

NORTHERN HOSPITAL OF SURRY COUNTY

Focus Group Study

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Prepared by:

NEW IDEAS IN TRAINING & DEVELOPMENT

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INTRODUCTION

Purpose Of The Project

The focus group study is one module of a comprehensive program to ascertain and address concerns and needs of the different functions of Northern Hospital of Surry County (NHSC), build commitment and loyalty of personnel, improve communication, and build teamwork skills of hospital administration and management. The goals of the focus group study were (1) to ascertain the concerns, needs, and issues important to the different groups in the hospital in order to determine how best to address them, (2) to determine the extent of dedication and loyalty of personnel to the hospital and how they can be strengthened, and (3) to facilitate communication between staff and hospital administration and among various functions of the hospital and to determine how communication can be improved.

Research Plan and Focus Group Participation

In order to explore complex factors such as those listed in the above goals, the hospital administration decided upon a series of two-hour focused discussion groups. The questions for these focus groups were designed to encourage discussion of feelings, opinions, and attitudes, which are often conditional, multifaceted, and specific to particular groups within or associated with an organization. Two experienced facilitators conducted a pre-test group on December 12 and then conducted a total of seventeen research groups on December 16, 17, and 18, 1996.

The pre-test was conducted in order to test the wording and sequence of the questions, familiarize assistants with the research protocol, and obtain feedback from participants on questions they wanted included. Questions pertaining to employee evaluations were added at the suggestion of pre-test participants. Data from the pre-test group were not included in the analyses.

In order to ascertain the concerns, needs, and issues important to the different groups employed by and affiliated with the hospital, focus groups were designed to represent particular categories of employees and affiliates. Because it was thought that some groups might be uncomfortable stating their concerns and opinions in front of members of another group, focus groups were planned to be as homogenous as possible. Categories which make up a larger proportion of hospital employees were allotted proportionally more groups. For example, three groups were scheduled for nurses, whereas only one group was scheduled for administrators and managers. Focus group categories are shown in Table 1. Individuals invited to participate in the focus groups were chosen at random from a list of all employees or affiliates in that category.

Table 1.

Participation by Group

Group	Total Employed or Affiliated	Number of Focus Groups Conducted	Number Invited to Participate in Focus Groups	Number (%) of Invitees Who Participated	Percent of Employed or Affiliated Who Participated
Administrators and Managers	38	1	10	8 (80%)	21%
Dietary, Laundry, Maintenance & Engineering	57	1	10	8 (80%)	14%
Nurses	219	3	30	20 (67%)	9%
Hospital Volunteers	76	1	10	6 (60%)	8%
Hospital Nurses' Aids	56	1	10	6 (60%)	11%
Home Health Nurses' Aids	66	1	10	6 (60%)	9%
Board of Trustees	7	1	7	4 (57%)	57%
Diamond Healthcare	25	1	10	5 (50%)	20%
Clerical and Support Staff	218	2	20	9 (45%)	4%
Medical Staff	103	2	20	7 (35%)	7%
Nurse Practitioners and Physicians' Assistants	16	1	10	3 (30%)	19%
Community Business (on Chamber of Commerce list)	29	1	10	2 (20%)	7%
Hospice/Lifeline Volunteers	26	1*	10	1* (10%)	0%*
Total	936	16*	167	84* (49%)	9%

* The focus group of Hospice/Lifeline Volunteers was canceled after only one person showed up. That group is not included in the total number of groups conducted, nor is that one individual included in the total number of participants.

Ten invitations were issued for each research group, for a total of 170 invitations to participate in the research. Of those, 84 invitees participated in their groups, for a participation rate of 49%. Twenty-six invitees canceled; 60 simply did not show up. One scheduled group had to be canceled due to lack of participation (one person came, two had canceled, and seven did not show up). Sixteen research groups were conducted with 84 total participants, representing 9% of all employees and listed affiliates of the hospital.

The level of participation was not as high as hoped, given that everyone invited to participate (with the possible exception of businesses from the community) had a high vested interest in the hospital. A number of factors contributed to the low turnout, perhaps most important being the request that people invest two hours of their time during the Christmas season. Invitees who canceled gave a variety of reasons, such as seasonal time demands, nervousness in groups, other engagements, inability to find childcare, and out-of-town travel. Fear of disclosure was another possible reason; the individual taking cancellations indicated that many callers were concerned about what they would be asked in front of the group or about talking freely in front of others. In addition, lack of trust in administration or in “outside” facilitators and a conviction that “it won’t do any good” were expressed to the contact person for cancellations and to the facilitators and may have reduced participation.

Comparison With Overall Hospital Staff

In terms of demographic data, focus group participants appear to be representative of all employees of NHSC. The average age of employees of NHSC is 42.6 years, with a range of 18 to 77. The average age of a participant in the focus group is 45.2 years, with a range of 22 to 69. Focus group participants had been employed at NHSC an average of 7.4 years, with a range of less-than-one to 24 years. All NHSC employees have been employed an average of 7.8 years, with a range of less-than-one to 40 years. Three African-Americans represented the 21 African-Americans and one hispanic represented the two hispanics in the personnel records. The remaining 80 participants were white.

SUMMARY SECTIONS

It is quite normal for participants in focus groups to use the opportunity to respond at some length to specific questions to spend a certain amount of time on emotional, hot-button issues. This is a normal dynamic which is often related to the lack of opportunity these individuals have to openly speak their minds. The function of a project such as this one is to go beyond the emotional content and to find the themes which are of greatest importance to the organization. This section summarizes the comments of the individuals within each of the groups.

The broad topics selected for examination in this project were perceptions, leadership, communication, change, and culture. The first four are summarized in this section. Culture is addressed in the Synthesis and Interpretation section of this report since it is a culmination of the other four topics.

Perceptions

The first step in developing a detailed picture of Northern Hospital of Surry County (NHSC) involved learning about the participants' perceptions in three areas.

- Participants' general perceptions of NHSC
- Participants' understanding of the community's vision of NHSC
- Participants' beliefs about NHSC as a place to work

Participants' Perceptions Of NHSC

The general consensus was that Northern Hospital of Surry County is a nice-sized, "homey" hospital, a place where as a patient or an employee "it's comforting to know so many people." They value its hometown ambiance and believe that the smaller size and hometown friendliness are important aspects of providing personal care. Many people echoed the pride of this Home Health nurses' aide, "It's the place where I work, and I am proud of it." However, hospital nurses would not have agreed with the same aide's sentiment, "I enjoy my work. If I didn't, I'd go somewhere else." For some, most notably for nurses, the enjoyment and pride in their work has disintegrated under the increase in patient loads and cutbacks in staff and the "small group feeling is gone."

