in relation to the patient's needs. Prior to the change, patients were treated by different nurses, moved between wards and dealt with by a diversity of different administrative and specialist staff. One of the participants in the study described the difference as:

> *[It aimed at] bringing services to the patients as opposed to taking patients to the services.*

The wards in the old hospital were often small with 12 or 13 beds and just prior to the move to the new hospital, the wards were reaggregated. For instance, coronary care (intensive monitoring of heart patients) was integrated with cardiac surgery and neurology was amalgamated with neurosurgery. The impact of the reaggregation meant that less supervisory positions or charge and assistant charge nurses were needed. Integration of different areas confronted nurses in these management positions with the need to learn new skills for treating the new kinds of patients in their areas. More pressure was placed on senior nurses because they had to also assist and show junior nurses. Some of the more junior nurses had several moves in this period and said:

- *It was awful because you did not have the chance to settle in one place because you were uprooted.*
- *It was a stress to learn a new discipline.*

The flattening of the administrative hierarchy meant making senior administrative and supervisory nursing positions redundant. It also meant a major shift in the role of charge nurses, who were to become Nurse Unit

Managers in the new structure, from a clinical role to a more management oriented one. Nurse Unit Managers became involved in matters such as staff recruitment and selection, appraisal, rostering, patient discharge planning, and budgeting. Nurse Unit Managers worked what could be deemed as regular 'office' week day working hours, whereas Assistant Nurse Managers (the old assistant charge nurses) had a patient load and worked both night shifts and weekends, deputising for the Nurse Unit Manager during those periods. These new wards of 25 beds on each side of a floor were grouped into care centres run by a director. This was a management position and did not require nursing experience. Two of the first directors were not nurses, although these positions are now filled by nurses. The care centres operate like mini-hospitals within the framework of the hospital. Pharmacy services were also decentralised to care centre level. One of the more experienced Nurse Unit Managers commented that with the new model:

We have more control and we know what is happening.

The focus on primary patient care and the related decentralising of decision making meant that nursing staff at ward level were seen as a semi-autonomous team, working closely with allied professional staff such as dietitians, social workers, physiotherapists and other support services staff. The redeployment of these allied professional and support staff to care centres and units was a core part of process improvement which was to shift the focus of services to patients. How this worked out in practice in the new hospital is discussed below. The outcome was to create what some of the research participants described as 'mini hospitals'.

Restructuring

This restructuring process involved major changes to the role of support staff, cleaners, catering staff and nurse attendants or orderlies. Negotiations between the Hospital Services Union, No 1 Branch and the hospital management in 1990-91 resulted in an agreement to multi-skill these employees. From 1991-92 onwards, these changes were accompanied by several rounds of major voluntary redundancies with the cleaning staff being reduced by two thirds. Generous funding support for the initial redundancies was provided by the Kirner government. Major advances in technology in the food preparation area led to the new, ‘cook chill’ system. This substantially reduced the numbers in the catering area and further voluntary redundancies occurred. Lower status employees such as cleaners were trained to do the nurse attendants’ work such as handling patients and serving meals. Many of the remaining staff experienced difficulty with the changes as they tended to be older and often from non-English speaking backgrounds (refer O’Donnell, 1997). Initially

there was resentment by union members towards the Hospital Services Union of Australia. Despite this initial resentment, it appeared that the 'multi-skilling' model became both accepted and efficient. As stated by a HSUA job representative:

> *For the most part there was a lot of animosity towards the union for having gone down this path in the first place… they were afraid that if people were going to be mixing and matching elements of their jobs that there would be less job security and that their levels of productivity would be exposed…In 1995 it appeared to reach a level of equilibrium where it seemed to be running a lot smoother, people were a lot calmer they felt they had reached a level of efficiency and a level of staff that they thought was manageable.*

The multi-skilling of these employees, who were to become Support Service Associates (SSA), was completed a year prior to moving to the new hospital. Multi-skilling these staff assisted in the primary care model, with fewer support staff needed to support the patients. As such, the SSAs became more integrated with the nursing units in the new hospital.

Another significant change was the integration of clerical support staff. The roles of the old ward clerks, medical records clerks and admissions clerks were combined. These employees were renamed Patient Service Clerks (PSC) and located in the reception area of each the care centres. Their initial working hours were between 7 am to 7 pm, but subsequent cost cuttings shortened these hours. This has resulted in an increased workload for nurses, who must answer the calls not occurring during the PSCs hours.

Information technology was an integral feature of the new hospital. Features included an intranet system for improved internal communication with several computer stations in each ward. The layout was considerably larger and several four patient rooms placed on opposite sides of the ward replaced the old centralised nursing station which had a clear view of all patients. New equipment such as ECG equipment was stationed on each ward and instead of having to transport the patients to a different ward and or floor, tests could be done on the spot. The increased use of technology assisted in the efficiency of the restructure in that many procedures such as checking blood could be done within an hour, whereas, in the past this could take several days. However, nurses were required to learn how to use this equipment in addition to their daily tasks.

