BEDPANS, VITAL SIGNS, AND MEDS:
HOSPITAL RESTRUCTURING AND THE SKILL POLARIZATION OF NURSING WORK

by

Martha Elizabeth Oesch


Submitted to the Department of Urban Studies and Planning
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the Requirements of

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ABSTRACT

In this thesis I examine hospital restructuring and its impact on the organization of nursing work. Regulatory changes in medicare reimbursements to hospitals, the nursing shortage, and the use of the professional practice model of primary nursing in hospitals have influenced hospital restructuring.

My research revealed that the Boston area hospital was undergoing restructuring and that cost and control of work were guiding principles in reorganizing nursing work. Evidence of the reorganization of nursing work included: changes in job descriptions, the merging of jobs, and the introduction of a new nursing worker. Nursing staff are being segmented in new ways. A new phase of skill polarization results from the segmentation with mixed consequences for nursing staff. To maintain control over their work, registered nurses need to form alliances with other nursing workers.

Thesis Supervisor: Dr. Edwin Melendez
Title: Assistant Professor
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INTRODUCTION

"A nurse does so many jobs in one day, I'm not sure what a nurse is any more."

"I can't give my full attention to a patient when we're understaffed with nurses. It's like an assembly line where you are always wondering if you did everything you were supposed to."

These comments by registered nurses at a Boston hospital reflect the complex and changing nature of nursing in hospitals today. This thesis is an exploratory case study of one hospital in Boston that is in the midst of changing the way nursing work is organized. I chose this case study as a glimpse into changes in the organization of nursing work, and more importantly what the consequences are for nurses.

Harrison and Bluestone(1988) show firms are changing the way they do business today because of competition. Changing the way they do business often in firms changing the way work is organized. It is important to understand how work is organized because the organization of work has consequences for which workers have access to which jobs. In addition, different ways of organizing work require different skills from workers.

The health care industry in the United States is
undergoing major transformations due to the skyrocketing cost of health care. Hospitals are responding to these changes in a number of ways. Hospitals are the major employers of registered nurses. Thus, nursing provides a good example of how changes in the health care industry and hospitals affect the organization of work.

As I learned from my research, nursing involves much more than giving medications, taking blood pressure, and changing bandages. Nursing is a complicated job with many competing demands.

THE SIGNIFICANCE OF NURSING

Occupational Growth in Health Care

Almost half of the job growth in the United States from 1972-1980 can be attributed to twenty occupations including registered nurses (Leon, 1982). The biggest employment gain among professional workers occurred among registered nurses. These gains paralleled the growing demand for health services during the 1970s. Though men increasingly entered nursing during this time, 95 percent of the job gains occurred among women (Leon, 1982). These gains are expected to continue in the nineties.

However, while the demand for health care services is expected to increase during the 1990s because of a rapidly aging population, it is uncertain whether this will translate into substantial job growth for wage and salary
workers in health care because of changes in the financing and delivery of health care (Kahl and Clark, 1986). Hence, what the job prospects are for registered nurses is uncertain.

My Argument

In this thesis, I argue that three factors over the last twenty years have influenced the restructuring or the reorganization of nursing work in hospitals nationally and in the Boston hospital under study.

1) Insurance Reform: Rapidly rising health care costs resulted in significant changes in medicare reimbursement to hospitals in the early 1980s. These changes caused hospitals to adopt different strategies for maintaining profits in the face of cutbacks in reimbursement (Applebaum and Granrose, 1986). Reorganizing employment and the organization of work appear to be important strategies in maintaining the profit rate.

2) The Nursing Shortage: Nationally a nursing shortage has plagued hospitals for the last ten years. The severity has fluctuated over time and by region. Unable to recruit registered nurses to fill vacant budgeted positions, the hospitals have often turned to using other workers to perform some of the work previously done by registered nurses.

3) The Primary Nursing Trend: In the last twenty years, what
is called primary nursing has become the professional practice model for nursing. Focused on giving registered nurses primary responsibility for the total care of patients, primary nursing has opened up new ways for organizing nursing work in hospitals.

CONSEQUENCES OF HOSPITAL RESTRUCTURING FOR REGISTERED NURSES IN THE HOSPITAL STUDIED

Evidence of Restructuring

I set out to study how hospital restructuring affects nurses, particularly in regards to the organization of work.

At the hospital I studied, I looked for evidence of restructuring of nurses' jobs in three areas: 1) changes in the job descriptions of head nurses and registered nurses; 2) the merging of jobs; and 3) the formation of a new category of nursing worker.

New Forms of Segmentation

Historically, there have been three tiers of nursing staff stationed on inpatient floors in my case study hospital: registered nurses, licensed practical nurses, and patient care assistants. The hospital has recently attempted to introduce a fourth tier, the nurse partner, an innovation which has met with limited success. However, hospital administrators state that there may be an attempt in the future to introduce more nurse partners (or people in a similar position), merge that tier with patient care
assistants, and decrease the number of licensed practical nurses through attrition. The anticipated effect would enable the hospital to handle the same case load even when the number of registered nurses decreases through attrition. I explore whether the strategy of introducing nurse partners is being used by the hospital to reduce costs and gain more control over the work of registered nurses. It is interesting to study how a new category of worker is introduced and what the implications are for registered nurses and other nursing staff. I suggest that the introduction of a new category of worker segments the nursing staff in a new form.

The Problem of Skill Polarization as Evidenced by Assessment Skill

Changes in the organization of nursing work often lead to a separation between what Braverman (1974) would have called the "conception" and "execution" of nursing work. Registered nurses, with more education, are assigned to do the planning and documentation of patient care and the assessment, while there is an attempt to assign some of the technical functions, such as changing dressings, to other nursing workers with less education. Whether conception and execution can be separated in the case of nursing is questionable. The ability to adequately assess a patient's overall condition, a primary nursing skill, is dependent
upon a registered nurse integrating hands-on, practical skills, with planning, or conceptual skills. My case study of a Boston hospital explores the problems registered nurses face in performing well when conception and execution are separated. I found that skill polarization was occurring at the hospital.

**Mixed Consequences for Nursing Staff**

The above changes have different effects for different tiers of nursing staff. The tensions that result from these differences, however, can point to the need for alliances between registered and other nursing staff. I explore this in my last chapter and conclude by recommending that it is in the best interests of registered nurses at this hospital to form an alliance with the patient care assistants if they want to maintain control over the organization of nursing work.

**The Semantics of the Case Study**

In this case study, I have chosen to use the feminine pronoun when referring to any nursing staff. There are more men entering nursing today than previously. However, the gender composition of the nursing staff at the hospital I studied was predominantly female, and as discussed in the case study, the gender composition of nursing has ramifications for how nursing work is perceived and
organized.

Though the sex-segregated nature of labor markets is decreasing slowly over time, nursing remains predominantly female. From its very origins, the nursing profession in the United States has been a highly sex-segregated occupation, evidenced by the extreme ratio of women to men in nursing jobs. As of 1988 little has changed, as women comprised 97 percent of all nursing occupations (Laster, 1989).

The Organization of the Case Study

In Chapter One I provide the theoretical framework for looking at hospital restructuring and the organization of nursing work. Next, in Chapter Two I examine the three factors affecting hospital restructuring nationally. Chapter Three is a descriptive case study of a Boston hospital undergoing restructuring. Chapter Four follows with a more complete analysis of the changes observed at the hospital. Lastly, Chapter Five provides my recommendations to registered nurses for maintaining control over their work in this hospital.
CHAPTER ONE

THE THEORETICAL FRAMEWORK FOR UNDERSTANDING NURSING AND HOSPITAL RESTRUCTURING

This chapter provides an overview of the theory which I use in analyzing my case study of nursing work at a local hospital in Chapter Four. First, I briefly review the history of the organization of nursing work. Then I examine the arguments for industrial restructuring, segmented labor markets, skill polarization and the acquisition of nursing skills; and demonstrate how they are interrelated and integral to understanding why changes in nursing work have different implications for different workers providing care to patients.

THE ORGANIZATION OF NURSING WORK OVER TIME

The First Thirty Years of the Twentieth Century

During this period, nurses' place of practice moved from the home to the hospital, where they initially served as private duty nurses. Soon they became employees of the hospital and their roles were legitimized by job descriptions and regular salaries (Manthey, 1980). Because registered nurses could take care of all a patient's needs, individualized patient care remained the goal of nursing using a case management approach. Under case management, a registered nurse was responsible for overseeing and coordinating all the needs of a patient. As
Manthey(1980:14) states, this "mark(ed) the first time that graduate nurse practice was subject to the rules and regulations that exist in a bureaucratic institution."

World War II

A severe nursing shortage during World War II precipitated the need to find new ways of organizing nursing work. Multi-level training programs were established both in the military and in civilian life to teach auxiliary personnel how to do simple care, such as taking vital signs and giving baths, and technical procedures, such as changing dressings. For civilians, two types of programs were established which Manthey(1980:15) describes:

(The first was) a one-year program preparing people to provide technical nursing care, and (the second was) on-the-job training which prepared people to perform the simplest types of care. The former were called Licensed Practical Nurses, the latter, Nurses' Aides. . . By the end of World War II, this role(nurse aide) had been institutionalized to the extent that most hospitals were providing their own on-the-job training programs for nurse aides.

Thus, during the fifties the concept of team nursing developed. Designed according to a mass production model of service delivery widely employed in industry, team nursing divided up tasks among workers based on education and training. Specialization meant more highly trained registered nurses performed the jobs which required special knowledge (ie. how to insert an intravenous device) and analytic abilities while less educated licensed practical nurses and nurse's aides performed
duties requiring less training, such as monitoring blood pressure and bathing patients. The work of all these workers was supervised by a team leader or "foreman" who was a registered nurse. The specialization of nursing skills is based on Taylorist principles where the least educated and presumably least skilled worker did the least complex task leaving the more educated workers to perform tasks requiring higher skill competency (Glazer, 1988).

While serving as a partial solution to a nursing shortage, team nursing also provided hospital administrators with an opportunity to keep the cost of registered nurse salaries down by using cheaper labor to perform some of the tasks previously done by registered nurses (Manthey, 1980).

The Sixties and Today

Dissatisfaction with team nursing came from both nurses and patients. Nurses were frustrated by the fragmented care given, and patients found the fragmented care dehumanizing (Manthey, 1980, and interviews). During the sixties nurses began to try and define what professionalism meant for nursing. Nursing organizations discussed how educational preparation separated registered nurses from other workers on a hospital floor. Registered nurses viewed this discussion as a positive step toward identifying nursing as a profession. At this time, there was also an attempt by nursing organizations to distinguish between nurses who held baccalaureate degrees as "professional"
nurses and those who held an associate degree or diploma as "technical" nurses.

In addition, in this period of exploration of what it meant to be professional, attempts were made by nursing organizations to "isolate the 'unique' body of knowledge that would 'belong' to nursing and to nursing only" (Manthey, 1980:19). This concern over what is the nature of nursing work is still evident today in the practice of "primary nursing" as I demonstrate in the case study exploration of a Boston hospital in Chapters Three and Four.

The seventies saw the development of primary nursing as a response to the fragmented care of team nursing. Conceptually, primary nursing consists of four design elements:

1) allocation and acceptance of individual responsibility for decision-making to one individual; 2) assignments of daily care by case method; 3) direct person-to-person communication; and 4) one person operationally responsible for the quality of care administered to patients on a unit twenty four hours a day, seven days a week (Manthey, 1980:31)

The element of one nurse being ultimately responsible for the care of a specific patient is the most distinctive feature of primary nursing as opposed to team nursing. As conceived by Manthey(1980:xv), who is seen as the key founder of primary nursing, primary nursing is "a system for delivering nursing care in an inpatient facility; that is all it is". While this may be true, it is also true that the implementation of any system is influenced by many factors such as the nursing shortage and hospital efforts at cost containment which will be examined in my
case study in Chapter Three.

With this background in mind, I turn now to theories which shed some light on why such changes are occurring.

EXPLANATIONS FOR THE CHANGING WORLD OF WORK IN THE UNITED STATES

The Emerging Era of Professionalization and Paraprofessionalization

The existence of segmented and dual labor markets in the United States explains how different groups of workers are slotted into different types of jobs. The dual labor market argument postulates the existence of a core and a peripheral sector in the economy, each with distinct labor markets. In this explanation, labor markets are organized vertically by industry. In contrast, Edwards, Reich, and Gordon (1973) describe a horizontal concept of labor markets based on occupation. These segmented labor markets are distinguished by jobs in the primary and secondary labor market. Jobs in the primary labor market are characterized by high wages and benefits, career mobility, and unionization. Jobs in the secondary labor market are typically dead-end, low-wage jobs in unstable industries.

Noyelle (1987) argues that the existence of dual labor markets and segmentation are on the decline. The disappearance of internal career ladders and a multiplication of entry points to firms are evidence of this. Noyelle (1987) postulates that the United States is moving toward an era of professionalization and paraprofessionalization. Noyelle (1987:99) identifies four key
factors in the emergence of professionalization:

1) the growing importance of knowledge-based inputs in processes of production; 2) the difficulty of traditional capitalism to assert its control over new critical inputs; 3) the desire of firms to increase their flexibility within markets by purchasing 'increments of expertise' as needed rather than by hiring people to which they must become committed; and 4) the concomitant attempt by occupational groups to reestablish control over blocks of knowledge as a way to enhance their leverage in the marketplace.

These factors, which may affect the development of nursing as a profession, are key elements to understanding the struggle over the organization of nursing work and are explored in my case study of a local hospital in Chapter Four.

Restructuring and Changes in the Organization of Work

Restructuring, or changes in the way firms conduct business, is driven by competition among capitalists (Harrison and Bluestone, 1988). Hospital restructuring is driven by competition. External changes, such as reforms in third party payments for medicare, have forced hospitals to refigure how to maintain profit levels, or even improve profit levels, by reorganizing the way health care is delivered.

Such restructuring at the firm level often results in restructuring or changes in the organization of work at the occupation level. Harrison and Bluestone (1988) argue that in the United States restructuring at the firm level to maintain profits has had severe ramifications for workers in the form of two-tier wage scales, a proliferation of part-time work, and union busting. Competition between firms represents a vertical
restructuring. The reorganization of work within a particular firm represents horizontal restructuring. This concept of a complementarity between vertical restructuring and horizontal restructuring provides a framework for analyzing the changes taking place in hospitals today.

Hospital restructuring often results in segmenting hospital nursing staff in new ways. These changes in the segmentation of occupations in hospitals, and the resulting changes in the organization of work, are evidenced by changing job descriptions, the elimination of or combining of jobs, the creation of new jobs, and the increased use of nonprofessionals. In this thesis, I use the term nursing staff to refer to workers in a hospital who may deliver direct patient care of some kind and are stationed on a floor in a hospital: head nurses, nurse-in-charge, registered nurses, licensed practical nurses, nurse assistants, and nurse extenders. Each of these workers represents a different segment of the workforce as distinguished by education, specified duties, and wage level.

**Skill Polarization**

The changes in the organization of registered nursing work reflect the debates on trends in the nature of work as articulated by Braverman (1974) and Noyelle (1987).

Braverman, in his seminal work on the degradation of work in the twentieth century, argued that workers were being deskillled through the reorganization of work along Taylorist lines.
Historic changes in nursing work seem to confirm Braverman's predictions about the reorganization of work. Braverman predicted that in work there would be: 1) a fragmentation and detailed division of labor; 2) a separation of the conception and execution of work, and 3) a polarization of skills, represented by high and low level educational requirements. I argue that the development of team nursing embodies all three predictions and that the move toward primary nursing reflects an attempt to reintegrate the conception and execution of work. Team nursing divided work among many different workers. Some workers, with limited training, performed technical skills such as inserting a tube or changing a dressing. Other workers, with more training, developed the plan of care for the patients. This is an example of the separation of the execution and conception of work, and the polarization of skills based on education. Primary nursing was conceived as a way to better integrate conception and execution by having one registered nurse overseeing and responsible for a patient's total care plan. However, as will be illustrated in Chapters Three and Four, primary nursing does not always achieve this. At the Boston hospital I examined, the emphasis is for the primary registered nurse to conceptualize and develop a patient care plan and then delegate the work needed to implement the plan. I argue that this is an example of the separation of the conception and execution of work.