A number of people spoke about the hospital's importance to the community socially and economically. It was repeatedly pointed out that many of the residents of Surry County have a personal connection to the hospital, either through their employment by the hospital, or through a friend or relative who either presently works or has at one time worked at the hospital. One of the more sophisticated views presented was that NHSC is "a necessary part of the community, an anchor. . . . Without it something would

be lacking. .. [It] provides social and economic stability. You don't do economic development without a hospital." One person mentioned that the hospital's structure on the hill is a town landmark and the first important building she saw when she drove into Mount Airy.

Participants' Understanding Of The Community's Vision Of NHSC

When asked about how they believe the community sees NHSC, the participants responded in four basic ways, each of them reflecting a somewhat different set of beliefs voiced in the community.

- 1) First, the community sees NHSC as "the hospital of Surry County," here for the local people. It does well within its limits, and it is a local hospital that specializes in small health issues.
- 2) Second, NHSC is a "Band-Aid station," and "a springboard" for sending patients down the road." This implies a belief that the level of care at the facility is below standard and that doctors are sending their patients elsewhere.
- 3) Third is the perception that patients receive poor medical care at NHSC. This appears to be a result of highly visible problems in the emergency room and on several floors of the inpatient unit -- primarily long periods of waiting coupled with less than personal care for patients and their families.
- 4) The fourth cluster of perceptions is rooted in the rural nature of this area and grows out of the increasing number of patients receiving treatment at satellites in the small communities around Mount Airy. Patients remain confused regarding what are now satellite offices of NHSC and the relationship these satellites have with the hospital. The satellites are often not seen as part of the hospital.

Participants' Beliefs About NHSC As A Place To Work

Another area of investigation explored participants' perceptions of NHSC as a place to work. Four distinct but related themes emerged:

- 1) The first is a generally positive picture of the organization. Many of the participants indicated that they are happy with the work environment, feel that it offers better security and benefits than other places that would utilize the same skills, and think that it is a great place to work. A position at NHSC offers these individuals ample opportunities and challenges, a sense of stability, and a source of pride.
- 2) A second, less positive, theme also emerged. Many of the same respondents feel that the organization has now become too money-oriented and that it is responding to the

- “managed care express train.” These individuals talked about this trend with a sense of sadness, loss and increased anxiety concerning the future of the hospital.
- 3) A third set of observations made by a broad cross-section of participants is that the nursing staff is understaffed. The perception here is that, historically, the nursing staff has carried the hospital and that they are now bearing the brunt of the changes.
 - 4) Another frequently heard theme concerns divisions in the physicians’ staff. This directly affects the participants’ work environment since it leads to other types of divisions throughout the hospital and it contributes to low morale, lack of communication, and lack of trust.

Leadership

Characteristics

An organization’s leadership is crucial to its overall success. Without a thorough understanding of the leadership structure of NHSC, the administration, staff, and employees will find it difficult, if not impossible, to confront and resolve the important issues that lie ahead.

The first task in understanding the participants’ views of leadership was to identify what they believe to be a list of leadership characteristics. A summary of these characteristics is shown in Table 2. Secondly, the participants’ were asked for their observations of the actual leadership in the organization, shown in Table 3.

The responses indicated that leadership characteristics identified by the clerical and support staff, dietary, maintenance, engineering, volunteers, nurses, aides, NP’s and PA’s were strongly weighted toward effective listening, showing appreciation, knowing co-workers well, friendliness, positive reinforcement, and especially, visibility and accessibility. Participants from these groups wanted their leaders to be connected to them, accessible, easy to work with and dedicated to them.

However, the administrative and managerial group, the medical staff, the Board of Trustees and representatives from the business community consistently described leadership in terms of open-door policies, communication skills, respect, honesty, vision, and an ability to get others to do what they are supposed to do. While there was a recognition in these groups of the need for leaders to work with others toward consensus and to keep dialogue open, the predominant focus was on managerial skills.

Table 2.

LEADERSHIP CHARACTERISTICS	
<u>Communication Styles</u>	
Clerical and Support Staff, Dietary, Maintenance, Engineering, Nurses, Aides, NP's, PA's, Volunteers	Administrators and Managers, Medical Staff, Board of Trustees, Business Community
<p>Gives honest answers Straight talk Listens well, implements ideas Relates well, considerate Acknowledges others' contributions Shows appreciation, visible Asks how you are doing and gives you five minutes to answer</p>	<p>Up front and honest Open-door policy</p>
LEADERSHIP CHARACTERISTICS	
<u>Interpersonal Skills</u>	
Clerical and Support Staff, Dietary, Maintenance, Engineering, Nurses, Aides, NP's, PA's, Volunteers	Administrators and Managers, Medical Staff, Board of Trustees, Business Community
<p>Ability to motivate, consistent Friendly, humorous, outgoing A friend, gives hugs, open Meets peoples' needs Appreciative, shows genuine concern Treats you like an equal, no favorites Keeps people reasonably happy Gives positive reinforcement</p>	<p>Consistency Fairness Respected, respect for others Available Facilitator for work development Lots of confidence</p>

Table 2 (cont.)

LEADERSHIP CHARACTERISTICS	
<u>Management Approach</u>	
Clerical and Support Staff, Dietary, Maintenance, Engineering, Nurses, Aides, NP's, PA's, Volunteers	Administrators and Managers, Medical Staff, Board of Trustees, Business Community
<p>Well-informed, has brains Knows and understands the employees' jobs Gives them autonomy Gives employees freedom to do job Works well together, able to get someone to do something Knows her people and not afraid to trust them, supportive Helps people work with others Can "go with the flow" Will jump in and help out Takes care of the person doing a task Good common sense Can problem-solve effectively Proactive, gets things done Not too aggressive or assertive</p>	<p>Vision, has a defined mission Can find out what people want and go with it Builds consensus Help staff develop more autonomy Will listen to complaints but not make exceptions Good skills, has the knowledge to guide people Knows who to call, good coordinator Gets people to do what they want Gets the job done Is able to admit a mistake Is able "to put some teeth into it if you don't do a good job"</p>

Observations of actual leadership at NHSC clustered along similar lines. The participants from the clerical, support, nursing and direct care groups strongly indicated that, in terms of general, hospital-wide leadership, they see most of the administrative leaders as distant, aloof, absent, money-oriented, and ineffective. With a few exceptions, most of these departments see their immediate supervisors as reasonably effective and supportive.

Once again, the administrative, medical and business groups saw the leaders of the hospital as generally doing a good job, working hard at bringing the hospital along, a bit lacking in vision, perhaps, but professional, business-like and fair.

Table 3.