Another important change, which complemented and to some extent resulted from the organisational restructuring, was the streamlining of procedures and

the creation of clinical pathways (clearly defined and standardised procedures for patient services initiated by medical staff and consultants). For instance, in the old hospital there were 71 steps involving 3 departments and 11 staff for one patient to have a chest X-ray (Patient Care Model Project Team Report 1993). The involvement of nursing staff in the decision making process leading up to the move to the new hospital resulted in a wide range of improvements. A current job representative commented that:

> *The design of how procedures were going to happen was open to the staff to have input about how things would change.*

One of the ANUMs commented on the positives of such changes:

> *It's amazing how much work that we have cut out for ourselves to how we do things now. The patient care is a lot better I think.*

It would seem that the reaggregation of wards and decentralisation helped to reduce the number of staff involved in servicing patients. It was a move from a functional to a more focussed organisational design.

Further Change-The Introduction of Casemix and WIES

The changes outlined above formed part of a coherent vision of improving efficiency and patient care, and the hospital soon became a state leader in these areas. The positives of the changes and the opportunity to work in a new state of the art building appeared to outweigh the negatives of the redundancies. There was a level of excitement to strive to meet the challenges of the changes. However, concurrent with these major changes, a new method of funding was introduced in the early 1990s, and this created further pressure to reduce costs.

The first was the development of casemix funding, based on diagnosis related groups (DRG). DRGs are a method of classifying treatments into different categories of illness, and specifying the nature and cost of each of the inputs required to treat the illness. One key aspect of the measures associated with each of the categories is the normal length of patient stay in the hospital (DRGs are referred to as Australian National (AN) DRGs due to the US origins of the concept).

Investigation of the use of DRGs first developed in Victoria during the mid 1980s under the Cain Government (Stoelwinder and Viney 2000). The government's attraction to use DRGs was that it provided a more accurate and potentially more equitable way of funding hospitals than the existing block grant system. By assessing the Casemix of different DRGs handled by a

hospital it was possible to weigh funding on the complexity of procedures carried out rather than just the number of patients treated. It also allowed benchmarking of hospitals against the average on the number of days in hospital for a particular DRG.

Just prior to losing office, the Kirner government had considered using DRGs as a basis for funding (Ibid). When the Kennett government was elected in Victoria in 1992, it moved quickly to cut health funding by 14% over the following two years (Ibid). It also introduced Casemix funding in July 1993. And used the introduction of Casemix as a vehicle for cutting costs in hospitals, instead of cutting services (Duckett 2000).

Casemix was used to increase efficiency by linking it to a funding formula, namely, Weighted Inlier Equivalent Separations (WIES). This formula works by calculating an average cost across all DRG groups for patient treatment. This average cost then becomes a unit of measure against which all DRGs are compared (Auditor General's Report 1998). Weights are then created against this unit for different DRGs. For example, the average cost for the removal of an appendix might be .75 of a standard unit whereas a heart transplant might have a cost weight of 15. The actual weights are revised yearly by the Department of Human Services and have been the subject of contention between hospitals and the Department (Ibid).

The WIES system allows hospitals to choose the number of patients they will treat in each DRG within their limit of WIES units allocated by the department and the weighting given to each DRG. Depending upon the type of DRGs chosen, the hospital will treat more or less actual numbers of patients. That is, wherever possible, they will select procedures that will provide maximum funding and try to reduce costs such as time spent in hospital.

The alignment of the Casemix system and WIES forced hospitals to improve discharge planning by reducing the length of patient stay in hospitals and by improving hospital organisational structures (Ibid). Major cuts in staffing levels also occurred across the system in 1993-94 to further reduce costs, with over 10,000 staff including 3,000 nurses losing their jobs (Harkness 1999). Improvements in efficiency did occur across the system in terms of patient throughput measured by separations which increased by 28% from 1991-92 to 1996-97 and recurrent costs per WIES unit which decreased by 25% (Auditor General's Report 1998).

As previously stated, 'the' hospital had already moved with organisational restructuring and process improvement before the implementation of the casemix/WIES system. Hence, it was better placed than other hospitals to

achieve efficiency improvements required under the new funding arrangements. Further efficiencies could only be achieved by further cuts in services and staffing. Such reductions placed unreasonable and in the longer term unsustainable pressures on remaining nursing staff. As argued by Stoelwinder and Viney (2000:220),*'Massive funding reductions were achieved by obfuscating them in Casemix funding rhetoric of hospital competitiveness and complexity of formulation.'*

The Process of Change

By July 1993, a project team assisted by Arthur Andersen, presented a report to the hospital board outlining the new care model and implementation process. Communication with staff in the development of the report was extensive, with a total of 25 separate presentations made. There were 11 different working parties, comprising a core of senior staff, plus representatives from other staff and Arthur Andersen staff. For instance, there were 5 groups examining the issues of reaggregation and redeployment. There was an average of 10 staff representatives in each group (Patient Care Model Project Team Report 1993).

The level of involvement in redesign of work processes and procedures was commented on favourably by the by the nurse unit managers, who said:

- *The working parties were taken from whole areas, not just senior people.*
- *An extraordinary amount of effort went into the communication about the change.*

However, a distinction should be noted between staff involvement in changes to procedures and involvement in the physical restructuring of wards. One of the job representatives commented:

> *I do not know how they decided which wards went together, that was probably more the upstairs management people with heads of units*.

This comment was endorsed by the Assistant Unit Managers, who would have been junior nurses at the time of the changes.