Noyelle (1987) postulates that the move from a manufacturing to a service economy has led to a need for increased flexibility
of workers’ skills as exemplified by advanced education and training. According to Noyelle, increasingly sophisticated technology requires an upgrading of skills. Thus Noyelle, like Braverman, depicts a polarization of the workforce into a cadre of highly skilled workers and a smaller cadre of low skilled workers, with technology replacing some of the middle level skill jobs. In nursing, it is not necessarily technology which is slowing the growth of the middle tier but hospital efforts at cost containment.

The debate in hospitals on the organization of nursing work ultimately focuses on what is nursing work and who should do it. It should be noted that the debate is in part guided by hospital cost containment efforts, the registered nurses desire to increase their professional status, and hospital strategies to deal with the nursing shortage. I examine this debate in my case study to understand whether it is really possible and desirable to separate the conception and execution of nursing work in providing patient care.

The Acquisition of Nursing Skills

Benner’s (1984) theory on the acquisition of nursing skills clearly raises questions as to how nurses’ work should be organized for nurses to obtain high degrees of competency. This theory suggests that the acquisition of nursing skills may be impeded by the skill polarization resulting from restructuring.

Premised on the idea of a continuum of levels of nursing
skill, Benner argues that graduate registered nurses begin as novices and progress to an expert skill level. The acquisition of advanced skill is based on the ability to interpret and integrate practical experiences with a theory base and to continually assess situations based on previous knowledge. The need for nurses to have both a practical (or clinical) and a theoretical base in order to advance raises questions as to how nursing functions should be delegated among staff. If primary registered nurses are relegated to planning and documentation but do not have the opportunity to spend time at the bedside and gain increasing practical experience and interaction with a patient, then how does that affect their development of nursing skills? Chapters Three and Four will address the concerns raised by this theory in the context of a local hospital.

Theories and Their Relation to My Case Study

These theories provided the framework for my questions and central hypothesis. I set out to explore two main questions: 1) Is restructuring of hospitals occurring and why?; and more significantly, 2) What are the impacts of restructuring for the organization of nursing work? In order to see if restructuring was occurring, I needed to examine how a particular hospital conducted itself as a business. Restructuring theory, with its focus on competition as the driving force, led me to look at external factors influencing all hospitals. Changes in medicare reimbursement to hospitals, the nursing shortage, and the
promotion of primary nursing as the state of the art professional practice model were all externally generated forces.

To assess whether skill polarization was indeed occurring, I needed to compare the education and training among different nursing staff and see how that affected what job they did. Segmentation analyses led me to examine the tiers within occupations and the qualifications needed to enter at any one tier.

In order to understand the effects of restructuring on the organization of nursing, it was essential to examine one case hospital to be able to get at the particulars. As Eli Ginzberg points out in the foreword of Noyelle’s(1987) Beyond Industrial Dualism, "It is always difficult to study and assess new trends before they become fully established . . . The only answer seems to be for researchers to take selective forays into the new reality by studying institutions in the process of change." My foray into the work of nurses at a Boston hospital allowed me this opportunity.

Summary

In this chapter, some of the changes in nursing are attributed to the emergence of an era of professionalization and new labor market mechanisms. Skill polarization resulting from restructuring has consequences for some nursing staff by limiting their opportunities to acquire nursing skills.

Chapter Two details the picture of nursing in hospitals.
nationally and regionally. It discusses three factors influencing hospital restructuring: changes in Medicare reimbursement to hospitals, the nursing shortage, and the use of primary nursing. Chapter Three will then examine these factors at a local hospital and describe the results for the organization of nursing work in the hospital.
In this chapter I examine three factors influencing hospital employment restructuring and place them within both a national and a regional context. I contend that regulatory reform of medicare reimbursements, the nursing shortage, and the development of primary nursing in the last two decades are the main factors influencing hospital employment restructuring. I conclude the chapter by discussing a relatively recent manifestation of this hospital restructuring in the development and growth of a new type of nursing worker called the nurse extender.

The Employment Structure in Hospitals

Before analyzing the main factors influencing hospital restructuring, it is necessary to understand the basic employment structure of acute care hospitals. The employment structure of hospitals is complex with many layers of technical, professional, clerical, and ancillary staff. In a simplified form, the employment structure can be divided into five tiers as follows: 1) physicians, administrators; 2) professionals (registered nurses, social workers, physical therapists and medical technologists); 3)
skilled technicians such as licensed practical nurses; 4) clerical employees and assistants; and 5) service workers such as nurse’s aide and housekeepers (Laster, 1989).

In analyzing the general changes in the hospital employment structure, I limit my focus primarily to registered nurses, licensed practical nurses, and nurse’s aides. The registered nurse, licensed practical nurse, and nurse’s aide positions are long-standing nursing positions within hospitals and represent the direct patient care providers who typically spend the most time with patients. In my case study, I also examine the supervisory position of the head nurse because it provides insight into the changes occurring over time at this particular hospital.

The duties of each category may vary slightly across hospitals and regions. It is also difficult to give a comprehensive picture of each position because of discrepancies between job descriptions and what a nursing worker may actually end up doing. However, there are some basic job descriptions which are useful for making comparisons between the job categories. (See Chart 1)

A registered nurse is in a licensed position which can be obtained through three different educational avenues: 1) two year associate degree; 2) diploma from a hospital nursing school; and 3) Bachelor of Science in Nursing through a four year college. Nursing organizations across the country are pushing for the baccalaureate degree to be the standard for
registered nurses. A registered nurse legally can administer oral and intravenous medications, hang blood, change sterile dressings, perform documentation and planning of patient care, as well as administer bedbaths, take vital signs, and change bedpans.

A licensed practical nurse is a technical nurse who legally can do most of what the registered nurse can do—except giving intravenous medications (unless premixed) and narcotics and hanging blood. The degree of documentation and planning of patient care a licensed nurse can do varies among hospitals. Educational preparation involves a nine to twelve month program.

Nurse’s aides, known also as nurse assistants, are not licensed, though they may have completed a certificate program. Thus, there are no set educational standards or training. Typically, nurse’s aides duties are neither technical nor clinical but are designed to assist the nurse in the daily routine care of patients. Duties may include taking vital signs, feeding, bathing, and ambulating patients.
<table>
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<tr>
<th>Registered Nurse (RN)</th>
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<td>Nurse’s Aide</td>
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Nursing Staff Wage Differentials

Wage differentials vary greatly by region and by type of hospital. The American Hospital Association in its 1988 Hospital Nursing Personnel Surveys lists an mean average hourly wage for full-time registered nurses of $12.17. Licensed practical nurses on average make roughly $8.50/hour, while nurse's aides earn minimum wage to $5/hour.

National Regulatory Reform and Its Impact on Hospital Restructuring

Reimbursement to hospitals for medicare underwent dramatic changes in the early 1980's. Given that in 1985, payments from medicare amounted to 38 percent of all hospital revenue, changes in medicare reimbursement to hospitals is an influential force in hospital restructuring (Appelbaum and Granrose, 1986). Responding to rising costs in health care, federal legislation was passed in 1983 establishing a medicare payment system based on Diagnosis Related Groups (DRGs) (Appelbaum and Granrose, 1986). Each of the 467 DRGs refers to a specific diagnosis or procedure and lists a cost for treatment. Prior to this, acute care hospitals were typically able to recover the full cost of services provided under medicare because reimbursement was based on the prevailing fees charged in a region. DRG reimbursement provides incentives for hospitals
to reduce the cost of treatment and thus pocket the extra money. However, if the hospital overspends then it must absorb the extra expenses.

Medicare reimbursement, while based on DRGs, included another factor which had differential effects for states. In the first year of implementation, reimbursement was to be based in part on 75 percent of the state's average medicare cost and 25 percent of national average cost for medicare. The second year, the basis was 50 percent state and 50 percent national, and the third year and on it was to be 25 percent state and 75 percent national. Hospitals in states where a large proportion of hospital revenues comes from medicare payments were likely to be hard hit.

This regulatory reform has lead to an increase in the number of outpatient services provided by hospitals, community health clinics, and private practice doctors establishing specialty practices because these services are more likely to be covered. In addition, patient length of stay has steadily decreased as hospitals strive to cut costs in accordance with specific DRGs. Some hospitals, with a large medicare caseload, have sought to reduce admissions of less acutely ill patients thus increasing patient acuity overall.

'Patient acuity refers to the degree of sickness of a patient.
The Impact of Regulatory Reform on Nursing Work in Hospitals

Rising patient acuity and abbreviated patient length of stay in acute care hospitals have combined to increase the work of all nurses in hospitals, in particular that of registered nurses. When a registered nurse first encounters a patient her/his acuity is generally already very high for two reasons. First, more outpatient services mean that people do not enter the hospital until they are too ill to be treated elsewhere. Second, patients scheduled for surgery can have preadmitting tests done on an outpatient basis so that the registered nurse may not see patients at all until they come out of surgery.

The result has been that nurses have had to provide more intense levels of services over a shortened period of time. Acute care hospitals and professional nursing organizations have argued that this necessitates more RNs and possibly all-RN staffs (Glazer, 1988). They believe that RNs could provide the fullest range of clinical and technical skills needed to care for very sick patients. The Department of Health and Human Services’ Secretary’s Commission on Nursing (1988:4), referring to a report by Aiken and Mullinix (1987), states that at the same time,

...additional reductions in non-nursing staff (e.g., lab technicians, physical therapists, medical social workers, unit secretaries, medical record clerks, etc.) also forced RNs to add a variety of additional clinical and non-clinical services to their existing nursing responsibilities.
Hospital Use of Nursing Personnel During Period of Regulatory Reform

The Secretary's Commission on Nursing (1988) reports that from 1983 to 1987, hospitals demonstrated a decrease of full-time equivalents of licensed practical nurses. At the same time, hospitals increased the number of full-time equivalent registered nurse positions despite the fact that registered nurses remained expensive relative to licensed practical nurses.

The American Hospital Association Nursing Personnel Survey (American Hospital Association (b), 1988) study supports this finding. The study shows that when looking at changes in nursing personnel full-time equivalent composition during 1987, hospitals experienced a larger mean increase in full-time equivalents for registered nurses than for licensed practical nurses or nurse's aides or orderlies. For registered nurses the mean change in full-time equivalents was +4.7 percent, while for licensed practical nurses and nurse aides or orderlies the changes were +0.3 and +1.0 respectively. The report also states that in 1988 registered nurses accounted for three-fifths of all nursing personnel working full-time in hospitals, whereas licensed practical or vocational nurses accounted for a little under one-fifth and nurse's aides or orderlies accounted for slightly more than one-fifth.
The Nursing Shortage and its Relation to Hospital Restructuring

Since World War II, the country's hospitals have experienced several shortages of registered nurses. The nursing shortage is measured by hospital employed registered nurse vacancy rates. The current situation is best described by Aiken and Mullinix (1987:641) who state, "The proportion of vacant positions for registered nurses in hospitals doubled between September 1985 and December 1986, reaching levels of the last national nursing shortage of 1979." Though there are both demand and supply factors driving the current nursing shortage, there is agreement that the demand is out-pacing the supply (Aiken and Mullinix, 1987; Igelhart, 1987).

The American Hospital Association Nursing Personnel Survey (American Hospital Association (b), 1988) showed that vacancy rates from June of 1984 to December of 1988 fluctuated considerably. Vacancy rates in 1984 hovered around five percent, then increased dramatically to almost eleven percent in 1986 and 1987 before returning to about ten and a half percent in December of 1988.

The current shortage, however, is distinguished from the others for a number of reasons. "This shortage is occurring during a time when the nation has actually increased its nursing supply steadily," according to a recent American Hospital Association on ways to address the nursing shortage (American Hospital Association (a), 1989) report. Moreover, the Secretary's Commission on Nursing (1988) reports that at the same time that
hospitals had been reporting an increased average registered nurse vacancy rate between 1983 and 1987, they were also increasing the average number of registered nurse full-time equivalents. It is of particular note that these reported nursing shortages are occurring concurrently with a reduction in the number of hospital beds, length of patient stay, and admissions in hospitals nationally (Aiken and Mullinix, 1987). While these trends might seem to indicate a decreased demand for registered nurses, increasing patient acuity in hospitals requires more registered nurses.

Nursing shortages often result in changes in how nursing work is organized in hospitals because hospitals must find new ways to deliver adequate patient care with fewer registered nurses. Thus, a nursing shortage can cause hospitals to restructure.

Studies of the current nursing shortage recommend a variety of coping strategies for hospitals, many of which necessitate the restructuring of the work requirements of nurses and other personnel (Aiken and Mullinix, 1987). In the short term, hospitals need to attract more registered nurses and encourage part-time nurses to work longer through improvements in wages, shift differentials, and schedule flexibility. In addition, studies suggest reorganizing internal management structures and making better use of nurse assistants and other lower level nursing personnel (American Hospital Association(a), 1989; American Hospital Association(c), 1989; and Roberts et.al.,
Recommendations for the long term include recruiting students not traditionally represented in nursing such as recent college graduates, minorities, lower income groups and nonnursing workers in health care settings. The development of scholarships and loan funds is also cited in these studies as critical in attracting some of these new recruits. Furthermore, remedial or bridge programs are needed to prepare students (Laster, 1989).

Changes in Nursing Professional Practice Models and Hospital Restructuring

Historically, nursing has utilized different models for the delivery of patient care (Manthey, 1980). Professional practice models detail who is to administer what type of patient care and how information is coordinated among nursing staff. I will focus on the changes in professional practice models in the past five decades. As discussed in Chapter One, the two dominant models employed during this time have been team and primary nursing. A brief reexamination of these models will provide insight into the relationship between hospital restructuring and the implementation of each.

Team Nursing

Implemented in the 1940's as a response to the nursing shortage resulting from the war effort and based on Taylorist principles of skill specialization, as detailed in Chapter One, team nursing is still used in many hospitals throughout the
country (Manthey, 1980). A basic definition of team nursing follows:

Team nursing is based on the premise of collaboration and division of responsibilities for the nursing care of patients. A team is comprised of several health care givers who usually have different education and skill levels. Each nursing team assumes the responsibility of nursing a group of patients for an eight-hour shift...individual staff are not responsible for any one patient's total nursing care (Gardner, 1989:9). (bold added)

Two variations of team nursing were described to me by both registered and licensed practical nurses who had practiced team nursing at different hospitals in the Boston area. First, while no one staff person had full responsibility for a patient's total nursing care in team nursing, each staff person on a floor was responsible for the care of a certain number of patients on each shift.

For example, on one floor with ten patients the duties may be distributed as follows: the registered nurse is assigned the three patients with the highest acuity level, the licensed practical nurse may take the four less acutely ill patients, and the nurse's aide would be responsible for the three remaining patients who are ambulatory and require minimal clinical assistance. In this scenario, the registered nurse would administer any medications for the patients cared for by the nurse's aide and licensed practical nurse. The planning of patient care was carried out by a team leader, who generally was a registered nurse.
The second form of team nursing described to me more closely resembled the division of tasks on an assembly line. In this variation, each member of the nursing staff, based on her education and training, is responsible for carrying out certain tasks and procedures for all of the patients. For instance, registered nurses administer all the medications, licensed practical nurses take vital signs and give bedbaths, and nurse's aides feed and ambulate patients.

The implementation of team nursing required many staff though a large percentage did not have to be registered nurses. Hospitals could conceivably keep personnel costs down by employing more lower level staff.

Primary Nursing

In the last two decades, "Primary nursing has emerged as a major development in health care. . . ."(Gardner, 1989:1). In primary nursing, each patient is assigned a primary nurse who is responsible for the planning and implementation of total care for that patient; this is in direct contrast to team nursing(Manthey, 1980).

