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STUDY OF THE PRESENCE OF CULTURAL LAG IN THE

CONCEPTS OF NURSING IN ONE NURSING SERVICE ORGANIZATION

By

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STUDY OF THE PRESENCE OF CULTURAL LAG IN THE CONCEPTS OF NURSING IN ONE NURSING SERVICE ORGANIZATION

CHAPTER I

INTRODUCTION

> Culture is like a map. Just as a map isn't a territory but an abstract reproduction of a particular area, so also a culture is an abstract description of trends toward uniformity in the words, deeds and artifacts of a human group. If a map is accurate and you can read it, you won't get lost. If you know a culture, you will know your way around in the life of a society.[1]
>
> --- Clyde Kluckholn

This succinct paragraph may well suggest one solution to the problem of a nursing service director faces as she attempts to reconstruct an organization composed of individuals who presumably derive personal satisfaction from helping the sick with skills and knowledge of a professional caliber.

Perhaps if we orient ourselves to nursing service as a "map", not of terrain, but as an area of structural and psychological import, we can sufficiently crystallize our thinking to visualize it even more objectively as a "culture," as a "society". Having done this we can apply to nursing service the theme Kluckholn's concept and come to know nursing service in a new perspective, from a fresh viewpoint.

[1] Kluckholn, Clyde, <u>Mirror for Man.</u> pp.28-29

In so doing we may be fortunate enough to perceive hitherto unidentified flaws and faults in the "terrain" which is its structure and its personnel. Having unmasked the disguised shortcomings of nursing service, we can "know" them, and knowing, correct them.

The nursing service organization defined in terms of our unique approach, as a social organization, is "a group of people who interact more with each other than they do with other people, who cooperate with each other for the attainment of certain ends."[2] We will also find that this particular group has a culture unique to it which defined means a "way of thinking, feeling, believing". The term "culture" refers to the distinctive ways of life of this group of people.

There are two broad forces at work within the organizaional structure of this "society", this "culture" which we have more familiarly known as nursing service. There is the formal organization--the operative planning, the methodology and the implimentation which determines the organizational efficiency. There is also the informal organization--consisting of the human beings whose interaction with each other shapes the organization, determines its behavioral life and its organizational effectiveness.

A social organization is efficient and effective when it

[2] Ibid. p. 24.

has common definitions of social goals and a commonly accepted program for their achievement; when there is a basic agreement as to the relationship of the individual to the group. A given society is harmonious and organized when all its members are in agreement on the definitions of certain fundamental situations, where there is an intrinsic harmony between the desires of the individual and the group.

"Complete social organization implies a unanimity of opinion and a stability in behavior patterns" ... in other words, "consensus".[3]

Social disorganization, on the other hand, is "a process by which the relationship between members of a group are broken or dissolved". The individual views the major group interests in individual rather than common terms. Such an attitude results in competition and conflict between the individual and the group, and and inevitable lack of consensus which leads to confusion and disorganization in the society.

Modern society in general is not static but dynamic -- constantly changing, constantly at grips with a bewildering succession of unprecedented changes. The impact of this changing experience upon static norms (ways of thinking, believing, acting) leads to social disorganization.[4]

Nursing service, this "society", this "culture", as we

[3] Elliott, M., Merrill, F., Social Disorganization, pp4-5

[4] Ibid. p 1.

speak of it here, has been no exception to the changes which are sweeping the larger society and culture of which it is a vital segment. Rapid changes have occurred and are still evolving in concepts associated with its formal structure--with nursing care and its performance standard; with the method of patient assignment upon admission to the hospital, and also the method of work assignment of hospital personnel. Perhaps the crux of the problem lies in the informal structure of this "culture" nursing service. This as we have observed, is composed of people, who react emotionally and psychologically to the changes. These people are often discouraged and sometimes defeated in their efforts to meet the staggering challenges of the present and the vaguer but more sinister threat of the future, with its unguessed changes. Nursing service is and will continue to be what they make it. Unfortunately we do not know statistically or in terms of research, what <u>effect</u> these changing concepts within the nursing service organization have had or are having upon nursing service personnel. We have rumor, hearsay, inference and the credence of a few eminent authorities who have ventured a shrewd assessment of the situation. But we do not have a scientifically substantiated confirmation of the vague rumors, the lurking suspicions, the whispered insinuations. No matter how forward-looking a director may be, she lacks precedent, criteria and even tested techniques to guide her in a personal investigation into these problems. The result is

that nursing service today is in itself a vague concept subject to a multitude of interpretations and/or misinterpretations. How it is administered and distributed is a matter of personal opinion and individual practice.

This research project was undertaken in the hope that at least some standardization may result from the findings in the area of one hospital nursing service which it proposes to investigate.

Statement of the Problem

The problem of this study is to estimate the degree of organization, or disorganization, of nursing service in a particular hospital. This organization is as reflected in the concepts of nursing expressed by personnel, and to suggest norms which may help to stabilize this particular hospital nursing service and to call to the attention of the "nursing civilization" the need for a general adoption of such norms.

Justification of the Problem

This study is a response by the writer to a perceived need for introspection, reorientation and reorganization in a particular nursing service. By externalizing assent and dissent this study should alert the profession to a critical lack of philosophical and practical norms. This study may stimulate corrective measures within this particular hosp-

ital nursing service department and possibly in other nursing service departments. Its suggestions and conclusions may serve as a working model for standardization in one particular hospital. Because it educes typical departmental opinions, this study should be useful as a guide for in-service educational programs.

Scope and Limitations

This investigation was conducted in one municipal 450 bed hospital. The basis for participation was purely voluntary. Since the investigator held a position of authority in the organization some of the respondents verbally expressed fear of identification. A questionnaire was the tool used to secure data. A total of 65 nurses from a possible 100 (65%) participated. Some of the questions were not answered by all of the participants. This fact, and this ratio, plus inherent limitations of the questionnaire, may subtract from the sample responses a degree of validity, thus limiting the value of the study as a representative exposition of the actual situation.

Preview of Methodology

Cultural data for this study was procured by the questionnaire method from 50 full time professional registered nurses representing the nursing service organization and 15 instructors (registered nurses) representing the school of

nursing. The questionnaire contained nine questions. It was administered to the supervisors and head nurses by the researcher and to the instructors by the educational director. It was distributed to the staff nurses in a sealed, addressed envelope by the supervisors with a return date of two days. Completion of the questionnaire required approximately one hour.

Sequence of Presentation

Chapter II presents a review of the literature, and the statement of the problem.

Chapter III contains the selection and the description of the sample, the tools used to collect the data and the procurement of the data.

Chapter IV contains the presentation, interpretation and discussion of the data.

Chapter V presents the summary, conclusions and recommendations of the study.

CHAPTER II

THEORETICAL FRAMEWORK OF THE STUDY

Review of Literature

An extensive review of the literature has shown that the author's problem has been duplicated many times in the experience of other nursing administrators and researchers. This literature shows a variety of tentative solutions, all of which have contributed structurally to better nursing service. None of them, however, seem to have resolved or to any great extent explored what the author postulates to be the basic issue--the adjustment of the nursing service personnel.

A perusal of the literature has revealed that the problem of nursing service adjustment has been regarded mainly as one of structure--adapt its structure to the exigencies of the moment, and you will have solved the problem - or such seems to have been the reasoning of the majority of investigators. Yet, with notable exceptions, they seem to have overlooked the factor of human personality which activates the structure - the nurses who must translate the structural schematic into terms of effective patient care.

The following "Review of the Literature" is not intended to deprecate the commendable contributions of other researchers. It is intended as a tribute to the profession's keen awareness of its responsibilities to society, to provide documentary justification for a new approach, and most of all to

further validate the time-honored maxim of all research, that progress is the product of many minds and diverse viewpoints, which, cumulatively, provide the insight for valid generalizations.

In order that the reader may appreciate the validity of the author's conception of nursing service as a society, the following sociological and anthropological data of a general nature are put forward in its support. The generalizations set forth in the authority subsequently cited have been applied to the nursing service group as it exists as a "culture" and a "society" in its own right.

