MPA 778

THE SHIFTING SYSTEM IN HOSPITAL /MULTIPLE HOSPITAL MANAGEMENT SYSTEM

WORK & LEARN

NATIONAL OPEN UNIVERSITY OF NIGERIA

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UNIT 1 LEVELS OF HEALTH CARE SERVICES IN NIGERIA

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1.0INTRODUCTION

This Unit will focus at the various levels of health care services in Nigeria, the functions of each level and how they inter-relate with each other. Health is a subject of concurrent list in the constitution of the Federal Republic of Nigeria as a result of its importance to the teeming population.

2.0OBJECTIVES

At the end of this Unit, the learner shou7ld be able to:

- List the levels of health care services in Nigeria.
- Describe the functions of each level.
- Explain the inter-relatedness of the levels.

3.0MAIN CONTENT

1. Organization at Federal Level
2. Organization at Sate Level
3. Organization at Local Level

Health system in Nigeria is organized at three levels (i.e.) Federal, State and Local levels.

3.1 Organization at Federal Level

The official "organs" of the health system at the Federal level consists of:

(a) The Federal Ministry of Health
(b) The National Council of Health

We shall talk of the organization and function of each one of them.

(a) The Federal Ministry of Health

The Federal Ministry of Health is headed by a Minister. It is a political appointment. Currently, the Federal Ministry of Health has 5 directorates/departments. These include:

i. Department of Personnel Management
ii. Department of Finance and Supplies
iii. Department of Planning, Research and Statistics
iv. Department of Hospital Services
v. Department of Primary Health Care and Disease control.

The following are the responsibilities of the Federal Ministry of Health

i. Take necessary action to review the national health policy and its adoption by the Federal Government.
ii. Devise a broad strategy for giving effect to the national health policy through the implementation by Federal, State and Local Governments in accordance with the provisions of the constitution.
iii. Submit for the approval of the Federal Government a broad financial plan for giving effect to the Federal component of the health strategy.
iv. Formulate national health legislation as required for the consideration of the Federal Government.
v. Act as coordinating authority on all health work in the country on behalf of the Federal Government, with a view to ensuring the implementation of this national health policy.
vi. Assess the country's health situation and trends, undertake the related epidemiological surveillance and report thereon to Government.
vii. Promote an information public opinion on matters of health.
viii. Support State and through them Local Government in developing strategies and plans of action to give effect to this national health policy.

ix. Issue guidelines and principles to help states prepare, manage, monitor and evaluate their strategies and related technical programmes, services and institutions.
x. Promote co-operation among scientific and professional groups as well as non-governmental organizations in order to attain the goals of this policy.
xi. Monitor and evaluate the implementation of this national policy on behalf of Government and report to it on the findings.

International Health

The Federal Ministry of Health shall set up an effective mechanism for the co-ordination of external cooperation in health and for monitoring the performance of the various activities. Within the overall foreign policy objectives, this national health policy shall be directed towards:-

i. Ensuring technical co-operation on health with other nations of the region and the world at large.
ii. Ensuring the sharing of relevant information on health for improvement of international health.
iii. Ensuring cooperation in international control of narcotic and psychotropic substances.
iv. Collaborating with Untied Nation agencies, Organization of African Unit. West African Health Community, and other International Agencies on bilateral and/or regional and global health care improvement strategies without sacrificing the initiatives of national, community, and existing institutional and other infrastructural arrangements.
v. Working close with other developing countries, especially the neighboring states within the region which have similar health problems, in the spirit of technical cooperation among developing counties, especially with regard to the exchange of technical and epidemiological information.
vi. Sharing of training and research facilities and the co-ordination of major intervention programmes for the control of communicable disease.

(b) The National Council of Health

The National Council of Health is composed of the following members:

i. The Honorable Minister of Health (Chairman)
ii. The Honorable Commissioners for Health (States)

The following are the functions of the National Council of Health.

The National Council of Health shall advise the government of the Federation with respect to:

i. The development of national guidelines.
ii. The implementation and administration of the national health policy.
iii. Various technical matters on the organization, delivery, and distribution of health services.

The council shall be advised by the Technical Committee

Technical Committee

The Technical Committee of the National Council on Health shall be composed of:

i. The Federal and States Permanent Secretaries (M.O.H.).
ii. The Directors of Federal Ministry of Health.
iii. The Professional heads in the state Ministry of Health.
iv. A representative of Armed Forces Medical Services.
v. Director of Health Services, Federal Capital Territory, Abuja.

Expert panels

a. The Technical committee shall set up as required, appropriate programme expert panels including the representatives of health related Ministries.

i. Agriculture, Rural Development and Water Resources
ii. Education
iii. Science and Technology
iv. Labour
v. Social Development, Youth and Sports
vi. Works and Housing
vii. National Planning
viii. Finance

b. Health related bodies

i. National Institute of Medical Research
ii. Medical Schools
iii. Schools of allied health professionals
iv. Non governmental organizations
v. Professional associations (Health) e.g. NMA, NANNM, PSN, among others.

3.2State Level

At present there are 36 states and the Federal Capital territory, Abuja and many types of health administration. In all the states, the management sector for health lies with the Ministry of Health while in some states, Health management Board also participates in the management.

i. State Ministry of Health

Organization: The State Ministry of Health is headed by an Honourable Commissioner, while in Health Management Board; there is a governing Board with an Executive Secretary. The Commissioner is the Political head of the Ministry while the Permanent Secretary is the administrative head. There are Directors manning the directorates assisted by Deputy and Assistant Directors.

Functions: The State Ministry of Health directs and co-ordinates authority on health work within the State via:

i. Ensuring political commitment
ii. Ensuring economic support
iii. Winning over professional groups
iv. Public information and education
v. Financial and material resources provision
vi. Inter-sectoral action
vii. Coordination within the health sector
viii. Organizing primary health care in communities
ix. Federal system
x. Logistics system
xi. Health manpower recruitment and retaining
xii. Priority health programmes
xiii. Health technology.

3.3Local Level

There are 774 Local Government Areas in Nigeria with various health facilities operating under the aegis of primary health care.

The Local Government Headquarters coordinates the activities of the health facilities proving manpower, funds logistics and control.

The Local Government is headed by elected Chairmen during political era with council members. Supervisory councilors are also appointed to oversee various aspects of Local Government activities including Health

and Social Services. The health department is always headed by a Primary health Care coordinator.

3.3.1: Functions of the Local Government

- Provision and maintenance of essential elements of primary health care: environmental sanitation; health education.
- Design and implement strategies to discharge the responsibilities assigned to them under the constitution and to meet the health needs of the local community under the general guidance, support and technical supervision of State Health Ministries.
- Motivation of the community to elicit the support of formal and informal leaders.
- Local strategy for health activities.

Examine this illustration, which provides an overview of health care delivery system at the three levels of health care i.e. primary, secondary and tertiary levels. As you know a full range of primary health care (first level contact of individual, family and community health system) are being rendered through the agency of primary health centers.

Secondary health care is being provided through the establishment of cottage, General Hospitals where all basic specialty services are being made available.

Tertiary care is being provided at Teaching and Specialist Hospitals where super specialty services including sophisticated diagnosis, specialized therapeutic and rehabilitative services are available.

4.0CONCLUSION

The health of the population of the country determines the strength and the future of that country; hence the understanding of the levels of health care services in Nigeria is crucial to the learners especially with reference to the adage that says “health is wealth” as a healthy nation is a wealth nation.

5.0SUMMARY

The learner has been exposed to the three levels of health care services in Nigeria, their functions and interrelatedness.

6.0TUTOR- MARKED ASSIGNMENT

1. List and explain the levels of health care delivery system in Nigeria.
2. Why is it not possible for each level to operate in isolation?

7.0 REFERENCES/FURTHER READINGS

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UNIT 2 THE STAFF DEVELOPMENT PROCESS

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    3.2 Conditions Requiring Training and Development
    3.3 Objectives of Training and Development
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5.0 Summary
6.0 Tutor- Marked Assignment
7.0 References/Further Readings

1.0 INTRODUCTION

This unit will discuss with you the essence of staff development as any organization that fails to develop its staff is planning for future failures because the society of today is ever changing. There is a need to develop the staff of that organization in order to meet the needs of the society where it operates. The organization needs to take the training and development of staff is taken with all seriousness.

2.0 OBJECTIVES

At the end of this unit, the learner should be able to:

- Explain the concepts of training and development of staff.
- List at least six conditions requiring training and development
- Discuss how training and development needs are determined

3.0 MAIN CONTENT

3.1 Employee Training and Development

Employee training and development are at the heart of employee utilization, productivity, commitment, motivation and growth. Many employees (especially in the hospitals) have failed because their need for training was not identified and provided for as an indispensable part of managerial functions.

Training is an organizational effort aimed at helping an hospital worker to the acquire basic skills required for the efficient execution of the functions for which he was hired while development deals with the activities undertaken to expose an employee to perform additional duties and assume positions of importance in the organizational hierarchy. Employee productivity is a function of ability, will and situational factors. Considering the hospital as a complex organization, training and development of the workers determine the survival of the hospital as an organization of social service delivery.

This is a continuing liberal education of the whole person to develop the worker's potential fully. It deals with aesthetic services as well as technical and professional education and may include activities such as orientation, internships, in-service education, conference, seminars, workshops etc. the manager plays an important role in the support of staff development and has a responsibility to review the goals for the staff development programme and to provide a budget for those activities.

The manager participates in needs identification and analyses education, effects change in the health services. Also, must be able to differentiate between staff development and administrative needs. For example, if a worker knows how to carry out a procedure properly but does not carry it out due to inadequate supply of needed materials, the need is administrative and not educational.

3.2 Conditions Requiring Training and Development

There are certain conditions that will serve as pointers to the need for training. These symptoms manifest themselves in a variety of ways but the most common ones are:

a) Lack of interest in one's job
b) Negative attitude to work
c) Low productivity
d) Tardiness
e) Excessive absenteeism rate
f) Excessive complaints
g) High rejects or low quality output
h) High incidence of accidents
i) Insubordination

When the hospital starts experiencing some of these warning signs, it should consider training. An employee will not complain to the employer that he requires training, instead he would hide his frustration

and use money, for example, as a scapegoat by demanding more wages, he may even complain of the lack of fringe benefits and use one or two isolated examples to justify has complaints/deficiency.

3.3 Objectives of Training and Development

Some of the main objectives of training and development of employees include the following:

1. Increase productivity

From the hospital's point of view, productivity is at the apex of all Training and Development programmes. A well-trained employee is capable of producing more than an untrained employee of equal physical ability. The success or failure of a hospital organization depends on employee's productivity.