Primary nurses are generally registered nurses, though legal requirements vary regionally with some hospitals using experienced licensed practical nurses. While Manthey(1980) lists no set rules for how many primary patients one nurse should have, examples of primary nursing in the literature generally refer to a ratio of 1:3 or 1:4. For example, a primary nurse may have
four primary patients. Two other registered nurses on the other shifts, sometimes referred to as associate primary nurses, would administer care to that patient based on plans developed by the primary nurse. A registered nurse can serve as a primary nurse for some patients and an associate nurse for others.

The reasons for the development of primary nursing are multiple. Professional nursing organizations cite patient and nurse dissatisfaction with the fragmentation of patient care provided by team nursing and the desire to professionalize the role of the registered nurse (Gardner, 1989; Glazer, 1988). In addition, others argue that while primary nursing is not a direct response to the national nursing shortage, it does provide one way to restructure nursing work in a time of increasing demand (Gardner, 1989). Registered nurses could do a wide array of duties, some of which before had been performed before by the nurse's aide or even some duties performed by the doctor.

Primary nursing influenced hospital restructuring because it allowed for new configurations of nursing staff with the potential for cost savings. With primary nursing, the number of licensed practical nurses and nurse's aides needed is often diminished. Though these are less costly to the hospital than registered nurses, the hope was that registered nurses could do a wider array of tasks than previously and lower overall personnel costs. Thus, the use of primary nursing contributed to the increasing number of registered nurses employed in hospitals (Glazer, 1988; Secretary's Commission, 1988). It is
noteworthy that the anticipated cost savings did not materialize and that this is part of the reason hospitals employing primary nursing are experimenting with increasing the number of lower level nursing staff (Secretary's Commission, 1988; interviews with Boston hospital administrators). In addition, the utilization of primary nursing corresponded to the rising patient acuity in hospitals due to the changes in hospital medicare reimbursements in the early 80's, and hence, provided another justification for the widespread use of primary nursing in acute care hospitals.

THE CASE OF MASSACHUSETTS AND BOSTON

While Massachusetts hospitals, and those in Boston in particular, are undergoing restructuring, some of the factors affecting it differ from those nationally.

Regulatory Reform in Massachusetts

As noted earlier, national changes in medicare reimbursement based on DRGs had severe implications for some states because of the reimbursement pattern. On average in Massachusetts, 40 percent of hospital revenue comes from medicare payments, thus making Massachusetts hospitals sensitive to changes in medicare reimbursement.

As changes in medicare reimbursement to hospitals were being implemented nationally, Massachusetts was adopting its own hospital payment system, Chapter 372, to limit health care costs.
Under Chapter 372, adopted in 1983, hospitals are reimbursed for medicare based on patient volume and not cost. Prior to Chapter 372 a hospital was reimbursed for whatever it cost to service a patient. Chapter 372 was modified in 1986 with Chapter 574 as a partial response to the creation of a state "uncompensated care pool" to help pay for hospital bad debt and free care. Free care is provided for patients who have a documented inability to pay for services, whereas bad debt refers to the noncollection of money from patients whom the hospital has reason to believe can actually pay.

Both of these state laws may be superceded in the future by Chapter 23. Introduced in 1988, this "universal health care law" would allow the state to distribute up to $50 million in state funds to hospitals experiencing shortfalls in medicare coverage. Massachusetts hospitals are more pressured by the changes in medicare reimbursements than other hospitals nationally.

Massachusetts and the Nursing Shortage

The extent to which a nursing shortage exists in Massachusetts is not clear. In interviews with administrators of Boston hospitals, the common perception is that Massachusetts has not experienced the nursing shortage as severely as the rest of the country. However, the Massachusetts Hospital Association Nursing Supply Survey(1989) reports that from May 1987 to December 1987 to May 1988, registered nurse vacancy rates in acute care hospitals remained relatively stable fluctuating from
10.9 percent to 10.8 percent to 10.1 percent. These figures closely resemble those produced by the American Hospital Association in its 1988 national hospital nursing personnel surveys. It should be noted that the American Hospital Association figures are based on all hospital-employed registered nurse vacancy rates, not just acute care hospitals. Nonetheless, the Massachusetts nursing shortage was felt most acutely in 1988. Between May 1988 and May 1989, the vacancy rate for registered nurses in acute care hospitals dropped from 10.1 percent to 5.8 percent. This is significant because "the decline in the registered nurse vacancy rate is due to an actual decrease in vacant full-time equivalents and not a result of downsizing", ie. a decrease in the number of full-time equivalent registered nurse positions (Massachusetts Hospital Association Nursing Supply Survey, 1989:1). This unexpected decrease in vacancy rate has occurred when all projections were for shortages to become worse.

The Confounding Boston Factor in the Massachusetts Nursing Shortage

Complicating the Massachusetts nursing shortage picture is the case of Boston. Boston is an anomaly in the state. It is well known as a center of respected teaching hospitals with excellent research facilities, numerous nursing schools, and cooperative education exchanges (Nash, 1989).

While, for acute care hospitals in the state the registered nurse vacancy rate in May 1989 was 5.8 percent, metropolitan
Boston reported the lowest average vacancy rate at 4.4 percent (Massachusetts Hospital Association Supply Survey, 1989:12). When examining the distribution of registered nurse vacancy rates by teaching status and bedsize, Metropolitan teaching hospitals and hospitals with over 300 beds have the lowest vacancy rates in their respective categories. Boston’s lower average vacancy rate corresponds to its high proportion of teaching hospitals with large bedsizes.

Boston hospital administrators I interviewed concurred that the dramatic decline in registered nurse vacancy rates between 1988 and 1989 is directly tied to city-wide increases in registered nurses wages at both union and nonunion hospitals. One hospital administrator stated that the hospital increased registered nurses salaries by 17 percent to try and beat other hospital increases and catch the new nursing graduates first.

Registered nurse wages in Boston are generally the highest in the state. Average hourly earnings, including all differentials, in Boston in 1988 were over $15 which translates into $30,000 per year working a 40 hour week (American Hospital Association, 1989). The Boston wage is 11 percent higher than the mean hourly wage of $13.35 paid to full-time registered nurses in April 1988 in the New England area (American Hospital Association Nursing Personnel Survey, 1988).

While vacancy rates for nursing assistants and unit secretaries show a similar decline during 1988-89, licensed practical nurses’ vacancy rate increased from 11.2 percent to
12.3 percent.

Between May 1987 and May 1989, the composition of the total nursing services in acute care hospitals by position has remained fairly constant. Total nursing services include the position of registered nurse, licensed practical nurse, nurse assistant, unit secretary, and operating room tech/mental health workers. Of these, registered nurses have consistently comprised the largest proportion ranging from 69.9 percent in May 1987, to 69.3 percent in May 1988, to 68.3 percent in May 1989.

The decrease in vacancy rate is not just because of the skewing created by decreases among a few large medical centers. The vacancy rate for registered nurses in all nursing services has decreased with the exception of Pediatric intensive care units. In addition, 75 percent of all acute care hospitals in Massachusetts in May 1989 reported registered nurse vacancy rates of less than 10 percent compared to 50 percent a year before.

Of particular interest in the Massachusetts Nursing Supply Survey (1989) is that hospitals have increased the use of four strategies for coping with registered nurse vacancies during a time when the overall vacancy rate has exhibited the largest decline. The four strategies center on increasing the use of nurse aides, licensed practical nurses, and auxiliary support workers, and developing a new category of direct care worker. In May 1988, 19 percent of all acute care hospitals in Massachusetts reported using a new category of worker. In May 1989, this figure increased dramatically to 28 percent.
The introduction of new direct care workers in the nursing setting in Boston teaching hospitals appears to be underway based on my interviews with administrators in five different hospitals. Most of the hospitals that introduced a new type of direct care worker practiced some variation of primary nursing. The name given to the new worker varied but one factor seemed to remain consistent, the worker was directly assigned to a registered nurse as a partner rather than assigned to help all patients on a unit. At one hospital where there was no new category of worker, plans were afoot to change the function of the nursing assistant to become a partner to the nurse.

The Introduction of a New Category of Nursing Worker: The Nurse Extender

During the last ten years, hospitals nationwide have been developing strategies for responding to regulatory reforms, the nursing shortage, and the changes in professional practice models. As touched upon in the analysis of acute care hospitals in Massachusetts, one strategy which has received much attention is the restructuring of the patient care delivery system (American Hospital Association (c), 1989). The development and use of nurse extenders as new workers in hospitals is a visible sign of hospital restructuring.

Referred to as "nurse extenders", these categories are created as a response to the increasing number of duties which a registered nurse, particularly in a primary nursing setting, has
to perform. The goal is to have the nurse extender do some of the more technical nursing functions such as catheterization and allow the registered nurse more time to do overall planning, documentation and clinical functions.

Training for nurse extenders varies but the new occupation is not a licensed one. Training generally is limited, for example seven to 12 weeks. Examples of nurse extender programs around the country fit the recommendations made by the American Hospital Association in its study on hospital strategies for coping with the nursing shortage: restructure the work of nursing personnel; recruit workers from outside of nursing and health care, and provide education and monetary support to move the worker to a registered nurse position.

The use of nurse extenders raises many questions as to how it will affect other nursing personnel professionally and is a potential source of controversy. In Massachusetts, the Massachusetts Nursing Association introduced legislation in 1988 to regulate the use of nursing assistants and nurse extenders by the Board of Registration in Nursing. Testimony opposing the legislation was given by the Massachusetts Organization of Nurse Executives, representing nurses in managerial or administrative positions, stating, "it is costly . . . and would reduce flexibility of health care institutions at a time when we need it most." To date, a resolve was passed but a Commission to study the issue has not been established. The Licensed Practical Nurses of Massachusetts, Inc. agrees with the need to regulate
unlicensed caregivers. Their position on unlicensed personnel by 
the Task Force II on The Future of Licensed Practical Nurses 
states, "the association has grave concern about the nursing 
administrators across this state who are reacting to their 
hospital's 'nursing shortage' by creating and training their own 
brand of unlicensed caregiver . . . these new unlicensed 
caregivers are being trained to perform functions which meet the 
hospitals' perceived need(s), which may include nursing functions 
that should only be performed by licensed nurses."

Summary

Hospital restructuring has been influenced by the 
interactive effects of regulatory reform, the nursing shortage, 
and the use of primary nursing. One of the most visible signs of 
hospital restructuring is the development of a new category of 
nursing worker called nurse extenders. The following chapter 
explores the impact of the three restructuring factors on 
restructuring in a Boston area hospital. The consequences of 
restructuring on the work of nurses in the hospital are examined 
with particular attention to the hospital's use of nurse 
extenders.
CHAPTER THREE

CASE STUDY OF CHANGES IN THE ORGANIZATION
OF NURSING WORK IN A BOSTON HOSPITAL

INTRODUCTION TO THE CASE STUDY

Having examined the national context for hospital restructuring, I now turn to a case study of a large metropolitan hospital in Boston where restructuring has been influenced by the factors described in Chapter Two. I will examine how restructuring has affected the work of nurses in this hospital.

In this chapter, I describe the occupational mix of nursing staff and the model of nursing care practiced in order to analyze the extent to which restructuring has occurred. I conclude that restructuring in the hospital is ensuing and is exemplified by the introduction of a nurse extender category, called a "nurse partner". In addition, I discuss the mixed consequences for different nursing staff. Before briefly examining the implications of this particular hospital's history for my research, I will describe my methodology.

The Methodology

With hospital permission, I conducted a case study of a large metropolitan Boston hospital in the spring of 1990. Interviewing and direct observation were my primary means of
gathering data. I interviewed the following categories and numbers nursing staff: head nurse (4), registered nurse\(^1\) (12), licensed practical nurse (3), patient care assistant (4), nurse partner (3). I attained names of nursing staff in a number of ways. Some names were given to me via an administrator from head nurses briefed on the purpose of my research by the hospital administrator. I attained other names attained from the interviewees themselves.

I conducted most interviews at the hospital on the floor during work hours. I also used telephone interviews. I attempted to concentrate on interviewing nursing staff on general medical/surgical floors because these are more common in acute care hospitals. However, this hospital has a large number of specialty floors, and some of the general medical floors are becoming specialized, thus making this a more difficult task.

In addition, I took advantage of a hospital program called "Spend a Day With a Nurse" which was designed to expose non-nursing personnel to the impact of their work on that of nurses and patient care. I shadowed a registered nurse on a day shift on a floor which had recently switched from being general medical to oncology. During this time, I

\(^1\)Head nurses are registered nurses. However, they are not included in this figure because they are categorized separately in this hospital.
spoke with other nursing staff on the same floor. I observed the registered nurse assisting patients, other nursing staff, medical interns, and doctors.

In addition, I interviewed six hospital administrators to capture a picture of whether hospital restructuring was occurring and, if so, why it was happening. Though limited, I obtained quantitative data on hospital finances and nurse staffing patterns.

History and The Messiness of it All

One of the greatest frustrations of my research was in trying to develop a picture of what nursing at the hospital looks like now and how it may have changed over the years. Hospital employment structures are complex, composed of a myriad of staff from janitorial to technicians to nurses to doctors. Disentangling what has happened to only one part of the employment structure, nursing, while seemingly more manageable, presents its own ambiguities. In this case, however, the ambiguities became even more overwhelming because the present hospital represents a merger of three hospitals in 1980. The result is a new 16 story, 720-bed facility. An acute care teaching hospital, it specializes in burn trauma, cardiology, high-risk obstetrics, diagnostic

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2This is the only floor on which I was able to interview nursing staff from all five categories: one head nurse, five registered nurses, one licensed practical nurse, two nurse partners, and one patient care assistant.
imaging, and joint replacement.

The hospital, hence, underwent another form of restructuring in 1980. As the 1989 Annual Report states, "The move and adjustments to working in a new environment with employees pooled into newly consolidated ancillary departments were among the most pressing issues faced by the administration during the first year and a half of the new hospital's operation." Consolidation problems in nursing are still evident today with the hospital attempting to incorporate one model of professional nursing practice on all in-patient floors. The three hospitals had used variations of different professional practice models. Reconstructing a history of nursing practice for the three hospitals is nearly impossible; reconstructing the last ten years of nursing practice at this hospital is difficult. Head nurses, responsible for implementing nursing practice on their floors, brought various models of professional nursing practice to the new hospital. Thus, until a year ago there was no formally stated model of professional nursing practice. Though head nurses generally said they had practiced primary nursing on their floors, further discussion revealed that primary nursing looked slightly different between floors. Thus, I attempted to construct a history of nursing practice in the cluster of hospitals based on the changes observed by nurses who had worked in the hospital for eight years or more, making allowances for
differences in the professional practice models they had worked under.

The gathering of quantitative data also proved challenging. The lack of a systematic collection of hospital statistics made this difficult. Some data was not collected until as recently as 1987 and even then there were many gaps.

To comprehend all of this it is important to remember that the hospital is in the process of change. As such, my research provides a snapshot in time of that process. The messiness of change, while posing certain difficulties for research, also highlights contradictions which provide insight to how processes happen. Speculations about the future direction of change can be gleaned from these contradictions.

Having acknowledged the messiness of change, I will describe below the larger picture of the hospital through patient and financial statistics. Following that I will delve into a more detailed picture of what nursing looks like in practice at the hospital.
AN OVERVIEW OF RESTRUCTURING AT THIS HOSPITAL

Changes in Patient Statistics

Like most acute care hospitals, this one has seen a sharp increase in patient acuity. The reason is twofold. As described in Chapter Two, increasing emphasis on outpatient services instead of hospitalization and same day admittance for planned surgery at this hospital result in patients who are more sick.

At the same time, the average length of patient stay in the hospital has steadily decreased over the last three years. The average length of patient stay in FY88 was 6.65 days, decreasing to 6.43 days in FY89; it is projected to decrease slightly again to 6.42 days in FY90. This average length of stay may be slightly lower than other comparable hospitals because the hospital has a large obstetrics unit where the average length of stay is almost half that of patients on a general medical/surgical unit.

It is interesting to note that there continues to be a decrease in average length of patient stay at the same time that patient acuity is increasing. One administrator called this seemingly counterintuitive trend "unbelievable." It portends increased workloads for registered nurses who are responsible for delivering more intensive services in a shorter period of time for very sick patients. Hence, it signifies that the work of nursing staff is crucial to the hospital’s ability to keep costs down.
Admissions at the hospital have increased from 35,015 in FY89 to a projected 36,000-36,500 in FY90. Administrators attribute the expected increase primarily to the opening of three new operating rooms.