The terms folk, folk society, folk culture, and folk regional society will be used to indicate the basic, elemental, definitive level of the nurse society. The folk (nurse) is characterized as the universal societal constant in a world of variables, since folk (nurses) are basic to all cultures (nurse cultures.) This would seem to be the problem voiced by Margaret Gillin when she says "All nursing service standards have to be adjusted to fit the needs of a particular nursing service because of the variables which make one situation different from all other situations no matter how similar they may be."[1] The author believes that Miss Gillin had in mind "structural" standards which may have to vary with the individual nursing service situation. But, if one keeps in mind

[1] Gillin, Margaret, "Your Staffing Situation is Different." The American Journal of Nursing, 52:1358, November 1952

the"universal societal constant" noted above, and bases standards upon nursing service personnel ("folk") rather than on structure alone, a more workable type of standardization may emerge. The "folk culture" (nurse culture) is characterized by close adherence to the primary institutions and like-mindedness. The "folk regional society" (nursing service organization in a particular hospital) is the generic term describing the "folk" (nurse) culture in hospital setting.

Culture is the sum total of the characteristics of a society (nursing society in a given hospital.) In contradistinction the concept "civilization" (total nursing society) is used to connote the more advanced stage of culture as reflected in modern society as a contrast to early culture. Technicways are modes of human behavior resulting from technology. Folkways are habits of the individual and customs of the group, which arise over long periods of time to meet the needs of human beings for continuing adjustment and survival. The Institution (nursing service, thehospital) is a sanctioned organization providing practical arrangements to enforce the judgments of the "mores" (matured folkways receiving continued approval from the society), as to what is "best", true and wise.[2]

The precipitate pace of modern civilization does not allow for the formation of mores and folkways. Social change

2 Odum, H., Understanding Sociology pp. 13-15

proceeds at a rate which negates folkways and mores.[3] In the hospital, the technicways are changing at a rate which is too fast for the folkways and mores of the nursing culture to adapt to without lagging and in the author's opinion it is this lag which is the root of the problem.

The author sees nursing as a "society" and a "culture" involved, as is the larger society of which it is a part, in the rending conflict between revered tradition and the strident clamor for change in order that it may survive. It would seem particularly apt to apply the term "folkways" to nursing tradition, because thereby the parallel between nursing and society in general becomes more forceful. Just as national or ethnic groups cling to their native language, traditions, customs and costumes in an alien environment, so do nurses instinctively and protectively cling to the traditions and the professional viewpoints which have been hallowed by generations of nurses. These traditions and viewpoints have come, by time and devout observance, to be the "Lares" and the "Penates" of our nursing society, and like all household gods, they are not lightly discarded.

This is one reason why the author feels that to adjust nursing service to a rapidly changing social order, outmoded traditions must be handled reverently and set aside with honor. The only ones who can do this without "sacrilege" will be the "folk" nurses who compose the "culture", which we con-

3 Ibid: p.364

sider here to be the individual members of the nursing profession.

Three historical events have changed the form of the hospital, its contribution to society and the care of the patient. These were the strengthening of medicine by scientific research, beginning in the seventeenth century; the trend toward preventive medicine, originating with Jenner in the eighteenth century; the abolition of "hospitalism" and the availability of hospitals to patients of all social and economical levels, begun in the nineteenth century.[4]

The changes germinated in these remote historical events have sired the perplexing problems which gradually, over the years, have come to confront the profession. Modern scientific advances have made imperative greater knowledge and wider skills, more and better formal teaching.[5] Preventive medicine has evolved into the credo, not merely the aspiration, of modern doctors. The shift from home to hospital care, after establishing the now traditional concept of "bedside" nursing, has superimposed upon this the newer idea of the nurse as a organizer, teacher, supervisor and administrator in the actual nursing situation.[6]

4 Faxon, N., The Hospital in Contemporary Life. pp. 1, 63-64.

5 Saunders, L., "Permanence and Change.," The American Journal of Nursing. 58:135, June 1958.

6 Hughes, E., Hughes, H., and Deutscher, D., Twenty Thousand Nurses Tell Their Story. p 135.

In an attempt to satisfy society's needs, the profession itself has increased its responsibilities, raised its educational standards and encouraged nurses to regard their profession in a more comprehensive light. It has instituted sweeping structural changes, in the concept of the "administrative climate" of the nursing department, the role and functions of the nurse, the definition of nursing care, as well as in the standard of practice, the method of patient assignment upon admission to the hospital and the method of personnel assignment. That in so doing it has lost sight of the sociological impact of these changes is evident from the expressedly negative or hostile attitudes of representative samplings of nurse-opinion. "There are too many conflicting demands, too much paper work and not time for patient care."[7] The patients report that "they find a stream of personnel who do something for or to them, but rarely with them."[8] "The law of making the individual feel that he belongs to someone or something and has a definite place has been ignored."[9]

From the wealth of testimony at hand, of which the above is but a suggestion, it is evident that structural change must be oriented to the nurse and the patient, who are exec-

[7] Graham, Margaret, "There Are Too Many Conflicting Demands.," The American Journal Of Nursing 47:76. February 1947.

[8] Brown, Esther Lucile, "The Social Sciences and Improvement of Patient Care." The American Journal of Nursing, 56:1148, September 1956.

[9] Manfreda, Marguerite, "Money Isn't Everything." The American Journal of Nursing, 47:80, February 1947.

utor and recipient of its mandates. There is an obvious need for a value reorientation or a re-evaluation from the nurses themselves in terms of qualitative and quantitive care.

Tentative solutions to the problem of how to adjust to these structural changes which have been proposed by other research individuals and groups are briefly mentioned in the following pages. These solutions will give some index to the really broad scope of the research in structural nursing service and suggest an awakening to the problem of personnel as a crucial factor in structural adjustment.

Brown, in 1948, advocated decentralized management and the substitution of co-operative team relationships for traditional authoritarianism. She also urged the differentiation of nursing service according to nursing function and an emphasis upon the function of the nurse rather than the nurse herself.[10] These two themes planted the seed for structural changes of great magnitude.

In the field of nursing service organization and decentralized management the <u>Hospital Nursing Service Manual</u>, published in 1950, stresses the basic conditions necessary to a good nursing service organization -- administration, organization, personnel, facilities and support.[11]

[10] Brown, E., <u>Nursing For The Future.</u> pp. 46-47, 57-58.

[11] National League of Nursing Education, <u>Hospital Nursing Service Manual</u>, p. 1.

Finer, in his study of the nursing service department from an administrative viewpoint, reveals the need for sound knowledge of administration and the social sciences for efficient patient care. He says, "Administration is ..... the understanding of hierarchy and discipline in an organization in which purpose and not one's own enjoyment is the first command; the understanding of staff consultation and the part which the democratic principle plays in it." [12]

A Program Guide for Nursing Service comes even closer to the point by saying that "Management is people-centered", and that effectiveness results in an administrative climate in which "individuals utilize their full capacities and are merged into the group activity ... not submerged by it." [13]

These and numerous other publications express the trend toward scrutinizing the efficiency and effectiveness of the nursing service organization and offer proposals for ameolioration. Brown's second theme, that of an emphasis upon the function of the nurse, rather than the nurse herself, took direction in a variety of ways and resulted in specific functional studies, a few of which are cited below.

The Harper Hospital Study showed that many procedures and practices now performed by professional nurses could be

[12]Finer, Herman, "Preparation for Administration of Nursing Services." The American Journal of Nursing, 51:701 - 703, December, 1951.

[13]Hauge, Cecelia H., A Program Guide For Nursing Service. pp. 111-112.

safely allocated to non-professional personnel and to other departments of the hospital.[14] The findings of this study were corroborated by those of the University of Pittsburg Nursing Study, which in addition provided the basic statistical data essential to a staffing pattern.[15] Another study of significance is that of the Effect of Nurse Staffing on Satisfactions with Nursing Care. This study reveals the effect of nursing hours on dissatisfaction with nursing services and suggests with reservation "the ideal staffing pattern".[16].... These and similar studies give the weight of experiment to the reality of the newly enlarged concept of nursing as a function not only of professionals but also of practical nurses and auxiliaries.

Literature which significantly and specifically altered traditional concepts of the nurse's function was the "Functions, Standards and Qualifications" in which the American Nurses Association redefined the concepts expressed in its title.[17] Its counterpart for practical nurses was assembled in conjunction with the National Federation of Licensed Practical Nurses.[18] These publications have altered appreciably

[14] Wright, M. Improvement of Patient Care: A Study of Harper Hospital. pp. 1-226.

[15] George, F., Kuehn, R., Patterns of Patient Care, pp, 1-266.

[16] Abdellah, F., Levine, E., Effect of Nurse Staffing on Satisfactions With Nursing Care, pp.1-82.

[17] American Nurses' Association, "Functions, Standards and Qualifications For Practice". pp. 8-13, July 1959.

[18] _____, "Statement of Functions of The Licensed Practical Nurse" The American Journal of Nursing 57:459-60, April 1957.

the traditional idea of the nurse as a direct bedside agent to the indirect management of a team of personnel under her authority.