2. Lower turnover rate

An employee who is incapable of producing is frustrated by failure and is more likely to abandon his work than those who are capable of producing. An untrained employee is like a dull school pupil, he hates school and likes to absent himself and is likely to be a school drop-out unlike other pupils who enjoy school because they are doing very well. An unproductive employee hates his work and abandons it at the smallest provocation from any source.

3. High morale

A man who is trained has confidence in his ability to perform. He believes that he has control of his environment and is equipped to tolerate occasional disappointments, frustrations and inconveniences. He learns to rationalize and to accept blame for his own failures instead of blaming the organization. A trained employee derives intrinsic satisfaction from his work which promotes his morale. Organizations that have regular training and development programmes give employees the feeling of being wanted and something to look up to.

4. Better Coordination

Training and development help in the coordination of men and materials. During the Training and Development programmes, employees are taught hospital expectations and objectives. They are shown the ladder through which they can attain their own objectives.

This gives rise to goal congruency and consequently, every one pulls in the same direction. Coordination becomes easy.

3.4 Determining Training and Development Needs

Before any programme is undertaken, the needs for Training and Development have to be determined or identified. The need for Training and Development increases as a result of new technology, new diseases, variety of new health consumers and other factors such as competitive strategy of competitors. To mount Training and Development programmes requires system analysis. The hospital Administrator tries to identify the problems encountered by different employees.

Training and Development could be a waste of time and resources if the area of emphasis of Training and Development is not properly isolated. Nothing can be more frustrating and demoralizing as teaching a person what he already knows. Concerted effort must be made to clearly identify areas of stress in a Training and Development programme.

3.5 Training Programmes

Training programmes are directed toward maintaining and improving current job performance while development programmes seek to develop skills for future jobs. Both managers and non managers may receive help from training and development programmes, but the mix of experiences is likely to vary. Non managers are much more likely to be trained in the technical skills required for their current jobs; whereas managers frequently receive assistance in developing the skills required in future jobs particularly conceptual and human relations skills.

New hospital employees have to learn new skills, and their motivation is likely to be high, they can be acquainted relatively easily with the skills and behaviour expected in their new position. On the other hand, training experienced employees can be problematic. The training needs of such employees are not always easy to determine, and when they can be, the individuals involved may resent being asked to change their established ways of doing their jobs.

Managers can use four procedures to determine the training needs of individuals in their organization or sub unit.

a. Performance Appraisal

Each employee’s work is measured against the performance standards or objectives established for his or her job.

b. Analysis of job requirements

The skills or knowledge specified in the appropriate job description are examined, and those employees without necessary skills or knowledge become candidates for a training programme.

c. Organizational analysis

The effectiveness of the organization and its success in meeting its goals are analyzed to determine where differences exist. For example members of a department with a high turnover rate or a low performance record might require additional training.

d. Employee survey

Managers as well as non-managers are asked to describe what problems they are experiencing in their work and what actions they believe are necessary to solve them.

Once the organization's training needs have been identified, the human resource manager must initiate the appropriate training effort. The most common of these approaches are:

- On-the-job training methods including job rotation in which the employee, over a period of time, works on a series of jobs, thereby learning a broad variety of skills.
- Internship: this is where job training is combined with related classroom instruction.
- Apprenticeship: Here an employee is trained under the guidance of a highly skilled co-worker.
- Off-the-job training: this takes place outside the workplace but attempts to simulate actual working conditions.
- Vestibule training: This is when employees train on the actual equipment and in a realistic job setting but in a room different from the one in which they will be working. The object is to avoid the on-the-job pressures that might interfere with the learning process.
- Behaviourally experienced training: The trainee learns the behaviour appropriate for the job through role playing.

3.6 Development Programmes

The management development is designed to improve the overall effectiveness of managers in their present works/positions and to prepare them for greater responsibilities when they are promoted.

Management Development Programmes have become more prevalent in recent years because of the increasingly complex demands on managers and because training managers through experience alone is a time-consuming and unreliable process.

The following D. Ps are used by managers:

1. On-the-job methods: These include:

   (a) Coaching: This is training of an employee by his or her immediate supervisor, this is by far most effective management development technique.
   (b) Job rotation: This involves shifting managers from position to position so they can broaden their experience and familiarize themselves with various aspects of the organization's operations.
   (c) Training positions: Trainees are given staff posts immediately under a manager, often with the title of "assistant to" such assignments give the trainees a chance to work with and model themselves after outstanding managers who might otherwise have little contact with them.
   (d) Planned work activities: This involves giving trainees important work assignments to develop their experience and ability. Trainees may be asked to head a task force or participate in important meetings. Such experiences help them to gain insight into how organizations operate and also improve their human relation skills.

2. Off-the-job methods: These techniques remove individuals from the stresses and ongoing demands of the workplace, enabling them to focus fully on the learning experience and also provide opportunities for meeting people from other departments or organizations. Thus the employees are exposed to new useful ideas and experiences while they make potentially useful contacts.

   These programmes may include classroom instruction, university – sponsored programmes which often combine classroom instruction, case studies, role playing and simulation.

4.0 CONCLUSION

Employees Training and Development programmes can be said to be the bedrock of any organization if that organization especially the hospital

must meet up with the expectations of the consumers of her services as the employees need to update their knowledge and acquire new experiences from other people for better performance in their fields of operation.

5.0 SUMMARY

This unit has exposed the learner to various programmes in training and development of employees. Training and Development are crucial to the existence of any organization (the hospital inclusive).

6.0 TUTOR- MARKED ASSIGNMENT

Different training and development programmes are useful at various times; discuss those training and development programmes used by your organization and what are the hindrances to effective training and development programmes at your work place.

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UNIT 3 SAFE STAFFING IN THE HOSPITALS

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1.0 INTRODUCTION

This unit will provide a picture of effective hospital system. Safe staffing determines the success or/and quality health care service that is required in a standard hospital. Considering the multi-various services needed in such hospital, safe staffing can not be over emphasized. For the hospital structure to be effective and in order to meet the changing demands of its consumers there must be safe staffing.

2.0 OBJECTIVES

At the end of this unit, the learner should be able to:

- Explain what safe staffing is
- Discuss some variables to consider when planning for safe staffing.

3.0 MAIN CONTENT

3.1 What Safe Staffing is

Safe staffing means that an appropriate number of staff, with a suitable mix of skill levels, is available at all times to ensure that patient/client care needs are met and that hazard-free working conditions are maintained.

Man has fundamental right to life and to dignified death and hospital workers as human beings exist and share the same nature and basic needs as the client / patient. Each professional must have acquired knowledge, skills and attitudes and ethics to provide safe and effective health care.

Staffing determines the quality of care rendered in the hospital which includes recruiting, selecting, orienting and developing personnel to accomplish the goals of the organization. It also involves determining / assigning systems and selecting staffing schedules to meet the needs the client, personnel and institution.

3.2 Variables for Planning Safe Staffing

There are many variables to be considered when planning for staffing that are connected with the competences of the staff such as:

- Access client / patient through history taking, physical assessment, review of relevant records and listing of appropriate actual and potential health problems.
- Assess the community through data gathering and identifying health needs to arrive at community diagnosis.
- Plan for individual client / patient's problems and family health needs for the attainment and maintenance of health status.
- Assume responsibility and plan for delivery of dependent and interdependent activities.
- Assist the client / patient to achieve optimum functioning.
- Utilize available resources within the home, community and hospital setting to achieve maximum provision of health care services.
- Participate in formulating health plans for the community.
- Provide rehabilitative services to individuals and families to enable the client / patient adapt to changing conditions.
- Demonstrate assertiveness in the management of health care for client / patient in the homes, community and health care institutions.
- Establish and maintain a two-way referral system.
- Ensure work discipline by providing adequate motivation for health workers.
- Initiate and carry out research to improve practice and develop new techniques to meet health needs of the people.

3.3 Recruitment

Recruitment is concerned with developing a pool of job for candidates in line with the human resource plan. Candidates are usually located through newspaper and professional journal advertisements, employment agencies, word of mouth and visits to College and University campuses.

Before employees can be recruited, recruiters must have some clear ideas regarding the activities and responsibilities required in the job being filled. Job analysis is therefore an early step in the recruitment process. Once a specific job has been analyzed, a written statement of its content and location is incorporated into the organization chart. Each box on the organization chart is linked to a description that lists the title, duties and responsibilities for that position.

Once the position description has been determined, an accompanying hiring or job specification is developed. The hiring specification defines the education, experience and skills an individual must have in order to perform effectively in the position.

3.3.1 Sources of Recruitment

Recruitment takes place within a labour market i.e. the pool of available people who have the skills to fill open positions. The labour market changes over time in response to environmental factors. Sources for recruitment depend on the availability of the right kinds of people in the local labour pool as well as on the nature of the positions to be filled. An organization's ability to recruit employees often hinges as much on the organization's reputation and the attractiveness of its location as on the attractiveness of the specific job offer. If people with appropriate skills are not available within the organization or in the local labour pool, they may have to be recruited from some distance away or perhaps from competing organizations.

3.4 Selection

The selection process ideally involves mutual decision. The organization decides whether to make a job offer and how attractive the offer should be, and the job candidate decides whether the organization and the job offer fit his or her needs and goals.

3.4.1 Steps in the Selection Process

S/NO	PROCEDURES	PURPOSES	ACTIONS AND TRENDS
1	Completed job application	Indicates applicant's desired position	Requests only information that predicts success in the job
2	Initial screening interview	Provides a quick evaluation of applicant's suitability	Asks questions on experience, salary expectation, willingness to relocate, etc.
3	Testing	Measures applicant's job skills and the ability to learn on the job	May include computer testing software, hand written analysis medical and physical ability
4	Background investigation	Checks truthfulness of applicant's resume or application form	Calls the applicant's previous supervisor (with permission) and confirms information from applicant
5	In-depth selection interview	Finds out more about the applicant as an individual	Conducted by the manager to whom the applicant will report
6	Physical examination	Ensures effective performance by applicant; protects other employees against diseases; establishes health record on applicant; protects firm against unjust worker's compensation claims	Often performed by company's medical doctor
7	Job offer	Fills a job vacancy or position	Offers a salary plus benefit package

3.5 Orientation / Socialization

Orientation or socialization is designed to provide new employees with the information needed to function comfortably and effectively in the organization. Typically, socialization conveys three types of information (a) general information about the daily work routine (b) a review of the organization's history, purpose, operations, and products or services, as well as a sense of how the employee's job contributes to the organization's needs and (c) a detailed presentation of the organization's policies, work rules and employee benefits.