The Financial Picture of the Hospital

A recent Boston Globe article cited a report of the Massachusetts Hospital Association detailing the critical financial condition of Massachusetts' acute care hospitals. While the study found that more than forty percent of these hospitals are losing money, have rising debt levels, and deteriorating cash flow, the hospital understudy was named as one of the two most profitable hospitals in Massachusetts.

Table 1 presents the revenues and operating expenses for FY89 and FY90. Before explaining Table 1, I will briefly define some terms used. Patient revenue is based on the total of all patient bills including outpatient visits, patient volume, case mix, and inflation. There are circumstances outside the hospital's control such as malpractice, insurance expenses, capital costs, or other government mandated programs which can affect patient revenues. Operating expenses or costs include salaries and benefits for all hospital personnel.

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Case mix is a measure of patient acuity based on certain diagnostic categories.
administration and nurses), patient supply costs such as pharmaceuticals, medical/surgical supplies and implants, building related supplies, plant related supplies such as linens, telephones and security, and administrative supplies.

**TABLE 1**

Patient revenue and operating costs for the hospital for FY89 and FY90 in millions of dollars

<table>
<thead>
<tr>
<th>Patient Revenue</th>
<th>Costs</th>
<th>Profit</th>
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<tbody>
<tr>
<td>FY89 $425</td>
<td>$421</td>
<td>$ 3*</td>
</tr>
<tr>
<td>FY90 (projected)</td>
<td>$475</td>
<td>$29*</td>
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The projected $50 million increase in patient revenue from FY89 to FY90 is attributed to the increase in volume or number of admissions. As one administrator said, "Volume and admissions are the key. The quicker you can get someone out, the quicker you can get someone else in."

An administrator states that the cause of a projected $25 million increase in operating costs from FY89 to FY90 is twofold: 1) the opening of three new operating rooms, and 2)  

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*This is the figure quoted to me by a hospital administrator.

*The administrator had originally told me that the projection was for the hospital to breakeven in FY90. Telephone calls to clarify the matter have not been returned.
an increase in contractual amounts not collected. An administrator told me that the hospital expected to not make a profit in FY90 because of the increase in operating costs described above. Further investigation into the profits of the hospital is needed for as shown in Table 1, it appears that the hospital will make a substantial profit. I was told that other revenues were not significant because the hospital is not in the business of having subsidiary corporations and that the cafeteria and parking facilities are rented at cost to support themselves. Revenue from rentals, investments, and endowments, however, are often sources of profit for other hospitals.

In understanding hospital revenue and expenses, it is important to know that fluctuations in either can occur for many reasons. For example, costs can sometimes be shown to increase by rearranging categories for reporting revenue so that excess revenues are not as evident. In addition, increased expenditures do not necessarily translate into improved quality of patient care.

Salaries and Their Relation to Operating Expenses

I now turn to examining salary as a proportion of total operating expenses. In FY89 the total salary budget not

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"Contractual amounts not collected refers to patient costs submitted by the hospital to medicare which are not reimbursed in full. The hospital recoups some of the nonreimbursed amount from the free care/bad debt pool of the state."
including benefits for all hospital staff' was $165 million or just over 39 percent of operating expenses. Registered nurse salaries are 40% of the total salary budget, about $66 million. Hence, registered nurse salaries represent 15.6 percent of total operating expenses. For FY90, the projected total salary budget without benefits represents slightly more than 40 percent of operating expenses for FY90. Registered nurse salaries for FY90 will likely be 16.14 percent of all operating expenses for FY90. While total salary and registered nurses' salaries as a part of total costs is rising slightly, an administrator noted that the cost of medical surgical supplies are increasing by about the same amount. Because the salary costs for licensed practical nurses and nurse assistants do not represent a significant part of the salary budget, administrators did not have figures on these.

As long as total cost per patient per day is used to gauge the hospital's success at cost containment, there will continue to be pressure on the hospital to change how nursing services are delivered. The total cost per patient per day has fluctuated in the past three years. Total cost per patient per day includes the salaries of nurses on the floor, supplies, and capital costs. In FY88 it came in at $1100, then dove to $920 in FY89 but is projected to reach..."
$1150 in FY90. An administrator attributes the 25% jump from FY89 to FY90 to the decrease in length of patient stay. For example, a patient is admitted for three days with the following costs per day: $1,000, $500, and $100. The average cost per patient per day for these three days is $533. If the length of stay is shortened to two days, with the same costs per day, then the average cost per patient per day is $750. An administrator suggested that using total cost per patient for the entire stay is a better measure. In the above scenario, the total cost per patient would have decreased from $1,600 to $1,500. Administrators estimate that costs per patient are likely to increase further as the hospital continues to try to reduce patient length of stay. Increased patient acuity is evidenced in the fact that seventy-five percent of the cost per patient is consumed in the first day of a patient's stay.

Hospital restructuring at the hospital is influenced by the increased focus on cost: cost of personnel and cost for servicing patients. Thus, it is not surprising that hospital administrators continually justify changes in the organization of nursing work based on cost. However, I will illustrate later in Chapter Three and Four that the need to better control nursing work is also a factor guiding restructuring at the hospital.
Nursing Staff Employment Patterns Over Time

Statistics on nursing staff employment patterns are limited because they have not been maintained on a regular systematic basis. The following data, nonetheless, provide some insight into changes in nursing staff employment.

The number of budgetted full-time equivalent registered nurse positions for FY87 and FY90 are 1,041 and 1188 respectively. Nurse-in-charge positions\(^6\) are included in this for both years. Over three years there has been a fourteen percent increase in the number of budgetted full-time equivalent registered nurse positions. There are no comparable budgetted full-time equivalent figures available for other nursing positions for these years.

A note of caution in interpreting full-time equivalent positions is needed. In the past when planning for expansion in staffing, administrators typically used the measure of full-time equivalent positions as a guide: for example, increasing the number of full-time equivalent positions(for all hospital personnel) by roughly 25 per year. According to one administrator, increases in staffing are now based on a percentage of the budget, ie. the percentage of the budget that can be changed each year. This points to restructuring choices being made based on cost. For example, there has been a slowdown in the number

\(^6\)Nurse-in-charge positions are filled by registered nurses and are distinct from head nurse positions.
of full-time equivalent positions added in each nursing category in the last few years. An administrator speculated that this will result in doubling up of nursing positions; for example, the combining of a patient care assistant and a unit secretary position.

Administrators also discussed the pressure to use less expensive nursing personnel in FY89, commenting that the use of nurse extender positions, such as the nurse partner, and changes in nursing practice models may be a result of this pressure. Another administrator discussing the future organization of nursing work on pods confirmed this possibility.

Changes in proportions of nursing staff are available. The hospital uses a system called Medicus to evaluate daily if the type of staffing mix on any particular pod is appropriate for the patient acuity mix on the pod. From these figures, the hospital can determine the proportion of hours worked by direct care givers during a given fiscal year on in-patient units. Table 2 illustrates the changes from FY87 to FY90 (to date).

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9Pod is the name for each of the four separate nursing stations on inpatient floors in this hospital and is discussed in more detail later in the chapter.
TABLE 2

Percent of direct care givers in the hospital who worked on inpatient floors in FY87, FY88, FY89, and FY90

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<tr>
<th></th>
<th>FY87</th>
<th>FY88</th>
<th>FY89</th>
<th>FY90</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered nurse&lt;sup&gt;10&lt;/sup&gt;</td>
<td>89%</td>
<td>NA</td>
<td>91%</td>
<td>92%</td>
</tr>
<tr>
<td>Licensed practical nurse</td>
<td>7%</td>
<td>NA</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Other&lt;sup&gt;11&lt;/sup&gt;</td>
<td>4%</td>
<td>NA</td>
<td>4%</td>
<td>3%</td>
</tr>
</tbody>
</table>

As indicated in Table 2, the proportion of registered nurses working during a fiscal year as direct care givers on a floor has increased by three percentage points since FY87. This percentage increase appears to correspond to the above increase in the budgetted full-time equivalent positions for registered nurses. These figures indicate that there was an actual increase in the number of registered nurses employed during this time.

Table 2 also reveals that the gain in registered nurses was at the expense of licensed practical nurses who lost two percentage points and the "other" category which lost one. It is difficult, however, to say whether the percentage

<sup>10</sup>Includes nurse-in-charge on general/medical units.

<sup>11</sup>Includes nurse assistant, some nursing students, nurse technicians in neonatal intensive care unit, nurse partners, and all orientees(including new registered nurses). Nurse-in-charge positions on intensive care units are included for FY87 and FY89 only.
decrease for licensed practical nurses represents an actual decrease in the number of licensed practical nurses, because it cannot be compared to budgetted full-time equivalent licensed practical nurse positions over the same time period.

Average vacant full-time equivalent positions for nursing staff are given below in Table 3.

**TABLE 3**

*Average number of vacant full-time equivalent positions*¹²

<table>
<thead>
<tr>
<th></th>
<th>FY88</th>
<th>FY89</th>
<th>FY90</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered nurse</td>
<td>89.69</td>
<td>40.35</td>
<td>25.61</td>
</tr>
<tr>
<td>Licensed practical nurse</td>
<td>12.74</td>
<td>15.60</td>
<td>10.48</td>
</tr>
<tr>
<td>Nurse assistant/ Technicians</td>
<td>9.94</td>
<td>0</td>
<td>19.82</td>
</tr>
<tr>
<td>Unit secretaries</td>
<td>12.32</td>
<td>8.18</td>
<td>15.28</td>
</tr>
<tr>
<td>Total</td>
<td>124.69</td>
<td>64.13</td>
<td>71.18</td>
</tr>
</tbody>
</table>

As shown in Table 3, average vacant FTEs for registered nurses declined sharply each year between FY88 and FY90. No other position experienced a consistent decline. The nursing shortage experienced in Boston in 1988 resulted in

¹²Vacant full-time equivalent positions were calculated based on positions in in-patient nursing floors, the operating room, recovery room, and day surgery.
substantial wage increases for registered nurses at this and other hospitals which may partially explain the dramatic decrease in registered nurse average vacant FTEs.

Licensed practical nurses experienced a slight increase in FY89 and then dropped in FY90 to below the FY88 average. The absence of an average for nurse assistant/technicians in FY89 could be attributed to a change in the number of budgetted positions or that all the positions were filled; administrators were not sure of the reason.

The only breakdown of nursing staff working full-, part-time, and on a per diem basis is for FY88. A large percentage of both registered nurses and licensed practical nurses worked part-time; 38 percent and 57 percent respectively. Registered nurses are the only category of nursing staff that worked on a per-diem basis. Twenty-seven percent of registered nurses worked on a per diem basis.

**Nursing Wage Structure and the Massachusetts Nurses Association**

The wage structure for each nursing position is different. Registered nurses are the only nursing staff represented by a union, the Massachusetts Nurses Association. The MNA represents 1700 registered nurses of which 300 are per diem. As a condition of employment, registered nurses are required to either become a full
member or pay an agency fee. The number of registered nurses in the bargaining unit has remained steady since 1988.

Contract negotiations settled in March 1990 provide for a twelve step salary schedule for registered nurses. The wages reflect a six percent wage increase over the previous contract. The wages of registered nurses at the hospital continue to be the highest in Boston. A new graduate staff nurse can begin at $16.66/hour and after thirteen years of continuous service at the hospital advance to $28.55/hour. Shift differentials, weekend work, overtime, and supervisory positions, such as the nurse-in-charge, serve to increase the base figures. One dispute during the most recent contract negotiations focused on health care benefits. The hospital wanted to make registered nurses pay for health care benefits which had been previously provided for free. Eventually, the hospital and the MNA agreed to keep the health care benefits as they were.

Limited wage information on licensed practical nurses, and patient care assistants was available from the hospital. Administrators estimated that the starting average wage for licensed practical nurses was $10.56/hour as of last October. The starting wage for nurse partners is $7.50/hour. Patient care assistants who have been working for over fifteen years report hourly wages of $6-7.

Turnover is not a problem according to one administrator,
as many nurses move up the salary steps and do not leave. Thus, registered nurses' salaries at the hospital are concentrated at the higher end of the scale. It should be noted that part of the concentration may be due to the large number of registered nurse positions in Intensive Care Units where registered nurses are hired at a higher salary step. According to one administrator there are not many nurses entering at the lower salary steps.

Changes in the financial picture and employment pattern of the hospital are occurring and appear to be driven by the attempt to control costs. The high cost of registered nurses was continually cited by administrators as a concern and an area where changes will probably be considered. The fact that registered nurses have proportionately increased their representation in the hospital makes cost containment a stronger goal for administrators. I now turn to a picture of what changes are happening in the organization of work on the nursing floor and how nursing staff are affected.
THE ORGANIZATION OF NURSING WORK AT THE HOSPITAL

A Walk Through an In-patient Floor in the Hospital

As I approach the elevators to the twelve in-patient floors, I see that the first four floors are dedicated to obstetrics/gynecology, the next six floors are medical/surgical, and the last two floors are orthopedics/rheumatology.

Walking down the hall on a floor, I am aware that it is shaped like an "H" with an extra crossbar. At the end of each of the four points on the "H" there is a pod or separate enclave with patient rooms arranged circularly around a nursing station. The four pods are labeled A, B, C, or D. Each pod has roughly 15 to 18 beds.

The Nursing Staff on a Pod or Who's on First Base?

For the case study, I define nursing staff as those employees who are situated on a pod to provide direct patient care and/or who are directly responsible for the administration of that care. This definition is more limited than that used by the hospital. The hospital definition used for budgetary purposes generally includes unit secretaries and other technicians not permanently situated on a pod.

As I enter a general medical pod, I see women dressed in

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13Each floor may have a specialty on one or more of the pods, i.e. medical/neurology, or surgical/intensive care unit.
light blue and green scrubs with stethoscopes looped around their necks. Without reading their name tags it is difficult to tell whether they are registered nurses, licensed practical nurses, nurse partners, or patient care assistants. Men and women in white lab coats float in and out -- doctors making rounds. Most of the women and doctors are white. Emptying wastebaskets and delivering food trays are women of color wearing blue dresses. There is a slight commotion as a young man in a white lab coat darts out of a patient's room and hunts for a cup to collect spit. The nurses look knowingly at each other and laugh; an overanxious medical student on the loose. Their attention is quickly diverted as the phone rings just as a patient's call light sounds. This is the beginning of a day on an in-patient unit.

Soon I find that each pod has a nurse-in-charge, a registered nurse, whose job is to supervise the other nursing staff on her shift, care for her primary patients, and deal with problems that arise. There are also three to four registered nurses. There is no licensed practical nurse on this pod but there is one on the pod down the hall. A patient care assistant is on this shift. Tomorrow's day shift will include one nurse partner. It is unusual to see a nurse partner because there are only four in the hospital. A head nurse, whose office is not on a pod, oversees the management of two pods on a floor.
What Each Nursing Staff Member Does

As described above, there are six categories of nursing staff which can be found on a pod: head nurse, nurse-in-charge, registered nurse, licensed practical nurse, nurse partner, and patient care assistant. See Chart 2 for a synopsis of duties and education of each.

Head nurses have administrative and fiscal responsibility for two pods on a floor. They do not administer direct patient care (except in an emergency) but supervise the nursing staff who do. There is a nurse-in-charge on each pod for each shift. She serves as the direct supervisor on the pod and is assigned primary patients. Registered nurses are primary nurses for an average of three to four patients and may have two to three other patients for whom they are an associate primary nurse. The actual number of primary patients assigned varies from pod to pod depending on the acuity of patients on the pod. Licensed practical nurses provide direct clinical patient care but are not assigned.

Intensive care units generally have a one to one, or one to two, registered nurse to patient ratio because of the severe acuity of the patients. "Patient acuity" is a commonly used term among nursing staff, and it is also used in the literature describing changing hospital conditions.
primary patients though they may be associate primary nurses for patients.