The idea of the nurse as a manager of the team is presented by Lambertson, who regards the nurse-practioner as one "who is responsible for the comprehensive program of nursing care--not as one who performs all the tasks associated with it." [19]

Lambertsen also expresses the unique function of the modern professional nurse in saying that she diagnoses the nursing problem, decides upon a course of nursing action for solving the problem, develops in cooperation with other team members a satisfactory plan of nursing care, directs the program toward optimum goals, and evaluates the nursing care program continuously as it relates to patient progress and nursing practice.[20]

This inevitable redefinition of the nurse's function leads to a redefinition of nursing care. Traditionally and to many of the present-day nurse practitioners the nurse's image of "real" nursing was and is the bedside care of the patient, "tender loving care" of dependent patients.[21] Since she is now admittedly a manager concerned with planning and

[19] Lambertsen, E., Education For Nursing Leadership, p. 190.
[20] Ibid: pp. 77-78.
[21] Benne, K., Bennis, E., "What is Real Nursing" The American Journal of Nursing. 59:380-1, March 1959.

control, the modern nurse must of necessity understand the nature of "comprehensive nursing care" so as to determine whether or not her subordinates are fulfilling their responsibilities. Such an understanding is contingent upon the existence of a basic standard or criterion for evaluation.

The meaning of the term "comprehensive care" has been broadened to include much more than the traditional attitudes and approaches to nursing. The Joint Commission in 1953 recommended that "Comprehensive nursing should be designed to provide physical and emotional care for the patient, care of his immediate environment, carrying out the treatment prescribed by the physician; teaching the patient and his family the essentials of nursing that they must render; giving general health instruction and supervising auxiliary workers."[22]

The change in the concept of "real" nursing to that of "comprehensive nursing" care has also altered its standard of evaluation. The standard for nursing care must not only include physical care, treatment, emotional support and spiritual needs but also must provide for rehabilitation and total health needs of the patient, his family and community.

Shafer attempts a basis for such standardization when she says "Good nursing care is practiced if good medical and surgical aseptic technique is practiced, patients are comfortable and clean, treatments and medications are adminis-

[22] _____, "The Joint Commission Recommends" The American Journal of Nursing 53:309, March 1953.

tered thoughtfully and on time, and if their physical, emotional and health needs are fulfilled."[23]

Kreuter has followed this standardization trend by classifying nursing care as: ideal, maximum, adequate and minimum. Because she believes that most of the care given in American hospitals is within the two lower categories, adequate and minimum, she further subdistinguishes nursing care into custodial, supportive and rehabilitative.[24]

In a subsequent article, Kreuter defines nursing care as "Acting and interacting with the patient through physical and personal contact for his welfare and intervening in his behalf between him and those stresses in the physical and social climate that impinge upon him."[25]

The foregoing material should lend insight into the debate upon the basic meaning of the term "comprehensive care", as well as provide a more concrete sense of the problem faced by nursing service personnel in changing their formerly valid notions of what constitutes nursing care. If further evidence were needed to substantiate the requirement by the profession for standardization, it can be found in the considered judgment of Finer, who recommends that attempts be made to formulate standards which can express observed differences in

[23]Shafer, M., "Measuring Nursing Quality." The Modern Hospital, 50:63-5, July 1950.

[24]Finer, H., Administration and the Nursing Service, pp. 188-120.

[25]Kreuter, F., "What is Good Nursing Care," Nursing Outlook 56:72-73, February 1956.

patient care, and which can summarize the differences in terms of differential qualities.[26] Block sustains a similar theme when he says that a standard of nursing care should be set below which it will be considered unsafe for a hospital to operate.[27]

The authorities cited here serve as pioneers in that they have diagnosed the symptomatic phenomena indicative of organic malaise beneath the surface of the nursing world. It remains with them or for those who come after them to find the remedy for the disorder which their insight has revealed. To the writer's knowledge there is as yet no definitive, standardized measurement for the effective control of nursing care. This is perhaps due to the possibility that the new concept of nursing care is still in the evolutionary stage, still to emerge from the shadows and pass through the perplexities of today into the clearer light of some tomorrow. Perhaps nurses are not psychologically prepared to accept the very structural changes within nursing service which accentuated the whole problem. Whatever its present stage of evolution, it is a concept to be reckoned with in the drafting of the basis of a master staffing pattern.

The author is cognizant of the indirect effect upon nursing service of the national accreditation program for

[26] Finer, H., op. cit. pp. 120-121.

[27] Block, L.,"Control Means More Than Low Costs." Modern Hospital, 56:72-73, February 1956.

schools of nursing. She is also aware that one of the purposes of accreditation is "to stimulate progressive changes in nursing education that will improve nursing service and provide better health care."[28] She mentions this to forestall the possibility of her being accused of incomplete coverage of the literature by those who might see in the accreditation of nursing education an attempt, at the level of nursing "civilization", to standardize nursing service. Such an actuality would, of course, nullify her contention that there is as yet no definitive, validated, standardized measurement for the effective control of nursing care.

In respectful rebuttal to these potential critics, the author hastens to refer them to the wording of the above excerpt from The Accreditation Manual. The key word is improve. "Standardization" is neither expressed nor implied. It is reasonable to assume that, had those who formulated the accreditation program intended to standardize nursing education, and through it nursing service, they would have said so. But they spoke only of "Progressive changes" in nursing education. To change is not to standardize, but to institute "progressive changes" is to improve.

This assumption is even more reasonable in the light of the following excerpt from the accreditation manual. It shows that accreditation evaluates educational units and nursing

[28] National Nursing Accrediting Service, Manual of Accrediting Educational Programs in Nursing, pp. 4.

programs according to their own standards (stated purposes) and their success in meeting these.

> "In evaluating an educational unit or program in nursing, the total pattern of nursing education within the unit will be considered in the light of its stated purposes and the extent to which these purposes are being realized ...".[29]

Despite the lack of definitive standards or even a satisfactory ontological definition of "comprehensive care", nursing research and nursing practice are not the arid wastelands of inert perplexity which one might erroneously infer from the painful absence of standards and definitions. Considerable practical activity in attempting to provide comprehensive care has been impelled by circumstances in the nursing situation and by the conscience of the profession itself. These empirical and somewhat "trial and error" ventures into the realm of the undefined and the uncomprehended have produced some very cogent examples of the value of exigency as a spur to inventiveness. Some of the more outstanding examples are mentioned here as pertinent to this thesis, and to the literature which reflects its theme.

One such approach to the problem has been in the method of personnel assignment. The overall approach practiced in the total nursing society is subdivided into three methods: the patient, the functional and the team. The patient method fosters a closer nurse-patient relationship and the "individualized" care. It seems to be the method which correlates

[29] Ibid. p. 4.

with the traditional concept of "real" nursing and fosters bedside care of the patient by the nurse. The functional method utilizes to greater advantage scarce equipment and helps situations in which staffing is limited although it does not provide "personalized" care. This method is the type of arrangement whereby each nurse and/or an ancillary worker is responsible for specific functions and duties for all the patients. The patient receives care from a number and variety of people. This method seems to be the structural adaptation to shortages and may well be the <u>catalyst</u> which started the trend toward recognizing patients and personnel as crutial factors in structural adjustments. The team method is a modification of the patient method. This method utilizes both nurses and non-professional personnel. A professional nurse as leader of a team composed of ancillary workers (student nurses, practical nurses, practical nurse students may be added) is responsible for the nursing care of a group of patients.[30] Lambertsen states that "This method seems to be the best means available to organize hospital nursing service personnel for achieving the most effective patient care."[31]-- Thus we have the evolution of the method of personnel assignment from traditional nurse-patient rela-

[30]Department of Hospital Nursing, <u>The Head Nurse At Work</u>, pp. 6-7.

[31]Lambertsen, E., <u>Nursing Team Organization and Functioning</u>. p.89.

tionship to transitional (functional adaptation) to one which meets present day concepts of efficiency and effectiveness.

Another noteworthy solution to the problem lies in the utilization of existing hospital facilities. Experimentation with the "recovery room" in the early nineteen forties was an attempt to solve the nursing shortage as it affected post-operative anesthesia patients. The recovery room provided the concentration of nursing care and emergency apparatus so necessary for patients in the post-anesthesia period. So well has this unit fulfilled its objective that today it is found almost universally in hospitals.[32]

Even more significant than the reality of the recovery room itself has been the trend which it began. The initial concept of the recovery room has resulted in other special care units - such as the minimal care unit[33] found in some hospitals and the intense care unit in others.[34] One hospital has structured its entire organization on the concept of "Progressive Care": Minimal care, intermediate care and intense care. Of these units, Thoms says "These divisions represent broad areas of patient care, but in practice they

[32] Pfizer Spectrum, "The Recovery Room, pp. 1-2.

