Quality, efficiency and integrity: value squeezes in management of hospital wards

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Aim The aim of this study was to explore and describe the value squeezes experienced by ward managers in connection with quality management in hospital wards. The study focused on integrity pressure and coping strategies to deal with such pressure.

Background Nurses in the role of ward managers have a key function in the field of quality improvement. These managers are also responsible for the efficient running of their wards and thus face tensions between demands for both quality and efficiency.

Method Data were collected through interviews conducted with 10 ward managers from six Norwegian hospitals. The data were analysed using both content and template analysis.

Results Ward managers felt squeezed between conflicting values associated with demands for both quality and efficiency. These tensions resulted in pressure on integrity for the managers as well as their nursing colleagues. Three different management strategies were used to cope with such pressure: quality conscious, efficiency adjusting and hybrid.

Conclusion A hybrid strategy appeared to be the best, both for the ward managers and the hospital organisations, despite the fragmentation associated with this strategy.

Implications for nursing management Hybrid management may be beneficial for coping with pressure on integrity, although more empirical research is needed.

Keywords: integrity, organisational health, quality deviation, value squeezes, ward management

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medical errors as well as adverse events that threaten patient safety (Hjort 2007).

In a study of how ward managers in Norwegian hospitals dealt with deviations in quality of care, it was found that managers faced tensions between demands for quality and efficiency as they tried to maintain professional standards with limited resources (Vågen 2008). Such tensions appeared to affect their organizational as well as their professional relationships. As nurses, the managers had been socialized into values of individualized and holistic care. However, they felt that these values were pressed by budget constraints and resource allocation decided by top managers. Such constraints on values challenged the integrity of the ward managers (Orvik & Vågen 2010).

The same study also noted that tensions in the management of deviations in quality often induced emotional distress among ward managers, including feelings of deficiency, powerlessness and annoyance. Ward managers felt under pressure from both the efficiency requirements of top management and the expectations of quality from colleagues and patients. Some ward managers thought it was problematic not to be acknowledged by top managers, while others found it difficult to be criticized by their colleagues. In such instances, the managers felt that they were in a defensive position and their personal and professional integrity was being questioned (Vågen 2008, Orvik & Vågen 2010).

The aim of this article was to explore and describe the implications of the value squeezes experienced by ward managers in connection with the management of deviations in quality in hospital wards. Values are here defined broadly as preferences concerning appropriate courses of actions and outcomes, which may include professional ideals as well as economic assessments (Aadland 2010). The focus of the analysis is on the possible effects of such conflicting values on the integrity of ward managers and their coping strategies. Possible implications for both the health of the ward managers and the health of the organisation are considered.

Conceptual framework

Hybrid management

Nurses working as ward managers have roles and tasks that include both professional practice and managerial responsibilities. They may therefore be described as hybrid managers (Ferlie et al. 1996, Exworthy & Halford 1999). In the nursing literature, hybrid management has been associated with conflicting identities and a dialectical interaction between nursing and leadership (Sørensen et al. 2011).

Hybrid management has also been characterized as a two-way window that enables managers to act in different worlds (Llewellyn 2001). In the health sector, however, hybrid managers may experience that their professional values are in conflict with wider organizational values, such as the efficient use of limited resources (Dellve & Wikström 2009). Hybrid managers may therefore experience value squeezes and a conflict between closeness and distance from professional practice (Causer & Exworthy 1999, Witman et al. 2011). As a result, hybrid management may be fragmented into different roles, depending on the different values and organisational logics involved (Wikström & Dellve 2009).

The concept of hybrid management was developed in connection with ‘new public management’ (Ferlie et al. 1996). In this context, hybrid roles were expected to be transformed into general management roles, focusing mainly on economic values (Berg et al. 2010). However, according to Jacobs (2005), such hybridization may challenge the core values of the profession. One strategy to reduce these tensions has been to introduce hybrid management teams in which the tasks are shared between two managers, one professional and one administrative, instead of having one hybrid manager to balance the different organisational values and logics involved (Choi 2011).