Many studies have shown that employees feel anxious upon entering an organization. They worry about how well they will perform in the job, they feel inadequate compared to more experienced employees, and they are concerned about how well they will get along with their co-workers. Effective socialization programmes reduce the anxiety of new employees by giving them information about the job environment and about supervisors, by introducing them to co-workers, and by encouraging them to ask questions.

Early job-experiences when the new employees' expectations and the organization's expectations come together or collide-seem to play a critical role in the individual's career with the organization. If the expectations are not compatible, there will be dissatisfaction; turnover rates are almost always highest among an organization's new employees.

4.0 CONCLUSION

The hospital workers have changes of roles that are frequent as a result of the dynamism of the society. Hence the need for these workers to be skillful as this will help them to meet the changes of providing safe health care services to the clients/patients at various times.

5.0 SUMMARY

The unit has examined safe staffing and its relevance to qualitative health care delivery. Also looked into, are the variables required for having a safe staffing in our health care delivery system in Nigeria.

6.0 TUTOR- MARKED ASSIGNMENT

State and explain the functions of orientation and socialization.

7.0 REFERENCES/FURTHER READINGS

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UNIT 4 STAFFING THE HOSPITAL UNITS

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    3.2 Deployment of staff to a Unit/Department
4.0 Conclusion
5.0 Summary
6.0 Tutor- Marked Assignment
7.0 References/Further Readings

1.0 INTRODUCTION

The last unit looked at the recruitment process into the hospital in order to have a safe staffing in the organization.

This unit will now build on the previous unit especially exploring the way staff recruited will be deployed for their primary assignment so that they can meet the needs of the consumers for if there is problem in deployment of staff to the right place of work, then the goals of the hospital will not be met.

2.0 OBJECTIVES

At the end of this unit, the learner should be able to:

- Explain what staff orientation is
- Describe what deployment of staff is
- Discuss how units in the hospital can be staffed.

3.0 MAIN CONTENT

3.1 Staffing the Units

Each unit of the hospital is expected to have a master staffing plan which should include the basic staff needed to staff the unit of each shift. Basic staff is the minimum or lowest number of personnel needed to staff a unit. It includes fully oriented, full and part-time employees.

The number may be based on examination of previous staff records and the expert opinion of the managers. It includes all categories of staff for each shift.

3.1.1 Core staff

Estimating a core staff per shift i.e. there are essential staff in each Unit/ department of the hospital in which if there are sets of staff that are not available, the day to day running of the activities of the Units/departments would ground to a halt; they are the movers and shakers of the Units, the nucleus staff. The hospital management will need to estimate these core staff of the department and ensure that they are available per shift.

It is also essential to note that the hospitals are run like a cycle and a system in which all the departments are interdependent and interrelated. Hence a particular department in a shift whose core staff are not available will affect negatively the performances of other departments/Units.

3.1.2 Complementary Personnel

These are scheduled as an addition to the basic group but the total number in both groups is controlled by financial resources and the availability of personnel. They provide the flexibility needed to meet short-range and unexpected changes.

Complementary personnel are not ensured as permanent pattern and are usually scheduled for 4-week periods.

3.1.3 Float Personnel

These are employees who are not permanently assigned to a station. They provide flexibility to meet increased patient loads as well as unexpected personnel absences. The number and kinds of float personnel can be accurately determined from general monthly records that show absence rates, personnel turnover and fluctuations in patient care workloads. Float personnel may be assigned to a pool.

Some administrators do not hire part-time personnel. They may be an economic or cost-control factor in staffing since they usually do not receive some benefits as full-time personnel. Part-time personnel will be better motivated if they receive some benefits, such as a number of holidays and vacation days proportionate to days worked and pay increases when they complete the aggregate days worked by full-time

personnel. Their total hours worked can be controlled to fill actual shortfalls.

Whatever the staffing policy, it should be arrived at through consultation with clinicians.

3.2 Deployment of Staff to a Unit/Department

The health worker is assigned to the specific Unit/Department where further orientation to her specific job is undertaken. Deployment to the specific unit should be based on qualification and needs for example, a specialist in A and E will perform better and be more relevant in the A and E Casualty Unit than in a medical ward.

The deployment will also be done in such a way that there is even distribution and adequate mix of the staff. The worker is well informed in the department and also knows about how the unit is run, specific methods of practice and communication system.

4.0 CONCLUSION

Staffing the various Unit/Departments in the hospital is essentially the responsibility of the Hospital Administrator/Manager and that is why he/ she has to be versatile in his dealings. He must carefully select the needed staff without undue influence or else the whole arrangement will collapse because the hospital operates as a system.

5.0 SUMMARY

We have looked at how hospital units and departments are staffed in this unit considering various needs of the units and departments because the needs of these units and departments determine staff deployment.

6.0 TUTOR- MARKED ASSIGNMENT

As a manager, in order to deploy staff to your various units/departments, what are your considerations?

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UNIT 5 CONFLICTS AMONG THE MAJOR GROUPS IN HEALTH CARE SERVICES IN NIGERIA

CONTENTS

1.0 Introduction
2.0 Objectives
3.0 Main Content
    3.1 Introduction
    3.2 Causes of Conflict among the Hospital Workers
    3.3 Resolution of Conflicts
4.0 Conclusion
5.0 Summary
6.0 Tutor -Marked Assignment
7.0 References/Further Readings

1.0 INTRODUCTION

The concept of conflict, being an outcome of behaviour, is an integral part of human life. Whenever there is interaction there is conflict.

Conflict can be defined as a disagreement between two or more individuals or groups, with each individual or group trying to gain acceptance of its views or objectives over others. Because people differ in their attitudes, values and goals, conflict among them becomes unavoidable. Management is concerned not so much with eliminating conflict which would be impossible, but to contain and manage it for organizational and individual benefits.

This unit will delve into conflicts among the major players in the health care services in Nigeria and its implications.

2.0 OBJECTIVES

At the end of this unit, the learner should be able to:

- Identify the causes of conflict among the major health professionals.
- Discuss the possible and/or resolutions of these conflicts.

3.0 MAIN CONTENT

3.1 Introduction

Any time two persons come together, there is a potential for conflict. The potential is there because each individual has his own unique way of perceiving or seeing situations and understanding information. As a result, when perceptions and understanding of situations or information differ, conflict occurs.

Conflict within a work sitting is a natural phenomenon and can be expected. Without conflicts, there would be complete agreement at all times. Under these 'no conflict' circumstances, persons would think alike and much like robots. Conflict only grows in intensity when ignored; therefore, conflict can be effectively managed by confronting it positively.

3.2 Causes of Conflict among the Hospital Workers

In today's health care environment, conflict abounds because individuals and groups have their own opinions about how to handle the many challenges that lie ahead as a new health care system emerges. Conflicts exist between health care organizations and the society as persons ask for health services in particular quantity and at a level of quality that varies from what can be delivered. Changing demographics and limited finances have stimulated professional groups to vie for the consumer's attention.

Conflicts are occurring between the private and public sectors as federal and state governments attempt to determine what their appropriate role is in financing and delivering health care. As resources have become more scarce, health care organizations are encountering increased internal conflicts, where personnel and/or work units compete for their fair share.

With hospital environment laden with conflicts and stress, relationships and interactions among colleagues are potentially more liable.

There may be conflicts because of given information or set of facts, emotions, perceptions about a situation that occurred in the workplace or the values held by other hospital workers.

Learning about conflict can also be differentiated by gender. Many women were socialized into believing that they were not suited to the vagaries of conflict. Being angry was not considered an acceptable

response and when differences occurred, women were supposed to either avoid or accommodate. Learning this message can cause women to feel fearful, powerless and immobilized when confronted with conflict situations.

There can be conflicts related to disagreements over goals and objectives of the organization or the policy of the management especially the conflicts may arise over the means to reach those goals and objectives or the policies.

When there are opinions from one health provider group to the management in order to subjugate other professionals, conflict results. It ought to be facts and not opinions as facts are generally indisputable resulting in agreements while opinions are highly personal and subjective and may provide for criticisms and disagreements. These conflicts are often results of personality clashes. People with widely differing characteristics and attitudes are bound to have views and aims that are inconsistent with the views and aims of others.

Health service delivery sector is an organization which is an interlocking network of groups, departments, sections or work teams, there can be conflicts within one group and another. These conflicts are not so much personal in nature, as they are due to factors inherent in the organizational structure especially conflicts between line and staff.

There can be conflicts as a result of inconsistent rewards and differing performance criteria for different units and groups.

Different functional groups within the health sector may come into conflict with each other because of their different specific objectives. There are some fundamental differences among different units of the organization both in the structure and process and thus each unit develops its own organizational subculture.

Conflicts may be between the day shift and night shift workers who might blame each other for anything that goes wrong from missing tools to maintenance problems or particular duties not performed which may have adverse effects on the client/patients.

Behavioural aspects of conflicts: These conflicts arise out of human thoughts and feelings, emotions and attitudes, values and perceptions. This conflict can arise by a simple misunderstanding or an error in communication. A misunderstood message can create viewpoints about various issues.

Role ambiguity can also lead to conflict. A role is a set of activities associated with a certain position in the organization or in the society. If the work activities are ill-defined, then the person who is carrying out these activities will not behave as others expect him to because his role is not clearly defined. This will create conflict, especially between this individual and those people who depend upon his activities.

3.3 Resolution of Conflicts

Except in very few situation in which the conflict may lead to competition and creativity so that those situations the conflict can be encouraged, in all other cases where conflict is destructive in nature it should be resolved once it has developed but all efforts should be made to prevent it from developing. Some of the ways to prevent and resolve conflicts are:

- Goals should be clearly defined and the role and contribution of each unit towards the organizational goals must be clearly defined. All units and the individuals in these units must be aware of the importance of their role and such importance must be fully recognized.
- The compensation system should be such that it does not create individual competition effort and should reflect the degree of interdependence among units wherever necessary.
- Trust and open the communication among them would be. Individuals and unties should be encouraged to communicate openly with each other so that they can all understand each other, understand each other's problems and help each other when necessary.
- Properly coordinated activities reduce conflict so there must be adequate coordination of the activities of the units/departments.

Generally, conflicts may be resolved by either or combination of Denial or withdrawal, suppression or smoothing over, power or dominance, compromise or negotiation and collaboration.

4.0 CONCLUSION

In today's health-care environment, conflict abounds as the individuals in the health industry have their own opinions about how to handle the many challenges that lie ahead as a new health-care system emerges.