[33] Shortcliffe, Ernest C., Brackett, Mary E., A Minimal Care Unit For the Short-Term Patient", Hospitals, 55:77-9 November 1955.

[34] Beardsley, J., Murray, J., Bowen, Robert J., Capalbo, Carmine J., "Centralized Treatment for Seriously Ill Surgical Patients", Journal American Medical Association, 162-544 -47. October 6, 1956.

shade into one another and form a continuum of care based on medical needs. The patient may enter at any zone and progress according to his medical needs in any direction."[35] Thus, a pattern has evolved which utilizes existing facilities to provide effective and efficient care by focusing upon a patient's needs and not on his medical diagnosis.- This is a structural adaptation for the patient.

In the "Review of the Literature" the author has presented what she believes is authoritative and voluminous evidence that nursing service is in the throes of tremendous changes, and has tried to do something toward adjusting nursing service to the changes; that measures to date have concentrated upon adapting the structure but not the personnel to the modern demands upon nursing service. She has also presented equally weighty evidence that research is just beginning to shed light on the problem of adjusting nursing personnel as a society, to the structure of its organizational medium. In mentioning the tentative solutions to the problems of standardization and the nature and practice of comprehensive care, she has remarked on their inadequacy, due to thevery newness of the concepts themselves.

This "Review of the Literature" is a category of beginnings, of gropings or shrewed guesses by those best qualified to guess correctly. Far from discouragement at the shad-

[35] _____, "Report on Progressive Care -- It Works." Modern Hospital, 58:73-4.

ows and the blurred outlines of the picture, the author sees in these rudimentary investigations and speculations an ultimate solution, which will surely germinate from them, just as the present problems of nursing service began with those three historic events which started it all.

The investigator has made many attempts to develop a master staffing pattern for Hospital X and has failed in her attempts. Formal and informal discussions with her co-workers, that is, the "folk of the regional folk society", were indicative of divergent viewpoints. Some of the nurses vehemently expressed traditional concepts as found in the "folk society" and others "technicways" as found in the nursing "civilization". Introspection by the author seemed to imply that the problem was two-fold, that of structure and that of value orientation of its individual members. Reorganization then could take direction in two ways. One would be to develop the basis of a staffing pattern which would be a blend of the "folkways" and the "techniways". The other would be to design the formal structure upon the concepts set forth by "techniways" and then determine the amount of "cultural lag" present in the "folk regional society". A systematic observation of similarities and differences between the "folkways" (habits of the individual and "customs" of the group which arise over long periods of time) and the "techniways" (modes of human behavior resulting from technology) as expressed by the "folk" (nurses, individually and collectively) in the

"folk regional society" (a particular nursing service organization) might provide a clue to the solution of the perplexing and challenging problem of structure and a clue to the ameliorative measures necessary in value orientation for adjustment and survival. Or, in other words, provide the design for the basis an efficient and effective master staffing pattern.

The author chose the latter approach on the supposition that "folk" (nurses individually and collectively) in the "folk regional society" (a particular nursing service organization) who are both the recipients and the executors of the "folkways" (traditions) and the "technicways" (modes of behavior resulting from technology) can integrate the "technicways" into the "folkways" and develop through cooperative arrangements a unified society (nursing organization) and a cultural pattern(basis for a (master staffing pattern) which is both efficient and effective.

Statement of the Problem

The problem of this study is to estimate the degree of organization or disorganization of nursing service in a particular hospital. This organization is as reflected in the concepts of nursing expressed by personnel, and to suggest norms which may help to stabilize this particular hospital nursing service and to call to the attention of the nursing

"civilization" the need for a general adoption of such norms.

More specifically, this research was designed to discover whether there existed in the concepts of nursing expressed by personnel demonstrable cultural lag, in the form of lack of acceptance of the most modern concepts of nursing, in the areas of the definition of nursing care, the standards of nursing care, the method of personnel assignment, and the method of patient assignment.

CHAPTER III

METHODOLOGY

Selection and Description of the Sample

Cultural data for this study were procured by the questionnaire method from fifty full-time professional registered nurses representing the nursing service organization and fifteen instructors (registered nurses) representing the school of nursing in a 450-bed municipal hospital. This institution is a teaching and research establishment providing clinical facilities for the education of medical interns and residents, laboratory technicians and dietary aides, affiliate students of practical nursing and students of professional nursing enrolled in the three year diploma program of its school of nursing.

The primary purpose and function (work) of this nursing service (society) is to provide nursing care. The department and its personnel in this hospital are influenced to begin with by the complicated system which controls the hospital-municipal fiscal and administrative policies; policies and attitudes of the medical staff in general; policies, needs and demands of other hospital departments; also by policies of both the hospital school of nursing itself, and those of its practical nursing affiliates; State Civil Service rules and regulations as they apply to ancillary personnel and

lastly, by State and City Retirement Rules and Regulations.

Subtler and largely unevaluated influences are at work within the department of nursing service itself. These are:

1. The formal, hierarchial structure of authority and organization through which the department provides nursing care (accomplishes its work).
2. Informal organizations (cliques) which oftenresist the hierarchyof authority and organization in order to "protect" the workers against it.
3. Dissimilarities among the nurse "folk" themselves. These differences exert powerful and often conflicting influences on the nurse "folk". Some of them are differences in:
    a. Education (basic diploma through post-baccalaureate)
    b. Social mobility; some are "natural folk", being graduates of this particular hospital school and exemplars of its "natural culture"; some are graduates of this particular hospital school whose value orientations have been altered by collegiate or university programs, and some are immigrants (nurses educated in other hospitals and instructors from the school of nursing and the affiliating schools of practical nursing.)
    c. The age-factor (21-62; with its associated variations in value orientation based on experience

and environment.)

Among these folk there are also differences of sex, of physical, psychological and cultural make-up. Among them there are differences of race and nationality, differences resulting from physical and mental handicaps, and differences in economic status.

Equally important are the structural changes which are evolving, merging and being assimilated willingly or reluctantly into the total nursing society. The review of the literature has highlighted four structural changes, those related to the definition of nursing care, the standards (gradations) of nursing care, the method of patient assignment upon admission to the hospital and the method of personnel assignment. The literature has also attempted to show that within these changes there are a variety of patterns to choose from and that the choices are made by the nurse practitioner as the result of her "cultural" conditioning and value orientation. The purpose of this sample is to determine statistically the extent to which the psychological shifts (values of the folk) have accompanied structural shifts. The author has attempted to study the phenomenon by means of a questionnaire. The persons selected were all nurses, but they were categorized in their formal functional role of supervisors, head nurses, staff nurses and instructors in the school of nursing. These four groups are an example of the nurse "folk" in a "folk regional society", a particular nursing

service organization.

Thus, the nursing service "society" under discussion is composed of widely divergent psychological elements subject to the pressures of external and internal influences. These elements are personified in a variety of nursing "folk" whose somewhat "Herculean" function is to provide nursing care for patients of societal and cultural backgrounds even more varied than their own.

The Tool Used to Collect Data

A questionnaire was constructed by the writer which included the four "nursing folk" opinion areas she perceived to be the structural basis for the formulation of a master staffing pattern: (1) The definition of nursing care; (2) gradations or standards of practice; (3) the method of personnel assignment and (4) the method of patient assignment upon admission to the hospital. The questions and statements were representative of the structural changes as they evolved in these four areas from the "folkways" (traditions) to the nursing "civilization" (total nurse society.) [1]

The questionnaire consisted of three parts. Part I was designed to determine the individual's concept of nursing care and a method of patient assignment upon admission to the hospital; Part II was constructed to appraise the quality of patient care given and the care goal sought by the nurse; Part III was to determine the method of personnel assignment

[1] Appendix

practiced and the method desired. An item was also included to retest the nurse's concept of nursing care.

The questionnaire was pre-tested on the "peer" group of the researcher and faculty members at Boston University. A minimum of changes were made.

Procurement of Data

The questionnaire in its final form was administered to the Nursing service staff by the researcher and to the instructors by the educational director. The purpose and content was explained by the writer to the supervisors and the head nurses at one of their respective monthly meetings. All were invited to participate in answering the questionnaire. All the supervisors present with the exception of one participated (15 out of a possible 17). All the head nurses present at their monthly meeting participated (20 out of 26). Because it was impossible to assemble the full-time staff nurses concerned with direct patient care, the questionnaire was distributed to them in sealed envelopes by the day, evening, and night supervisors with a return due date of two days to the Director of Nursing Office. (There were 15 returns from a possible number of 40). All instructors present at their monthly meeting answered the questionnaire (15 out of 17).