Another strategy has been to incorporate a value-based form of management into hybrid management (Graber & Kilpatrick 2008). It has even been suggested that new forms of hybridization may lead to a post-new public management era (McNulty & Ferlie 2004).

Quality and efficiency

Ward managers are deeply rooted in the clinical context and accountable for creating a caring culture of dignity and safety (Bondas 2009). However, ward management also implies an administrative role and involves a close collaboration with middle- and top-level managers, especially with regard to the allocation and use of resources. As nursing professionals, ward managers promote quality by emphasizing clinical values and professional standards. As administrators, they promote efficiency by emphasizing economic values and budget constraints (Kippist & Fitzgerald 2003).

These considerations of quality and efficiency are not always compatible. While efficiency refers to the
ratio between resource inputs and production outputs (Shortell & Kaluzny 2006), quality is a multidimensional concept that includes different aspects of the structure, process and outcome of care (Donabedian 1988). The efficiency of production may be detrimental to the quality of care and vice versa. However, quality may also be an important condition for efficiency, and efficiency may be regarded as an element of quality (Maxwell 1992, Nelson et al. 2007). Thus, although there are tensions, there are also mutual dependencies between quality and efficiency, which means that they may both be conducive to the effectiveness of the organisation. Effectiveness refers to the relationship between the outputs and the objectives of an organisation (Shortell & Kaluzny 2006).

The tension between two equally valuable competing considerations makes a dialectical approach necessary. From this perspective, it is important for ward managers to bridge the worlds of quality and efficiency to achieve organisational effectiveness. This means that the tensions between quality and efficiency must be preserved, as they may both be beneficial to the overall effectiveness of the organisation (Van de Ven & Poole 1995).

Integrity

Ward managers often find themselves in a buffer position between professional work and management (Richard 1997). This may result in value conflicts, pressure on integrity and consequences for health and wellbeing. Traditionally, integrity has been seen as a personal and moral concern. However, it is also linked to the broader organisational environment in which an individual is working (Schabracq & Cooper 1998, Schabracq 2003). In this regard, three key aspects of integrity are relevant.

First, integrity requires an individual to work in accordance with personal values. Following Schabracq (2003), work should be oriented towards the values of the person who is performing it. Nurses are socialized into values of individualization and quality of patient care, and they bring these values to their management roles (Bergin 2009). As ward managers they also have to manage limited resources, budget constraints and efficiency requirements, which may put their integrity under increasing pressure.

Second, integrity requires an individual’s willingness to perform the actual work. To ensure integrity, the actions performed should therefore not be in conflict with individual convictions (Schabracq 2003). In other words, integrity should be mentally undivided and requires a continuity or unity between the values and the actions performed. For ward managers, the maintenance of integrity may result in resistance to change.

Third, integrity requires an individual to be integrated into the environment. According to Schabracq (2003), such integration contributes to good performance, personal development, health and wellbeing. The environment of ward managers includes interactions with professionals and the hospital organisation itself. When such interactions function poorly, the integrity of the managers may be threatened.

Integrity enables ward managers to integrate themselves within the broader social structure of a health-care organisation, making it possible to maintain productive relationships with others and to undertake their job in accordance with their own values (Schabracq 2003). Conversely, research has shown that there are increases in stress when integrity is threatened (Hasson & Arnetz 2008, Arman et al. 2012). Integrity may therefore affect the health of the ward managers and the organisational health, depending on how the organisation is able to cope with the tensions associated with diverse and competing values (Orvik & Axelson 2012).

Methods

Data collection

The empirical data were collected in connection with a study of deviations in quality in six Norwegian hospitals in three different health regions (Vågen 2008). The hospitals selected varied in size and had different organisational structures and administrative routines for reporting deviations in quality. Semi-structured qualitative interviews were conducted to capture the experiences, reactions and emotions concerning these complex and sensitive issues (Kvale & Brinkmann 2009).

Interviews were carried out with 10 ward managers from inpatient and outpatient wards. Some of the participants were recruited by their own department heads, some applied voluntarily to participate, while a few were contacted directly by the interviewer. All except one of the participants were women, but they constituted a heterogeneous group of diverse managerial competencies. The length of their managerial experiences ranged from 1 to 12 years, while their span of control ranged from 30 to 50 employees in the inpatient wards and from 11 to 20 in the outpatient wards.