METHOD	RESULTS	APPROPRIATE	INAPPROPRIATE	SKILLS REQUIRED
Denial or withdrawal	Person tries to solve problem by denying its existence; results in win-lose	When issue is relatively unimportant; when issue is raised at inopportune time	When issue is important; when it will not disappear, but will build to greater complexity	Judgment of what is needed in the situation
Suppression or smoothing over	Differences are played down; results in win-lose	Same as above; also when preservation of relationship is more important than issue	When evasion of issue will disrupt relationship; when others are ready and willing to deal with issue	Empathy
Power or dominance	Authority, position, majority rule, or a persuasive minority settles the conflict; results in win-lose	When authority is granted by one's position; also when group has agreed on method of decision making	When those without power have no means to express their needs and ideas, especially if this lack of opportunity has the potential of future disruption	Decision making; running effective meetings
Compromise or negotiation	Each party gives up something in order to meet midway; result in some loss of each side's position	When both sides have enough leeway to give; when resources are limited; when win-lose stance is undesirable	when original Position is inflated or unrealistic; when solution must be watered down to be acceptable; when commitment by both parties is doubtful	Attentive listening and paraphrasing; problem solving
Collaboration	Individual abilities and expertise are recognized, each person's position is clear, but emphasis is on group solution; result in win-win	When time is available to complete process; when parties are committed to and trained in use of process	When time is limited; when parties lack training in or commitment to collaborative efforts	Attentive listening and paragraph; problem solving

VARIOUS METHODS OF CONFLICT RESOLUTION

5.0 SUMMARY

In this just concluded unit, you learnt about various means of conflict in the health care delivery system and the likely ways of resolving these conflicts but it is important to know that conflicts abound in any organization and managers should know how to contain conflicts.

6.0 TUTOR- MARKED ASSIGNMENT

1. Why should there be conflicts among the professionals in health industry in Nigeria?
2. If there is intra-professional conflict in your department, how will you resolve it?

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UNIT 6 STAFFING MODULES AND MODIFIED APPROACHES TO STAFFING AND SCHEDULES

CONTENTS

1.0 Introduction
2.0 Objectives
3.0 Main Content
- 3.1 Cyclic Scheduling
  - 3.1.1 Advantages of Cyclic Scheduling
- 3.2 Staff Policies
- 3.3 Modified Approaches to Staffing and Scheduling
  - 3.3.1 Modified Work Weeks
    - 3.3.1.1 The 10-Hour Day
    - 3.3.1.2 The 12-Hour Shift
    - 3.3.1.3 The Weekend Alternative
    - 3.3.1.4 Team Rotation
    - 3.3.1.5 Premium Day Weekend
    - 3.3.1.6 Premium Vacation Night Staffing
  - 3.3.2 Advantages
  - 3.3.3 Disadvantages

4.0 Conclusion
5.0 Summary
6.0 Tutor- Marked Assignment
7.0 Reference/Further Reading

1.0 INTRODUCTION

This unit will expose the students to cyclic scheduling used in the hospital as the arrangement of the hospital is such that it has to open to consumers for 24 hours. You will also learn about the advantages or this method in the unit.

2.0 OBJECTIVES

At the end of this unit, you will be able to:

- Explain what cycling scheduling of staff is
- List five (5) advantages of this method
- Discuss various ways of establishing staff policies
- Explain the various modified approaches to staffing and scheduling and state the advantages and disadvantages of flexible staffing

3.0 MAIN CONTENT

3.1 Cyclic Scheduling

Cyclic scheduling is one of the best ways of staffing to meet the requirements of equitable distribution of hours of work and time off. A basic time pattern for a certain number of weeks is established and then repeated in cycles.

3.1.1 Advantages of Cyclic Scheduling

1) It is a relatively permanent schedule, requiring only temporary adjustments.
2) Workers no longer have to live in anticipation of their time off-duty, as it may be scheduled for as long as six months in advance.
3) Personal plans may be made in advance with a reasonable degree of reliability.
4) Requests for special time off are kept to a minimum.
5) It can be used with rotating, permanent or mixed shifts and can be modified to allow fixed days off and uneven work periods, based on personnel needs and work period preferences.
6) It can be modified to fit known or anticipated periods of heavy workload and can be temporarily adjusted to meet emergencies or unexpected shortages of personnel.

Cyclic scheduling is relatively inflexible and only works with a staff that rotates by policy and personal choice. An infinite number of basic cyclic patterns can be developed, tailored to suit the needs of each unit. The patterns should reflect policy, work load factors and staff preferences, staffing board may be used to develop a pattern and cycle satisfactory to them.

Patterns should be reviewed periodically to see that they meet the purpose, philosophy and objectives of the organization and the divisions that they are practical with regard to the numbers and qualifications of personnel, that they are meeting patient needs, and that they are using people effectively.

Scheduling records should be retained for a specific time, probably one year. They provide valuable statistical information for planning staffing as well as historical information for questions related to personnel on duty when specific events occurs.

3.2 Staff Policies

Staffing policies should be established such as:

1) Personnel are scheduled to work their preferred shift as much as possible.
2) Personnel choices are balanced to meet the needs of the units and other employees.
3) An employee is allowed to make his/her own arrangements for special time off or exchange within specific personnel policies.
4) Policies have been established for making schedule changes.
5) Each employee has a copy of his or her work schedule.
6) Consideration has been given to staffing during hours of clinical experience for students.
7) There is a weekend and holiday schedule policy. It is a common practice to plan alternate weekends off for shifting personnel. Weekend overage can be by weekends only employees, staffing levels needed can be influenced by hospital policies on admissions and discharges and weekend staffing policy.

3.3 Modified Approaches to Staffing and Scheduling

Many different approaches to staffing and scheduling are being tried in an effort to satisfy the needs of employees and meet workload demands for patient care. These include game theory, modified work weeks (10 or 12- hour shifts), team rotation, premium day, weekend staffing and premium vacation night staffing. Such approaches need to support the underlying purpose, mission, philosophy, and objectives of the organization and the division and should be well defined in a staffing philosophy and policies.

Shift has to be staffed and patient care needs met. The successful hospital executive will try to accommodate both by using the best administrative staffing methodologies available. It must be considered from the economic or cost/benefit view point.

Staffing and scheduling are reasons for turn-over and retention. Understaffing has a negative effect on staff morale, delivery of quality care and the hospital practice modality. It can close beds; it causes absenteeism from staff fatigue, burnout and professional dissatisfaction. On the other hand, the managers want to receive value for their money. There are economic constraints that are further stretched by the costs of recruiting, hiring and orienting new workers and for overtime and temporary hires when the environment creates turnovers and absenteeism. Overstaffing is expensive and has a negative effect on staff

morale and productivity. Staffing and scheduling must balance the personal needs of workers with the economic and productivity needs of organizations.

3.3.1 Modified Work Weeks

Modified work week schedules using 10 and 12- hour shifts and other methods are commonplace. An administrator should be sure they are fulfilling the staffing philosophy and policies, particularly with regard to efficiency. Also, they should not be imposed upon the hospital staff but should show mutual benefit to employer, employee and ultimately the clients served.

3.3.1.1 The 10-Hour Day

One modification of the work week is four-10-hour shift per week in organized time increments. A problem of this model is time overlaps of 6 hours per 24 – hour day. The overlaps can be used for patient – centered conferences, care assessment and planning and staff development. Also, the overlap can be scheduled to cover peak workload hours. Peak workload demands can be identified by observation; consensus or self recording by professionals. It can be done by hour or by a block of 3 to 4 hours.

Longer work days can decrease overtime because of overlapping shifts. Absenteeism and turnover are decreased because workers have more days off. All of these factors decrease costs. Such a system can increase staffing needs if mechanisms are not used to maintain productivity. Some organizations use a 7 – days – off schedule but only pay for 70 hours in two weeks.

The 4-day, 10 hour work schedule for night workers was studied in a hospital that had difficulty recruiting qualified professionals to the night shift. It had been perceived that 10 – hour shifts had stabilized staffing in intensive care with increased productivity and decreased turnover.

Turnover on the night shift had been 70 per cent for an 8 – month period. Positions stayed vacant longer than for other shifts and sick time was higher. This increased recruitment and orientation time. Workers were involved in planning the 4 – day, 10 – hour night shift schedule. Night workers agreed to use overlap hours to assist with day shift care. The day shift agreed to reduce staff by one FTE. This resulted into reduced sick time on the 10-hour shift, reduced turnover, increased incentive, and increased requests for night shift and decreased labour hours.

3.3.1.2 The 12-Hour Shift

A second scheduling modification is the 12- hour shift in which the workers work seven shifts in 2 weeks; three on, four off; then four on, three off. They work a total of 84 hours and are paid 4 hours overtime. Twelve- hour shifts and flexible staffing have been reported to have improved care and save money because workers can manage their time and personal lives better.

Vik and Mackay reported a study of the quality of care by nurses who worked 12-hour versus 8 – hour shifts. It was a matched study of three units each.

The quality patient care scale was used as the measuring instrument. The quality of care received by patients on the 8-hour shift units was significantly higher than that received by patients on the 12-hour shift units. Shift patterns worked by nurses do affect the care received by patients. However, recruitment and retention of workers can balance out reduced quality of care when vacancies are high. There is a break-even point for costs. It is the point at which recruiting, absenteeism, retention and overtime cost savings equal the shift losses from 12-hour scheduling.

3.3.1.3 The Weekend Alternative

Another variation of flexible scheduling is the weekend alternative. Nurses work two-12-hour shifts and are paid for 40 hours plus benefits. They can use the week to go to school or for other personal needs. There are several variations of the weekend schedule Monday through Friday while they have all weekends off.

3.3.1.4 Team Rotation

This is a method of cyclic staffing in which a working team is scheduled as a unit. It would be used if the team working modality were being practiced by a team.

3.3.1.5 Premium Day Weekend

This is a scheduling pattern that gives a worker an extra day off -duty called a premium day. If he or she volunteers to work one additional weekend beyond those required by the worker a premium day off for every additional weekend worked beyond those required by the worker policy. This technique does not add directly to hospital costs.

3.3.1.6 Premium Vacation Night Staffing

This follows the same principle as premium day weekend staffing; it is a policy of giving an extra five working days of vacation to every worker who works a permanent night shift for a specific period of time like 3 months, 4 or 6 months. This would be in addition to regular vacation time.

A study by Imig, Powell and Thorman indicated that while flexible staffing filled vacant positions, it did not increase pay roll costs, hours per patient day, or overtime and decreased absenteeism by 60%. The hospital in this study turned to 8 -hour shifts because primary nursing was threatened. In this particular study there was no change in medication errors, patient and staff injuries, and quality of care plans, complaints, recruitment and staff attitudes for 6 months after flexible staffing.