The time span involved in testing the four groups was

four weeks. Completion of the questionnaire by the participants required approximately one hour. The data was analyzed from the total scores of the raw data rather than in the hierarchial categories.

Chapter IV
FINDINGS

Presentation, Discussion and Interpretation of Data

The data will be presented, discussed and interpreted in four parts. Part I is concerned with nursing care: Part II with its standard of practice; Part III with the method of personnel assignment; and Part IV with the method of patient assignment upon admission to the hospital.

Part I: Nursing Care

Regardless of the different branches in which a registered nurse may specialize, she was first a student in a nursing school and was dependent upon the patient for the dynamic foundation of her career as a nurse. She developed her potential ability, skills, understandings and increased her knowledge by giving nursing care to the patient. If she has been taught a pattern of nursing care which was synchronized with current definitions and then in post-graduate practice meets with patterns of patient care incongruous with or varying from her undergraduate conceptualizations, the result may well be a nurse practitioner who feels inadequate, frustrated and anxious. The product may be a nurse practitioner who is in constant conflict with herself and her environment in the face of the present aim of nursing education, which is to develop a nurse who is "psychologically effective" (knows what

to do, expect and anticipate).[1]

Because there is apparently no general standardized definition of nursing care in the literature the author constructed the following definition based on the recommendation of the Joint Commission as an operative research standard and as the criterion upon which the findings were determined.

Operative Research Definition of Comprehensive Nursing Care

> Nursing care of the patient is his medically prescribed regimen of physical care, treatment, and emotional support, amplified by attention to his environmental, spiritual, rehabilitative and total health needs as they extend to his family and community.[2]
>
> The attributes of nursing care are: physical care, treatment, emotional support, environmental needs, spiritual needs, rehabilitative needs and health needs.

The objective of this part of the study was to determine if there is in this particular nursing "folk regional society" an identifiable predominant concept of nursing care, and to compare this concept with the research definition of comprehensive nursing care.

For this purpose the author used the principle of the unstructured stimulus situation:

> "The more unstructured the stimulus situation the greater the relative contribution of internal factors in the frame of reference. As stimulus situations become more unstructured, the relative contribution of internal factors (motives, emotions, attitudes, identifications of the person, other products of past learning) to the ensuing psychological structure becomes greater."[3]

[1] Cantor, N., The Learning Process for Managers. p. 78
[2] "The Joint Commission Recommends" op. cit. p. 309.
[3] Sherif, M., Sherif, C., An Outline of Social Psychology, p.82.

The raw data was gathered from three questions:

1. How would you, as a nurse, define nursing care explicitly and comprehensively?

2. What are you doing?

   Mr. Jones was admitted today with a diagnosis of cancer of the colon. He is scheduled for a colostomy tomorrow morning at 9:00A.M. Please write briefly and specifically the kind of care you are able to give him, pre-operatively, and in his convalescent period at this time.

3. What would you like to do?

   What kind of care would you like to be able to give him? (Please be specific)).

Table I presents the attributes of nursing care mentioned by respondents in reply to the request that they define nursing care explicitly and comprehensively.

TABLE 1.

ATTRIBUTES OF COMPREHENSIVE NURSING CARE MENTIONED BY RESPONDENTS

Position of Respondent	No. of Responses	ATTRIBUTES							Nebulous Response	No Ans.
		Phy. Care	Tr't ment	Emot. Supt	Needs					
					Enviro	Spirit	Rehabi	Health		
Instructors	15	12	5	11	1	7	3	2	1	2
Supervisors	15	10	6	10	10	7	2	1	0	5
Head Nurses	20	18	18	14	1	8	0	1	0	2
Staff Nurses	15	11	10	10	0	2	1	2	3	1
Total	65	51	39	45	12	24	6	6	4	10
(Percent)	100	78	60	69	18	37	9	9	6	16

Table 2 presents the attributes of nursing care mentioned in reply to the question about the care they practice and Table 3 about the care they would like to give.

TABLE 2

ATTRIBUTES OF COMPREHENSIVE NURSING CARE MENTIONED BY RESPONDENTS IN DESCRIBING NURSING CARE PRACTICED

65 = 100%

Position of Respondent	No. of Responses	ATTRIBUTES							Nebulous Response	No Ans.
					Needs					
		Phy Care	Tr't ment	Emot. Supt.	Enviro	Spirit	Rehabi	Health		
Instructors	15	9	9	6	4	5	5	4	3	3
Supervisors	15	15	15	9	1	2	3	4	0	0
Head Nurses	20	17	17	12	0	4	0	6	2	1
Staff Nurses	15	10	11	10	2	2	1	1	1	3
Total	65	51	52	37	7	13	9	15	6	7
(Percent)	100	78	80	57	11	20	14	23	9	11

TABLE 3

ATTRIBUTES OF NURSING CARE MENTIONED BY RESPONDENTS IN DESCRIBING NURSING CARE DESIRED 65 = 100%

Position of Respondent	No. of Responses	ATTRIBUTES							Nebulous Response	No Ans.
					Needs					
		Phy Care	Tr't ment	Emot. Supt.	Enviro	Spirit	Rehabi	Health		
Instructors	15	10	10	10	5	3	6	7	2	3
Supervisors	15	13	13	13	4	0	7	7	0	2
Head Nurses	20	14	14	14	2	2	4	7	2	4
Staff Nurses	15	10	10	10	2	2	1	2	2	3
Total	65	47	47	47	13	7	18	23	6	12
(Percent)	100	72	72	72	20	11	28	35	9	19

The finding from all three questions about nursing care indicate that the majority of the "folk" in this particular "folk regional society" identify physical care, treatment and emotional support as the attributes of nursing care. This is the kind of nursing care they are practicing and this is the kind they desire to practice. There is a minority of the "folk", however, who are in accord with the others' definition of nursing care. They are practicing and desire to practice "comprehensive nursing care".

Some of the "folk" defined nursing care as "Meeting the needs of patients";"giving care to the best of your ability"; overall care of patients' needs";"quality and quantity of care given to do the patient the most good". These and similar definitions were considered by the author as nebulous.

There is a notable difference in percent between nursing care practiced and desired in the attributes of environmental religious, rehabilitative and health needs. Eleven percent of the "folk" state they are including environmental needs in contrast to twenty per cent, who state they would like to include this need. Twenty per cent state that they are including religious need in contrast to eleven per cent who feel religious need is a desireable attribute of nursing care. Fourteen per cent state they are including rehabilitative needs in contrast to twenty-eight per cent who state they would like to include rehabilitative needs in nursing care practice. Twenty-three per cent state they include health

needs in practice in contrast to thirty-five per cent who would like to include this attribute in the practice of nursing care. Fifteen per cent of the respondents did not answer the three questions.

Part II. Standards of Nursing Care

If the role of the nurse in contemporary society is that of an organizer, teacher, supervisor and administrator of nursing care, she must understand the nature and scope of her responsibilities, and also the policies and limitations within which she must work in order to fulfill her obligations. These understandings are possible only if she has a suitable evaluative standard by which to measure her performance and the performance of those whom she supervises.

Because in the literature there is apparently no generally acknowledged standard of practice nor an evaluative measurement, the author defined three categories of nursing care; minimum, adequate and optimum, as evaluative measurements for performance, The categories of minimum and adequate nursing care were constructed from the concepts postulated by Kreuter,[4] and the category of optimum from the operational research definition

[4]Finer, H., op cit., pp.118-121.

of "comprehensive nursing care".

Definitions of the Operative Research Standards of of Nursing Care Practice:

Minimum Nursing Care: Is the least quantity of attention and treatment necessary to maintain the patient's comfort, safety, and prevalent condition.

The patient adapts to the established routines of the hospital. He receives the treatment and medication prescribed by the physician in a safe and clean environment. He ver balizes his needs and these are gratified by the nursing personnel.

Adequate Nursing Care: Is a quantity of attention and treatment sufficient to arrest the symptoms indicated in the diagnosis and to promote health.

The patient is recognized as an individual personality and the nursing personnel help him to adjust to his condition and environment. Routines, treatments and medications are carefully explained to the patient and adjustments are made whenever necessary. The nursing personnel are aware that the patient has many needs which may be physical, emotional, spiritual or environmental in nature and attempt to meet these needs.