The nurse partner is a new category created within the last year. A form of nurse extender, the intended role of the nurse partner is to free up the RNs' workload by performing some of the nonnursing and nursing tasks previously done by the RNs such as taking vital signs or bathing. The controversy over this position, and its duties will be discussed in detail later.

The patient care assistant was historically called a nursing assistant or aide but the name changed after the merger of the hospital. According to one administrator, the need for consistency of language and the need to develop a title that captured the varied nature of the positions as practiced in the hospital resulted in the new name. Each pod utilizes the patient care assistant differently. On some pods patient care assistants are assigned directly to a registered nurse, on others they assist all the nurses on a pod, while on still others they may be assigned to patients turning to a registered nurse for clinical help. Nursing students often serve as patient care assistants.
### Job descriptions for nursing staff at the hospital

<table>
<thead>
<tr>
<th>Position</th>
<th>Duties</th>
<th>Education</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>head nurse</strong></td>
<td>- managerial</td>
<td>same as registered nurse</td>
</tr>
<tr>
<td></td>
<td>- administrative</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- fiscal manager</td>
<td></td>
</tr>
<tr>
<td><strong>nurse-in-charge</strong></td>
<td>- supervise staff on a pod</td>
<td>same as registered nurse, push to be BSN</td>
</tr>
<tr>
<td></td>
<td>- same as registered nurse</td>
<td></td>
</tr>
<tr>
<td><strong>registered nurse (RN)</strong></td>
<td>- primary nurse</td>
<td>licensed: associate, diploma, bachelors (BSN)</td>
</tr>
<tr>
<td></td>
<td>- medications</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- documentation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- planning and coordination of patient care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- assessment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- administer blood</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- IVs</td>
<td></td>
</tr>
<tr>
<td><strong>licensed practical nurse (LPN)</strong></td>
<td>- can't be primary nurse</td>
<td>licensed: one year program or shorter</td>
</tr>
<tr>
<td></td>
<td>- technical duties</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- some meds</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- some IVs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- vital signs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- baths, feeding</td>
<td></td>
</tr>
<tr>
<td><strong>nurse partner</strong></td>
<td>- can't be primary nurse</td>
<td>not licensed, 7 week in-hospital training</td>
</tr>
<tr>
<td></td>
<td>- no meds</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- can adjust IVs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- vital signs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- observation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- helping registered nurses</td>
<td></td>
</tr>
<tr>
<td><strong>patient care assistant</strong></td>
<td>- can't be primary nurse</td>
<td>not licensed, often have certif.</td>
</tr>
<tr>
<td></td>
<td>- no meds</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- vital signs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- feeding, bathing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- bedpans</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- helping nurses with patients</td>
<td></td>
</tr>
</tbody>
</table>
Though it is difficult to describe the "average" pod, I will make some generalizations based on medical/surgical pods in Table 4 below. Pods A and B have one head nurse and pods C and D have another head nurse. Each pod has a certain number of RNs, LPNs, Nurse Partners, and PCAs depending on the type of unit. Pods A and B or C and D may share nurses on a night shift or when staff call in sick.

On a general medical/surgical pod, which is the most common type of floor in any hospital, a typical staff breakdown for the three shifts might look as follows:

<table>
<thead>
<tr>
<th></th>
<th>RN</th>
<th>LPN</th>
<th>Nurse Partner</th>
<th>PCA</th>
<th>secretary</th>
</tr>
</thead>
<tbody>
<tr>
<td>days</td>
<td>3-4</td>
<td>0-1</td>
<td>0-1</td>
<td>0-1</td>
<td>1</td>
</tr>
<tr>
<td>evenings</td>
<td>2-3</td>
<td>0-1</td>
<td>0</td>
<td>0-1</td>
<td>1 for two pods</td>
</tr>
<tr>
<td>nights</td>
<td>1-2</td>
<td>1-2</td>
<td>0</td>
<td>0-1</td>
<td>0</td>
</tr>
</tbody>
</table>

Whether the pod has three or four registered nurses on any particular day shift is based in part on patient acuity. In other words, if pod A has four registered nurses scheduled but pod B has only three and has sicker patients, then one

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15 There are only four Nurse Partners in the hospital, three of which are on general medical units.
of the registered nurses from pod A may work on pod B for the day. On the day shift it would be unlikely to find both a nurse partner and a patient care assistant. Licensed practical nurses are not plentiful in the hospital and from my observations were more likely to work the evening or night shift.

As can be seen in Table 4, the number of staff on a pod diminishes from day to night shift. The minimum staff per pod is two and one of these two must be licensed. This can place much stress on a registered nurse. For example, a possible staffing combination on a night shift might be one registered nurse and one patient care assistant. Because the patient care assistant cannot be directly responsible for a patient, it means that the registered nurse may be responsible for as many as fifteen patients. On a night shift there typically is no unit secretary which means the registered nurse will spend some time answering the phone.

Evening shifts with one secretary for two pods create problems for staff because patients are often returning from surgery after 3 p.m. The admittance of a patient on a unit entails paperwork and phone calls.

Head nurses and registered nurses alike described the problems with staffing. Head nurses, who are responsible for the staffing budget for their pods, complained about how they have had to count patient care assistants as staff who can be responsible for a certain number of patients. They
believe that licensed nurses are the only ones who should be counted in this way. One head nurse who had to absorb a few patient care assistants into her budget when another pod closed said it has created tension among the registered nurses because there is little that the patient care assistants can do on the unit given the high acuity of the patients. One head nurse felt that the quality of the staffing mix on the pods had gone down over the last few years because registered nurses are being replaced with patient care assistants. Tight budgets are the primary cause according to this head nurse and others.

Educational Preparation of Nursing Staff

As explained in Chapter Two, the educational background for registered nurses and licensed practical nurses varies. There is no standard educational preparation for patient care assistants at this hospital. Most patient care assistants hired at the hospital since the late 1970s and after the merger have attended an in-hospital program. Such differences in education and training are thrown into relief in this hospital with the introduction of the nurse extender position, the nurse partner which is discussed later in this chapter. A source of conflict in this hospital, these differences are explored further in this chapter and Chapter Four.
A Brief Note on Documentation

Nurses at this hospital, both registered and licensed practical, are responsible for putting in writing the care they have administered to a patient. Patient records reflect not only what dosages of medication have been given but also changes in temperature, reactions to food, and emotional fluctuations. Progress notes on patients must be written at least once every 48 hours. This hospital also uses a Kardex system for quick referencing of patient care plans. The Kardex is a system using oversize note cards to document a patient's daily progress. Registered nurses tape record daily patient updates at the end of shift for the oncoming nursing staff. This is called doing "report". Registered nurses must also prepare a discharge plan for patients which is signed by the patient. Accurate and substantiated documentation is crucial because of the quick turnover of patients at the hospital. Under primary nursing, as described below, registered nurses are responsible for the majority of documentation at the hospital. As will be shown, one result is a decrease in time spent directly at the bedside of patients.
The Move Toward Primary Nursing

In February 1988, the nursing department's new vice president of nursing surveyed registered nurses on the delivery of nursing care. Results showed that staff nurses valued the one-on-one relationship with patients and preferred primary nursing as a professional practice model. In September of 1988 the nursing department at the hospital began planning for the implementation of primary nursing on all inpatient units. According to one administrator, the move toward primary nursing was prompted by the need to utilize a model which "more clearly depicts the role of the nurse." Higher patient acuity combined with shorter lengths of stay required more intensive care and direct patient accountability on the part of registered nurses at the hospital.

The Nursing Organization Tenets for Primary Nursing at this hospital were developed by administrators in staff education. Based on primary nursing guidelines established by Manthey (1980), these tenets are tailored specifically for this hospital. Highlights of the overarching hospital guidelines are as follows: all patients have a primary nurse; primary nurses are registered nurses; the head nurse or nurse-in-charge is responsible for insuring that each patient has a primary nurse; the primary nurse is responsible for coordinating the patient care plan and for
communicating with other health care staff; the primary nurse is recognized as the manager of patient care throughout the hospital; the method of identifying the primary nurse will be centrally located (ie. on the bulletin board); and all new hospital employees when oriented are told that primary nursing is the model of professional practice of the hospital.

While these tenets provided guidelines for the hospital, each pod and floor was given leeway to decide how best to structure primary nursing. Thus, each pod and/or floor developed its own guidelines and timelines for the implementation of primary nursing.

Administrators state that some floors have not fully implemented primary nursing as indicated by the fact that not every patient is assigned a primary nurse. One explanation given by an administrator is that when pod staffing levels are down, each patient may not be picked up by a primary nurse. Thus, the implementation of primary nursing is partially dependent upon sufficient staffing of registered nurses. Administrators do not have a strict timetable for the hospital to fully implement primary nursing. As one administrator said, "It took X hospital, an exemplar of primary nursing, ten years to implement their program fully."

Other problems cited by administrators as impeding the implementation of primary nursing included patient turnover,
transferring of patients, and the influence of medicare reimbursements based on DRGs. Both rapid turnover and transferring patients within the hospital makes record keeping or documentation more important. This puts pressure on registered nurses, as primary nurses, to keep detailed and updated patient records as patients are switched from floor to floor. DRGs, which often limit the amount of time a patient can spend in the hospital, make it more difficult for nurses to provide the services needed. "Patient flow and who controls it has a big impact on nursing," said one administrator.

Some administrators and head nurses believe that full implementation has not occurred because of registered nurses' opposition to primary nursing. However, registered nurses' concerns about primary nursing are related to having adequate staff to effectively implement it and the pressure it creates for detailed documentation as mentioned earlier. As one registered nurse said, "I believe it is difficult to carry out primary nursing in the exact way it should be. It's impossible because you have different shifts with different staff ratios." As shown earlier, there is less nursing staff on night and evening shifts which means that primary nurses on those shifts may have to cover more patients. Most registered nurses interviewed liked the continuity of patient care under primary nursing.

To better understand what is happening around the
introduction of primary nursing, it is necessary to examine what model(s) previously were used at the hospital. Prior to the merger of the three hospitals in 1980, each utilized a different professional nursing model. After the merger, many variations of different professional nursing models were practiced on the inpatient units. The professional nursing model implemented often depended on which hospital the head nurse came from. Some units practiced variations of team nursing. Certain pods have practiced a form of primary nursing for a number of years. Other pods have practiced total patient care which differs from primary nursing in that there is no one registered nurse ultimately responsible for a patient's care plan.

While the hospital does not have a set number of how many patients each primary nurse should have, it was clear from talking with registered nurses that the understood norm was two to four on most pods except intensive care pods where the ratio is typically one to one. In addition to the average number of primary patients a registered nurse might have, she may also have a couple patients for whom she serves as associate primary nurse. Registered nurses and head nurses both referred to budget constraints as the main factor influencing staffing patterns and that this affected the nurse to patient ratio.

In addition, there seem to be shared understandings among the registered nurses about what primary nursing entails as
far as planning and assessment of patients is concerned. Registered nurses try to maintain continuity of patient care for those patients who are not their primary patients. However, given that registered nurses' schedules vary from week to week, this is not always easy to accomplish. The rapid turnover of patients on some pods also adds to the problem.

In talking with head nurses, it was clear that they modified the primary nursing model to meet the needs of the pod. For example, one head nurse said patient assignment on her pods was by room; a nurse was always responsible for patients in rooms 1, 3, and 5. On other pods, patient assignment was based on patient needs and the skill level of staff on the shift.

As explained in Chapter One, Manthey (1980) says primary nursing consists of four basic elements: allocation of individual responsibility for decision-making; case method assignment of daily care; direct person-to-person communication; and one person responsible for quality of care given to patients on unit twenty-four hours a day, seven days a week. According to Manthey (1980), within these there is much room for nurses to use common sense in adapting primary nursing to the particular needs of a pod. Thus, the hospital's policy for each floor to design an individual implementation program of primary nursing is in keeping with Manthey's philosophy.
Different Perspectives Among Nursing Staff

An understanding of why head nurses say registered nurses are reluctant to adopt primary nursing and how registered nurses understand the purpose of primary nursing illustrates some of the tensions in the hospital concerning the organization of nursing work.

Head nurses and administrators say registered nurses are reluctant to take on the added responsibility associated with primary nursing for a number of reasons. First, primary nursing, with its emphasis on accountability for specific patients, increases a registered nurse's legal responsibility regarding the care of her primary patients. As one head nurse explained, "There is no longer another registered nurse to share the responsibility or blame for patient care." However, from a registered nurse's point of view inadequate staffing and the use of unlicensed staff place much pressure on her in trying to adequately meet the needs of her primary patients. As described in Chapter Two, under team nursing and total patient care there was no designated registered nurse for a patient and legal responsibility for patient care was likely to fall on the head nurse or team leader.

In addition, administrators point to the lack of a good model of primary nursing care at the hospital, thus making it anxiety producing for registered nurses to take on the added responsibility. This implies that the variations of
primary nursing used on the pods may impede the development of good nurse role models as well. Registered nurses did not indicate a lack of role models. Most registered nurses felt that they knew what was expected in primary nursing but that inadequate staffing did not always allow them to carry it out as they would like.

The one point administrators, head nurses, and some registered nurses agreed upon was that the perception of nursing as women's work and the accompanying stereotypes of women as passive and nonassertive has slowed the implementation of primary nursing. Nurses and the medical profession in general have viewed nurses as only there to do the bidding of doctors. Thus, nurses have rarely been given credit, by themselves and the medical profession, for the decisions and assessments they must constantly make in caring for patients. Historically, nurses have not been trained nor expected to be assertive with the doctor on behalf of the patient. All agreed that primary nursing challenges this by giving registered nurses more authority.

However, head nurses' examples of registered nurses' reluctance to take a more assertive role varied. Head nurses cited the same example; primary nurses have business cards which they are to distribute to their primary patients when they introduce themselves. However, the business cards printed almost a year ago are piling up and not being used. The registered nurses rarely mentioned the business cards.
when describing what primary nursing meant to them. Registered nurses experienced feelings of professionalism not in the act of giving out business cards but when they identified themselves to their patients as primary nurses, responded well to patient needs and managed the competing demands on their time. One nurse explained, "Making a patient physically comfortable, talking with them about their diagnosis... I do all this and still get my paperwork done and meds out. That's a good job."

Some of the practices of primary nursing at this hospital are stipulated by the Joint Commission on Hospital Accreditation. Under the Joint Commission on Hospital Accreditation, which monitors hospital practices nationally, only registered nurses can serve as primary nurses and not licensed practical nurses. According to the JCOHA only registered nurses are trained and educated to perform patient assessments, develop patient care plans, and do documentation.

The Introduction of Nurse Partners

In 1989 the nursing department introduced a pilot program for a new worker on inpatient pods. Called a nurse partner, the worker was to be an unlicensed assistant to a registered nurse. Trained for seven weeks and placed on inpatient pods for further clinical training, the nurse partner's skill was to be a step above those of a patient care assistant.
A flyer distributed by the nursing department describes the nurse partner this way:

The nurse partner supports the work of the primary nurse, doing those basic aspects of the primary nurse's responsibilities that she/he is educated to perform -- meeting the physical, safety, and belonging needs of the patient. This frees the primary nurse to address the higher level needs of her patients -- need for self esteem and actualization, as well as the planning and evaluation functions of the registered nurse's role.

As this passage clearly shows, a key concept of the introduction of the nurse partner is to divide the conception and execution of nursing work among different workers based on educational credentials. The execution of nursing work described includes "meeting the physical, safety, and belonging needs of the patient." The registered nurse with more training is to be freed to do the conception work, addressing the patient's "need for self esteem and actualization, as well as the planning and evaluation functions." This polarization of skills already existed to some extent in the hospital because the patient care assistant helps the registered nurse perform many of the basic functions described in the above passage.

Designed to alleviate some difficulties in recruiting registered nurses and to introduce nursing to college educated people from outside the health professions, the nurse partner program has met with limited success and has been a source of contention at the hospital. Of the nine original recruits to participate in the program only four are still at the hospital. The reasons for this are varied.
One of the trainees moved and another went to nursing school. However, administrators, head nurses, and registered nurses all indicate that opposition to the use of nurse partners from the Massachusetts Nurses Association and registered nurses in the hospital contributed to the attrition.