3.3.2 Advantages

- Flexible scheduling accommodates the workers' personal lives better.
- Gaining more control over the workers work environment
- Transportation becomes more efficient and feasible
- Employees having better control of work activities

3.3.3 Disadvantages

- Minimum weekend staffing or excess staff on weekends
- Unsafe travel times
- Shift overlaps that decrease total number of ‘on duty’
- Cost for overtime
- Fatigue
- Strain on family life
- If the schedule is not carefully planned, the loss of shifts can require increased staffing.
- State law may require overtime pay for hours worked in excess of 8 in a day and 40 in a week.
- Less continuity of care.

4.0 CONCLUSION

The cyclic schedule of the hospital and the workers need to be guided by the policies of the hospitals so as to achieve the intent of the hospitals maximally.

5.0 SUMMARY

In this unit, the learner has been exposed to what staff scheduling is, the advantages and on what staff policies of the hospital are based upon.

6.0 TUTOR -MARKED ASSIGNMENT

What is the relevance of staff scheduling to the goals of the hospital?

7.0 REFERENCE AND OTHER RESOURCE

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UNIT 7 STAFFING THE HOSPITAL UNITS

CONTENTS

1.0 Introduction
2.0 Objectives
3.0 Main Content
    3.1 Staffing the Units
        3.1.2 Complementary Personnel
        3.1.3 Float Personnel
    3.2 Deployment of Staff to a Unit / Department
    3.3 Staffing Schedules
4.0 Conclusion
5.0 Summary
6.0 Tutor- Marked Assignment
7.0 References/Further Readings

1.0 INTRODUCTION

The last unit looked at the recruitment process into the hospital in order to have a safe staffing in the organization.

This unit will now build on the previous unit especially exploring the way staff recruited will be deployed for their primary assignment so that they can meet the needs of the consumers for if there is problem in deployment of staff to the right place of work, then the goals of the hospital will not be met.

2.0 OBJECTIVES

At the end of this unit, the learner should be able to:

- Explain what staff orientation is
- Describe what deployment of staff is
- Discuss how units in the hospital can be staffed.

3.0 MAIN CONTENT

3.1 Staffing the Units

Each unit of the hospital is expected to have a master staffing plan which should include the basic staff needed to staff the unit each shift. Basic staff is the minimum or lowest number of personnel needed to staff a unit. It includes fully oriented, full and part-time employees. The

number may be based on examination of previous staff records and the expert opinion of the managers. It includes all categories of staff for each shift.

3.1.1 Core Staff

Estimating a core staff per shift i.e. there are essential staff in each unit / department of the hospital in which if these sets of staff are not available, the day to day running of the activities of the units / departments would ground to a halt; they are the movers and shakers of the units, the nucleus staff. The hospital management will need to estimate these core staff of the department and ensure that they are available per shift.

It is also essential to note that the hospitals are run like a cycle and a system in which all the departments are interdependent and interrelated. Hence a particular department in a shift whose core staff are not available will affect negatively the performances of other departments/units.

3.1.2 Complementary Personnel

These are scheduled as an addition to the basic group but the total number in both groups is controlled by financial resources and the availability of personnel. They provide the flexibility needed to meet short -range and unexpected changes.

Complementary personnel are not ensured a permanent pattern and are usually scheduled for 4 -week periods.

3.1.3 Float Personnel

These are employees who are not permanently assigned to a station. They provide flexibility to meet increased patient loads as well as unexpected personnel absences. The number and kinds of float personnel can be accurately determined from general monthly records that show absence rates, personnel turnover and fluctuations in patient care workloads. Float personnel may be assigned to a pool.

Some administrators do not hire part-time personnel. They may be an economic or cost-control factor in staffing since they usually do not receive some benefits as full-time personnel. Part-time personnel will be better motivated if they receive some benefits, such as a number of holidays and vacation days proportionate to days worked and pay increases when they complete the aggregate days worked by full -time

personnel. Their total hours worked can be controlled to fill actual shortfalls.

Whatever the staffing policy, it should be arrived at through consultation with clinicians.

3.2 Deployment of Staff to a Unit / Department

The health worker is assigned to the specific unit / department where further orientation to her specific job is undertaken. Deployment to the specific unit should be based on qualification and needs for example; a specialist in A & E will perform better and be more relevant in the A & E / Casualty Unit than in a medical ward.

The deployment will also be done in such a way that there is even distribution and adequate mix of the staff. The worker is well informed in the department and also knows about how the unit is run, specific methods of practice and communication system.

3.3 Staffing Schedules

A substantial portion of hospital beds are in institutions that are in multiple hospital systems having varying degrees of formal linkage. Relatively few core teaching hospitals are part of such systems, but they do share strong relationships with their parent medical schools and affiliated hospitals. The missions of core teaching hospitals are patient care, education and research. The traditional affiliation arrangement between hospitals permits the parent university to achieve these missions.

The possible benefits to be gained through participation in a multiple hospital system do not appear to be of sufficient magnitude to either core teaching hospitals or their parent universities to persuade them to join or form such a system.

The number and types of multi-institutional arrangements among health care facilities are on the increase and the days of the completely autonomous, independent hospital are coming to a close. Although by themselves hospital systems are no panacea for dealing with the challenges facing hospitals today, many such arrangements offer more opportunities than problems in coping with rapid changes currently facing the health care industry.

For every health institution, the staffing must be comfortable so that all the shifts can be adequately covered. Some pertinent questions should be raised when considering the schedules in the interest of patients:

- Who is responsible for original scheduling or daily adjustments?
- For what period of time will schedule be prepared? 1, 2, 4 or 6 weeks?
- How far in advance will staff know their work schedule?
- Will there be an adjustment in staffing based on the identification of patient needs.
- Will there be shift rotation?
- If there is shift rotation, how often, daily, weekly or monthly?
- How often are weekend off guaranteed?

Whatever method / strategy is adopted, all efforts must be geared towards adequate coverage of every shift to ensure delivery of quality nursing care.

4.0 CONCLUSION

Staffing the various units / departments in the hospital is essentially the responsibility of the Hospital Administrator / Manager and that is why he / she has to be versatile in his dealings. He must carefully select the needed staff without undue influence or else the whole arrangement will collapse because the hospital operates as a system.

Since the number and types of multi-institutional arrangements among health care facilities are on the increase in order to meet the ever increasing changing demands of the society, which now makes the need of schedule of staff to be clearly stated so that the staff will be able to operate in an atmosphere of clarity and cohesiveness.

Shifts have to be staffed and patient care needs are met hence the skilful and intended successful manager would have to accommodate both adequate staffing and scheduling by using the best administrative staffing means available.

5.0 SUMMARY

We have looked at how hospital units and departments are staffed in this unit considering various needs of the units and departments because the needs of these units and departments determine staff deployment. The learner has been exposed to various modified approaches to staffing and

scheduling including the advantages and disadvantages of flexible working hours of the workers.

6.0 TUTOR- MARKED ASSIGNMENT

As a manager, in order to deploy staff to your various units / departments, what are your considerations? Critique the various modified approaches to staffing and scheduling in the hospital set up.

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UNIT 8 TEAM- BUILDING IN SHIFTING SYSTEM

CONTENTS

1.0 Introduction
2.0 Objectives
3.0 Main Content
    3.1 Team- building
    3.2 Types of Team
    3.3 Ingredients for team -building
4.0 Conclusion
5.0 Summary
6.0 Tutor- Marked Assignment
7.0 References/Further Readings

1.0: INTRODUCTION

Shifting system requires that the outgoing officers properly hand over both in writing and verbally to the in-coming officers. This unit will look at team- building in shifting system as it is an essential part of achieving the best in shifting system.

2.0 OBJECTIVES

At the end of this unit, the learner should be able to:

- Explain the concept of team-building
- List the types of teams in any organization
- Discuss the basic ingredients for team-building.

3.0 MAIN CONTENT

3.1 Team-building

A team is when two or more people interact and influence each other towards a common purpose. The development of a team and team work does not just happen because a group of individuals happens to work together. There are certain factors that determine whether work groups be they staff members at a meeting or a team working on an assignment.

Members of a team choose to be team players. They work together because they are willing to assist each other and operate under a set of common rules. Team players fully participate in work planning and problem solving and positively confront conflict. The work groups in

the hospital shift system are composed of human beings and therefore, can be considered as organic. To function fully as a team, they must mature. In order that any work group may become a team, all the team players (i.e. all the members of health team) must be conscious of how groups function.

Team-building deals with looking at the individuals in the groups. It also represents an approach to enhance the overall performance of the work group, and the ability to make the group participate effectively in the change process. Team-building deals with facilitating the work group to appreciate that much more can be accomplished if they work together as a team. In team-building the goal is to get the sum of the parts that is greater than the ordinary product of the sum of the parts. It seeks to emphasize the synergy in efforts.

There are two sets of functions that operate interactively within a group at all times. One set of functions focuses on the tasks of the group, that is, the actual work being done by the group. The other set of functions deals with the personal relations among group members and serves to maintain the group process while tasks are being performed. These functions include such activities as encouraging others to speak or making sure everyone has the necessary information. While the leader of the work group has responsibility for these functions, so do the members of the group.

To reach optimal levels of team development, groups must pass through several stages of development. Each developmental stage integrates specific task functions with personal relations processes. For example, when groups first form, group members often feel dependent on others for information. As a result, to reach the next stage of development, orientation must occur. In a similar fashion, each stage of development is illustrated by a type of personal relation and the task function necessary for movement to the next stage. Optimum team development is characterized by interdependence and mutual problem solving.

While reaching optimum team development is a goal, it is not always achievable. As new members (such as new employees transfer) are introduced into the work group, the dynamics of the group may change and the group may regress to an earlier stage of development. However, effectively functioning work groups continually reach for optimal team development (team work). The ability of a work group to be successful in becoming a team is contingent upon its members becoming team players, no matter what the stage of development.

Every team player in a shifting system must have:

- A clear understanding of and commitment to the goals of the work unit, that is, developing quality patient care, however, that may be defined in the organization.
- Access to the knowledge, skills and expertise of fellow colleagues such as sharing patient information informally or in a staff meeting.
- A willingness to trust others
- A commitment to clearly and directly communicating work group problems.

3.2 Types of Team

Traditionally, two types of teams have existed in organizations: formal and informal. Today, however, teams exist that have the characteristics of both.