The restructuring or reaggregation of wards meant a reduction from 20 wards to 14. Each ward at that time had a charge nurse and 4 assistant charge nurses. This meant an obvious need to reduce the number of senior nursing staff at ward level. This was achieved by redundancies and by filling promotional positions on a short term basis prior to the move to the new hospital. This lack of

permanency created anxiety amongst those in the temporary positions. However, the job representative at the time argued:

> *My intention as a union representative at the time, was to look at the situation and make sure that at the end of the day we did not put anyone out of work.*

Both the reaggregation of wards and the loss of promotional positions were of concern to nursing staff, as was the need to learn new skills for different sorts of patients. The more experienced of the staff interviewed found the reaggregation difficult. For instance one commented:

> *It was awful. It was really difficult because you didn't have a chance to settle into one place because you were always being uprooted. Each ward, I believe is a specialty unto themselves so there's a learning curve as well, then you'd move somewhere else and have to start all over again and get your bearings.*

Responses to the first round of redundancies were somewhat ambivalent. That is, the first round was seen by many as an opportunity for senior administrative nurses to move on. Their roles had changed and this was seen as a positive for many. However, the subsequent cost cuttings and continuous reaggregation was seen as disturbing and stressful. The impact of the redundancies also varied. For example, some nurses were in wards that either did not have any redundancies or were not affected by reaggregation. Such persons were also specialists with much needed skills. As such, they did not feel directly threatened. Secondly there was a perception that those who took the redundancy package wanted to go. For example, one ANUM said:

> *I knew people who took the packages. So I do not consider that it was a negative thing, because they wanted to take redundancies. They felt happier to go.*

Another of the Nurse Unit Managers confirmed the positive aspect of the redundancies:

> *Some were thinking about changing to another hospital so this was a good opportunity to get some money and go.*

One of the job representatives commented that since there was no paid maternity leave at the time, it was an opportunity for some to leave and have children.

Some of the participants were also in more junior positions at this stage and were less directly affected by what happened. They saw opportunities in the changes with the removal of seniority based promotion and liked the removal of the layers of unnecessary bureaucracy. The restructuring was also generally seen as bringing better patient care. There was a shared feeling amongst the NUMS and Care Centre Directors that those who had left, could not cope with the changed roles and workloads and would be happier elsewhere. One of the NUMs remarked that the response for some of those who left was fear driven:

> *It was really a fear of change not knowing how things were going to work out.*

The loss of experienced nursing staff, who took the Voluntary Departure Package or just left, was also demoralising to some of those who remained. One ANUM commented that:

> *You were seeing the dismantling of a significant and well established culture…You were sympathetic to the people who left and you seemed to be going to a lot of farewells.*

Another ANUM noted:

> *But it was demoralising seeing these positions go, seeing people exit from the organisation and some people did not get redundancies actually left the organization and they were what I consider good people.*

The shift to the new structure meant that the senior nurses up to the ANUM level had a patient load, whereas in the old hospital, student nurses handled the more mundane patient work. One of the job representatives reflected on the old system:

> *The RNs [registered nurses] just followed the doctors with clipboards, with their lipstick on and answered the phone and just got the students to do everything.*

Other nurses interviewed shared this perception that the senior nurses at the old hospital did little, if any, direct nursing of the patients. They therefore saw this as a positive and more equal change.

Two important issues to emerge in the restructuring, were that of career pathways for nurses and multi-skilling of other staff to do nursing work. The Australian Nurses Federation was strongly opposed to breaking the ratio of one charge nurse to four assistant charge nurses. However, this created a lot of

inflexibility in rostering staff, with assistants forced to be permanently on night shift or working weekends because they were responsible for certain staff. Having a smaller number of ANUMs in a ward also enabled senior nurses to get the experience of running the ward for a shift. The idea of multi-skilling non-nursing staff to do nursing duties, e.g. physiotherapists doing nurses work, was proposed as part of the concept of multi-disciplinary teams which formed part of the new patient care model. The ANF did not want non-nursing staff to do nursing work, successfully opposed this change.

The perception of those in senior management at the time driving the changes appeared ambivalent. The HSUA representative saw the CEO as a person who had a strong and well developed vision for the hospital, but was, *as cool as ice but sharp as a razor blade*. He also described the management below the CEO as *autocratic.*

Responses to the New Hospital

The essence of the positive side of the new model was an empowered nursing staff through decentralising of control. It also meant that responsibility for managerial and staffing tasks were incorporated into the role of nurse unit managers and assistant nurse unit managers in the new structure. Directors of care centres were conceived of as running a smaller business within the fabric of the larger hospital, with clerical support staff under their control. They managed jointly with a medical person who worked with them part-time.
In general, the response by nurse managers to the new structure was positive in a number of respects. For example, all nurses up to the assistant unit manager level having a patient load was seen as positive. This comment typified the sentiments of the participants:

> *When I was a student nurse, certainly the registered nurses did not take patient loads…and that stood out to me as inefficient.*

The change to the new model was also seen as giving younger motivated nurses the chance to advance into managerial positions, which was not available under the old seniority based system. The shift towards more patient focussed care was also seen as positive and better for the patients. The job delegate commented:

> *All of a sudden I had gone from washing half the ward and doing the obs to having four patients and doing everything so it was really good and I felt positive about it.*

Most of those interviewed believed that the new system improved patient care, which was of great importance to them.

A key feature of the new model was to decentralise decision-making and give greater responsibilities to nursing staff in care centres. The positive side of decentralisation was put forward on more than one occasion by the participants in the study. The following comments reveal this:

- *…I think it is much better managed now that nurse managers manage their own staff.*
- *…I think it is a bit less regimented in that staff do a lot more for themselves.*

The new system places considerable strain on the assistant nurse unit manager positions as they had to care for patients as well as undertake management duties. The new model tended to attract staff who were achievement oriented and liked the responsibility. Those who did not fit in with this mould tended to leave or remained at their current level.