OBSERVED LEADERSHIP	
<u>Communication Style</u>	
Clerical and Support Staff, Dietary, Maintenance, Engineering, Nurses, Aides, NP's, PA's, Volunteers	Administrators and Managers, Medical Staff, Board of Trustees, Business Community
Mysterious, distant, aloof, never see them, not visible, absent Those in the trenches don't see them Doesn't try to see what we are doing Lots of distance from day-to-day work	Better communication Never see them
OBSERVED LEADERSHIP	
<u>Interpersonal Skills</u>	
Clerical and Support Staff, Dietary, Maintenance, Engineering, Nurses, Aides, NP's, PA's, Volunteers	Administrators and Managers, Medical Staff, Board of Trustees, Business Community
Business-like, uncaring Too money-oriented, profit-oriented Make good business decisions without considering the employees	Business-like, professional Company-run administration Fair

Table 3 (cont.)

OBSERVED LEADERSHIP	
<u>Management Approach</u>	
Clerical and Support Staff, Dietary, Maintenance, Engineering, Nurses, Aides, NP's, PA's, Volunteers	Administrators and Managers, Medical Staff, Board of Trustees, Business Community
<p>They must see what the community wants</p> <p>Don't know how to be effective</p> <p>Poor training, inability to do job</p> <p>Mostly a mess, no leadership, non-existent, indecisive</p> <p>Not as good as it should be</p> <p>Do what they say</p> <p>His/her way is the only way</p> <p>Plays favorites (housekeeping)</p> <p>Too many managers</p> <p>Insufficient within the dept.</p> <p>I hear they are in fear of their jobs</p> <p>Doesn't help with the departmental split</p> <p>Still at the trial stage</p> <p>Responsive, progressive, involved, headed in the right direction</p> <p>Good within the department</p>	<p>Hard to know where we are going</p> <p>Need a better focus</p> <p>Getting things together</p> <p>Better in the past two months, going in the right direction</p> <p>Very effective</p> <p>Very good, "whoever is leading them is obviously effective"</p> <p>Conflict of interests (contract)</p> <p>Major problems below Bill James</p> <p>Uncomfortable with chief nurse doing more with less</p> <p>Nurses don't like their director</p> <p>Was promised a walk-through, but there wasn't one</p>

Three things are evident in the above tables:

1. The desired characteristics of leadership vary dramatically between the two groups. Expectations of the organization's leaders, how they should function in their daily routine, and how they should treat the people around them, are very different.
2. What most of the staff members of the hospital want regarding their leaders is considerably different from what they believe they are getting.
3. While the administrative and managerial staff members, medical staff and business community believe that the leadership is generally good within the organization, the employees and staff members believe that the overall leadership in the organization is lacking.

Together, these three observations make it fairly clear that there exists between these two groups a leadership gap in both definition and in daily experience. Related to this is the recognition that the staff sees business-like leadership as cold and uncaring, while the administrative staff, medical staff and Trustees see business-like leadership as professional and effective

Communication

General Observations

Along with the movement to a broader continuum of care, the many changes at NHSC over the past five years have resulted in major disruptions in the communication of information within the inpatient facility itself, to the satellites and branches, and throughout the community. Nearly every group participating in this study consistently mentioned the communication patterns at NHSC as a source of deep concern and in great need of change. From the medical and nursing staffs to the administrative staff to the community at large, information about the hospital is most frequently acquired through the media, the grapevine, the rumor mill and gossip. More formal means of communication such as meetings, bulletin boards, faxes, and memos were mentioned as moderately effective to poor.

A positive note was that nearly everyone interviewed agreed that changes in the communication patterns were critically important and worth working on. This indicates an organization which is eager and ready to change, and it presents everyone with an opportunity to make a significant contribution.

Specific Groups

Administrators and Managers

The senior administrators have a communication system which appears to be open, flexible, efficient and generally effective. Informal types of communication are most prevalent -- they talk easily and openly to each other and have high levels of trust in what they hear. Disagreements and conflicts are handled, in general, without too many problems, and resolution is usually forthcoming. During their monthly meetings and through fairly frequent personal contact, the senior administrators distribute relevant information to the departmental managers in a timely manner.

Both the administrators and the managers, however, indicated that they find it difficult to deal with the large volume of information they receive and are unsure about how to effectively distribute it to the staff. They see the open-door policies which are in place in a number of departments as effective, but they do find it increasingly difficult to get out and around the hospital as much as they used to and as often as they would like. They hear the employees saying more positive things, but they seldom hear praise for the

jobs they do. The administrative and managerial staff members also recognize that the overall communication difficulties and the communication overload throughout the hospital are causing problems throughout the staff and resulting in increased turnover.

Clerical and Support staff

The clerical and support staff members report that they regularly have problems finding out what is going on. They rely on the grapevine for most of their information, although they also mention memos, faxes, and meetings as their primary formal sources. Several people mentioned “Northern Notes” and their director as good sources of information, although “some of us are not as happy as we let on and wish we were listened to more frequently.”

Dietary, Maintenance, and Housekeeping

Communication issues within the Dietary, Maintenance, and Housekeeping departments were diverse. Currently, maintenance staff report fairly high levels of satisfaction regarding the way in which information is disseminated. Dietary personnel reported that the cross-training initiative has significantly changed their jobs and made it more difficult for them to get the information they need. Housekeeping reports similar problems with information flow. All three of the groups indicated that the newspaper, neighbors, meetings, and rumors provide them with a significant amount of their information about the hospital. Although communication at NHSC has “improved over time,” “some hear, some don’t.”

Nursing Staff

Nurses were among the most dissatisfied with the amount and quality of the information they receive. They report that most of their information comes from the grapevine. They also report that communication from above is low, that they have “no personal contact with administration” and do not know “Karen O’Donnell, Chief of Something.” Communication is “few and far between.” “Older nurses and newer nurses do not communicate.” One area of concern was that regular staff meetings have been discontinued and replaced with meetings held on a crisis basis and on their own time. This prevents them from feeling fully informed. “Sometimes you just don’t know” what is going on.

Diamond Health Care

A special case in the area of communication is the group affiliated with Diamond Health Care. Communication with their co-workers at NHSC is perceived as generally informal but adequate. Information is received from other staff members and from the grapevine, but very little from elsewhere. However, in regard to Diamond Health Care, nobody except the secretary talks with them, and even this is infrequent. They rarely have contact from the home office in Virginia and “we only see them in their Jaguars.” The lines of communication are very informal and not very effective, and they report feeling isolated and on their own.

Although this group reported general communication with NHSC co-workers to be fairly good, their sense of isolation also appears in how they feel treated by the larger hospital system. An example of this was related by two of the group members. One of the nurses on the Diamond Health Care-affiliated unit needed lunches for two patients. The secretary who usually orders the meals was out sick, so the nurse called down for the lunches herself. She was told that her request must be made through the computer, so, because she was new and did not yet know how to use the computer system, she called the computer department for assistance. No one was in the computer department at the time. She got voicemail twice. Then, when she finally talked with one of the computer department personnel, she was told that she would either have to learn to put it on the computer herself or get the other staff nurse on duty to do it for her. The other nurse could not get the meals successfully entered into the computer either. When they called Dietary they were told that they were using the wrong code numbers and that Dietary couldn't deliver the meals without the proper codes. Finally, three hours later, a supervisor went down and got the lunches herself.