Optimum Nursing Care: Is the quantity of attention and treatment wider in scope and of superior degree concentrating not only on the complete recovery of the patient but also on his psychological preparation for post-convalescent life.

The patient's needs are anticipated by the nursing personnel and a therapeutic plan is designed for the individual patient which includes physical care, treatment, emotional support, environmental needs, spiritual guidance, health instruction and an attempt at rehabilitation so that the patient returns home with renewed confidence in himself and is willing to adjust his living to his physical abilities.

The purpose of this part of the paper was to determine from the "folk" of this particular nursing "folk regional society" the standards of nursing care they felt were practiced in this particular society and to identify what the

"folk desired as a standard of performance, using as the criterion of measurement the three operational research categories of nursing care practice.

To elicite opinions for this part of the study the author listed the three operational research categories of nursing practice as gradations and the respondents were asked to check in one column the kind of care the majority of patients were receiving from the nursing staff and in the second column the kind of care, she, the respondent, would like the nursing staff to give.

Table 4 presents the replies regarding the standard of nursing care practice and Table 5 presents the care desired.

Table 4

STANDARDS OF NURSING CARE PRACTICED

65 = 100%

Position of Respondent	No. of Respon-	GRADATIONS PRACTICED						
		Minimum	Adequate	Optimum	Min. Ade	Min. Opt.	Min. Ade. Opt.	No Ans.
Instructors	15	7	5	0	2	0	0	1
Supervisors	15	11	0	0	1	1	1	1
Head Nurses	20	5	7	0	5	0	3	0
Staff Nurses	15	5	4	0	3	1	2	0
Totals	65	28	16	0	11	2	6	2
(Per cent)	100	43	25	0	17	3	9	3

TABLE 5

STANDARDS OF NURSING CARE DESIRED

65 = 100%

Position of Respondents	No. of Respondents	GRADATIONS DESIRED			
		Minimum	Adequate	Optimum	No Ans.
Instructors	15	0	3	11	1
Supervisors	15	0	1	14	0
Head Nurses	20	0	0	19	1
Staff Nurses	15	0	5	9	1
Totals	65	0	9	53	3
(Per cent)	100	0	14	81	5

The findings indicate that the majority of folk (68%) feel that the standard of nursing care practice in this particular nursing "folk regional society" (hospital) ranges from minimum to adequate. Twenty-nine per cent indicated a nebulous concept of practicing all three in various combinations and degrees. None feel that optimum care as such is practiced. Three percent of the respondents did not answer this particular question.

On the other hand, the majority of the "folk" (81%) in this particular nursing "folk" regional society" acknowledged optimum as the desired standard of practice; fourteen specified adequate as the standard of practice; whereas five per cent of the respondents did not answer this particular question.

It can be concluded that the respondents perceive a discrepancy between the nursing care which they would like pat-

ients to receive and that which they think patients do receive, and it can be concluded that there is far less consensus about the latter than about the former.

Part III. The Method of Personnel Assignment

Since nursing care is the task of the Nursing Service Personnel it is important for them to know how the work is to be done and how the man-power will be apportioned. The review of the literature specifies that there are three methods of personnel assignment operating in the nursing "civilization" at the present time.

Definitions describing the three methods of personnel assignment were constructed from those listed in the Head Nurse at Work.[5]

Operative Research Definitions of Methods of Personnel Assignment.

Case Method: The professional nurse is assigned to the care of one or more patients and she is responsible for giving complete care.

Team Method: A team composed of a professional nurse as the leader and one or more ancillary workers are assigned to the care of a group of patients. The professional nurse of the team is responsible for the complete care of the group of patients.

Functional Method: Nurses and/or ancillary workers are assigned to specific functions for all the patients in the ward, such as taking temperatures, giving treatments, and medications and patient care assigned to any nurse or ancillary worker(s) is limited mainly to physical care.

[5]The Head Nurse at Work., op cit. pp. 6-7.

The intent of this part of the study was to determine from the "folk" of this particular nursing "folk regional society" the method(s) of personnel assignment practiced and the method desired, using as a criterion the research operational definitions of methods of personnel assignment.

The author listed the three methods of personnel assignment and the respondents were asked to check in Column I the method(s) practiced and in Column II the method preferred.

Table 6 gives the replies regarding the methods of personnel assignment and table 7 gives the ones desired.

TABLE 6

METHODS OF PERSONNEL ASSIGNMENTS USED

65 = 100%

Position Respondents	No. of Respondents	METHODS PRACTICED							No Ans.
		Case	Team	Func.	Case Team	Team Func.	Case Func.	Case Team Func.	
Instructors	15	0	0	7	0	0	0	3	5
Supervisors	15	0	5	9	0	1	0	0	0
Head Nurses	20	2	1	10	1	1	4	1	0
Staff Nurses	15	2	0	7	1	3	1	0	1
Totals	65	4	6	33	2	5	5	4	6
(Per cent)	100	6	9	51	3	8	8	6	9

TABLE 7

METHODS OF PERSONNEL ASSIGNMENT DESIRED

65 = 100%

Position of Respondents	No. of Respondents	METHODS DESIRED					No Ans.
		Case	Team	Func.	Case Team	Team Func.	
Instructors	15	5	7		2		1
Supervisors	15	3	9	3			
Head Nurses	20	10	8	1			1
Staff Nurses	15	5	5	2		1	2
Totals	65	23	29	6	2	1	4
(Per cent)	100	36	44	9	3	2	6

The findings denote that the "folk" in this particular nursing "folk regional society" feel that the functional method of personnel assignment is most often used. Twenty-five per cent mentioned two or more methods. Eleven percent of the "folk" did not answer this question.

On the other hand, thirty-six per cent of the "folk" in this particular nursing "folk regional society" disclose that the case method is the method of choice; forty-four per cent prefer the team method; nine per cent the functional method; and five per cent a combination of methods. Six per cent of the "folk" did not answer the question.

These data indicate a marked discrepancy between methods used and methods preferred. There is consensus that the

functional method is not desired, but there is no unity of preference for case or team assignments, as the two receive about the same amount of support.

Part IV. Method of Patient Assignment Upon Admission to the Hospital.

Although the method of patient assignment upon admission to the hospital is not within the jurisdiction of the nursing service department it directly determines the pattern of nursing service organizational structure and indirectly the type of nursing service action taken in accordance with this pattern. Such action would include: provision for the number and kind of personnel needed, the nursing activities, the planning and scheduling of work assignment and the kind and amount of supplies needed on each ward.

Up to the present time the universal method has been to assign the patient according to his medical diagnosis. Structural variations and adaptations in patient assignment have emerged and are still in the process of assimilation. Others are in the evolutionary stages. The latest of these is that of "Progressive Care." By structuring itself upon the "universal" method of patient assignment by medical diagnosis nursing service may have been operating according to a standard

imposed by a department exterior to it. The emergence of a new type of care maybe a departure from this standard of nursing "civilization" to less universal standards of particular nursing "folk regional societies." Does this mean added fragmentation of nursing service practice or a trend toward a new "universal" standard?

The psychological effect of this departure from standardization would be interesting to observe in the light of the present research. It is the author's belief that the progressive care pattern, which is restricted at present to one hospital, is of high potential general adaptability and is a structural adaptation, and that the significance of the individual patient's needs will emerge after the structural adaptation has been assimilated into the nursing culture, through recognition by the nursing "folk regional societies" as it is a better medium for standardized nursing care. Consequently, the author sought to gauge the possible effect of this new concept upon this particular nurse "folk regional society" by sampling their opinion of the present method of patient assignment and their reaction to the emerging concept of "progressive care". The "zones of progressive care" defined below were developed from the classification of the

acuity of illness used in the Pittsburg study.[6]

Operational Research Definition of Progressive Care

Critically Ill: A patient whose condition is such that the doctor believes death may occur at any time.

Acutely Ill: A patient whose illness is severe or intense and whose prognosis is doubtful.

Moderately Ill: A patient whose physical and emotional responses indicate satisfactory progress toward recovery but who is confined to bed.

Mildly Ill: A patient who is ambulatory and relatively self-sufficient within the limits of the hospital environment.

The raw data was gathered from two questions:

Question I: Do you think the present method of patient assignment to the various wards is adequate and meets the needs of the patient, the doctor and the community as well as your needs as a Staff Member?

Question II: Many hospitals are developing wards which are designed to provide services according to the severity of a patient's illness. Illnesses are classified as critical, acute, moderate, and mild. Patients are transferred in and out of these wards according to their progress. Some of the wards are staffed primarily with professional nurses and others primarily with ancillary personnel. Do you think it would be possible to provide each of these wards for the patients at Hospital X?