Casemix funding meant that nurses at director and unit manager level were very conscious of resources and materials usage and the need to operate within budget. Initially, the increased responsibilities were not seen as too onerous. One of the younger ANUMs said:

Initially the pressure was not too bad.

Criticisms of the physical layout of the new hospital was vented by many of the participants. These concerned the size and isolation. Carpeting was also seen as a negative. However, the centralised air conditioning and heating was welcomed, as was the introduction of decentralised facilities such as satellite pharmacies The new structure had four separate rooms each with four beds. Bathrooms were spread out along each side of the floor. Decentralised workstations with computerised terminals replaced the central workstation, which allowed visual surveillance of patients. Typical comments were:

- *It took us a long time to get used to the distance of one end of the ward to another.*
- *You have got half an acre of floor and you can't see the patients.*

The new structure resulted in what was seen as mini-hospitals, which meant that there was little ability to learn from the experience of other care centres. The recent establishment of the Nurse Professional Practice Council was seen as

providing a vehicle to share ideas on clinical practice and was strongly welcomed.

Primary Care

The Patient Care Model Project Team (1993) had advocated a decentralised model of patient care, which was based around a primary care model of nursing and multi-disciplinary teams of health professionals and support services operating within care centres. The initial reaggregation of wards in 1994-95, did integrate nursing and medical care of patients with related illnesses. Support and clerical services were also managed at a care centre level and allied health professionals were also more integrated with nursing and medical staff within care centres. Changes were also made to focus nursing care on primary nursing of four or five patients. The cessation of nurse education in the hospital in the early 1990s also contributed to changes in care, because registered nurses took a patient load.

However, the interviews revealed discrepancies between the model and its implementation. Differences emerged between medical and surgical wards with regard to primary care. The issue of high dependency of patients in medical wards was cited as a reason for the breakdown in primary care. One ANUM believed:

> *We have primary care nursing at this hospital, but it has fallen down a bit as we have gone on…because the way it is with such heavy [dependent] patients …we work as a team. I think that from a medical ward, you work more as a team than a surgical ward.*

Nurses in non-medical wards also indicated that primary care did not work properly because of the inability to focus on one patient. One ANUM in a non medical ward noted:

> *No-one really does primary nursing…. It does not mean that they have to nurse the patient every day that they are in here, sometimes it is not an easy thing to do, but they are a resource person for that patient.*

A senior NUM in a surgical area remarking on the need to assist junior staff commented:

> *Primary care did not work because of the skill mix….but if you have a junior looking after that person [the patient] and some one overseeing them, the patient misses out. So in reality you have more that one person dealing with the patient.*

The issue of patient stay was also raised as a problem with primary care. An ANUM in a busy surgical ward said:

> *We just started to adapt it [primary care], because it was not working…we have some really sick patients, we have patients who have been here for six months, so imagine looking after a patient every single day for six months.*

Another commented:

> *[We have] lapsed back into old ways…can't look after one patient every day…need a break.*

The evidence as to whether ward level multi-disciplinary teams had been established in the new hospital was mixed. Allied health professionals such as physiotherapists, dieticians, social workers, pharmacists were linked more closely with the wards. However, their interaction with nurses tended to be based on the needs of patients, e.g. dieticians and pharmacists were involved with heart patients, whereas for other health professionals this was less the case. The greater accessibility of pharmacy services due to decentralisation was seen as linking them more to the wards.

The emphasis on discharge planning also meant greater involvement of allied professionals. However, their integration into the ward team as part of regular meetings was not common. The pressure on nurses especially in those areas identified above, where it was strongest, militated against this. One of the NUM's said:

> *We are still very much doctor nurse teams and then when we need a member of a multi-disciplinary team we call them and refer patients to them…they want me to run these meetings [with allied health] but I do not have the time.*

Reaggregation

Once the move to the new hospital was completed in 1995 the new structure of wards did not remain intact. Despite the major restructuring, job losses and resultant efficiency gains that had occurred previously, budgetary pressures caused further reaggregations and closures of wards. The cause of this can be traced directly to the WIES funding formula and the changing of the continual changes in weighting of diagnostic groups. Failure to increase throughput of patients to match the level of WIES available resulted in the closure of beds.

This inability to meet budget raised concerns that the hospital might be closed. Government attempts to move the hospital to an outer suburban location further exacerbated the problem.

Pressures on the hospital to cut costs led to two major reaggregations, one in 1996 and another in October 1998. One of the NUMs said:

> *The first reaggregration was totally WIES driven and one of the surgical wards was closed.*

The second reaggregation came about because of the gradual closure of beds across the wards which lead to an assessment by management that a whole floor should be closed to save costs. As such many units within wards were reallocated throughout the hospital. These changes came on top of the several reshufflings of wards prior to the move to the new hospital. Inevitably, one would not expect to find the new ward structure to remain due to the impact of changes in technology and methods of treatment. However, the time and effort devoted in the planning of the structure of the new hospital was undermined by the piecemeal changes that followed.

Perceptions on the impact of the reaggregations were varied. Most had been subject to reaggregation, although several claimed that they had not been affected. On both occasions with the ward closures, Nurse Unit Managers were forced to reapply for their jobs creating considerable anxiety. ANUMS and other nurses were reallocated to different wards. The closures led to further redundancies amongst senior nursing staff including: Patient Support Clerks and Support Service Associates.