The first interview was conducted in September 2007 and the last one in February 2008. All interviews were in-depth and face to face. They lasted
approximately 1 hour and were conducted by the second author. After 10 interviews, a data saturation point appeared to be reached and the interview phase was concluded (Polit & Beck 2008).

The interviews focused on specific questions related to the management of deviations in quality in hospital wards – for example, reporting routines and implementation of standards in quality. There were also questions on emotional reactions, resistance to change and support from top management. The interviews were tape-recorded, transcribed verbatim and coded by the first and second authors.

The empirical study was approved by Norwegian Social Science Data Services. In accordance with a requirement for informed consent, the participants were given written information about the research project and that they could withdraw from the study without specifying a reason.

Data analysis

The analysis was based on a template approach of organising interview data, which allows the researcher to describe a phenomenon by predefined codes. Such a coding template reduces the amount of data being considered, brings together related data earlier in the process and helps to establish connections between data (Crabtree & Miller 1999). The predefined codes may be based on the aims or the conceptual framework of the research project, but may also be modified, supplemented or even deleted in the subsequent analysis. The advantage of template analysis is the flexibility of the approach, which means that it can be adapted to the needs of a study, while the disadvantage is that the template may be either too simple to allow for a depth of interpretation or too complex to be manageable (King 2004).

In this analysis, the three main aspects of integrity were used as predefined first-level codes. At the same time, the interpretation of data was also an opportunity to examine the concept of integrity itself. The analysis was performed using a stepwise approach. First, all the 10 interviews were read through and then reread, and notes were made each time when value squeezes related to the different aspects of integrity were explicitly mentioned. Following this, the content of each of the interviews was analysed in more detail, which generated second-level codes as well as other relevant findings across or beyond the different aspects of integrity.

The content analysis was performed in accordance with qualitative methodology (Graneheim & Lund-
maintain high standards of care. Some of them noted that quality and professional standards should not only be required by law, but also form ethical norms within health-care settings:

‘Nursing is grounded in ethics. …People and respect come first, and then comes the professional discipline with all its tasks. But if your possibilities to contribute to a holistic approach or to the patient’s integrity are limited, it may lead to deviations’.

(Manager 1, hospital 4)

Many ward managers were aware that their colleagues were genuinely concerned about ethical dilemmas related to quality. However, at the same time, they felt their professional standards were being squeezed by other competing demands. For example, they were given instructions to prioritize goals that were quite different from quality improvement and professional development:

‘The top management says goals number one, number two and number three are to keep the budget. What should we do? They have said so for 2 or 3 years now. Maybe once they will remind us of the value of professional quality, but without sufficient resources it will never work’.

(Manager 1, hospital 3)

To balance such incompatible requirements, the ward managers needed both clinical and administrative skills. However, many of them pointed out that their opportunities to communicate upwards in the organisation were limited. The top managers were not involved in the daily operations of the wards and were therefore unable to see the problems:

‘We want someone who is blowing the whistle in the organisation, but at the same time… we are responsible for the wards. …We are in a squeeze, in a tension between loyalty to the system and its economy, and loyalty to our professional judgment’.

(Manager 1, hospital 4)

According to ward managers, time was a key resource for ensuring quality. A lack of time could lead to deviations in quality and explain the under-reporting of such deviations, as the completion of incident reports was very time consuming. Some ward managers compared their daily operations to constant ‘fire-fighting’, which they saw as being at the expense of strategic development. However, a few had been able to establish long-term strategies that prioritized professional development. By separating significant and insignificant tasks, they gained control over their work situation.

Openness towards colleagues and others

An atmosphere of openness was emphasized by many ward managers. They pointed out that communication with colleagues, other professional groups and department heads should be characterized by regular dialogue. In their opinion, openness was important for the management role:

‘I think it is essential which signals I give about which deviations should be reported. An authoritarian approach… may inhibit the dialogue and be an obstacle to criticism and openness. These aspects are important for me to take care of in my work’.