Recognizing that there were a series of reasonable and rational system checks at work in this example, what was of practical importance to the nurses involved was that it took them three hours to get meals for these two patients and during which time they got very little assistance from their co-workers in other parts of the hospital. Examples of this type were mentioned on several occasions during the various group discussions, indicating that barriers to effective communication exist throughout the organization and that these barriers can be difficult to overcome.

Hospital Nurses' Aides

Principal sources of information for the inpatient nurses' aides are newspapers, gossip, bulletin boards, and, occasionally, feedback from nurses' meetings. Their daily contact with the nurses is high, but they lack regular contact from their supervisors and from those higher up in the organization, causing them to feel like they have to work very hard to find out what they need to know. In general, they feel that the bad things they do are recognized but that they receive little encouragement for doing a good job with an increasing work load. They report feeling looked down on, ignored and taken advantage of. Given their position at the bottom of the patient-care hierarchy, they believe that they are carrying the brunt of the changes that have occurred at the other levels.

Home Health Nurses' Aides

The Home Health nurses' aides reported feeling content with the amount of information they receive. They depend upon memos, "Northern Notes," and meetings with Betty. "Betty will tell us what we need to know." Perhaps because of their position outside of the physical plant, their relative autonomy when they are in their patients' homes, and their greater amounts of contact time with the patients, the satisfaction levels of this group are considerably higher than those of their counterparts in the inpatient facility.

NP's and PA's

The Nurse Practitioners and Physicians' Assistants reported that most of their information comes from word of mouth, the doctors, the secretaries' network, meetings and faxes. They observed that nurse-to-nurse conflict is fairly low and inter-departmental conflict is somewhat higher, but that there is back-stabbing and cut-throat behavior going on between the doctors, the management and the staff. These conflicts, from their position, remain unaddressed because they are "perpetually ignored."

Hospital Volunteers

As a group, the hospital volunteers are one of the most positive groups interviewed. Although they cite gossip as their main source of information, they also mentioned their newsletter, director, and telephone committee as important sources of information. Because of their unique position as volunteers, the communication difficulties they experience with the various departments leave them frustrated but not nearly as dissatisfied as other groups we interviewed.

Medical Staff

The medical staff participants consistently indicated concern about the lack of communication within their own ranks and within the entire organization. There is "no dialogue", i.e., they don't feel like they have sufficient input. They also indicate that they are not consistently informed about what is happening within the organization, leaving them dissatisfied and critical. They reported being interested in improving organizational communication, recognizing that better communication would help the rumor situation within the staff. They want more input into the direction and mission of the hospital and are interested in working with the administration and the rest of the staff to develop a clearly focused mission.

Board of Trustees

Members of the Board of Trustees acquire their information in fairly predictable ways, including reports from Bill James, talking with other trustees, occasional phone calls from employees and people in the community. They also gather a significant amount of information from casually asked questions, comments made by community members at church or in stores, consultants and the Gallup poll.

Business Community

Primary sources of information for the business community include the newspaper, radio, and the Board of Trustees. Other sources include local service clubs, the rumor mill, and community members.

Communication Observations

As the focus group discussions progressed, a picture emerged of the communication patterns at NHSC. Communication flow is highly centralized and mostly one-way. Top administrators communicate well with each other, meeting weekly and

talking frequently and openly with each other. They make definite efforts to disseminate information to the managerial staff and to the medical staff during monthly meetings and through memos and informal discussions. However, the employees do not consistently and systematically receive that information from the managers. As a result, the employees feel uninformed and attempt to fill in the gaps with information from rumors and gossip. Rarely did staff members mention that they feel heard by the levels above them. Finally, the satellite offices reported that they do not get information in a timely way, if at all.

This type of communication system leaves everyone in the organization vulnerable to misinformation and misunderstandings, and it practically guarantees that the community will have less than favorable impressions about the hospital. It also leads to a feeling of systemic helplessness because the patterns become self-sustaining and difficult to change.

Two other communication trends emerged during the group discussions. First, information about technical issues, patient needs, and necessary changes is being communicated throughout the hospital without too many difficulties (although information overload is certainly a problem). However, the reasons and motivations behind the desired changes are not consistently communicated. While these may be understood by the administrators and managers, nearly everyone below these levels indicates that they do not have the opportunity to share it with them. When they indicate that they want this information, they report occasional retaliation from the administrators or managers. This was indicated on several occasions with comments like “do it or leave,” and “if you don’t like it, you can hit the door.” While these comments can be understood from an overworked and understaffed perspective, they are extremely destructive to a healthy work environment.

Secondly, although the technical information is generally accurate and effectively communicated, the messages of praise for the staff’s hard work and dedication are often missing or replaced with critiques of problem areas. Face-to-face discussions happen in many departments all too infrequently because everyone is so busy. The irony here is that individuals working in a place of healing are too busy to take care of each other.

Change

General Observations

NHSC is beginning to feel the direct impact of changes occurring nationwide in health care. Recent administrations began tightening expenditures and downsizing staff in order to stabilize profitability and to improve the competitive position of the hospital. The impact of these changes has been felt most profoundly by the members of the nursing staff, who have seen staff cuts and high turnover as well as an increase in the acuity of patients under their care. These changes have also affected the medical staff and inpatient

nurses' aides. Additionally, there appears to be a degree of ambivalence regarding the changes that have occurred during the two years that Quorum has managed the hospital. Most of the participants recognized the necessity of many of the changes that were made, but they also expressed anxiety in response to the impact of those changes and how they were handled.

A fairly large number of the participants indicated that their resistance to change is increasing. They want more information and greater communication of the reasons for things being changed. They feel helpless and have little control over what is happening around them. Nearly everyone indicated that they feel a need for some stability within the hospital.

Specific Groups

Administrators

The changes implemented over the past two years have added to their responsibilities as well as to their authority. They generally feel increasingly empowered, and they recognize that this sense of empowerment needs to be extended to the other levels of employees, although none of the group members followed up with suggestions as to how that could be accomplished. They are also aware of some of the negative effects that the increased drive for productivity and the concurrent need to improve profitability have had on other staff members, principally higher stress levels, overwork and increased sick leave.

Clerical and Support

Major reorganizations have caused a great deal of disruption in daily routines. This has made the work environment confusing, stressful, and more difficult. It has also led to some insecurity about their jobs, fewer people and more work. Increased crosstraining has changed what they do and has created increased levels of anxiety. The required attention to confidentiality is difficult for them because of their close ties to the community and their proximity to patient information. Some departments have experienced an increase in available budgetary funds. They see the organization as open and accepting of change, although some staff members are set in their ways and inhibit changes.