Nursing staff found themselves affected by either being placed in a new ward or having to integrate new staff from a different area of specialisation into their ward. In some cases specialist areas were allocated to a ward, taken off that ward and then returned again.

One of the NUMS, who did not change wards but experienced a lot of upheaval, commented:

> *So we have had a few moves physically and downsizing of staff and totally splitting teams up and reconfiguring them again. We had a unit running well [after the first reaggregation] and then they reaggregated again. That soul destroyed staff.*

Another NUM observed that:

> *What was across the whole floor [each floor has two wards] became one ward, that was a massive change for staff.*

The reaggregations had several effects on staff. The first was the need to learn a new specialism for those that were dispersed to other wards. This also applied to remaining staff who had another specialist group integrated into their ward. One ANUM said:

> *Each ward is a speciality unto themselves, so there is a learning curve as well.*

Another noted that:

> *I was very worried about renal because I knew nothing about it.*

Seemingly, no formal training was provided for staff to cope with these changes and they were left to learn from the nurses familiar with the area and also from medical staff. Most claimed that this was stressful and placed an extra demand on their already diminished free time.

The second problem was that nurses had difficulties adapting to new unit managers and becoming effectively functioning teams again. One senior NUM noted that:

> *The staff became very unsettled because…most people got on well with their NUM and did not really want to change.*

One ANUM remarked on the importance in taking time to build teamwork:

> *We built a lot of teamwork knowing each other.*

The third problem was the pressure placed upon NUMs in particular to help get the new staff integrated into the ward and up to speed on new specialisms. One NUM said that:

> *In the first six months I was doing this job after reaggregation, I think I was working from 7 a.m. to 6 p.m.*

The fourth major impact was that for some nurses the reaggregations increased the number of patients they nursed. The reduction in the number of beds and

ward closures created constant pressure to find beds for patients and an increased nurse patient ratio. One NUM said:

> *When the ward went from 20 to 25 patients, I found it busier.*

Staff were also disconcerted how abruptly the changes occurred and the lack of communication, particularly with the first reaggregation.

- *They told us it was happening when it happened.*
- *Every time there is a reaggregation, it just depresses you the way they do it…they don't take people aside and tell them solo before it is told to a big audience.*

The current ANF job representative indicated that with the second reaggregation in 1998:

> *When the eight floor shut I did not find out until it was happening…[the ANF organiser] had been to see management a week before it happened and she couldn't believe they had not mentioned it.*

However, some communication did occur with NUMs who were directly affected. One of the senior NUMs, affected by the reaggregation, indicated:

> *With the last one there was quite a bit of communication with it all.*

Another senior NUM also commented:

> *Management walked around from top to bottom and said we should actually close another floor and think this through again.*

The ambivalence in the comments probably reflects the change in senior management at the time. The new management were more consultative compared to the previous management. The job representative believed that management were more approachable, but they still did not necessarily always communicate.

In summing up the nurses' responses to the reaggregations and WIES driven cost reductions one of the ANUMs said:

> *So we are placing too much emphasis on that budget by reducing, closing beds, wards and re-aggregating them so that we can provide the services just with less beds, a higher turnover and lesser work.*

Pressure on Nurses

Increased acuity of patients, the pressure to increase patient throughput because of the WIES based funding system, increased nurse-patient ratios and the new responsibilities added to the duties of ANUMs and NUMs, contributed significantly to the work pressures experienced by nurses. However, it was apparent from interviews that the nurses differed in their assessment of the extent of pressure that they felt.

This can be attributed to the following factors. First, whether the ward was a general medical ward, in contrast to a specialist surgical ward with intensive patient monitoring, often made a significant difference to perceptions by nurses of their ability to cope. The work in specialised surgical areas often made for lesser staff patient ratio. One of the ANUMs in a surgical ward noted:

> *I think we are pretty well staffed with one to four [patient ratio] but I know on the medical wards on the 9th floor they are one to five, they work a lot harder than we do.*

Another noted:

> *Our work is different. It is not as physically demanding.*

Surgical patients also tended to be very sick initially and then required less attention. They were also more likely to be ambulant in the recovery phase and did not need the continuous heavy lifting required by very sick medical patients. An ANUM said:

> *Because we are a medical ward we are very heavy [workload]…You can have five patients but four can be bed bound. We aren't a surgical floor, where, once you fix their problem, they can walk around and all that. The type of patients we have need 24 hour care.*

This was supported by one of the NUMs in a surgical ward:

> *If you are in medical, people don't stay because it is heavy and hard on your back.*

The challenging nature of the work in specialist surgical wards also made it attractive to nurses, enabling such wards to retain skilled staff. A senior NUM said:

So you have a better chance of maintaining staff if you are in a surgical area in preference to medical area because they have had holes in their roster as long as I can remember.

An ANUM in a medical ward commented:

I think medical nursing needs a big uplift…we need more nurses…we can't get our just regular staffing filled because of the shortage.

The ability to retain senior staff and as result have a relatively stable team was a second factor that affected the level of stress. One senior NUM in a largely surgical area noted that:

I have the luxury of having very senior staff and a very stable workforce…and five to one is adequate and if you have good regular staff, you manage.