The formal teams or groups are created deliberately by managers and charged with carrying out specific tasks to help the organization achieve its goals. The most prevalent type of formal type is the command team, which include the hospital manager and all employees who report to him. In some organizations, that want to de-emphasize hierarchy, the titles may change.

Another type of formal team is the committee, which generally lasts a long time and deals with recurrent problems and decisions. For instance, the hospital system has various committees charged with various responsibilities, the members of the committees may come and go, but the committees remain in place over time.

The informal teams serve four major functions; they maintain and strengthen the norms i.e. expected behaviour) and values their members hold in common, they give members feelings of social satisfaction, status and security, they help their members communicate and they help in solving problems within the groups. The informal groups may also act as reference groups i.e. groups that we identify with and compare ourselves to.

3.3 Ingredients for team-building

Team-building requires some ingredients. The ingredients are particularly more important when it is realized that we have to not only build teams but also sustain the team spirit.

(a) Respect for the individuals that make up the team: where the identity of the group members are obvious especially differences in profession as we have in the health sector, respect for the

profession of other team members will encourage trust among the team members.

(b) Communication: Communication is the means by which people are linked together in an organization. Where there is openness in communication, there is consultation with others and actions of the team leader agree with communication, threats and fears will be removed from the team.

(c) The personal disposition of the team leader and team members: Where the team leader is very disposed to consultation, he will most likely promote the team spirit. Also, where team members are disposed to listening to other people's views before taking decisions, then the team spirit is well embraced.

4.0 CONCLUSION

It is essential that in team work, optimum levels should occur. Hence the team members need to be flexible and sensitive to the needs and feelings of others. Involvement and creativity are maximized through participation. In a service industry like health care, organization goals must always be at the forefront. A strong sense of belonging to a team encourages the attainment of those goals.

5.0 SUMMARY

In this unit, the learner has gone through team-building approach in any organization especially where shifting system operates and the ingredients that enhance team-building.

6.0 TUTOR- MARKED ASSIGNMENT

Discuss why team-building is important in shifting system in any hospital.

7.0 REFERENCES/FURTHER READINGS

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UNIT 9 CHANGING SHIFT SCHEDULES

CONTENTS

1.0 Introduction
2.0 Objectives
3.0 Main Content
    3.1 Changing Shift Schedules
4.0 Conclusion
5.0 Summary
6.0 Tutor- Marked Assignment
7.0 References/Further Readings

1.0 INTRODUCTION

The previous unit had looked into the negative effects of frequent shifting system. We shall now look at the changing shift schedules in this unit as considering the nature of health services which have to be run for 24 hours. Shifting system can not be undermined.

2.0 OBJECTIVES

At the end of this unit, the learner should be able to:

- Review the negative effects of frequent shifting.
- Discuss the changing shift schedules of the health workers.

3.0 MAIN CONTENT

3.1 Changing Shift Schedules

Working outside normal hours either by extended days or shift work is a fact of industrial society. Its economic advantages must be weighed against the detrimental effects on the individual worker in the form of circadian rhythm disturbance, poorer quality and quantity of sleep and increased fatigue. The link between shift work and increased cardio-vascular morbidity and mortality has strengthened in recent years.

Due to several problems resulting from frequent shifts and long hours work especially that most workers are aging, the managers are now looking at a way of modifying shift schedules in order to encourage the workers so that the work d6not suffer and at the same time the workers' social and domestic responsibilities do not paralyze to make them responsible in the society.

The care for an association with gastro-intestinal disease remains quite good. Evidence of poorer work performance and increased accidents, particular on the night shift, is persuasive, although individual factors may be as important as workplace factors. Correct shift work scheduling is important and for rotating shifts, rapid forward rotation is the least disruptive option. The compressed working week of 10 to 12 -hour shifts is gaining popularity unit evidence is too scanty at present to suggest there are many long-term health and safety risks provided the rest day block is preserved. The inherent conflict between the interest of the worker and the enterprise over unsocial hours can be mitigated by improvements in working conditions especially at night and by advice to the worker on coping strategies.

Three main problems that are interrelated emanate from frequent shifting system such as biological, medical and social, some of these problems are relatively avoidable while others are considered to be more basic but some of these problems can be solved by changing the type of shift system, re-scheduling of shift and the counselling of individuals involved in shifts.

Night work and shift work are related to a wide range of health effects, the evidence for the risk of cardiovascular morbidity being the strongest. Insufficient or poor sleep, related to insufficient recovery, can be a common pathway from long work-hours, shift work, and work stress to cardiovascular illness. The most promising work-time related means for decreasing the psychosocial workload and negative health effects of work hours would be to regulate overtime and excessive work hours, increase individual work time control and increase recovery from the introduction of sleep-promoting principles into shift rotation.

Change from an 8-hour shift to a 12-hour shift has effect on sleep schedule, sleepiness, performance, perceived health and well being as working the shorter sequences of the work days has positive effect on the shifting workers, the longer sequences of consecutive days off, the fewer types of shifts (easier planning) and the elimination of quick changes although these may differ in groups with a higher work load.

In order to decrease as much as possible physiological, psychological and social problems connected with shift work, the working hours should be organized to take account of shift workers' tolerance to shift work. When recruiting new shift worker, certain personal characteristics that make work in any shift work system in advisable should be checked. As shift work can be considered to be an additional load, shift workers' health requires regular checking-up. If there are signs of health impairment, the workers should be removed from night shift work

permanently or at least temporarily. The shift workers' free time should be arranged so as to facilitate recovery from shift work, especially after night shift. To decrease the work load during the night shift, if possible, workers should be given opportunity to take naps during work.

There must be a special consideration by the hospital managers to ensure that adequate shift staffing, and staff mix are done in order to reduce the work load on the few individuals that may be on shift duty although this will have effect on the economy of the management because in shift work a higher number of staff is required to meet all the shifting hours and not only that, that adequate staff mix is done so that all required personnel are available at each shift.

Changing shift schedules from a full-day to a half-day shift before a night shift has more effect on the physical activities and sleep patterns of married shift workers than single workers as the duration of sleep before a night shift of married workers will be significantly shorter than that of single shift workers due to their family / home responsibilities as these workers are more likely to feel sleepy at work and are more likely to have work-related accidents and sick leaves but when their shift is rescheduled to suit them they will have enough time to sleep before work, enough time for meeting their family / home responsibilities and they will be effective at work as they will keep awake.

There are effects of a one hour delay of shift starting times on sleep and alertness in younger and older shift workers, in a rescheduling a three shift system designed to improve sleep before the morning shift, and alertness during the morning shift, by delaying shift start and end times a change of as little as one hour in shift starting times can improve morning shift sleep and alertness, but there are trade offs from these improvements in terms of night shift effects and social considerations. It seems, then, that optimal shift start and end times for an entire organization are difficult to institute on a wide range but tailoring shift schedules to subgroups within an organization is suggested.

4.0 CONCLUSION

Shift work is related to problems in sleep, wakefulness and social life. The effects of a very rapidly forward rotating shift system on sleep, health and well-being are essential to hospital managers so the managers should look into the rescheduling of shifts for the workers for the benefits of both the workers and the employers.

5.0 SUMMARY

This unit has presented to you the necessity of changing shift schedules if the workers and employers will interact maximally and positively.

6.0 TUTOR- MARKED ASSIGNMENT

Why do you think changing shift schedules is beneficial to both employees and employers?

7.0 REFERENCES/FURTHER READINGS

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UNIT 10 THE NEGATIVE EFFECTS OF FREQUENT SHIFTING

CONTENTS

1.0 Introduction
2.0 Objectives
3.0 Main Content
    3.1 The Negative Effects of Frequent Shifting
4.0 Conclusion
5.0 Summary
6.0 Tutor- Marked Assignment
7.0 References/Further Readings

1.0 INTRODUCTION

The essence of shifting system in any service organization especially hospital is for the consumers (clients / patients) to get health care anytime and uninterrupted for 24 hours. But as good as the shifting system is, there are inherent problems especially where the shifting is frequent for the service providers. This unit will look at the negative effects of frequent shifting system especially in Nigeria.

2.0 OBJECTIVES

At the end of this unit, the learner should be able to:

- List the reasons why there will be a frequent shift in a hospital
- Discuss the negative effects of frequent shifting of the health workers.

3.0 MAIN CONTENT

3.1 The Negative Effects of Frequent Shifting

There are several reasons why shifting in the organization especially hospital may be frequent. These include underemployment, unemployment, budget deficit, lack of workers' motivation leading to resignation of the workers *en mass*, instability of hospital policies, harsh hospital environment, lack of interpersonal relationship, intra and inter conflicts etc all this will lead to shortage of staff and since all the 24 hours of the day must be covered then the few available workers would be over worked; hence there will be frequent shifting of the staff.

It has been discovered that if shifting is too frequent, it has negative effects on both the employer and employees. Some of these negative effects are:

(a) Shift length as a determinant of retrospective on-shift alertness: The combined effects of shift length (8 versus 12 hours) and night-to-morning-shift change over time on retrospective on-shift alertness. The 8-hour workers would have higher levels of alertness than longer hours of work. The effects on alertness can be explained in terms of differences in elapsed time on duty, sleep duration, sleep disruption and chronic fatigue.

(b) Age of the workers and adjustment to night work: Age is significant to performance especially in shifting work; age is significantly related to the adjustment to night work. Age is also significantly related to an increase of alertness and to the feeling of being refreshed after the day sleep. Aging decreases the ability to recover after several but not after the first night shift. The younger the workers in age, the better.

(c) "Burnout" of the shifting workers: The hospital workers that have frequent shifting experiences burnout situation especially working in a very busy departments like intensive care unit, Accident & Emergency department etc. The individual is being over worked over a period of time and then become unable to continue working because of tiredness, illness, unable to think of any new ideas or emotional exhaustion.

(d) Role conflict, job dissatisfaction and psychosocial work environment: The shifting workers in the hospitals are at high risk of burnout, role conflict, and job dissatisfaction especially where there psychosocial work environment is not stimulating where they experience both psychological -emotional and physical stress couples with a frequent shifting.

(e) Sleep disorders in a frequently shifting worker: Irregular work schedules often results in a disruption of the normal circadian rhythm that can cause sleepiness when wakefulness is required and insomnia during the main sleep episode. Working on a rotating day time shifts causes significant sleep disturbances. As consequences, these workers are more likely to feel sleepy at work and are more likely to have work-related accidents and sick leaves.

(f) Effects on Psychological health of the workers: There is impact of frequent shifting on the psychological health of the workers. There supposed to be the improvement in psychopathological symptoms at the end of the shift cycle with the favourable psychological attitude of workers in the perspective of time off but the reverse is the case since the shift is frequent and no or enough time off duties.