The registered nurses' union, the MNA, opposed the use of nurse partners for three main reasons. First, it believed the use of nurse partners threatened the quality of nursing care and patient safety because of the nurse partner's inadequate educational preparation. Second, the use of nurse partners raised questions of liability as to who is responsible if the nurse partner makes a mistake. Registered nurses are concerned that the registered nurse may be jeopardizing her license if the nurse partner makes a mistake. With the use of nurse partners, part of a registered nurse's job becomes training and supervising someone who may make mistakes and cause problems from her point of view. Third, nurse partners are half as expensive as registered nurses; so there is a concern that nurse partners will replace registered nurses in the future. Registered nurses interviewed voiced these same concerns.

The MNA held meetings at the hospital and sent letters to all registered nurses discussing the implications of nurse partners for registered nurses and asking registered nurses not to participate in the pilot program. In meetings with
administrators, the MNA suggested improving the use of ancillary staff so the registered nurse did not have to fetch food trays and make beds.

In a memo from July 1989, the vice president for nursing responded to the MNA concerns. Referring to the sound fiscal solvency of the hospital she wrote:

(E)ven ‘the best’ cannot remain untouched by the realities of dwindling resources - both financial resources and human resources (particularly nurses). . . . I have been quoted to the effect that we are targeting a 60% Registered Nurse/40% non-professional staffing mix. That is untrue. We are certainly examining all our vacancies more stringently. During these times of constrained resources, it is much easier to make changes in vacant positions.

Originally nurse partners were to be funded through a special pot of money so that head nurses interested in having nurse partners on their pods did not have to use their own budgets for the position. This money did not materialize and thus head nurses still wanting nurse partners would have had to use their budget for the position. However, one floor that has two nurse partners was able to get additional funding for the positions because the floor had already documented a substantial increase in patient volume indicating a need for more staff and because this floor had been targeted by the hospital as a particularly busy floor. The nurse partners hired on other floors filled vacant patient care assistant positions.

Interviews with administrators, head nurses, registered nurses, and some nurse partners indicate agreement that the
pilot program has not been successful. As implemented the nurse partners function basically as patient care assistants. As registered nurses explained, they often do not permit or ask the nurse partners to carry out technical procedures because they are unsure of what the nurse partner is actually capable of doing.

For now, the pilot program is on hold pending further evaluation. Despite these setbacks, administrators acknowledge that there will probably continue to be a move toward the use of more nurse extenders. There is a need for "more assistive people to the nurse" says an administrator. The name and some of the duties may be changed but the concept of a helping hand to the nurse would remain the same. In the meantime, hospital administrators are trying to build a relationship with the union. The Board of Registration in Nursing is convening a task force to begin developing criteria on the role of the nurse extender. A hospital administrator hopes that if the MNA chooses to participate in the process it will be a step toward alleviating the resistance of the MNA to the nurse extender position in the hospital.
The Work Redesign Task Force and Its Implications for Nursing

In the last two years the hospital has convened a Work Redesign Task Force to evaluate the work of all hospital personnel and develop ways to restructure work in the hospital. The first assignment of the task force has been to address problems on one inpatient nursing floor which had high patient turnover and high patient acuity. Surveys of nursing personnel on the floor revealed that registered nurses were spending almost forty percent of their time doing non-nursing work which included getting medications from the pharmacy, and running to the kitchen to find a missing menu item for a patient’s tray. Much of this non-nursing work was supposed to be done by ancillary staff in dietary, pharmacy, or housekeeping but because of inadequate staffing and coordination this was not happening. Thus, the task force has identified three small projects for this floor to be undertaken in coordination with the dietary department, the pharmacy, and housekeeping. The projects are slated to be implemented in the fall.

Thus, the hospital is addressing the extra work created for registered nurses because of insufficient ancillary staff and coordination between departments. However, this does not address the problems in organizing nursing work raised by the introduction of nurse partners. As will be analyzed further in Chapter Four there is disagreement about
what actually constitutes nursing work once the problems associated with insufficient ancillary help are alleviated.

THE FUTURE OF LICENSED PRACTICAL NURSES AND PATIENT CARE ASSISTANTS AT THE HOSPITAL

The Future of LPNs

Since the merger, this hospital has not had a large proportion of licensed practical nurses on its nursing staff because licensed practical nurses are not considered appropriate for an acute care facility. It is unclear from quantitative data and conversations with administrators what is happening to the position of licensed practical nurses. As reported earlier, the proportion of licensed practical nurses in the hospital has decreased slightly since 1987. Administrators indicated that licensed practical nurses would continue to play a minimal role at the hospital and not be expanded: if anything, there would be attrition. However, one nurse told me that two licensed practical nurses were recently hired on a cardiac step-down unit which is an intermediate unit between an intensive care unit and a medical/surgical floor. "I was aghast. Licensed practical nurses are not appropriate on such a unit because patients are just two days out of cardiac surgery. Licensed practical nurses can't take orders from the docs or do intravenous medications. This puts added responsibility on the registered nurse. She has to be looking over her shoulder constantly." The cost of hiring licensed practical
nurses over registered nurses is seen as a factor by this registered nurse. Other licensed practical nurses are found mainly on general medical/surgical units.

Head nurses report that these limits on licensed practical nurse's duties is discouraging for the remaining licensed practical nurses because they are not permitted to perform some of the functions of which the longer term licensed practical nurses feel they are capable such as assessment and documentation. According to one head nurse, prior to the merger of the three hospitals, one of the hospitals had nursing staff of 50 percent registered nurses and 50 percent licensed practical nurses on day shifts. During this time, a pilot study of documentation in nursing was undertaken. The results of the study were used to demonstrate that licensed practical nurses were not educated to do assessments and that "they lacked adequate writing skills for documentation purposes" according to a head nurse.

However, in describing their work, licensed practical nurses talked of being an integral part of any patient assessment and indicated that they did documentation in the form of progress notes. Talking about discharge planning and referrals to outside services, one licensed practical nurse said, "All licensed practical nurses and registered nurses do it themselves. If I thought a patient needed rehabilitation then I would call for someone to come do an
evaluation. I can do this without checking with the registered nurse." What administrators say a licensed practical nurse does and what she may actually do may differ. One licensed practical nurse said, "I do almost exactly what a registered nurse does," citing the hanging blood as the only difference.

The Future of Patient Care Assistants

The patient care assistant role varies from pod to pod depending on the needs of the patients and the registered nurses. For example, on some pods the patient care assistant may be assigned directly to a registered nurse while on other pods the patient care assistant may be responsible for helping all the patients as needed. Typically patient care assistants have worked in the hospital for many years, often as much as twenty years. They are more likely to have worked in another department in the hospital, such as dietary, before becoming a patient care assistant. The duties of a patient care assistant vary depending on years of experience and the needs of a unit. Nursing students who are patient care assistants report that registered nurses often spend time teaching them more procedures than they do with long term patient care assistants. This was supported by some registered nurses.

16 In general, patient care assistants are not found on intensive care units unless they are nursing students.
Administrators believe that the future holds changes for the patient care assistants in the hospital. Though there are no definite plans as to how to restructure the role of the patient care assistant, a few options are being contemplated. One is to combine the patient care assistant and the pod secretary position. Another consideration is to put all patient care assistants through an abbreviated nurse partner training program. A third option is to develop a host or hostess role on the pod based on a model of hotel service delivery. It is not clear what affect this last option would have on the work of the patient care assistants. However, the skills used as a hostess would be very different from those used by a patient care assistant today.

One reason cited by administrators for proposed changes in the patient care assistant position is that the way nurse partners are actually used, there is a minimal difference between what a patient care assistant and a nurse partner does. The hospital's intent was to have the nurse partner perform more technical functions than the patient care assistant. This has not happened because registered nurses are not sure what the nurse partners are sufficiently trained to do. A patient care assistant performs tasks such as giving baths, making beds, taking vital signs, answering patient call lights, feeding patients, and running errands to dietary as needed. Some, but not all, patient care
assistants and nurse partners agree that there is little difference in job duties.

Perceptions of their roles vary for nurse partners. One of the nurse partners says her work is more like that of a registered nurse. Another nurse partner, who had previously been a patient care assistant, says her work is still basically that of a patient care assistant. From her point of view, the title nurse partner is a way for the hospital to be able to pay her more money for all the work she has done anyway. The nurse partner who aligns herself with the registered nurse intends to go back to nursing school unlike the nurse partner who moved up the hierarchy. One nurse partner also said that people in her job classification are not allowed to do all the things they are trained to do because of resistance from the registered nurses. Registered nurses say they are reluctant to have a nurse partner perform some functions because either the registered nurses do not know what the nurse partners are trained to do, or because the nurse partners often are nervous and request not to do particular functions.

CHAPTER SUMMARY

The organization of nursing work in the hospital is in the midst of change. While it is not clear what these changes will mean in the long run, the introduction of the nurse partner and the restructuring of the patient care
assistant job highlight the tensions among nursing staff as to what nursing work is and who should control it. Chapter Four analyzes these tensions in the hospital.
This chapter provides a broader analysis of the changes in the organization of nursing work at this hospital and the resulting tensions among nursing staff. Based on my observations, I found three changes in the process of work occurring. First, restructuring is taking place as evidenced by changes in job descriptions and the formation of a new job category. Second, a result of this restructuring is an experiment with a new form of job segmentation in nursing in the hospital. The new job segmentation portends a possible move from a three tier to an interim four tier to a final two tier job segmentation. Third, skill polarization is entering a new phase, and the essential nursing skill of assessment is key for examining skill polarization. In discussing each of these changes, I will show that the outcomes of each are mixed for different nursing staff in the hospital.

The Evidence for Restructuring at the Hospital

As seen in Chapter Three, many changes have occurred or are underway in the organization of nursing work at this hospital. The last two years at the hospital have brought
changes in job descriptions for head nurses and registered nurses. Head nurses' roles have become more managerial because they are now responsible for their own budgets. By their own admission, this responsibility has made head nurses watchdogs for cost. During this same time, primary nursing as the professional practice model was formally introduced as hospital policy. For some registered nurses, this policy meant a change in their responsibility for patients as described in Chapter Three. Underlying the concept of primary nursing is the idea that quality patient care can be best delivered using this professional practice model. Taken together, these changes in job descriptions point out two tensions: 1) the conflicting goals of the head nurse's position, and 2) the conflict between what a head nurse is being asked to do and what a registered nurse is being asked to do. First, at the same time that head nurses are being asked to implement primary nursing and consider the quality of care associated with it, they are also being forced to focus more on costs. Second, registered nurses, who do not have the budgetary responsibilities of head nurses and who are directly at the bedside, are apt to be more concerned with issues of quality of care than cost.

Moreover, restructuring is indicated by the attempt to form a new job category, nurse partner. Though the pilot program has been put on hold, as described in Chapter Three,
the nurse partner position represented an attempt to reorganize nursing work by having a nonlicensed position report directly to a registered nurse rather than be assigned specific patients. This is a different method of assignment than that generally used with the patient care assistant position where assignments were typically patient based. However, it should be noted that some patient care assistants may report directly to a registered nurse, but it is not a consistent policy across pods. None of the patient care assistants I interviewed were supervised in this way.

In addition, the nurse partner position was premised on the idea that there was some technical work which registered nurses do that is not or cannot be done by the licensed practical nurse or the patient care assistant. The nurse partner, however, functions basically as a patient care assistant on the pod. Administrators in charge of the pilot program stated that discussions with registered nurses on floors with nurse partners revealed that nurse partners were used more for basic patient care than intended, giving baths, taking vital signs, and feeding patients.

Registered nurses' reasons are many for having nurse partners perform basic patient care instead of more technical functions. Many registered nurses were confused as to what a nurse partner was actually trained to do and expressed concern over having responsibility for someone whose training seemed inadequate. As one nurse said,
"Myself with my license, I wouldn't have the nurse partner do more than a patient care assistant. On our floor she functions as a patient care assistant. I'd let her change a simple dressing as long as I get to assess the site."

Several registered nurses talked about how nurse partners were supposed to be able to insert feeding tubes. All agreed they would not want a nurse partner to do this because it is an invasive procedure into the stomach requiring checking for residual fluids, checking on the line for blockage, and making sure the patient is sitting up. A registered nurse explained that a broader medical background is needed because air is injected into the tubes requiring the nurse to be alert listening for unusual sounds.

Benner(1987) explains how a new registered nurse may know the technical aspects of doing a specific procedure but not know what for what other signals she is to be looking. A registered nurse summed up the sentiments expressed by many, "Someone (the registered nurse) who is responsible for the patient should be the one to know what's going on with the patient."

One registered nurse described the difference in training between herself and less trained staff this way, "The reason I'm a nurse is because I know there are scientific reasons behind what I'm doing. I can't imagine getting all that in seven weeks or nine months(referring to licensed practical nurses) in the depth that it was presented to me."
Registered nurses also expressed concern that the nurse partner ends up spending more time with their primary patients than they do which impedes their ability to perform assessments well. "When the registered nurse has to go to the nurse partner to ask about her own patient, it doesn't make the registered nurse look good. It's as if she doesn't know her own patient. Especially with primary nursing in place this is a problem," stated one registered nurse.

Implied in this comment is that too high a nurse:patient ratio under primary nursing, defeats the purpose of having one nurse be a primary care giver. Moreover, redesign of the patient care assistant position is being contemplated by administrators. Whether it is merged with the secretarial position or transformed into something totally new such as the position of hostess on the pod, administrators implied that the patient care assistant position on the pod is not consistent with patient care delivery needs. I found this implication intriguing given that some registered nurses said that patient care assistants can be very helpful doing bedpans, taking vital signs, feeding and ambulating patients. "It's best to have patient care assistants on the day shift because A.M. patient care (ie. bathing, weighing) takes a lot of time," said a registered nurse. Many registered nurses felt that the use of more patient care assistants would ease their workload without keeping them away from the bedside.
Not all registered nurses found patient care assistants helpful. Some said that patient care assistants did not take the initiative enough and were not motivated to perform on the job. However, this criticism was most often levied against patient care assistants on the evening and night shifts. One alternative explanation may be that registered nurses on these shifts, because they are working with less licensed staff, have greater responsibility for patient care and can only utilize the patient care assistants minimally. The higher the patient acuity on a pod the more likely this is to be true.

As shown above, the reorganization of nursing work has included changes in job descriptions, the development of a new job category, and the possible merging of jobs. It is unclear what other changes will present themselves and what the result will be for nursing staff. However, it is clear that shifts in the organization of nursing work are occurring.

Resegmenting the Nursing Labor Market in the Hospital

I believe that the attempt to introduce the new job category, nurse partner, is a step toward establishing a different segmentation of the nursing staff in the hospital. Before the introduction of the nurse partner, registered nurses, licensed practical nurses, and patient care
assistants all provided direct patient care, of varying degrees. Though it has not yet succeeded in this, the nurse partner position was intended to be a step above the patient care assistant, incorporating some of the patient care assistant duties and then adding other technical duties. Thus, administrators' idea to merge the patient care assistant position and the unit secretary is evidence that the introduction of the nurse partner position has the potential to eliminate other jobs.

Hence, what had been a three tiered segmentation (registered nurses, licensed practice nurses, and patient care assistants) is now a weak four tier system with the potential to move toward a two tier system (registered nurses and nurse partners). The future of the licensed practical nurses is unclear. As a percentage of nursing staff on in-patient units licensed practical nurses have declined slightly, nonetheless, registered nurses reported the recent hiring of licensed practical nurses on one unit. Given that the administration has said that there have never been many licensed practical nurses at the hospital and given that the patient acuity at the hospital is increasing and more pods are becoming specialized, I speculate that licensed practical nurses will not increase and may well decrease in number.