Higher turnover of staff plus the inability to fill vacancies meant there was a need to use the hospital's bank of casual staff and outside agency staff. These nurses required more supervision, were not necessarily as competent as permanent staff and did not form a close knit team. A skill mix, which included more experienced staff also, helped to take pressure off supervisory staff. An ANUM noted that:

I worked on a general [medical] ward and now I am in working in specialised area so we have less junior staff.

The higher acuity also interacted with the issue of skill mix. According to one of the senior NUMs in a surgical area the greater acuity meant that:

[There was a need] for more grade twos [experienced nurses] and less grade ones

A third factor differentiating wards and the level of pressure was the degree of focus of the work. General medical wards particularly with their variety of different types of patients meant that nurses do not develop the same level of skills and resultant efficiency. One senior NUM said:

Our ward is acute medical …so we have a massive variety of patients.

The fourth factor was the likelihood of patient recovery. A senior ANUM in oncology said:

We have always had high turnover in our area anyway. It is because of the type of nursing we do. Young people, serious illnesses, a lot of death and dying and people tend to burnout fairly quickly.

As noted previously the high turnover of staff adversely affects the skill balance and increases pressure on senior staff.

The fifth factor was higher turnover of patients. Obviously the WIES/Casemix system had increased pressures to discharge patients, but some wards, especially surgical. had a particularly high turnover of patients.

The final factor related to the mix of patients. If most patients in a ward were just back from surgery or treatment it could mean a very heavy workload, since they required constant attention. One NUM described this:

Sometimes when you might have a ward of twenty-two patients, they might be very independent, they can do a lot of things for themselves and there might be twenty two who can't and it just makes the workload a lot busier and heavier and that is hard to judge and plan for.

Hence, although the overriding impact of the broader factors mentioned above, particularly the pressure to discharge patients, was felt by all participants, there were also the specific factors in the nature of the ward which were a source of stress for nurses. Variance in the capacity to cope obviously relates to the specific characteristics of wards and patients outlined above.

'Invisible' Overtime

In this study questions regarding overtime, hours worked and whether breaks such as lunch and tea breaks were taken were asked. Overwhelming the majority acknowledged that overtime was worked in terms of working longer hours than their shifts, not only as managers, but the other nursing staff not only worked overtime, but often missed lunch and tea breaks in order to get through the work.

but the girls are still doing quite a bit of overtime or not getting to tea breaks, which is something new, that never used to happen as well…. Lunch often gets busy… so it's often difficult to get staff off for half an hour they're often run off for fifteen minutes.

Three of the participants held slightly different views, one expressing that it was more of a give and take between management and staff and making sure that

when he was in charge he would let people off earlier when he could or have longer breaks to make up for the overtime.

> *I feel that it's a two way street and there are times, a lot of the time when we get off ten minutes late, so I try and get people off early, especially on the weekend.*

One of the participants regarded the issue as a status quo, in that she regarded that the problem existed previously in the old structure.

> *Much the same, even in the old unit, the problem shift is always the evening shift going over to night shift and the night shift leaving in the morning, being organised enough because there's lots of unforeseen things that can come up and you can be as organised as you possibly can and something can hit the fan so to speak and can put you half an hour behind and we try and we always have done, its very unusual for people to get off late on an early shift.*

Overtime was described as a *major issue* that affected not only this hospital but all nurses in Victoria:

> *It is a major issue. They work it because they have always been refused. The managers have never paid it and they'll turn it around and put it back on the people and say its just that you are inefficient… It's not just at ……., it's state-wide.*

It would seem that the majority of nurses at all levels work overtime, with those in management roles accepting that they need to work longer in order to get their work completed. This is consistent with the research done by ACCIRT 1999:104, which found that most people working in managerial positions in most occupations worked overtime

> *…the big difference, however, between white collar and blue collar jobs is that white collar don't get paid for their overtime.*

The nurses in management positions indicated that overtime had become invisible and almost expected by management. Some of the nurses saw this as a deterrent from applying for more senior roles and for recruiting young nurses.

Attitudes to Casemix and WEIS

In examining the effect of Casemix and WIES based funding on nurses the impact of increased acuity needs to be taken into account. Repeatedly in interviews this issue was raised. For instance, the job delegate commented:

> *Before on a ward you would have patients come in and they would be really sick and then they would get a little bit better…so you would have a balance of sick and a balance of ones nearly ready to go home, but now the patients are kicked out so quickly, they are sick all the time so there is no break so the graduates are burning out. So the pressure is more constant now…so their workload has increased but they have not changed the staffing numbers*

So irrespective of other changes the impact in the increase in acuity has added to the nurses' workload.

The perception of nurses regarding Casemix and WIES varied in two ways. Firstly, those ANUMS, who carried a patient load, tended to respond to the pressure created by the interaction between Casemix and WIES:

- *I know because of the WIES targets it puts the pressure on…there is a set number of days a patient stays for a procedure.*
- *We just have a higher turnover of patients coming through. Everyone is out of control, everyone is so busy and working so hard that you think well this is no good.*
- *It has created a lot of pressure for beds and.… then you have got the pressures of patients being admitted who have not got a bed and you are desperately trying to find a bed or facilitate a discharge to make that happen, so it has been very stressful.*

The response of the NUMS reflected the pressure, but also focussed more on the issue of efficiency. For instance:

- *In some ways I think it is a good thing, because it has meant that things are a lot more efficient, and we look at our practices.*
- *Now there is this constant demand and bean counting for us, but you are being more co-ordinated instead of putting a multitude of tests over five days you are doing them in two. There was a lot of waste.*