(g) Shift work-related problems: Effects on subjective symptoms, physical activity, heart rate and sleep may be experienced on frequently shifting workers as there will be lower levels of sleepiness, difficulty in concentration, fatigue, physical activity and the heart rate especially where appropriate counter measures are not taken during and after the extended shift.

(h) Increased workload: Where there is shortage of staff which eventually leads to frequent shift then the work load of the few available workers will definitely increase.

(i) Domestic responsibilities and frequent shift work: These workers are being partnered and having dependents and they need to meet up their domestic responsibilities. Unpredictable and frequent internal shift rotations including night duty which are traditional and typical in hospitals are inimical to maintaining workers' health.

(j) Shift work and health: Frequent shift work in particular night work causes disruption of biological rhythms, perturbation of social and family life with a negative influence on performance efficiency, health and social well-being. Deterioration of health can manifest in the short-term as sleep disorders and accidents, in the long term there is an increased risk of gastrointestinal, psychoneurotic and cardiovascular diseases and impairment of the reproductive function.

(k) Absenteeism among the shift workers: Due to frequent shifting especially night duty may lead to sickness and hospital admission eventually to absenteeism at work either justified or unjustified especially when some social needs / responsibilities more serious problems than sickness absences must be met.

(l) Effects on the diet and gastrointestinal complaints: Several works in the hospitals are connected with shift and night work. Shift work can be responsible for some gastrointestinal disturbances such as heartburn, dyspepsia loss of appetite, stomach pain etc.

These workers most often consume cold meals and drink more cups of coffee.

(m) Low Productivity: There is no doubt if there are fatigue, increased absenteeism of the workers, sleep disturbance, all these and some others will lead to low productivity of the workers and at the long run affect the performance of the hospital's service delivery.

4.0 CONCLUSION

Occupational health physicians should evaluate workers' fitness for shift and night work before their assignment at regular intervals and in cases of health problems connected with night work. The evaluation should be accompanied by a careful job analysis to ensure that shift schedules are arranged according to ergonomic criteria as this arrangement can reduce health problems and make coping with irregular work hours possible even for people suffering from contra-indicative illnesses.

5.0 SUMMARY

The learner has been taken through the negative effects of frequent shift duty on the workers and the employer. Frequent shifting is not profitable to both the employer and employees.

6.0 TUTOR -MARKED ASSIGNMENT

Using a particular hospital as your case study:

1. What are the reasons for the worker's having frequent shifting?
2. What are the likely effects of this frequent shifting on the workers?

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UNIT 11 THE HOSPITAL MANAGEMENT SYSTEM

CONTENTS

1.0 Introduction
2.0 Objectives
3.0 Main Content
    3.1 Hospital Management System
        3.1.1 Registration
        3.1.2 Billing
        3.1.3 Financial Accounting
        3.1.4 Fixed Assets
        3.1.5 Payroll
        3.1.6 Outpatient Management
        3.1.7 Inpatient Management
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        3.1.15 Service
        3.1.16 User Manager
4.0 Conclusion
5.0 Summary
6.0 Tutor- Marked Assignment
7.0 References/Further Readings

1.0 INTRODUCTION

This unit will expose you to the Hospital Management System where a typical multiple Hospital System (Medinous Hospital Management System (HMS) will be presented to you for proper understanding.

2.0 OBJECTIVE

At the end of this unit, you will be able to:

- Discuss a typical Hospital Management System.

3.0 MAIN CONTENT

3.1 Hospital Management System

Medinous Hospital Management System is powerful, flexible and easy to use and has been designed and developed to deliver real conceivable benefits to hospitals and clinics. And more importantly, it is backed by reliable and dependable Medinous support.

Medinous Hospital Management System -HMS -Solution for Hospitals

Medinous is a Hospital Management System -HMS designed for multispecialty hospitals to cover a wide range of hospital administration and management processes. It is an integrated client server application which uses Visual basic as the front-end GUI builder and Oracle as the database.

3.1.1 Registration

The registration module is an integrated patient management system, which captures complete and relevant patient information. The system automates the patient administration functions to have better and efficient patient care process.

- Patient Registration Details
- Inpatient and Outpatient Registration
- Medical Alerts Details
- Appointment Scheduling (Patient / Doctor wise)
- Doctor's Schedule Summary
- Doctors Daily Schedule List
- Patient Visit History
- Medical Record Movements
- Appointments for Radiology tests and Operation Theatre
- Patient Visit Slip
- Sponsorship Details

It provides for enquiries about the patient, the patient's location, admission, and appointment and discharge details. Furthermore, this system even takes care of package deals for a cost. Medical Record keeps an abstract of clinical data about patients. It allows easy records on patients.

3.1.2 Billing

The Patient Billing module handles all types of billing for long-term care. This module facilitates cashier and billing operations for different categories of patients like Outpatient, Inpatient and Referral. It provides automatic posting of charges related to different services like bed charges, lab tests conducted) medicines issued, consultant's fee, food, beverage and telephone charges etc. This module provides for credit partly billing and can be seamlessly integrated with the Financial Accounting Module. The billing module is extensively flexible by .which each of your billing plans can be configured to automatically accept or deny. The system is tuned to capture room and bed charges along with ancillary charges based on the sponsorship category. The Billing Screens is used for In-patient and Outpatient Billing and Invoicing. Further more the charges for various services rendered can be recorded through service module and this can be used for billing purposes.

- Payment Modes / Details
- Sponsorship Conditions Details
- Patient Billing Details
- Package Installment
- Approval from Sponsor
- Company Sponsorship Details
- Package Registration
- Sponsor Verification
- Retroactive Processing.
- User-defined Billing Cycles
- Automatic Room and Board Charges
- Recurring Ancillary Charge Capability
- Auto-generated Codes and Billing Criteria
- Provision for Pre-billing
- Extensive Third-party Billing

The system supports multiple reports utilizing various print options with user-defined parameters.

3.1.3 Financial Accounting

The Financial Accounting Module deals with Cash Bank, Receipt / Payments, Journal Voucher and General Ledger etc. Books like Cashbook, Bankbook and Ledger book can be generated. This module generates reports like Balance, trial Balance Sheet and Profit and Loss statements. The Financial Accounting screens describe about the

Account Payable, Account Receivable and General Ledger. Also describe the activities related to IP, OP, Bank related activities and provision to clearing the Supplier Invoice and keep track of the Account Receivable and Revenue related activities. The services that are covered by the sponsors, companies, Insurance Agencies, Family Accounts, Individual Accounts, sponsorship details of the patient, Health Card Insurance are recorded in the system.

3.1.4 Fixed Assets

The fixed Assets Module deals with all the activities that are related to the Fixed Assets part of financial accounting. This description included the activities that are related to identifying an item and then allocating depreciation, managing its movement, maintenance, and revaluation.

3.1.5 Payroll

The payment and Personnel module deals with pay (and deduction) calculation, printing of certificates, and PF statements, gratuity statement and provides a monthly analysis and maintenance of employee bio-data, attendance/ overtime details. It also reports on encasements etc. The personal and payroll department is responsible for employee relationship, appointing the staff, maintaining the employee database, fixing allowance and entitlements, leave sanctions, loan termination process, maintenance of hospital document details, tenancy contracts and vehicle registration etc.

3.1.6 Outpatient Management

The outpatient module serves as an entry point to schedule an appointment with the doctor or consultant doctor for medical consultations and diagnosis. This module supports better and timely consultation decision by providing instant access to comprehensive patients' visits which are divided into new, follow-up and review. This module also handles report of laboratory tests and other examination. Some patients may avail only the hospital facilities like lab, radiology, nuclear, physiotherapy and so on.

- Medical Alert Details
- Consultation Duty Roster
- Diagnosis Details
- Triage Details '1
- Patient's Appointments
- Daily / Weekly Schedule Summary

- Appointment Scheduling / Rescheduling
- Outpatient Medical observation Details
- Investigation / Treatment History
- Clinical Services Details
- Group / Packages Registration Facility
- Common Billing Clinical Services
- Doctor's Diagnosis Statistics

Furthermore, confidentiality of doctors' observation, previous history of patients' visits, online request for investigations and so on, are the special features in doctors observation system that calculates the cost for the services rendered to the patient and reflects in appropriately resulting in smooth billing process.

3.1.7 Inpatient Management

The inpatient module is designed to take care of the activities and functions pertaining to management. This module automates the day-to-day administrative activities and provides other modules, which leads to a better patient care. It provides a comprehensive admission of patients and ward management: availability of beds, estimation, agreement collection of advance, planned admission, emergency admission and so on. The inpatient deals with ward management: shifting from one ward to the other, bed available administration of drugs, nursing notes, charge slip and so on.

- Admission cost estimation
- Admission Approval
- Admission request
- Doctor Transfer Details
- Nursing Notes
- IP Medical Observation
- Pending Drug Request
- Surgery Scheduling Details
- Discharge Notification Summary
- Expected Date and Time of Discharge

The module tracks every visit made by the patient and caters to follow-up visits of patient multiple appointments.

3.1.8 Pharmacy

Pharmacy module deals with the automation of general workflow and administration made of a pharmacy. The pharmacy module is equipped

with bar coding facility, which makes medical items to the patient more efficient. This module deals with the activities such as:

- Enquiry
- Quotation
- Purchase order
- Online approval
- Pharmacy drug configuration
- Pharmacy stored configuration
- Drug issues to patients and billing
- Unit dosage facility
- Supplier information
- Maintenance of drug inventory
- Automatic reorder level setting
- Purchase requisitions
- Purchase order
- Online request for stock from various sub-stores
- Online Stock transfer
- Maintenance of stock at different sub-stores
- Return of items nearing expiry
- Destruction of expired items
- Physical stock verification and adjustment
- Goods receipt
- Stock transfer (inter store stock transfer)
- Stock adjustment
- Stock in hand reports

In addition, the online prescription facility assists and facilitates the physicians to the prescription details and as well reflects the medication billing details in the billing module.

3.1.9 General Stores

General stores and inventory module deals with purchase of items, issue of items, main automatic reorder level setting, online request for stock from various sub-stores, online maintenance of stock at different sub-stores, physical stock verification and adjustment, supplier etc.

3.1.10 Laboratory

The laboratory module automates the investigation request and the process involved results to the concerned department / doctor of the hospital. Laboratory module starts online request from doctors and also

allows laboratory personnel to generate request module supports to perform various tests under the following disciplines: biochemistry hematology, microbiology, serology, Neurology and radiology. Tests are grouped under sample type (specimen). Based on the request the user can input the sample number. Results can be entered based on the sample type either to one test or the test result requires approval, the supervisor has to approve the result and it is concerned doctors.