(Manager, hospital 1)

This openness was important not only in the context of the management of quality, but also for managing change processes. Some ward managers believed that they had succeeded in making improvements because they had not imposed radical and rigid changes. Instead, they had managed change processes by involving colleagues and entering into a dialogue with them about what was most important both for them and others, without ignoring anyone:

‘As a manager you must have a very low threshold into your office and accept to be involved all the time in small and large concerns. If you are available they will come if they want input and feedback’.

(Manager, hospital 6)

Time shortages and a lack of meeting places limited the opportunities available for dialogue. Moreover, the dialogue was also limited by a fear of making mistakes and a fear of reprisals from physicians and department heads. Some managers also said that they needed to limit discussions for the sake of their own health and wellbeing at work.

Willingness to perform the work

The ward managers indicated a willingness to do what they were actually doing, although there were some potential tensions associated with their tasks.
Following tasks were particularly problematic and emerged as second-level codes: dealing with deviations in quality, maintaining professional standards with limited resources, and collaborating with colleagues and other professional or non-professional groups.

Dealing with deviations in quality
Because of alleged under-reporting of deviations in quality, many ward managers worked hard to increase the number of reports on deviations. In some hospitals these reports were delivered to the managers, while in others they were sent directly to quality control. In general, the managers perceived their role as a driving force for improvement in quality:

‘I think my role is very important. It is my responsibility to remind the staff to report quality deviations. When I remind them, the number of reports increase, but after that they decrease again. This indicates the importance of management in such processes’.

(Manager, hospital 1).

Several ward managers indicated that they were prioritizing the follow-up of reports on deviations to motivate staff to focus on improving quality. However, colleagues who had been conscientiously reporting deviations in quality sometimes questioned what happened to their reports after they were submitted.

Specific concerns about under-reporting emerged in several interviews. Some ward managers were worried about staff members who disregarded important aspects of quality or kept quiet about severe medical errors out of loyalty to colleagues or physicians. Some also admitted that they had negative feelings about reporting deviations in quality:

‘I think we are part of the quality system, but at the same time ward managers, me included, sometimes signal that it can be burdensome; “It was not so serious, it was a one-time event” etc....On one hand it is great that people report quality deviations, but on the other hand I can feel that the reports evoke something bad in me’.

(Manager 1, hospital 4)

Some of the managers were enthusiastic about dealing with deviations in quality, while others were more reluctant. The latter minimized their discomfort by requesting reports only in instances where a deviation had resulted in injury. By doing so, these managers also reduced the extent of reporting.

Maintaining professional standards with limited resources
The majority of ward managers had experienced shortages of resources that had impact on the quality of care. In some instances they had to inform top management about the unacceptable consequences of these shortages. In other instances, they had to tell their nurse colleagues to increase efficiency. In general, the managers were trying to maintain the professional standards even if the resources were limited:

‘When it comes to patient care, my loyalty is there. If the head of the outpatient ward said we are now going to use all the resources on outpatient surgery, I would have protested strongly. Then my loyalty would not be with the management anymore’.

(Manager 2, hospital 4)

Adequate staffing was important to provide quality of care, and many deviations in quality were seen as consequences of cutbacks in resources. Colleagues were frustrated by inadequate staffing levels relative to the amount of work. They perceived that money seemed to matter more than the consequences of the shortages of resources for quality of care.

The ward managers were sometimes more rigorous than their colleagues with respect to the professional standards, but this was not always the case. Some managers adjusted their standards to the limited resources by referring to nursing ethics:

‘Our ethical guidelines stress that we should face new challenges actively and, if necessary, be able to adapt to new challenges. ...When I started as a manager in the outpatient ward we treated six or seven thousand patients a year. This year we have more than fourteen thousand patients. It is clear that we cannot do the same now, it is absolutely impossible’.

(Manager 2, hospital 4)

These tensions between professional standards and limited availability of resources were regarded as an integral part of hospital ward management, and a variety of different approaches had been adopted in response to them.