Both the ANUMs and NUMs who were in wards where the pressure was greater, felt much more strongly the impact of the need to juggle beds, the turnover of patients and the need to meet the Casemix DRG benchmarks for

number of days stay per patient. The following comments from NUMS in such areas are typical:

- *The ward just gets busier and busier…getting people in and out quickly or as quickly as we can.*
- *A lot of a Nurse Unit Manager's time is spent dealing with the bed disaster…We never have enough beds, it's a nightmare.*

In the discussion, concern was expressed about the nature of the casemix system and the weighting inherent in WIES. The issue of the averaging of treatment costs for a DRG across a floor even though nursing intensity (nurse patient ratio) differed was one issue. Concern about the capacity of the hospital to accurately cost the nursing component of various DRG's was also raised by some of those interviewed. The weighting in the WIES system was also seen as a source of mounting pressure. Comments by NUMS who felt most pressured included:

- *You have to achieve so many procedures including operations to get points…so the weight [changes] so the money goes down so we have to do more to achieve the same amount.*
- *Juggling the beds and the length of stay is dropping all the time.*

Another concern raised was that the incessant and increasing pressure had made it very difficult for ANUMs and nurses to provide emotional support for patients. For instance, one talked about this with compassion and concern:

I know I don't have time to sit down and talk to a patient.

Generally, it was apparent that the emphasis on shortening bed stay and discharging patients had become unduly onerous in some areas of the hospital. The improvements in efficiency in terms of working smarter and using resources better were recognised by the NUMs as valuable. However, this sort of improvement was inherent in the new structure and the use of quality improvement techniques to identify inefficiencies in existing procedures and protocols. The remorseless pressure of the continuing revised WIES weights for particular DRGs went well beyond what seemed reasonable.

Survivors and Reluctant Managers

The participants in this study were survivors of an environment of change that had lasted for almost a decade. Analysis of similar processes of restructuring and downsizing (Dawkins, et al. 1999) revealed that managers who remain in downsized organisations tended to suffer from poor morale, lack of

commitment and motivation, job dissatisfaction and insecurity. These symptoms were clearly not evident with the participants in this organisation.
The process of restructuring and downsizing can be divided into two phases. Phase one included the major changes in job roles, organisational structures and downsizing that occurred with the move to the new hospital. As previously discussed, these changes did cause anxiety amongst the nurses and the loss of some senior and experienced nurses who did not want to change the way they worked. The downsizing was also handled with short term contract appointments filling most promotional positions in the year leading up to the move to the new hospital, thus avoiding further redundancies. The restructuring was also accompanied by extensive consultation about the new model for running the hospital. This model of downsizing fits the criteria of what Dawkins et al. (1999) have described as 'good downsizing'. The discussion above about nurses views of the results of the change process show a relatively positive response.

The second phase of change, which led to further downsizing with the reaggregations and the growing pressures of the WIES/Casemix system present all the features of bad downsizing; repeated job cuts, increased pressure on remaining staff and likelihood of further cuts. In effect this second phase was driven by economic, bottom line considerations and did not appear to have any of the positive benefits like the previous phase.

Despite the experiences of the second phase of change, the nurses' morale, commitment, motivation and job satisfaction remained relatively good. One important reason for this was that despite being put in managerial positions, most of them remained reluctant managers. That is, they remained committed to their vocation. Concern for patients and attachment to specialist areas of nursing stood out in the interviews. Many spoke with passion about their work and this was illustrated in the following comments:

- *I stay here because I want to be a nurse and I still see myself as a clinical nurse as well as a manager.*
- *The reason I am here is because of the patient contact and I love what I do, so that gets you over everything else most times, even having a bad day.*
- *We are torn between the increased managerial role [and clinical nursing].*
- *My passion is surgery, [but] all I feel I am doing at the moment is managing beds and staff allocation.*
- *If I move into management I would like to stay in an area I know some thing about.*
- *I started of in plastics which is my main passion in life.*
- *I love haematology.*

Thus, whilst most expressed some frustration with the managerial side of the job, the positive attachment to the clinical role was very important in maintaining morale and job satisfaction. The inability to give what they considered an appropriate level of emotional support to patients due to work pressure was the only other source of job dissatisfaction expressed.

Besides their commitment to clinical nursing, strong commitment to the hospital was also apparent. This was despite the negative views of previous senior management who were seen as only interested in cost-cutting and lacking the ability to communicate. Typical comments about the hospital included:

- *It is a very supportive organization…It has done an enormous amount of work to review our priorities and be efficient and good at what we do.*
- *It has always been very caring and like a big family.*
- *People who stayed through the second re-aggregation were dedicated and working very hard to keep the place afloat.*

The character of the employees who remained after all the restructuring was another important factor in the positive attitudes expressed. First, they were a relatively young group with an average age of 31, which made them more receptive to change and able to cope with pressures they faced. Secondly, most of those interviewed showed a capacity to deal with change, despite expressing initial misgivings about changes to their work routines. Some commented about how they liked change:

- *I have really learned to like change.*
- *It was a total revelation to me that I turned out to be an early mover and a change agent.*
- *Then you think about it [change] and think about it as a challenge, something new and different and so it is a positive thing.*

The third factor was an ability to cope with what were often unreasonable pressures and to think positively. Comments such as the following from a NUM in one of the more stressed wards illustrate this strength:

> *But you have to try and get on with it keeping everyone positive and I guess that is the way you run the ward… We could not survive if we had a heap of negativity here. Because I was an associate it was important to keep positive with everyone because otherwise it reflects badly with everyone down the line.*

The ability to cope was also aligned with the love of clinical nursing. For instance an ANUM in a very stressful ward explained:

- *The reason I am here is because of the patient contact and I love what I do, so that gets you over everything else most times even having a bad day.*
- *Maybe I am a survivor, I love my job and I think that helps.*
- *The reward comes from knowing you have done your absolute best for people.*
- *Then you realise you are a good nurse and I know what I can do and I do it for that.*

Several also commented on the ability of the nurses who remained to surprise themselves by coping with the pressures.