Segmenting the labor force allows management better control over workers and the work process (Edwards, 1979).
If nursing illustrates Noyelle's (1988) idea of the trend in labor markets toward "an era of professionalization and paraprofessionalization" where professional organizations, such as the Massachusetts Nurses Association, rather than specific firms within an industry, set the standards for work and social reward, then the hospital's attempt to introduce a new segment, namely nurse partners, may reflect in part an attempt to regain some control over the work of nurses. How? Presently, there are no standards governing the use of unlicensed nursing personnel such as nurse partners, whereas the Board of Registration in Massachusetts oversees licensing standards for registered nurses. This point is not lost on the registered nurses at the hospital who are being encouraged by the MNA to write the Board of Registration to register their concerns about the nurse partners.

As Noyelle (1987:99) explains, the move toward professionalization "may well be one of emerging relative independence vis-a-vis the owners of capital reflecting ... the desire of firms to increase their flexibility within markets by purchasing 'increments of expertise' as needed rather than by hiring people to which they must be committed."

Nurse partners were intended by administrators to be an "increment of expertise" above the patient care assistants based on their seven week training. This training proved to be woefully inadequate based on
registered nurses' assessment of nurse partners skills in performing more technical functions.

Noyelle (1987:99) refers to "the growing importance of knowledge-based inputs in processes of production" during this emerging era of professionalization. I believe that registered nurses' objections to the use of the nurse partners reflect their understanding of this. Nurses believe that to do take care of a patient in a complex environment like the hospital requires a broad conceptual understanding of disease and its treatment. Such an understanding cannot be attained in a seven week training course. Noyelle's analysis implies that reaching a desired outcome in production, in the case of nursing quality patient care, requires the ability to conceptualize as well as execute a procedure.

The use of education as a means of dividing workers has interesting implications in this hospital. The hospital's use of education as the justification for allowing nurse partners to perform more tasks than patient care assistants is illustrative of Noyelle's professionalization era where professionalization is marked in part by education. In the case of the hospital, nurses are demanding that the personnel working under them be properly trained to meet professional standards. It appears that the hospital tried to meet those demands but only by meeting the most minimal standards for training.
A New Phase in the Skill Polarization of Nursing

The skill polarization resulting from the new segmentation of nursing staff in the hospital illustrates the role of assessment in nursing work and raises questions as to how it is best performed. Once again, the impact of this occupational shift for different categories of nursing staff is complex and varied. In this section, I will analyze the role of assessment and how the move toward a new segmenting of the nursing staff affects this skill. Before moving to that, I will briefly discuss what is meant by skill polarization.

Before the hospital formally introduced primary nursing two years ago and the nurse partner, there was already a form of skill polarization in nursing. Under team nursing, individual workers had specific tasks which they were responsible for performing depending on their level of education and training. The process of administering patient care was strictly delineated. As described to me by registered nurses and patient care assistants, under team nursing no one felt any ultimate responsibility for a patient. One patient care assistant said that for her the biggest difference between team nursing and primary nursing is the increased responsibility under primary nursing. She explained, "If a doctor complains to a nurse that a patient hasn’t been weighed on a daily basis according to the care plan, then she’s in trouble because she is supposed to
check. Then I’m in trouble if taking the daily weights is my job." While primary nursing is designed to make registered nurses more directly accountable to patients, it is obvious from the description above that the increased sense of responsibility for patients gets transmitted to other nursing staff as well.

The introduction of primary nursing represented a move toward the reintegration of the processes involved in caring for patients. Today, the hospital is looking for ways to divide that process up in new ways.

Skill polarization according to Noyelle(1987) is exemplified by a splitting of the work between more highly educated and trained workers and those with less education/training. Braverman’s assertion that polarization is characterized by a split between the conception and execution of work is a useful way to understand the significance of skill polarization for the work of nurses in this hospital. I will now examine the role of assessment as it relates to skill polarization.

Assessment as a Predominant Nursing Skill and Its Relation to Skill Polarization

Nursing is a 24-hour occupation. It does not stop when the patient goes to sleep. It does not stop when the family stops by to visit. A nurse is always watching and listening. It is not a job where strict delineations abound
about what a nurse can or should do. If the waste baskets are overflowing and the housekeeper isn’t there, the nurse may well end up emptying the trash. What the lay person may consider to be minor chores such as giving a patient a back rub or listening to a patient vent her/his fears about surgery may actually be events which give the nurse information about a patient and allow her to make judgements about how the patient is progressing. The nurse’s goal is to help a patient progress to a stage where s/he is functional enough to go home.

The judgements that a nurse makes during the course of her shift are related to the nurse’s ability to assess the condition of a patient. This need to constantly assess the emotional and physical well being of a patient is a primary part of what it means to do nursing work. Assessment is a skill. Skill is "the ability to do something well, arising from talent, training, or practice" according to the dictionary. As a nursing skill, assessment entails integrating information from a myriad of sources including a nurses own five senses, as well as written reports, technical information, and conversations with other nurses, doctors and assistants, in making an informed judgement about the well-being of a patient.

The nurse enters the patient’s room and administers the patient’s early morning medication. "This may make you nauseous so just let me know", she says. The patient
affirms that she is not feeling nauseous. As the nurse walks out the door the patient begins to vomit. The nurse later describes this episode as an example of the patient's denial of his illness which typically includes much nausea. For the nurse this was not an example of poor communication or misunderstanding between nurse and patient but a sign of how the patient is coping with his illness and what that means for his total care plan. It is part of making an assessment.

Registered nurses state that assessment represents much of what they do even though it may not formally get acknowledged as such. The development of this skill depends upon the effective interaction of all the nursing personnel on a floor. For example, a registered nurse with three to four primary patients may depend upon a patient care assistant to provide her with pertinent information about her primary patients that the registered nurse may not know because she may not have enough time to spend directly at the bedside of the patient. Instead, she may be spending her time doing documentation. A registered nurse told me, "I might ask the patient care assistant what the patient did for himself today when bathing or she (the patient care assistant) might come and tell me that the patient's skin is broken out or the muscles feel weak." Registered nurses credited patient care assistants with particular perception regarding skin care and felt that they often learned from
the patient care assistants who had been working for many years. Transmittal of such information to the registered nurse is necessary for her to make decisions about what a patient needs in order to get better.

As highlighted above, registered nurses must rely on indirect as well as direct information when making patient assessments. One of the problems with team nursing according to Manthey (1980) and the registered nurses I interviewed, was that it required "complex channels of communication." Information was funneled from a registered nurse to a team leader to a head nurse and then back down again when shifts changed. Primary nursing tried to alleviate the number of people through whom one piece of information was transmitted to the nurse in charge of a patient. However, the primary nurse ends up being an information manager, managing information from other workers, computers, written reports, lab tests, and the patients themselves. Technology in the hospital has meant greater access to more complex information. It is often indirect information in that the nurse may not have administered the test but must interpret the results. It appears that under primary nursing, registered nurses are responsible for assimilating much indirect information. Whether or not the assessment process itself is more complex, it is somehow different because of this.

How well assessment can and is being performed is
important given that patient acuity is rising and that registered nurses have less time to perform assessment through direct means. Because of outpatient services, a registered nurse may see a patient for the first time when s/he come out of surgery and are at her/his sickest. The registered nurse has no baseline of what the patient's normal appearance, manner and state of well-being were prior to surgery. This makes assessment difficult requiring a more skilled nurse than when a patient is admitted to a pod before surgery. Administrators and registered nurses often stated this as the rationale for why there is a need for more registered nurses versus licensed practical nurses in the hospital.

Assessment and its Relation to Nursing and Non-Nursing Functions

One of the debates in nursing that arises from attempts throughout the years to reorganize the work of nurses is what exactly does/should a registered nurse "do." In the sixties when there was a focus on the professionalization of nursing, "nurse administrators, mindful of the efforts to identify the unique body of knowledge that is nursing's

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1 Nurses in Intensive Care Units provide insight as to the increased importance of assessment and close monitoring when patients have higher acuity levels. Given that acuity levels in general are increasing in this hospital, in part because of specialty units, nurses work in Intensive Care Units can provide insight on the future staffing needs of the hospital.
alone, and in an effort to solve the manpower(sic) shortage problem, began to analyze the non-nursing activities being undertaken by nurses" (Manthey, 1980:19). This background is important to keep in mind because it demonstrates that historically the division of activities among nursing staff was done for varying motives and not necessarily because of how it facilitated or hindered the development of nursing skills. It is here that Brenner's(1984) theory of the acquisition of nursing skills provides insight into what information and activities are essential for registered nurses to develop a process for doing assessments. For nurses to move from technical proficiency to a more conceptual proficiency requires that a nurse have the opportunity to be involved in the total care of a patient and be able to make comparisons between patients with similar diagnoses.

I developed my understanding of what are nursing and non-nursing functions based on interviews with nursing staff in this hospital. I use the word functions in a broad sense to mean not only specific and discrete tasks but also processes such as assessment, teaching, and planning. In this way, I hoped to capture in one word the idea of both conception and execution of work.

There was overlap in the functions described as nursing and non-nursing. However, when I asked who should do each function it appeared that the functions roughly broke down
into three categories based on who should do what: 1) direct patient care functions which can legally only be done by a licensed nurse; 2) direct patient care functions which can legally be done by a non-licensed worker; and 3) functions which require little if any direct patient contact but which are performed to keep the patients' physical environment clean. Everyone agrees that function three should be the domain of ancillary staff such as janitors and housekeepers. The dispute is over who should do functions one and two. The dispute has ramifications for the organization of nursing work and thus to some degree represents a struggle for control over the work of nurses in the hospital between the administration and the registered nurses.

I believe that registered nurses' description of nursing functions was more inclusive than that of the head nurses because the registered nurses are direct care givers and the head nurses no longer are. Both new registered nurses and registered nurses who had been working for ten years or more included in their description of nursing functions a broader array of functions than did head nurses. However, head nurses felt that longer-term registered nurses were less receptive to attempts to restructure what had been nursing functions in the past.

Head nurses tend to more sharply delineate the difference between nursing and non-nursing functions and who should perform each than registered nurses. Teaching,
coaching, assessment, documentation, discharge planning, and administration of medications were generally cited by head nurses as nursing functions to be performed by registered nurses. Non-nursing functions assigned to PCAs and nurse partners included doing bed pans, baths, vital signs, answering patient call lights, transferring a patient from bed to stretcher, running errands for supplies not on the unit, and keeping the unit tidy.

Disagreement arises over the direct patient care tasks which can and/or should be done by a non-licensed position. Registered nurses on general medical/surgical pods typically agree with the head nurses’ description of nursing functions but tend to add to the list of nursing functions the taking of vital signs, bathing, monitoring intake and output of fluids, and feeding. Registered nurses on intensive care pods state that while the high acuity level of their patients requires them to perform the additional nursing functions listed by registered nurses on general medical/surgical pods, they felt that some of these functions might not need to be performed by a registered nurse on a general medical unit.

For example, one registered nurse on an intensive care pod said that vital signs need to be taken by a registered nurse in an intensive care pod because a patient’s vital signs may change every twenty minutes as s/he comes out of anesthesia. She suggested that on a general medical unit
with more stable patients this could be done by a patient care assistant with the results given to the primary nurse for evaluation. In other words, for registered nurses on general medical/surgical pods the transmittal of indirect information may sometimes be sufficient for making assessments. Registered nurses on general medical/surgical pods did not always agree with this, explaining that it depended on who was transmitting the information and what type of information was being transmitted.

Nonetheless, registered nurses discussed how these additional functions contribute to their ability to adequately assess the emotional and physical state of the patient. Many of the additional functions put the registered nurse directly at the patient's bedside where the registered nurse can use all her senses to evaluate the patient's well-being. For most registered nurses this is what primary nursing at its best does. One nurse said her emphasis on monitoring patient intake and output earned her the nickname "the Bowel Queen". For patients on intravenous fluids discrepancies between intake and output can signal a problem. In addition, many registered nurses talked about how giving patient backrubs can be a chance for them to talk quietly about how the day has gone while allowing the registered nurse to more thoroughly assess a patient's skin condition, muscle tone, and emotional state. Registered nurses added that these are the type of functions they like
to perform for their sicker patients for whom doing an assessment may be more complicated so that they feel the need for more direct information. Registered nurses may delegate a bath or backrub for a less sick patient to a patient care assistant.

Patient care assistants who perform some of these tasks on the pods confirm that information needed for assessment is obtained when performing these tasks. Patient care assistants feel that communication of this information to the registered nurse is important to the registered nurse’s ability to make accurate assessments. One patient care assistant said that registered nurses were always asking her about patients because she often spends more time at the bedside than they do. A registered nurse supports this saying, "It used to be that patients complained that they only saw the doctor maybe once a day or less and now patients make the same complaint about the nurses."

The key in this relationship is the transmission of information between these staff. The assumption in delegating nursing functions to non-registered nurses is that the information garnered from the functions or time spent interacting with a patient will be transmitted back to the registered nurse in a form which contributes to her assessment of the patient. It also assumes that whoever performs the nursing function for the registered nurse will know what information is important for making assessments.
This increased need for communication between workers when the work process is fragmented as observed in this hospital corresponds to Braverman's analysis of the problem associated with separating the conception from the execution of work. This observation is descriptive of Braverman's (1974) analysis of what happens when the conception and execution of work are separated. Such separation furthers the "necessity of maintaining a shadow replica of the entire process of production in paper form" (Braverman, 1974:239). Because accurate assessment comes from practice and detailed observation of a patient's progress, it may not be desirable to replace these functions for nurses.

It should be noted that registered nurses also expressed ambivalence about some of the functions performed by other nursing staff such as patient care assistants or nurse partners. While they considered the functions to be nursing functions and did not necessarily want to permanently delegate them to another person, the tasks are also time consuming to perform for all their patients. There is a tension because registered nurses also face increased pressure to do more documentation and planning of care in their role as primary nurses. Registered nurses said these functions can be very time consuming -- as much as one to two hours a day. I think part of the problem is that it is not always possible to do it at one sitting and thus
documentation becomes a disruption or it is difficult to find the "quiet" time to do it well.

The head nurse's position is now primarily administrative in contrast to earlier phases of work structuring at the hospital. One head nurse explained that over ten years ago, head nurses provided direct patient care on a floor and worked directly with the other registered nurses in administering care. This role change was emphasized when in 1988 head nurses at this hospital were given control of the budgets for their pods. Previously, budget planning was centralized. Many head nurses had no experience with budgets and had to be trained. As one head nurse explained, "Now head nurses have to justify overexpenditures...at the old hospital head nurses had clinical autonomy but no administrative autonomy." Decentralized budgetting also means that head nurses on different pods make different decisions about where to spend the money; nurses may wear hospital scrubs on one pod but not another.

The head nurse's job has become all managerial or in Braverman's (1974) term all conception where it once encompassed both conception and execution of nursing work. The registered nurse's job on a general medical/surgical unit is becoming more managerial as the registered nurse must coordinate extensive amounts of information. The hospital's attempt to train nurse partners to do more technical functions is an attempt to give the execution of
nursing work, in this case the administering of certain procedures, up to less-trained workers. Such a hierarchical division of work raises questions about how registered nurses can fully develop their skills. As Brenner (1984) points out, registered nurses progress from a novice to an expert level by being involved in both the technical and the conceptual part of nursing work. Mastery of the technical must come before moving onto the conceptual, but Benner also indicates that attaining the expert stage requires spending much time in one area, such as cardiac, to develop a complete mastery of it.

Registered nurses complained about the overwhelming number of what they considered to be non-nursing functions which they were expected to perform as needed. An in-hospital survey in 1988 confirmed this perception showing that registered nurses spend nearly forty percent of their time performing non-direct patient care activities. Registered nurses complained about emptying wastebaskets, fixing broken beds, running for food trays, and changing the linen. These functions are slotted for ancillary staff such as housekeepers but do not always get done. Such ancillary staff generally work weekdays but are not on call on nights or weekends. As one registered nurse said, "Nurses are the only position in the hospital that do their own job and everyone else's." This nurse was also referring to the duties of doctors which registered nurses sometimes end up
performing when doctors are unavailable.