Dietary, Maintenance, and Housekeeping

The maintenance department has received funds to replace outdated equipment, so they have more time available to do other tasks now. They like it when their supervisor works with them and is one of them. They appreciate this and work harder and better and are under less stress. The dietary staff feels they need more personnel to deal with increased patient turnover. Crosstraining has changed their jobs. Housekeeping has fewer people and more work. Crosstraining has changed their jobs as well.

Nurses

The consensus in this group is that there have been too many changes recently and they are struggling to keep up with them. They want more stability and the opportunity to speak in groups and to be listened to. Their concerns about overwork, high levels of stress and burnout, and reduced patient contact were significant. Due to the combination of reduced numbers and more responsibilities, (some of which are, out of necessity, being moved to them from the medical staff), the nurses in all of the groups reported steadily increasing levels of frustration and resentment over their inability to see their patients as often as they have in the past. One telling comment along these lines was a nurse who said that she and many of her nursing friends no longer enjoy their work like they used to. It is more difficult for them now to do the jobs they were trained to do and they can no longer get all of their paperwork done. They feel that all of these issues have caused the quality of care to drop. They indicated that their morale is low, their trust levels have dropped, and that they fear they will experience reprisals for speaking up.

Another area of concern among the nursing groups is their loss of benefits. Although they recognize that cutbacks in nursing staffs are occurring nationwide, they have a sense of insecurity about their jobs and retirement benefits. There has been a change in the sense of the hospital being a small, hometown place. "Same story, different book." Changes in OB are an example of what distresses them: the nursery was eliminated and babies now stay with the mothers; mothers do not get enough rest and are sent home earlier -- exhausted and without adequate education about being new mothers.

Diamond Health Care

The most significant change described by the nurses employed by Diamond Health Care is in the policies and procedures required by their home office. They have little or no say in their operating procedures and report that they feel isolated and out of touch. This group was required to resign from their positions at NHSC and to reapply to Diamond in order to keep their jobs. In the process they lost their years of seniority, causing a great deal of unresolved animosity and resentment. They report that many of their personnel policies seem to be unfair and that they have little or no control over their work environment.

Inpatient Facility Nurses Aides

Recent changes have been consistently negative for this group, resulting in rising frustration, alienation from managers and administrators, and greater work loads. They are clearly at the front edge of patient care, receiving more tasks and responsibilities that have been moving down the patient care line. A comment one of the aides made was, "work in our place and see what we do and what goes on." They want more information and greater communication of the reasons for changes, and their resistance to change is increasing.. They report feeling helpless, with little power over anything in their area. They do not indicate receiving much encouragement for doing a good job and they feel taken advantage of.

Home Health Nurses' Aides

This is one of the only groups which reported high levels of satisfaction and the participants indicated that it is because their jobs have not changed. “We always have done what we always have done.” The department has grown from six nursing assistants in 1988 to over sixty now and their overtime was recently stopped. They attend more meetings than they did before. This members of this group enjoy their work and they feel appreciated. They do extra things for their patients and find that it has been noticed and appreciated by their supervisor. They have clear instructions about what to do, and they feel comfortable that there are good reasons for the restrictions (“If you do something not on the list, you make it hard for the next CNA.”)

NP's and PA's

There were “problems with trust with the first administration.” With the new CEO it is “not as bad does not exist as it did.” They see the hospital as divided and fractured and they feel that recent changes may not last. For example, “changes were made for JCAHO, then three weeks later it had all changed back to what it was before.”

Hospital Volunteers

Their biggest change was in the patient confidentiality area: they are no longer allowed to talk with their friends and neighbors about people who are in the hospital. They have found this to be difficult because they feel very strong ties to the community. However, they understand it and go along with it. The volunteers see the hospital as very open to change. They are impressed with the CEO's leadership and they are extremely happy with their director.

Medical Staff

Participants from the medical staff expressed clear recognition of the increasing demands of the managed care system and the consequences of the recent downsizing. They reported that the medical staff accepts the hassle factor of the increased paperwork demands and the more intrusive nature of managed care. However, they expressed concern about the negative impact on daily patient care of the smaller numbers of nurses and aides many of whom are less experienced or working outside their specialty areas. Their primary concerns were two-fold: 1) that their patients are increasingly less satisfied because of the reduced numbers of contacts with the nursing staff; and, 2) that the stress and related unhappiness of the nurses themselves is increasing. They also reported that many of the changes made over the past couple of years do not seem to have a clear focus and that they are unsure of the organizational direction.

Board of Trustees

Many organizations are changing, and NHSC is having some of the same problems as any changing organization. However, the changes are also producing some fear of the unknown in the community and are contributing to the negative image of the hospital. Board members reported that concerns about staffing adjustments, fewer patient days in the hospital, and lost individual coverage choices at the employees' expense with reduced benefits and increased premiums are common knowledge in the community. Increased demand on Home Care (partly because of changing insurance rules), MBA's

making health care decisions, and doctors losing independence and forming larger groups are all dynamics which are having an impact on the community.

Business and Industry

The business and industry participants reported that recent changes have concerned the community. People are no longer sure what the hospital is anymore or who owns it. They want more stability and they feel that the changes have affected the quality of care to some degree.

In summary, the recent changes experienced at NHSC have resulted in patients seeing their doctors less, their nurses less and the nurses aides more as the various tasks associated with patient care are moved farther down the line. Consequently, these tasks are being performed by staff members who are not as well trained as the previous level, but are being held accountable for the tasks' successful completion. This is the source of much of the increased stress now being experienced by the staff. Providing the nurses and the nurses' aides with the emotional ability to handle these increased responsibilities will be every bit as important as training them to complete the tasks. Without this, they will not develop the confidence that they need in order to help their patients feel well cared for.

SYNTHESIS AND INTERPRETATION

Organizational Culture

The culture of Northern Hospital of Surry County is reflected in the topics we have covered: perceptions, leadership, communication, and change. These areas were examined separately to allow for discussion of the findings from specific groups within the hospital on those topics. In this section, the underlying values and assumptions will be examined, as well as topics related to culture:

- explicit and implicit values and the ways in which they are communicated,
- style,
- structure,
- communication patterns,
- how work is viewed (and by extension workers),
- flexibility, and
- assumptions about leadership and power.

Some of these topics are illustrated by stories told by participants in the focus groups or by catch-phrases and sayings that were repeated so frequently by a variety of study participants that they apparently reflect cultural attitudes and beliefs. These stories and sayings are the myths of the culture, although this does not imply that they are untrue. They are cultural myths in that they illustrate and support the cultural belief system.