Collaborating with colleagues and other groups
Processes of collaboration were regarded by ward managers as beneficial to the quality of care. Collaboration with colleagues was described as a condition for the follow-up of deviations in quality. However,
collaboration depended on meeting each other face-to-face and this created a potential for conflicts within and between professional and occupational groups. Such conflicts were not always resolved for the benefit of the patients:

‘The hygiene has become much worse, but I notice how loyal we are to the cleaners. We do not report any quality deviations, but instead try to take up the issues with them face to face. So, in order not to expose them to what a deviation report on their cleaning might lead to, we talk to them, but this does not necessarily contribute to improved cleanliness. …We spare our collaborators, but at the same time we may not spare the patients’.

(Manager, hospital 4)

Collaboration with other professional groups, particularly physicians, was often challenging. This was regarded as something of a paradox, as quality of patient care and treatment requires a close collaboration between nurses and medical staff.

Collaboration with physicians was often described as sensitive and inhibited by fear. Working in close proximity made it difficult for a nurse to report a physician for deviations in quality. Therefore, the ward managers often took over this responsibility and reported physicians to the department head. Some of the managers had a tough attitude:

‘What I wanted to do was to take all the cases, run away to really hit the physician on the head and say: “you will never be allowed to work at our outpatient clinic any more if you don’t behave!” I felt that I almost wanted to report it to the police’.

(Manager, hospital 6)

While some of the ward managers were willing to have conflicts with physicians, others preferred dealing with them in a more gentle way. However, both strategies seemed to require considerable energy and effort.

Integrating into the environment

The interviews indicated that ward managers were integrated into three areas of their work environment that seemed to be particularly important and therefore emerged as second-level codes: nursing colleagues; other professional and occupational groups; and the hospital organisation and management.

Nursing colleagues

Most ward managers characterized themselves as well-integrated into the nursing environment, and for many of them the nurses were a source of inspiration and support:

‘When it comes to quality improvement, it is the support from my colleagues, together with the response from the patients and their families that make me go on, to a very large degree indeed’.

(Manager 3, hospital 4)

Nursing colleagues were described as critical and questioning, but also as able to reach joint solutions on clinical problems. According to the managers, many nurses were confident in their professional roles and could disagree frankly with each other, but at the same time they were also seen as being genuinely concerned with the welfare of their patients. There were times, however, when dedicated colleagues could be a source of annoyance:

‘One of my colleagues reports on quality deviations again and again. All the time I experience that there is a report from her and I think: “what is it now?” …She has perhaps taken on a role of being a reporter’.

(Manager, hospital 5)

In addition, some of the managers noted that it could be a challenge to communicate with colleagues unwilling to change or to embrace new knowledge important to quality improvement.

Other professional and occupational groups

Ward managers pointed out the importance of good relationships with different professional and occupational groups in their work environment. The relationships with the physicians were the most important. Deviations in quality were sensitive issues when physicians were involved:

‘These matters are difficult to talk about. …If we want the physicians to participate in quality improvements, their leader must be with us. But if the medical manager is fundamentally against the reporting of quality deviations and thinks it is nonsense, then the other physicians will hide themselves behind it’.

(Manager, hospital 6)

Nurses who reported deviations in quality often regarded themselves as ‘whistleblowers’, while
physicians regarded them as informers. Ward managers argued, therefore, that they should proceed gradually in their improvement efforts and communicate in ways that preserve good interprofessional relationships.

Hospital organisation and management

Deviations in quality often occurred in the interfaces between different clinical departments and these deviations were also most frequently reported. For example, when patients had to be transferred between different departments because of their treatment, specific routines had to be followed. Failure to do so could lead to medical errors and adverse events that threatened patient safety.

Cutbacks in resources were often the reason for an increasing number of deviations in quality. However, when the ward managers raised such issues with the top management of the hospitals they were often told that the quality of care should just be good enough. Such a response was a great challenge to the loyalty of the ward managers:

‘I am a manager, not a representative for the employees. My loyalty is therefore with the management. ... However, being very close to and involved in daily operations, I also have a loyalty to my professional colleagues. This means a conflict of loyalties’.