However, it was clear that the number of nursing functions to be performed in one day was tremendous and also a source of conflict. In the daily routine, many of the nursing functions described by the registered nurses may be carried out by the patient care assistants and nurse partners. The lack of common understanding among nursing staff of what nursing work is can be cause for conflict. One registered nurse said that patient care assistants think that because a nurse is sitting and writing, she is not doing anything, when in fact she is doing documentation. A comment from a patient care assistant about the nurses on her unit verified this perception that managerial functions do not necessarily look like "nursing." While registered nurses agreed that doing paperwork is essential for the smooth practice of primary nursing, they also agreed that it was not satisfying and was not the reason they became nurses. In other words, being responsible for paperwork does not feel like "nursing" to them either.

The Mixed Blessing of Primary Nursing

Throughout my interviews at the hospital no nurse specifically told me that she didn’t like primary nursing. However, the problems that registered nurses described to me relate to the way primary nursing is practiced on their pods. I think one reason no one said she did not like
primary nursing is because primary nursing is touted as the "professional model" for nurses and no one wants to say that she is against being professional.

The consequences of primary nursing for different nursing staff are mixed. Primary nursing, and the reconfiguring of the nursing workforce which it entails, easily reinforces and helps to justify the evolving segmentation of nursing staff at the hospital.

Primary nursing has had some very positive benefits for registered nurses. Registered nurses' increased responsibility for patient care has increased their self-esteem. While with the added responsibility come more tasks, there is also satisfaction in providing continuity and coordination of patient care. Primary nursing gives registered nurses more authority to act on a patient's behalf with other health care professionals such as doctors, technicians, and social workers.

Head nurses and registered nurses alike have commented on how nurses' self confidence and self esteem suffers from being seen as part of a women's profession. Nurses have not traditionally been trained to take an active role in speaking up on behalf of patients or asserting themselves with the doctors. In the past, nurses have often been passive according to head nurses and registered nurses in the hospital. Thus, primary nursing has helped to change the low self perception nurses may have had of themselves in
the past.

Registered nurses and head nurses agree that primary nursing increases the status of nursing as a profession. Some registered nurses complained to me that patients viewed them as glorified maids and expressed shock when they were told that the registered nurse had a four year college degree. Along with primary nursing has come a move in the nursing profession to try and standardize registered nurse education so that all registered nurses are baccalaureate degree nurses. Nurses said that for many positions such as the nurse-in-charge and the head nurse position, there is increased emphasis on having a four year nursing degree.

Primary nursing also has negative consequences for some nursing staff. First, it entails more paperwork to be done at a higher level of detail. This requires time and is often cited by registered nurses as negative because it takes away from time they would prefer to use interacting with patients through teaching or coaching. Second, primary nursing requires that a registered nurse coordinate all care for a patient which means that a registered nurse must interact with many other departments in the hospital. The registered nurse must talk with the social worker, the visiting nurse, the physical therapist, the occupational therapist, the doctor, the family, and community groups. The registered nurse becomes the point person for total patient care from start to finish.
In addition, while primary nursing typically means that inpatient units are staffed by a higher proportion of registered nurses, it also means that these registered nurses have to perform a wider array of tasks because there often are fewer licensed practical nurses and patient care assistants. As noted in Chapter Three, a minimum of two nursing staff on a pod are required in the hospital. For example, a pod can be staffed by one registered nurse and one patient care assistant. This staffing pattern, however, requires that the registered nurse monitor all the patients because the patient care assistant can only do a limited number of tasks and cannot assume full responsibility for a patient.

One of the reasons staffing patterns as described above occur is because head nurses must count patient care assistants as full staff persons in their budgets. Head nurses state that using patient care assistants would not create such a problem if they could have more registered nurses and not have to count a patient care assistant as a full staff person. With tight budgets, head nurses are placed in the position of constantly considering cost, how to get the most staff with the least amount of money. Obviously, head nurses must and do consider staffing needs based on patient acuity on the pod, but it appears that cost is becoming an overriding factor.

Primary nursing has been harder for older nurses to adapt
to than younger nurses, according to both registered nurses and head nurses. One registered nurse said that the older nurses were "frightened of the concept" because of the changes that it entailed with documentation and responsibility. She said that the older nurses were afraid their evaluations would not be as good once primary nursing started. New graduates are socialized to primary nursing from the beginning and thus do not seem to be intimidated by it. Hence, older nurses may be afraid that the younger nurses may out-perform them and that may jeopardize their own job.

Furthermore, head nurses suggest that nurses are loathe to change routines. According to head nurses, primary nursing at this hospital ideally involves giving up some tasks to others so that the primary nurse can concentrate on doing assessments and documentation. Though the registered nurses did not say this explicitly, the giving up of tasks may feel like a giving up of power and control to the patient care assistants or nurse partners.

For patient care assistants, primary nursing has mixed impacts as well. It is not clear whether primary nursing has greatly changed the type of duties patient care assistants perform or how the duties are carried out since each pod implements primary nursing slightly differently. In the hospital, the supervision of patient care assistants on the unit varies. On some pods, the patient care assistant
who assists all patients is not directly responsible to one registered nurse. In other cases, the patient care assistant works with the nurse-in-charge and is assigned patients under the care of the nurse-in-charge or other nurses as needed.

Summary

The work of nursing is being reorganized in this hospital as evidenced by a number of changes. First, job descriptions are changing and a new job category is being tested. Second, these changes in job description lead to new forms of segmenting the work of nurses among different workers. Third, a new form of skill polarization results, which has consequences for the acquisition of nursing skills. These changes have had mixed consequences for nursing staff. For registered nurses, the introduction of primary nursing increases their authority and encourages a continuity of care. At the same time, primary nursing increases the amount documentation to do which takes registered nurses away from the bedside. The tensions that are highlighted help show that there is a struggle going on in the hospital over who does and who should control the organization of nursing work.

In Chapter Five, I briefly describe the implications of this struggle for the future of registered nurses at the hospital.
CHAPTER FIVE
IMPLICATIONS FOR REGISTERED NURSES

As shown in Chapters Three and Four, nursing work at this hospital is in the midst of change; some of the change is beneficial to registered nurses, some has more questionable implications. Where the change will lead ultimately is uncertain. In this chapter, I discuss possible directions for this change. I argue that registered nurses can take two forms of action to maintain control over the organization of nursing work in this hospital: form an alliance with the patient care assistants, and, work to increase the number of registered nurses. The second action is dependent upon the first as will be shown.

Registered Nurses and the Protection of Their Job
Description and Duties

Registered nurses at the hospital, with the assistance of the Massachusetts Nurses Association, have thus far successfully stymied the introduction of nurse partners at the hospital. If the registered nurses are afraid of nurse partners causing a decrease in their control over nursing, then history shows that this is a valid concern. Licensed practical nurses and nurse's aides were introduced to the hospital in World War II in response to a nursing shortage and became a permanent feature. Though the hospital has put
the pilot program for nurse partners on hold, they are interested in introducing some type of new nursing worker on inpatient pods in the future. The name may be changed along with some of the duties but the intent is the same.

The Significance of Race and Class Differences in Forging Alliances

Forming an alliance between registered nurses and patient care assistants requires bridging race and class differences. The racial divisions at the hospital are quite clear. Nearly all the registered nurses at the hospital are white. Most of the long-term patient care assistants are women of color while the nursing students serving as patient care assistants are white. Exacerbating the racial differences between registered nurses and long-term patient care assistants are the class differences based on differential education and training. Added to this is the race and class division within patient care assistant positions: white nursing students, who will be registered nurses, see themselves as more aligned with the registered nurses than they do with the long-term patient care assistants, who are women of color and unlikely to return to school.

I believe that registered nurses see themselves working to help nursing students join the "class" of registered nurses. Most registered nurses and nursing students are
also the same race which makes the bond stronger.
Registered nurses need to understand that long-term patient care assistants are important allies in registered nurses' desire to control nursing work in the hospital.

Nurse Partners and the Implication for the Racial Composition of Nursing Staff

The recruitment methods for the nurse partner position raises questions as to how the racial composition of the nursing staff may change over time. From all accounts, it does not appear that extensive outreach was made to long-term patient care assistants who might have wanted to apply for the nurse partner position. As noted above, most of these patient care assistants are women of color. Recruitment from outside the hospital for people with college degrees eliminates advancement opportunities for these long-term patient care assistants and possibly increases the chance that those hired from outside the hospital will be white.

The Double-Edged Sword of Professionalization

The desire of registered nurses to encourage the professionalization of nursing is a double-edged sword. On the one hand, keeping nurse partners out of the hospital helps registered nurses maintain control of their craft. Yet, this control may sometimes come at the expense of other
nursing workers in the hospital, specifically patient care assistants. Patient care assistants did not apply for the nurse partner program, which would have increased their wages, for a number of reasons. Some may not have applied because it would have meant switching pods and shifts. For others, however, the opposition of the registered nurses on their pod to the use of nurse partners kept them from applying for the training. Patient care assistants work closely with registered nurses and are dependent on them to answer questions and help the patient care assistants when needed. For still others, information on the training was not disseminated to patient care assistants in a timely manner. This raises the question of whether the hospital administration did not want patient care assistants to apply for the position. Some patient care assistants when queried emphasized that the only reason they did not apply for the nurse partner position was the registered nurses' opposition. All patient care assistants I spoke with were interested in the higher wage of the nurse partner position.

Thus, some patient care assistants, who take home roughly $200 per week after twenty years, forfeited an opportunity to increase their wages in part because their work is dependent upon their interaction with the registered nurses. While factors besides wages are important in work satisfaction, it was the only topic of my interviews in which patient care assistants expressed extreme
dissatisfaction. I also recognize that for some patient care assistants to choose this option would have been difficult because their position in the hospital hierarchy makes them dependent upon the registered nurses and because some patient care assistants have worked certain shifts for many years which they may not want to give up. At the same time that registered nurses do not want nurse partners, it is clear that on general medical/surgical floors there is a need for some form of assistant to the nurse to answer call lights, fill water pitchers, help feed patients, and other non-technical functions. The increased time spent by registered nurses doing documentation increases the need for help doing these other tasks listed above. Registered nurses utilize the few nurse partners as patient care assistants not only because they are afraid the nurse partner does not have enough training but also because the functions done by a patient care assistant are the ones registered nurses seem to be most in need of. As one head nurse said, "The burning issue of why we didn’t hire more patient care assistants in the first place is something that many of us asked ourselves given all the hoopla that was raised over the nurse partner."

Given that the hospital intends to pursue other forms of nurse extenders, registered nurses could benefit from a more explicit alliance with the patient care assistants. The alliance could be based on the desire of both registered
nurses and patient care assistants to be sufficiently recognized for the work they do. For registered nurses this would mean having the hospital acknowledge that the registered nurse is the only worker sufficiently trained to perform certain functions and thus abolish the nurse partner program. For the patient care assistants, monetary recognition and maybe more training would be the goal. The patient care assistants at the hospital do not receive ongoing training for their positions. An alliance would benefit the registered nurses because it helps them develop better control over the work of the patient care assistants and elicit support for their position on nurse extenders. In addition, nursing students often serve as patient care assistants making this alliance a way to bridge the move from patient care assistant to registered nurse.

Patient care assistants, because of their more limited training, do not pose the same threat to the registered nurse position that a nurse extender position such as the nurse partner potentially does. Nurse partners cost half as much on a per hour basis as registered nurses and have more training than patient care assistants. The hospital can make a better argument for cutting back on registered nurses if it can replace them with workers shown to have more training than the patient care assistants. This factor cannot be underestimated. The proportion of registered nurses on inpatient units has increased in the last three
years as shown in Chapter Three, giving the hospital more cause to want to replace them with less costly personnel. The extent to which the hospital can do this and still deliver the sophisticated care needed by patients with high acuity levels is not clear.

Another way to build alliances between registered nurses and patient care assistants is through support for continuing education. If registered nurses believe that what is needed to make nursing work more efficient and productive is more registered nurses, then they must present a way to recruit more nurses. They can encourage the development of substantial scholarships for patient care assistants who want to become registered nurses.

By helping to create a career ladder within the hospital, the registered nurses can dismiss the argument that nurse partners, drawn from outside the health care profession, provide an opportunity to develop a pool of prospective registered nurses. Developing this career ladder would also eliminate the fact that there seems to be two different labor markets at the hospital for nursing staff; one for whites and one for people of color. There is tuition reimbursement for full-time employees, but by all accounts it is inadequate both in terms of amount and limitations on the type of programs that can be pursued. Many of the patient care assistants, who could benefit from a career ladder, have families and cannot afford to leave their jobs
to go to school fulltime. Recruiting and training workers from within the hospital is an idea supported by some registered nurses. Registered nurses want to work with assistants who are comfortable working in a hospital setting. Some nurse partners' lack of work experience in a health care setting has been a factor in registered nurses opposition to working with them.

The Implications of Hospital Policies

While it may be argued that technological change precipitates the need for differentiation by training, I believe that technological change is not the motivating factor behind the training of nurse partners nor do I believe, based on interviews with registered nurses, that help with technical nursing functions is what is needed at this hospital. First, licensed practical nurses historically represented a more "technical nurse." It does not make sense that the hospital argues both that licensed practical nurses are not appropriate in an acute care hospital because of their more limited training and that there is a need for a nurse partner who has considerably less training to assist the registered nurse. Furthermore, there are already specific technicians situated off the inpatient pod, who are trained to operate some of the more sophisticated technology that is used on the pod such as electrocardiograms.
Why not have registered nurses develop more of a "partnership" between licensed practical nurses and registered nurses? Not all registered nurses would agree with this because some argue that even the licensed practical nurse does not have adequate training for them to feel comfortable delegating more complex functions to licensed practical nurses. However, I suggest this to illustrate that there is already a worker in the hospital who could fill technical functions. However, licensed practical nurses cost more than nurse partners.

Moreover, as licensed workers, licensed practical nurses' work is subject to particular standards. Nurse extender positions, such as the nurse partner, are now unregulated though this may change in the near future depending on the ruling by the Board of Registration in Nursing. I contend that it is easier for the hospital to gain control by introducing a brand new position with no set standards and mold it, than it is to try and change existing positions which must meet certain standards.

Furthermore, registered nurses did not indicate that they needed help from other staff with the introduction of new technologies on the pod. They wanted staff available to help with more non-technical functions such as taking vital signs, feeding and bathing patients, filling water pitchers and answering call lights. One example of technology introduced at the bedside is the Patient Controlled
Anesthesiology. A device designed to allow patients to adjust their dose of pain medicine as needed, it requires registered nurses to closely monitor the patient because of the changes in respiration that occur as doses are increased. Most registered nurses thought this device was helpful.

Going Against the Grain of the Craft Union Model

Registered nurse’s unions, such as the Massachusetts Nurses Association, are typically designed along the lines of a craft union. In craft unions workers are organized along skill or craft lines as opposed to being organized along firm lines as in industrial unions. Historically, craft unions were more conservative and sought more often than not to keep certain workers out of the craft based on race or religion. For registered nurses to form an alliance with patient care assistants breaks with the tradition of organizing those workers who share a common training or skill.

However, given the complex and changing organization of nursing work in this hospital, it may be that registered nurses can no longer afford to try and stand alone. The hospital is looking at redesigning numerous jobs that are not performed by registered nurses but which may affect their work. Unions representing both registered nurses and nurse’s aides support the position taken by registered
nurses represented by the MNA at this hospital. District 1199, a union which represents both registered nurses and nurse's aides, holds the general position that nurse extenders are the wrong way to deal with the nursing shortage and that there should be better mobility for nurse's aides to become registered nurses via hospital sponsored educational reimbursements and loans. This union supports making the work of registered nurses more professional through better staffing of registered nurses and better organization of in-service training. However, rulings by the National Labor Relations Board make it difficult, at present, to establish a bargaining unit of workers across a hospital.

I describe the above not to say that registered nurses' alliance with the patient care assistants should automatically mean the formation of a different kind of union. For one thing this may not be possible given the NLRB ruling and MNA sentiments about breaking from a craft union model. I do believe that registered nurses can include patient care assistants in discussions of what the future holds for nurse partners and of how they, registered nurses and patient care assistants, think patient care on a unit is best delivered.

In the rapidly changing world of health care in hospitals, it is important for registered nurses, in their quest to maintain control over their work, to have an open
eye to potential allies in sometimes unlikely places.
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