Any organizational culture is a dynamic system, shaped by history, by the community in which it was formed and continues to participate, by the profession it supports, and by the interpersonal relationships shaped through and continually creating the experiences of those within it. These forces shape the NHSC organizational culture, but the process is not one-way. The organizational culture also sets up meaning systems, explicit and implicit values, preferred styles, structures, communication patterns, insider/outsider definitions, and assumptions about leadership and power that constrain and construct the ways in which the community, professionals, and employees relate to the organization, to each other, and to outside influences. Although employees enter NHSC with their own individual abilities, dispositions, and levels of education, their behavior, capabilities, and experiences are largely shaped by the cultural practices and values of the organization. Culture is an active system whereby the range of variability of behavior is guided, shaped, and constrained. By examining the limits of variability the cultural constraints and values can be understood.

Cultural values at NHSC are both explicit and implicit, but by far the largest part of the system is implicit, operating below the level of awareness. As in any other kind of human cultural group, the basic beliefs and assumptions that NHSC holds are hidden from the employees. Because so much of culture operates below the level of awareness, hidden as assumptions and meaning, it is both powerful and persistent in shaping and constructing people's behavior. This also makes it difficult to change. Certain ways of

behaving carry meaning long after the literal, practical reason has lost relevance. For health organizations in the rapidly changing health care environment, it is frequently true that patterns of behaviors, norms, and accepted practices that no longer foster the organization's success are continuing to replicate the old system to the detriment of the organization's survival. In examining NHSC's culture, certain questions must be asked: Does it support the mission of the hospital? Does it foster its success? Does it support members of the organization in doing their work?

Explicit and implicit values

Employees of NHSC explicitly value its small-town atmosphere. It is important to them to know people in the halls and to have many levels of connection to the hospital. They communicate a sense of pride in the hospital by employees and other members of the community. Behind their complaints about patients "going down the road" is a belief that people in Mount Airy should patronize the hospital because it is there for them. A corollary of this is that the hospital is failing in its responsibilities if it does not provide everything that any citizen of Mount Airy may want or need in the way of healthcare.

For almost everyone in the focus groups, "the hospital" is equivalent to the inpatient facility, and since those services are shrinking, the hospital is not doing well. This is a misunderstanding of the reality of the current NHSC system. While ward census and emergency room visits are down due to changes in insurance rules, other services such as Home Health and satellite offices are growing. If employees and members of the community knew more about the broad spectrum of services that NHSC now provides, their image of its vitality, fitness, and readiness would improve.

Rapid changes in the types of services provided, staff cuts, and the impact of having "four administrators in four years" (statement made by a member of the medical staff) have left many associated with the hospital uncertain about the basic values of the organization. Those affected most by the changes have the strongest feelings about the values they now see as encouraged by the hospital administration. Members of the medical staff expressed concern about the impact of reductions in nursing staff on patient care and expressed the belief that profit is valued over patient care. Nurses themselves feel that the organization once valued patient care but now values speed and dollars. Other groups identified such a wide variety of encouraged and valued skills, behaviors and attitudes that the value system appears to be unclear.

Organizational values at NHSC are disseminated and encouraged through rewards, benefits, and policies. For example, funds for education are an issue for many employees. The overall picture presented is of educational funds awarded solely to managers (more than one participant said they were for managers to get their MBA's), while, at the same time, continuing education for nurses has been eliminated. Other policies appear to indicate the devaluation of employees below the level of manager or valuing profit more than patient care. Examples include:

- Requiring on-call nurses to be in their uniforms at home and waiting in case they are called in to work.
- Sending nurses home and requiring them to take a vacation day when patient census is down.
- Home Care nurses and aides must take a vacation day if they cannot make their rounds due to snow.
- Twenty-four hours' notice is required for an "approved absence." If a child is sick in the morning and an employee calls in to work, the absence is "unapproved." Supervisors have no leeway in dealing with these situations.
- The "flower fund" in housekeeping - if there is a death in the family, the department sends flowers only to the contributors to the flower fund.
- People in satellites had to reapply to keep their jobs and lost their seniority. People who had worked 15 years at the same job in an office were on six months' probation in their "new" jobs.
- Putting a de-tox patient opposite a child appendectomy patient.
- Waking patients on the med-surg ward at night to bathe them.

Some of the above policies were cited as evidence that nurses and other front-line employees are numbers, "assembly-line" workers, who are "on commission," or that the inpatient units are too short-staffed to provide good patient care. They represent the explicit value system at NHSC.

Style

The current administration's style is informal and efficient, presenting a congenial, friendly, hard-working face (as compared, for example, to a scientific, authoritarian, powerful face). Although the CEO is seen as accessible, other administrators and managers are not. This may be an artifact of the more formal style of previous administrations. The present casual style is manifest in the office location, layout and decoration, open office doors in the administrative wing, and employee reports of going to the CEO when they have difficulty getting problems addressed.

Structure

There appears to be a boundary between senior administration or managers and the rest of the staff. With a few exceptions, employees report that they do not know their administrators, would not recognize the CEO if they saw him, and that the director of nursing is inaccessible and is never seen on the units. The prevailing message from most employees is that "there are too many chiefs" and that the hospital is "management heavy." It is this barrier between administrators and their staff members that is reflected in staff views of administration as "distant," "inaccessible," "mysterious," "aloof" (See Table 3, Observed Leadership) and in barriers to communication.

Communication Patterns

Several aspects of the communication patterns point to an authoritarian culture, including knowing your place, acting respectful, saying only what is safe or risk being branded as a trouble-maker, fear of making waves, and waiting for orders. Ten of the sixteen focus groups began with questions by the participants regarding their “safety” in answering questions. An assumption underlying the discussion of these groups was that communication is one-way from higher-ups, and that communication from employees to administration is unsafe. There is an appreciation for managers and administrators who have an “open-door” policy. Only two were mentioned specifically, indicating that an openness to communication from below is unusual.

When opportunities for feedback are few or non-existent, the organization conveys the impression that conformity is expected. In many departments at NHSC, the atmosphere does not encourage collaboration and teamwork. On the contrary, with some uncertainty about the security of their jobs, people engage in playing politics, blaming, and dichotomous thinking. When asked how policies and procedures are made and improved, only the board, managers and administrators had answers. Other groups had no idea and reported that they look up policies and procedures in “the book.” When asked how they proceed if a policy or procedure needs improvement, most did not know; some responded that they talk with their supervisor about it. They also reported that problems have been brought to the attention of a supervisor with no effect.

There is some indication that this barrier to the flow of information to or from employees may be a remnant of previous administrations. Several participants told of having to go directly to the CEO to get something done. They relate that the current CEO is open to communication from other sectors, even when other members of the administration are not. As discussed in the summary of communication issues, this barrier is felt by employees as a lack of information from administration. At times, communication appears to be managed on a “need to know” basis, disenfranchising and devaluing lower level employees and leaving them feeling “out of touch” and left out. Two explanations could account for this. Either administrators or directors are inadvertently failing to allow information through to their employees, or they are guarding it.