- *Nurses just seem to cope with it all.*
- *I thought we will never function with this number of beds but we have managed.*
- *I believe everyone has all these things happening and all these deadlines and maybe not enough staff to help out, but it works out, it works out.*
- *But we got through it all and people made excellent adjustments.*

A fourth factor was the perception that senior NUMs and Care Centre Managers communicated well to staff and were supportive in so far as they could be, given the budget stringencies. Meetings at Care Centre level were viewed as good vehicles for discussion and decision about operational issues. The ability of NUMs in a lot of cases to do some hands on work and argue for more resources for staff was seen as a positive feature. Previously senior management was seen as uncaring and non-communicative but the more open approach of senior management of the hospital was also appreciated.

- *It's more open now than it was.*
- *We are well consulted with and communicated with by management of the hospital.*

There was some ambivalence about senior management communication. In the area of professional nursing practice issues, such as work practices, the revivification of a consultative forum called the Professional Nurse Practice Council was viewed favourably. It was seen as a vehicle for tackling issues hospital wide and actually implementing agreed changes.

However, with some policy issues there seemed to be little dialogue. For instance, one NUM noted:

> *But there are still decisions made they go to executive and they get passed and we hear later or you hear about it the day before it goes to the executive, there is nothing you can do. It upsets people.*

The job delegate indicated that communication had improved with the new senior management, but said:

> *They will only let you know what they want you to know.*

There was also a feeling from some of the participants that there was not enough appreciation by some senior management of the pressure staff were under.

> *Some managers are really good they will do their best to get you more staff when you need it, but there are other managers who say, "It's not in the budget, it is just the way you work, your skills, that is why you are not coping".*

Overall, despite the ongoing pressures faced by the management nursing staff to achieve bottom line targets, it is evident that their morale, commitment and motivation remained positive, unlike that of managers in the 'bad downsizers' surveyed by Dawkins et al. (1999).

Conclusion

This paper set out to explore the response of nurse managers to the continuous change experienced by public sector hospitals in the 1990s These changes also occurred in the context of increasing acuity of patients and technological change affecting nursing care. The hospital chosen was a leader in grasping the need to change and acting on it. It was also from comments provided by nurses interviewed a better place to work in terms of workload than other major public hospitals.

The organisational changes of the first half of the 1990s provided a new more patient focussed model of nursing in an environment of decentralised decision making. Those interviewed were largely positive about these changes, having chosen to remain, while others who did not like the changes had left. Those who remained expressed some regret about colleagues who had left and were critical of senior nursing management. There were also adjustment problems with the initial reaggregation of wards prior to the transfer to the new hospital.

Consultation about these changes was extensive even though there were criticisms of it. The levels of redundancies of nurses were considerably less than those experienced by support staff and allied professionals. Generally, morale of nurses on entering the new hospital was positive, despite major changes to their work roles to encompass managerial responsibilities.

Subsequent changes brought about by State Government policy through the application of the WIES funding formula in interaction with Casemix put great pressure on nurse mangers. Each reaggregation and related cost cutting made the situation more intolerable. The impact of this pressure, however, was uneven as the discussion of pressure on nurses revealed. Some wards were harder hit than others due to the nature of the wards, treatment measures and the type of patients.

Research by Dawkins et al. (1999) indicates that managers in organizations suffering repeated downsizings and increasing work pressures would show poor morale, low commitment and motivation. However, this research has shown that to a large extent the nurses interviewed were reluctant mangers, whose overriding concern for their work and patients largely counteracted such negative feelings. Further, they were a self-selected group in that they remained when others left. They were also a relatively young group of managers with considerable energy. These factors assisted them to absorb a lot of pressure, whereas, with a group of people less dedicated this would not have been possible.

However, the broader labour market consequences of this situation were to render acute care nursing unattractive to potential nurses, as the hospital found it difficult to fill positions in key wards where the pressure were felt most. This outcome raises a key issue: the inability of politicians, health department officials and in some cases hospital management to see when an equilibrium point of reform had been reached beyond which further change and cost cutting became counter productive. By the time labour market pressure demonstrated by a nurse shortage became apparent, considerable damage had been done to the hospital and to the community it serves. The plight of the present government in not being able to create new beds in hospitals due to a nurse shortage is a reflection of this situation.

Innovation, better quality and efficiency are admirable, but this research indicates that there is a need to recognise when the equilibrium point has been reached beyond which damage is done to the organization, its employees and clients. More effective understanding by management of the situation faced by employees is critical to stop the need for crude responses such as labour market pressures being the only warning sign. Bodies such as the Auditor-General in

his report did highlight the issues. However, there is need for an independent body such as the Auditor-General to develop a methodology to assess these issues to improve public policy making.

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