Table 8 presents the data regarding adequacy of the present method of patient assignment and Tables 9 and 10 give opinions about the progressive care plan.

[6] George, F., Kuehn, R., op. cit. pp. 23.

TABLE 8

OPINIONS OF ADEQUACY OF PRESENT METHOD OF PATIENT ASSIGNMENT

65 = 100%

Position of Respondents	No. of Respondents	Present Method of Patient Assignment: Adequate	Inadequate	No Answer
Instructors	15	2	12	1
Supervisors	15	3	10	2
Head Nurses	20	6	12	2
Staff Nurses	15	4	8	3
Total	65	15	42	8
(Per cent)	100	23	65	12

TABLE 9

OPINIONS OF DESIREABILITY OF SPECIFICALLY DESIGNED WARDS

65 = 100%

Position of Respondents	No.of Response	Critically Ill			Acutely Ill			Moderately Ill			Mildly Ill		
		Yes	No	No Ans	Yes	No	No Ans	Yes	No	No Ans	Yes	No	No Ans
Instructors	15	12	3	0	13	1	1	12	3	0	10	5	0
Supervisors	15	10	3	2	13	1	1	12	2	1	13	1	1
Head Nurses	20	16	2	2	15	2	3	12	4	4	13	2	5
Staff Nurses	15	10	5	0	11	4	0	11	3	1	10	2	3
Totals	65	48	13	4	52	8	5	47	12	6	46	10	9
(Per cent)	100	74	20	6	80	12	8	72	19	9	71	15	14

TABLE 10

OPINIONS OF PROGRESSIVE CARE EXPRESSED AS THE MEAN OF OPINIONS OF FOUR TYPES OF WARDS

65 = 100%

Opinions	Mean of Replies Regarding Wards	Per cent
Desireable	48	74
Undesireable	11	17
No answer	6	9
Total	65	100

The findings are that sixty-five per cent of the folk in this particular nursing "folk regional society" feel that the present method of patient assignment (assignment by medical diagnosis) is inadequate whereas twenty-three per cent feel that it is adequate. Twelve per cent of the respondents did not answer the question.

On the other hand, seventy-four per cent of the "folk" in this particular nursing "folk regional society" express the feeling that "Progressive Care" is a desireable method, whereas seventeen percent feel it is undesireable. Nine per-cent of the respondents did not answer this particular quest-ion.

There is more consensus regarding the desireability of the newer method than about the adequacy of the present one.

The data for this thesis are summarized in Tables 11.& 12.

The problem of this study, to investigate the presence of cultural lag in the concepts of nursing, has resulted in the discovery that in each of the four areas there is a con-siderable discrepancy between present practice, as viewed by respondents, and the most modern concepts, and also a descre-pancy between modern concepts and desired practice.

TABLE 11

SUMMARY OF FINDINGS

Norms Operating in the Nursing Civilization Review of Literature	Author's Research Operational Definitions	Most Advanced Technicways Visualized by the Researcher	One Particular Nursing "Folk Regional Society" Expressed in Percent		
Definition of Nursing Care	Attributes of Nursing Care	Assigned Percent	Definition	Present Norms	Desired Norms
Many Definitions	Physical Care	100%	78%	78%	72%
	Treatment	100%	60%	80%	72%
Variety of Attributes	Emotional Support	100%	69%	57%	72%
	Environmental Needs	100%	18%	11%	20%
Choices are made by the individual nurse practitioner	Spiritual Needs	100%	37%	20%	11%
	Rehabilitative Needs	100%	9%	14%	28%
	Health Needs	100%	9%	23%	35%
	Nebulous Responses		6%	9%	9%
	No Answers		16%	11%	19%

TABLE 12

SUMMARY OF FINDINGS (Cont'd)

Norms Operating in The Nursing Civilization	Author's Research Operational Definitions	Most Advanced Technicways Visualized by The Researcher	One Particular Nursing "Folk Regional Society" 65 Participants Expressed in Percent	
Review of Literature		Assigned Percent	Present Norms	Desired Norms
Standards of Nursing	Standards of Nursing Care	Standard	Standards	Standards
None	Minimum Adequate Optimum	Optimum 100%	Minimum 43% Adequate 25% Optimum 0 Nebulous 29% No answer 3%	Minimum 0 Adequate 14% Optimum 81% No answer 5%
Methods of Personnel Assignment	Methods	Method	Methods	Methods
Case Team Functional	Case Team Functional	Team 100%	Case 6% Team 9% Functional 51% Nebulous 25% No answer 9%	Case 36% Team 44% Functional 9% Nebulous 5% No answer 6%
Methods of Patient Assignment	Medical Diagnosis Progressive Care		Medical Diagnosis	Progressive Care
Medical Diagnosis Special Unit Progressive Care	1. Critically Ill 2. Acutely Ill 3. Moderately Ill 4. Mildly Ill	"Progressive Care" 100%	Inadequate 65% Adequate 23% No answer 12%	Undesirable 17% Desirable 74% No answer 9%

Chapter V

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary

A review of the literature revealed that there is a chaotic degree of latitude operating in the nursing "civilization" (nursing profession) in general. The findings of this study show a comparable chaotic degree of latitude operating in the "folk regional society". (This particular nursing service). There is a range of choices operating in the definition of nursing care; the standards of nursing practice; in the method of personnel assignment and in the method of patient assignment. These divergent opinions imply that standardization is a necessity in the nursing "civilization" if the "folk" regional societies" are to function in harmony and in a uniformly organized fashion. Because the "folk" in the nursing "folk regional society" are apt to be mobile and because they are members of the nursing profession they are dependent upon nursing"civilization" as represented in the national organizations for overall direction and policy. This fact suggests that there is a need for official recognition, understanding and uniform interpretation of professionally accepted policy as it applies to nursing care, standards of practice and method of personnel assignment.

A comparison of the nursing "folk regional society" observed in this study with that of the nursing "civilization"

as reflected in the literature indicates that a cultural lag is present in this nursing "folk regional society" in the areas of nursing care, its standard of practice, method of personnel and patient assignment. This study shows that many of the "folk" in this nursing "folk regional society" are reluctant to change their traditional concepts of nursing care. This may be due to a feeling of threat to their personal "self-image". If change permits them to reorient their personal "self-image" they may seem more willing. This study indicates the variety of choices a nurse practitioner has in each of the four topics mentioned. It suggests the importance of a common frame of reference between the nursing "civilization" and this particular nursing "folk regional society" and within separate nursing "folk regional societies".

The comparison not only reveals but highlights the areas of cultural lag between nursing "civilization" and this particular nursing "folk regional society". It suggests that this nursing service organization is primarily traditional in its nature and character. It reflects traditional norms in its definition of nursing care since physical care, treatment and emotional support are mentioned on the average by seventy-two percent of the respondents whereas environmental, religious, rehabilitative and health needs are mentioned on the average only by twenty percent. It also reflects traditional norms in standards of performance since no one mentions op-

timum care as the standard being used. Traditional methods of patient and personnel assignment are being used, but the norms seem to be in a state of transition.

Conclusions

Conclusions drawn from this study are that:

1. There is a need for a standardized definition of nursing care at the level of nursing "civilization", the attributes of which can be identified, attained and measured.
2. There is a need at the level of nursing "civilization" for standards of nursing care practice which are definable and measurable and for a standard to be set below which practice is considered unsafe.
3. If the role of the nurse is to be that of a manager as well as a practitioner of nursing care she needs background and practice in the following areas:
    A. Work simplification and skill development.
    b. Management and principles of supervision.
    c. Principles of teaching
    d. Principles of guidance (non-directive)
    e. Principles of rehabilitation
    f. Team concept.
4. There is a need for policy, procedure, practice, program and standardization in this particular nursing "folk regional society" in the following areas:
    a. The administrative climate
    b. The role of the nurse
    c. Definition of nursing care

d. A standard of nursing care practice

e. The method of personnel assignment

5. There is need to evaluate critically the method of patient assignment.

6. Policy, procedure, program, practice and standardization are extrinsically dependent upon the consensus of the controlling groups within the hospital structure, namely, the director of nursing, the medical staff and administration.

7. Once policy, procedure, program, practice and standardization have been established responsibility should be delegated to the "folk" of "folk regional society" for implementation.

8. In-service programs be designed to make the assimiltion of policy, program, procedure, practice and standardization a democratic process with acceptance based upon consensus by the nursing "folk regional society".