(Manager, hospital 1)

Many ward managers were continually stressed by the demands of hospital managers, particularly those related to keeping within the budget. They also realized that many department heads were in the same situation.

Discussion and implications for nursing management

The analysis has illustrated how the values of ward managers may be squeezed by conflicting demands for quality and efficiency, creating pressure on their integrity. In addition, findings emerged from the empirical data across and beyond the different aspects of integrity. These findings, which can be regarded as integrative themes, indicated that ward managers were using three different strategies to cope with integrity pressure:

- Quality-conscious management was a strategy employed by those who saw their primary responsibility as ensuring high ethical and professional standards of care and treatment. They were conscious of both their professional backgrounds and their management roles.
- Efficiency-adjusting management was a more defensive strategy adopted by those who did not see any conflict between quality and efficiency. They accepted being pushed into difficult situations because of their managerial position. Some were surprised by their own adaptability, while others were concerned by the frustration of their colleagues.
- A hybrid management strategy was adopted by ward managers who were particularly aware of their role across and between two very different organisational arenas. Such managers experienced fragmentation of different roles, but were able to combine considerations of quality and efficiency.

Quality-conscious ward managers were squeezed by budget constraints but regarded the support from top management as limited, for example when they were told that the quality of care should only be ‘good enough’. Such responses increased work stress and a feeling of ‘voicelessness’ (Gaudine & Beaton 2002). The quality-conscious managers were strong advocates for colleagues and patients, but such an emotional commitment may carry a risk of burning out (Lutzen et al. 2003). The quality-conscious strategy may therefore have negative consequences for their health and wellbeing. A strategy with such a strong emphasis on quality is also unlikely to sustain organisational health (Orvik & Axelson 2012).

Ward managers with an efficiency adjustment strategy may have been operating in a state of cognitive dissonance by holding concurrent, conflicting values (Wikström & Dellve 2009). They defended requirements for efficiency, while in other contexts they described themselves as driving forces for quality. Switching emphasis like this may have been a survival strategy responding to cross-pressure from competing organisational demands. Such a strategy may affect integrity and be associated with health risks (Sørensen & Grimsmo 2004). Moreover, this strategy is unlikely to be sustainable in hospital organisations, as effectiveness rather than efficiency is their main obligation towards society (Shortell & Kaluzny 2006).

Ward managers who adopted a hybrid strategy used a double set of roles to cope with integrity pressure. They attempted to integrate competing demands, although the tensions associated with the competing values remained unresolved (Östergren & Sahlin-Andersson 1998, Llewellyn 2001). Some ward managers described their roles as having one foot in each of
two very different camps, as they strived simultaneously to manage values of quality and efficiency. This is in line with a ‘bicultural approach’, which may be optimal for the integrity of managers as well as professionals when being confronted with tensions in values (Kramer & Schmalenberg 1977).

Despite the fragmentation caused by different roles, the hybrid strategy seemed to balance quality and efficiency considerations in a way that diminished pressures on integrity. Researchers have argued that a hybrid strategy reflects a fundamental polarization between professional and managerial identities (Jacobs 2005). Some of the managers expressed reluctant acquiescence over the cutbacks they faced and the resultant poor quality of care, while others felt cross-pressured by their professional and managerial responsibilities. Despite this, a hybrid approach may be more sustainable for the health of ward managers and for the health of the entire organisation.

Conclusions

This study analysed value squeezes and pressures on integrity in connection with the management of deviations in quality in hospital wards. The data indicated that the ward managers felt squeezed by competing values, especially the tensions generated by demands for both quality and efficiency.

Three different strategies for coping with pressures on integrity were identified and their possible implications were explored. Quality- and efficiency-focused management strategies may have negative consequences for the managers as well as the organisations. A hybrid strategy appears to be more sustainable and may have a positive impact on the health and wellbeing of the managers as well as organisational health.

Further empirical research is needed on the relationship between value squeezes and pressure on integrity. More research is also needed on the importance of coping strategies for both individual and organisational health.

Ethical approval

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