The approach to the education of these workers reinforces this impression that information is being managed. Growth and development are not encouraged, which amounts to their being discouraged. Rather than enjoying their present position, people begin to compete with each other to climb to the top, so that they can get into the position of control over communication and benefits, rather than working as team members, collaborating, and empowering others.

Stories such as the one about the administrators not talking with the new employees during the orientation lunch or situations in which an employee is told to “do it or leave” are important reflections of the value system at work and reinforce employees’ views of how NHSC operates. These stories communicate NHSC’s value

system and shape the behavior of individuals and the organization. In these instances they reflect the view of the employee as an economic unit, not as an individual with creative capacity and a role in shaping current and future health care.

How Work (And Workers) Are Viewed

Traditionally, many people in healthcare have identified more with their profession than with their organization. Many participants in the focus groups involving medical staff, nurses, and inpatient-facility nurses' aides view their work at NHSC as a ministry. They experience frustration and disillusionment when the hospital's business goals take priority over patient care and when they see their managers as concentrating on money and paper profit, while their own focus is on taking care of their patients. Their pride in their profession and their sense of ministering to the sick are endangered by the movement in health care to operate as an industry rather than a ministry.

When reasons given for change at NHSC are based on a value system that is in conflict with the value system under which employees are operating, those changes are resisted and either intentionally or unintentionally compromised by front-line workers. Although the source of the conflict is below the level of awareness, it shows itself in the relationships between adherents of the two different views of work. For example, many of the more-experienced, long-term, traditional nurses refuse to communicate with the new nurses, many of whom have associates' degrees rather than the traditional BSN and are seen by some as approaching nursing as a means to a paycheck. On the other hand, for some, the hospital is, as one long-time nurse said, an "avenue to see patients." Differing views of work run throughout the organization and underlie many of the factions and conflicts.

Flexibility

In its efforts to adapt to the changes required for survival in the nation-wide health care environment, NHSC has encountered community-based resistance to change. Surry County has a tendency to be quite insular. Insiders are trusted; outsiders are viewed with a certain amount of reserve, if not distrust. Participants in the focus groups frequently noted which individuals were "from Mount Airy" in the course of their comments. More than one person said with sadness that "Mount Airy is changing." The impression was that outsiders were bringing about change, and that both change and outsiders are unsettling.

The insiders = stability, outsiders = change dichotomy and the local tendency to distrust outsiders were reinforced by the experience the hospital had with the brief tenure of one of their recent CEOs. The current CEO has encountered a legacy of traumatic changes as well as some resistance related to his outsider status. If NHSC maintains its flexibility in dealing openly with these issues, the employees will establish a sense of trust and belief in the stability of the hospital.

Assumptions About Leadership

In regard to general elements of leadership, most of the focus group participants tended to relate to positions or roles. Position power rather than power through relationship appears to be predominant throughout most of the hospital. A telling example of this is a story related by a new nurse. During orientation, the incoming employees were told that the administrators would join them for lunch. The administrators arrived and sat at a table together, never mingling with the new employees. “Why did they bother?” was the prevailing sentiment after the administrators left. This incident created a sense of alienation for the individual relating the story and prompted an echo of understanding from the other participants of her focus group.

As observed in the summary of leadership, administration and managers, the medical staff, the business community, and the board have very different views and expectations of the hospital’s leaders than do the rest of the employees. This may reflect the persistence of the previous, more authoritarian culture throughout the hospital system. This divergence in leadership expectations makes it incumbent upon the entire hospital organization to develop a new picture of leadership.

Critical to the development of the hospital is the understanding that each and every member of the hospital staff must take it upon themselves to lead in the growth and development of their individual departments and units. The staff members throughout the organization possess considerably more power over their work environment than they believe that they do. This concept of co-construction, the ability of all involved to mutually construct the work environment, will be important for the administration to understand and encourage, and will be a true test of the leadership throughout the hospital.

In summary, the culture of NHSC is one which contains a number of internal contradictions. The values and behaviors of its long-standing culture is conflicting with the new requirements of health care and the new management style of the current administration. Contradictions between explicit and implicit values, disrupted patterns of communication, ways in which work is viewed, and assumptions about leadership lead to conflicts, cliques, and a feeling by some elements of the organization of being victimized by others. Participants in the focus groups expressed a desire to rally around their strengths and to construct an organizational culture which reconciles their beliefs with their workplace realities.

Internal Variances

Administrative/Management and Employee

An important point which arose from the focus groups was a variance in perception within the staff. The closer the staff member is to direct patient care within the hospital itself, the stronger the feelings are of dissatisfaction, stress, and overwork. The farther the staff member is from direct patient contact, the more satisfied, challenged and energized the staff members reported themselves to be. The only exceptions to this trend appeared in the Home Health program.

Administrators and managers consistently indicated that the changes over the past two years have had several positive results for them. These changes have given them more authority and autonomy with which to do their jobs, in effect empowering them to a degree they had not experienced before. This has permitted them to feel more challenged professionally and has provided them greater professional opportunities and higher levels of support to stretch their creativity and managerial skills.

Aside from the recognition of the negative effects of downsizing on the staff noted earlier, the administrative and managerial members of the focus groups were striking in their belief that, although NHSC has certain problems which need to be addressed in these other groups, their own jobs are increasingly energizing, challenging and exciting and offer those elements which keep them happy. It was also noticed that the higher the administrative position, the greater the level of reported satisfaction.

The support staff we interviewed, however, painted a different picture. Here we began to hear increasing levels of concern and dissatisfaction. Although the improved economic position of the hospital has enabled a few departments to actually receive more budgetary support, employees in most of the departments reported uncertainty about the status of their positions and fears that they might be let go. This was an issue that never surfaced in the administrative group.

Additionally, because of the cutbacks already experienced within the support staff, these employees are now reporting considerable disruption in their daily routines. As crosstraining has been introduced (in an effort to maximize the work potential and flexibility of the remaining staff members) these employees have begun to experience considerably higher levels of anxiety and stress as they have been required to learn new job skills that were not expected of them before and for which they are neither technically nor emotionally prepared.

STRENGTHS OF THE ORGANIZATION

When dealing with the problem areas identified in this report, NHSC has a variety of strengths upon which to draw. It is clear that many of the employees interviewed take great pride in their association with the hospital and in their own jobs. For some, both their expressions of pride and their sense of frustration are indications of the significance with which they see their jobs. With a few exceptions, they have confidence in and trust their immediate supervisors and their CEO.