9. From the norms suggested by the "folk" in the nursing "folk regional society" it follows that the basis of a staff-constructed master staffing pattern is possible:

   a. Nursing Care: Comprehensive

   b. Standard of Practice: Optimum

   c. Method of Personnel Assignment: Team

   d. Method of Patient Assignment: "Progressive Care"

10. A permissive climate is a necessity in the nursing

service organization if each nurse is to help herself and others carry out the assigned task, nursing care, through <u>self-discipline</u>, within the limits set by policy, procedure, program, practice and standardization.

11. The percentage of non-responses can be regarded as an indication of the traditional (authoritatian) conceptualization of administration by this particular nursing "folk regional society."

Recommendations

On the basis of the findings the following recommendations are made:

1. That a similar study be conducted in which the researcher is able to secure 100% participation by the personnel.
2. That a comparative study be carried out between two nursing service organizations in the same area.
3. That a similar study be done limiting the category to be tested to either supervisors, head nurses, staff nurses, or instructors.
4. That a similar study be done limiting the category to the supervisor, head nurse and staff nurses on one unit.
5. That a functional study be conducted to determine the number and kind of personnel needed on each ward using as the basis of a master staffing pattern the following concepts:
   a. Administrative Climate: Democratic
   b. Role of the Nurse: Organizer, Teacher, Supervisor and Administrator.
   c. Nursing Care: Comprehensive
   d. Standard of Practice: Optimum
   e. Method of Personnel Assignment: Team
   f. Method of Patient Assignment: Progressive Care
6. That the director of Hospital X, administration and the medical staff evaluate the findings and the significance of the findings of this study.
7. That the "folk" of this particular nurse "folk regional

society" evaluate the findings and develop the in-staff-education program.

8. That the nursing "civilization", as represented in its official organizations, consider the necessity of standardization in the areas of: a definition of nursing care, the standard of practice and the method of personnel assignment.

9. That the "folk" of the nursing "civilization" seriously consider the translation of Dr. Fred Polok's theory of the future of a "civilization":-

> '"If a society has optimistic ideas, dynamic aspirations and cohesive ambitions, the civilization will grow and prosper. If it exhibits negative trends, uncertain ideas and hesitant faith, the society is in danger of disintegrating."' The idea, then is that by thinking about the future, man creates the same future according to his image."[1]

10. That the "folk" who represent the nursing "civilization" strive toward that maturity defined by Strecker and Appel as:

> '"Basically maturity represents a wholesome amalgamation of two things: 1.) dissatisfaction with the status quo, which calls forth aggressive, constructive effort, and 2.) social concern and devotion. It is morale in the individual."'[2]

11. That the "folk" within this particular nursing "folk regional society" and the allied professional and other societies associated with them in the hospital structure

[1]Ewing, D., Long Range Planning For Management, p. 488 (citing Dr. Fred Polok.)

[2]Wittenberg, R., The Art of Group Discipline, p. 111 (citing Strecker and Appel.)

pool their ideas, energies and creative thinking and through consensus provide comprehensive care.

12. That less-provincialized and a more cosmopolitan type of nursing education be adopted so as to decompartmentalize the student and consequently the graduate.

13. The existing nebulous concepts as a further indication of a traditionally-oriented nursing "folk regional society" might be clarified by:

    a. Formal contact by students in the basic diploma program with the philosophical principles of nursing.

    b. Effective in-service education.

14. Potentially static traditionalist attitudes should be anticipated and modified in the basic diploma program by teaching students to distinguish clearly between:

    a. The constant, ontological principles which comprise the nature, essential properties and reality of nursing.

    b. The variable logic of nursing which is methodology, alterable to suit the requirements of different nursing situations and environments.[3]

[3] Cotter, A.C., A B C of Scholastic Philosophy, pp. 1 - 434.

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APPENDIX

APPENDIX

___________ Hospital

Department of Nursing

Questionnaire - Registered Professional Nurse

The Director of Nursing would appreciate knowing your feelings about the nursing care you give at Hospital X and some of your thoughts about nursing care in general.

This is your opportunity as a member of the Nursing Staff to state your opinions and views and to make your suggestions for improving patient care. We hope you will feel free to say anything you wish. You need not sign your name. Your criticisms and recommendations will help us to find out how patient care can be improved at lesser cost to the patient and greater satisfaction to you as a Staff member. You can help us formulate the basis of a staffing pattern by cooperating with us by answering these questions carefully and thoughtfully.

Please return the questionnaire by _____________. Our goal is 100% participation by the Nursing Personnel.

Questionnaire - Professional Nursing Personnel

Part I.

I. How would you as a nurse, define nursing care explicitly and comprehensively?

II. Do you think the present method of patient assignment to the various wards is adequate and meets the needs of the patient, the doctor, and the community as well as Your Needs as a Staff Member?

III. Many hospitals are developing wards which are designed to provide services according to the severity of a patient's illness. Illnesses are classified as critical, acute, moderate and mild. Patients are transferred in and out of these wards according to their progress. Some of the wards are staffed primarily with professional nurses and others primarily with ancillary personnel. Do you think it would be possible to provide each of these wards for the patients at Hospital X?

Please indicate your preference by making a check mark (✓) for degree of illness in the appropriate column below.

Acuity of Illness	Have a Specifically Designated Ward	Not Desirable
Critically Ill: A patient whose condition is such that the doctor believes death nay occur at any time.		
Acutely Ill: A patient whose illness is severe or intense and whose progress is doubtful.		
Moderately Ill: A patient whose physical and emotional responses indicate satisfactory progress toward recovery but who is confined to bed.		
Mildly Ill: A patient who is ambulatory and relatively self-sufficient within the limits of the hospital environment.		

Part II.

The Director of Nursing is interested in providing better care to the patients. What is meant by nursing care can only be expressed in relative terms. However, your point of view as a nurse would help us define your expectations for patient care.

Listed on the following page are three definitions of grades of nursing care.

In Column I, please indicate by a check mark (√) in the appropriate space the kind of care the nursing staff is giving at the present time to the majority of patients and in Column II make a check mark (√) in the appropriate space indicating the kind of care you would like the nursing staff to give the patients.

Gradations of Nursing Care	Care Patients Now Receive	Care You Would Prefer
1. Minimum Nursing Care: Is the least quantity of attention and treatment necessary to maintain the patient's comfort, safety and prevalent condition. The patient adapts to the established routine of the hospital. He receives the treatment and medications prescribed by the physician in a safe and clean environment. He verbalizes his needs and these are gratified by the Nursing Personnel.		
2. Adequate Nursing Care: Is a quantity of attention and treatment sufficient to arrest the symptoms indicated in the diagnosis and to promote convalescence. The patient is recognized as an individual with an individual personality and the nursing personnel help him to adjust to his condition and his environment. Routines, treatments and medications are carefully explained to the patient and adjustments are made whenever necessary. The nursing personnel are aware that the patient has many needs which may be physical, emotional, spiritual or environmental in nature and attempt to meet these needs.		
3. Optimum Nursing Care: Is the quantity of attention and treatment wider in scope and of superior degree concentrating not only on the complete recovery of the patient but also on his psychological preparation for post convalescent life. The patient's needs are anticipated by the nursing personnel and a plan is designed for the individual patient which includes physical care, treatment, emotional support, environmental needs, spiritual guidance, health instruction and an attempt at rehabilitation so that the patient returns home with renewed confidence in himself and is willing to adjust his living to his physical potentialities.		

Part III.

The Director of Nursing is contemplating a revised overall staffing pattern for the hospital. Many factors enter into the establishment of a staffing pattern. Basic among them are the methods for assignment of personnel to the care of patients. Please bear in mind the cost and the difficulty of securing professional nurses.

In Column I, please check (√) the method or methods of assignment now practiced at Hospital X and check in Column II the method you prefer.

Method of Assignment	Method(s) Practiced	Method you Prefer
1. Case Method: The professional nurse is assigned to the care of one or more patients and she is responsible for giving complete care.		
2. Team Method: A team composed of a professional nurse and one or more auxiliary workers are assigned to the care of a group of patients. The professional nurse of the team is responsible for the complete care of her group of patients.		
3. Functional Method: Nurses and/or ancillary workers are assigned to specific functions for all the patients in the wards, such as taking temperatures, giving treatments and medications and patient care assigned to any nurse or ancillary worker(s) is limited mainly to physical care.		

Nursing Care

1. What are you doing?

   Mr. Jones has been admitted today with a diagnosis of Cancer of the colon. He is scheduled for a colostomy tomorrow morning at 9:00 a. m. Please write briefly and specifically the kind of care you are able to give him pre-operatively and in his convalescent period at the present time.

2. What would you like to do?

   What kind of care would you like to be able to give him? (Please be specific.)