Employees and those groups closely connected to the workings of the hospital are in considerable agreement concerning its strengths. The three areas most frequently mentioned as strengths or high quality were the nursing staff / nursing services, Home Health, and the hospital's leadership. Two groups mentioned their own director or immediate supervisor. Next most frequently mentioned were the dedication, quality, and talent of the staff, and the pride and joy that they take in their jobs.

Nurses and inpatient facility nurses' aides expressed the opinion that their desire to work hard, their caring, and their vision of being on the front line is a strength of the hospital. Four groups (dietary, maintenance, housekeeping, and the medical staff) selected their own functions as "highest quality," a clear indication of the pride they take in the roles they play. Day surgery, the specialty care unit, psychiatric unit, and Hospice were mentioned as "highest quality." They mentioned as strengths their connections to the community and cooperation between departments. They also clearly valued and frequently read "Northern Notes."

IDENTIFIED PROBLEMS AREAS

Focus group participants' lists of problems clustered around six themes: problem departments or functions, need for a particular specialist or skilled worker, issues with management, unpopular or unfair policies, systemic issues, and needed information or special requests.

Problem Departments Or Functions

- 1) Nursing -- By far the most nominations for problem area went to nursing. Cuts in nursing staff and the poor morale of nurses are highly visible.
- 2) ER -- Long waits, inconsistent care, and ineffective or inaccessible management of ER were frequently mentioned.
- 3) Billing -- Problems with billing are a source of considerable frustration for patients and can negatively affect their satisfaction with hospital services. Employees report having been turned over to a collection agency for payment of an account which was to be covered by insurance and being told by neighbors and friends about problems with the hospital's billing department. The billing department's use of voice mail was also mentioned.
- 4) Radiology -- No services at night.
- 5) Obstetrics.
- 6) Medical-surgery floor.

Need For A Particular Specialist Or Skilled Worker

- 1) Pediatrician and emergency pediatric services.
- 2) Another general surgeon.
- 3) An anesthesiologist.
- 4) Pathologist for emergencies.
- 5) Spanish language translator.
- 6) Another social worker for geriatric patients.

Issues With Management

- 1) The hospital is “management heavy.”
- 2) Lack of visibility of upper management to rank-and-file employees.
- 3) Departmental leadership -- Poor, inflexible, not accessible.
- 4) Director of nursing -- Not providing leadership for nursing.

Unpopular Or Unfair Policies

- 1) Lost benefits, especially decreased insurance benefits.
- 2) Loss of hospital daycare.
- 3) Need for adult daycare.
- 4) “Approved” and “unapproved” absence policy.
- 5) Housekeeping “flower fund.”
- 6) Last minute scheduling changes by management that cost nurses vacation days.
- 7) Snowy, impassable roads cost Home Health workers vacation days.
- 8) Merit pay raises for excellent evaluations were all under the expected 3%.
- 9) Funds for education consistently given to middle and upper management.
- 10) Patients discharged too soon.
- 11) Not enough full-time positions. Some “part-time” employees are working full-time hours and not receiving insurance benefits.

Systemic Issues

- 1) Infighting between doctors.
- 2) Communication breakdowns, lack of information at rank-and-file level.
- 3) Split in dietary department.
- 4) Conflict is ignored.

- 5) Poor image in the community of the care offered at the hospital.
- 6) Separation of Home Health and satellites creates a feeling of isolation and a sense of not being part of the hospital.

Needed Information/Special Requests

- 1) Community and employees do not fully understand the mission of the hospital.
- 2) Help in emotionally processing the death of a patient.
- 3) Help at the emotional level in dealing with changes.
- 4) A full-time security guard.
- 5) More parking.
- 6) Volunteers would like a room of their own where they can rest and put their coats.

GENERAL CONCLUSIONS

In order to effectively meet its long term objectives and thrive in the current health care market, NHSC must successfully define itself in a way that is recognized and valued by the community and by the hospital staff. Is it a small-town hospital? If so, its services are necessarily limited, and those limits need to be clear and well-defined. There is no shame in sending patients “down the road” to a larger hospital if their needs are outside those limits. If it is to be something else, then the organization needs to identify what this is and clarify what actions will need to be taken in order to work toward it. With a broadly-based and clearly-defined mission and approach, NHSC can help create a set of expectations which are congruent with reality and which can be successfully met. The result will be satisfied patients and a sense of accomplishment for the employees.

Given the diversity of services provided by the hospital, it must redefine itself along the full continuum of services in order for its successes to be recognized. We cannot emphasize strongly enough here that this must happen with BOTH the employees and the community as a whole. The extensions of the hospital (Home Health, satellite offices, etc.) are the components which are experiencing the greatest growth, while the inpatient unit is experiencing a decline in patient load. As long as the citizens of Mount Airy and the employees of NHSC see “the hospital” as only the inpatient facility, they will see it as shrinking and struggling. Once the more robust units are also recognized as “the hospital,” they will begin to see it as a strong, successful, multi-dimensional organization.

RECOMMENDATIONS

Administrative Staff

- Address the issue of retaliation. Does it happen? How often does it happen? Why do some of the staff members feel this?
- Increase administrative visibility among the staff by meeting with them more frequently, talking with them on the floor, getting to know each supervised staff member.
- Listen to how the individuals they are supervising feel about their supervision and about the environment in which they work.
- Develop a vision of the preferred working environment which NHSC wants at every level of employment with every staff member.

Nurses And Inpatient Facility Nurses' Aides

- Set up a process by which they can grieve the changes in nursing care -- the new ways are likely to remain for the foreseeable future.
- Re-evaluate what motivates them in this new system where there are fewer nurses and aides, more patients and greater responsibilities while at the same time reduced benefits in order to help the hospital remain viable.
- Introduce the concept of co-construction -- this can help them with the issue of empowerment because they are the ones who will construct a new type of environment which is exciting and fulfilling.
- Convene a series of meetings where they can define for themselves what they need from their administrators.

Hospital Employees And Staff

- Develop understanding and support of the hospital's mission from all areas.
- Define the boundaries of the hospital and the scope of the services it provides.
- Create expectations congruent with the hospital's mission.

- Develop a plan of action by which these expectations can be effectively communicated to the community.

The culture of NHSC reflects the change and conflict in health care nationwide. Many of the feelings expressed by the participants in these focus groups are outgrowths of the inherent inconsistency between the methods of the health care industry and the belief that the patient is an individual with specific needs, requiring individualized care. Reducing the anxiety and stress the participants reported will be dependent upon their ability to reconcile the macro changes of patient-as-inventory with the desire to nurture and care for their patients as individuals. Re-learning to treat each other as respected, valued co-workers will result in the creation of an environment which blends the necessity of cost-consciousness with the capacity for care-consciousness. As the administration and staff at NHSC adapt creatively to these tremendous pressures, an explicit understanding of the underlying values and meanings they are constructing through their decisions (the culture) will be essential to maintaining the “care” in this health care facility.