- Sample Result Entry
- Test Association Details
- Specimen Association Details
- Antibiotic Details
- Result Range for Test
- Investigation Request
- Bulk Sample Request
- Sample Details
- Samples Received from External Laboratory
- Samples Dispatch to External Reference Laboratory
- Investigation and Treatment History

Test report can be made confidential. Tests can be performed only after the billing is exempted when the case is declared as urgent. In addition, this module facilitates referral patients.

3.1.11 Radiology

Radiology module caters to services such as X-ray, Scanning, Ultra sound etc. Sched resources is possible. The system stores all the result details of various tests and makes the test results. These tests are carried out both for Inpatient and Outpatient. The system details (like patient number, test report like X-ray, Scanning details) and for each generates a unique number for the image.

Investigations can be done only after the billing is done. This rule is exempted when though as urgent.

3.1.12 Nuclear Medicine

The main function of this module is to conduct the various Tests and make a report of the Results and a unique number is generated for each image. The tests are carried out Outpatient. Appointments have to be fixed by the Patient before the test. The conduct analyses the result and makes a report based on the findings.

3.1.13 Physiotherapy

This module facilitates tracking the services given to patients depending on recommendations. Physiotherapy sessions are carried out both for Inpatient and Outpatient has to be fixed by the patient for these sessions. All the appointments to the Physiotherapy will be through the consultant. These are on appointment.

3.1.14 Dental

Dental module caters for the service rendered by the dentists. Treatment and follow-up is tracked using this module. Progress readings can be recorded through this module.

3.1.15 Service

The service module deals with all the services available in the hospital and the charges are stored through this module. There are various services that are available in the hospital.

Service master: This master gives the details about package details, group details etc.

Room Type master: This gives the details about Room Type (Ex: Private, Semi-private, Suite etc) and their charges.

Consultation Charge master: This gives the details about doctor and the charges; follow-up, review and call-on.

Revenue Type master: This gives the predetermined charges for various service giver (Ambulance, anesthetists' fee, baby cot etc).

3.1.16 User Manager

The User Manager module basically deals with security through controlling the access available in the application. Any user associated with a user group can access only those that the user group has rights. It also deals with the System Related Activity like User Monitor, Group Master, User Master and view the User Group Lookup of employee database company documents, User defined error message, Generating Daily Statistical Summary.

4.0 CONCLUSION

No doubt Medinous Hospital Management System is a solution for hospitals as it is designed for multi specialty hospitals to cover a wide range of hospital administration and management processes.

5.0 SUMMARY

The learner has now learnt the Hospital Management System, what a detailed hospital system should be and when fully operational especially in the teaching hospitals, the service delivery will be easier, accountability can be guaranteed and it will be obvious if some parts of the system are not measuring up to the set standards.

6.0 TUTOR- MARKED ASSIGNMENT

1. What is out-patient management?
2. What does it entail?

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UNIT 12 THE QUALITIES OF HEALTH MANAGER

CONTENTS

1.0 Introduction
2.0 Objectives
3.0 Main Content
    3.1 The Essential Qualities and Characteristics of a Health Administrator or Manager
4.0 Conclusion
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1.0 INTRODUCTION

In a place of work, as one moves up the ladder through promotion or appointment, the possibility of becoming a leader or health administrator becomes higher. However, since there are always few administrative or managerial positions, not everybody can become an administrator. Those who are lucky to reach that level are usually those that have been found to possess certain characteristics and qualities. In a good organization, administrators are usually appointed by going through a process of interview and not handpicked. The person selected might not be the most senior person but by virtue of having certain qualities, the management believes that he / she would perform most efficiently if given the necessary resources and, supported with good policies. The qualities found in the person are expected to help carry out, some defined functions and roles. What are these characteristics and qualities?

The students will be exposed to the qualities the health manager must exhibit in the industry for effectiveness of the hospital and wherever they find themselves so that they can be leaders that achieve.

2.0 OBJECTIVE

At the end of this unit, the students should be able to:

- List and explain the essential qualities of a health manager.

3.0 MAIN CONTENT

The essential qualities of a health manager.

3.1 The Essential Qualities and Characteristics of a Health Administrator or Manager

Health administrators, as a class, whether a young doctor, serving as the head of a local hospital, a public health nurse in-charge of a primary health care facility or an environmental health officer coordinating a national health programme, occupy a strategic position in the health industry or institution. Although experienced, long serving health workers might not find this section as something new but every health administrator needs to be reminded of these basic ideas, which if forgotten or not applied, might prove inimical to harmony and peace in the work environment. Every administrator wants peace to reign in the work milieu but the only way to achieve peace is to deliver the administrative services efficiently in order to meet the expectations of the workers and the management board. The qualities as discussed by Adebayo (2004) are as follows:

Tact: A health administrator must be tactful in dealing with his / her boss and the colleagues. Although an administrator must be efficient and brilliant when dealing with his boss or colleagues, he should avoid being arrogant or pompous. This is very important in every activity, whether in minuting, in submission of a file, in correspondence or during discussion. It is a sign of immaturity for a health administrator to display his wealth of experience or knowledge or the superiority of his education to his boss. A sense of modesty and a habit of courtesy are indispensable assets for a health administrator who wishes to carry along both his boss and colleagues in the fulfillment of the programme objectives. As a top manager in a health facility, it might be suicidal to engage in open confrontation with your boss. Even when you are sure that your boss is wrong, you should devise a subtle way to correct him. This does not imply that you should devise a robot or 'zombie' but you should always avoid being tactless or undiplomatic. In other words, you should always seek to persuade your boss, especially your political boss of the wisdom of your view through courteous and gentle discussion.

Modesty: A health administrator should be modest in everything being done. This implies that he should express a humble opinion of himself or his accomplishments or abilities. He should not be ostentatious, extreme or excessive when dealing with either colleagues or bo**ss**.

Sense of judgment: A health administrator should have a fine sense of judgment. On daily basis, a health administrator is engaged in assignments that require assessment of the degree of urgency, evaluation, weighing of evidence and assessing the mood and temper of those working with him and perhaps his clients. As the overall head or

manager, the accuracy of his judgment is very crucial to address any administrative issue. He should gauge the facts about any issue and tender advice to the department or management in the best interest of the organization and to the best of his knowledge. Before making recommendations or taking decisions, the health administrator should critically analyze the available information, make consultation with relevant individuals or groups and reflect on his professional knowledge and past experience. He should not be in a hurry to dispose of a case and neither should he delay taking action. As people say: justice delayed is justice denied.

Foresight: A health administrator should be able to forecast the probable consequences of measures proposed for policy or guidelines based on his knowledge and experience. He should also be able to predict likely developments that might arise in the work place in the nearest future based on available statistics, a set of factors, circumstances and historical perspectives. For example, the direct or of nursing services should be able to forecast the future rate of utilization of bed in his hospital based on annual statistics that should show the rate of increase annually over a period of time. It is this aptitude that will help him to advise accurately and effectively on the formulation of health policies and plan for the resource needs. This quality is related to the sense of judgment.

Ability to delegate: A good administrator should utilize the human resources available to him to achieve the organization's goals. He should understand the nature of each of his team members, their abilities, and level of resourcefulness, talents and limitations. Based on this, he should delegate work to them either as a group or individual and motivate them to be able to accomplish the task. By inspiring his team members to have belief in themselves and supporting them with technical skills when necessary, the job can be accomplished more efficiently and accurately. The role of the administrator is to give accurate directives and monitor the performance based on objective indices. If a team or individual is found to be inefficient, the administrator should identify the problem, analyze the factors responsible and seek for the best solution instead of taking over the work of the group.

It is a bad administrator that seeks to handle by himself all the essential assignments in the unit or department. This type of practice often leads to bottlenecks, which might cause endless delays and burnout syndrome on the part of the administrator. The end result is that little or nothing will be achieved and the number of complaints from clients and colleagues will be endless. Furthermore, this type of inefficient administrator will leave his subordinates with little activities and thus

deprive them the opportunity to learn and gain experience. In other words, the team members will lack empowerment and professional growth.

Sympathy and consideration: The health administrator should have sympathy for both his workers and clients. Although he should not be soft and spineless, he should have in him some milk of human kindness. This is especially relevant to nursing where most patients / clients and subordinates often complain of the bad treatment often meted out by the nursing sisters, matrons and other nurses. It is a sad development in the history of nursing in Nigeria that to date many nurses still do not see anything wrong in bullying those under them. I once witnessed a situation whereby a nursing sister bullied a male nurse in the presence of his wife, who incidentally was also a nurse in the same hospital. What could have been more derogatory and psychologically traumatic to that gentle man than that! Gush!

A health administrator can be firm and strict and yet be sympathetic and considerate. His role is to inspire and guide his subordinates to give their best. He should cultivate the habit of praising and encouraging their modest effort and when vetting their activities, he should do it with sympathy and consideration. A good administrator should learn to appreciate everybody that works with him in the spirit of team approach. Nobody should be considered to be small or big. In the spirit of primary health care approach, every member of the team is important, including the cleaner, driver, community people and messengers. In fact, experience has shown that it is the weak, inefficient administrator, who has little or nothing to offer as a leader, who bullies his / her subordinates in order to hide his / her inefficiency. If you are sure of yourself, why do you have to abuse or bully people! An efficient administrator who is not arrogant is often respected and honoured by his subordinates because they can fee the impact of his leadership roles in their life as they are mentored to attain high professional goals.

A health administrator should not destroy the initiative and self-confidence of the workers or hurt their feelings for nay reason because human beings are the best resources at the disposal of a manager. Even when they make mistakes, corrections should be done with human face. They should be allowed to grow by learning from their mistakes and should not be shouted down or battered to submission. We should always remember that somebody was in that position before us and one day, we shall also become part of history.

Flexibility and wide range of interest: A health administrator should possess a flexible mind; a mind capable of comprehending enough about

every conceivable subject and interrelating them in clear and logical sequence. The point being made here is that health administrators are not just technical experts or specialists but a seat of wisdom who should be able to recognize the political, socio-economic, financial and practical implications of a situation that presents itself. This point should be taken seriously by doctors and nurses who often think deeply and sometimes obsessively about their particular field that they do not recognize the interaction between their work environment and the remaining segments of the society. This is where lawyers often excel as members of the society. One day, as I was listening to a Radio programme, a lawyer was asked by the presenter why lawyers often refer to their colleagues as learned colleagues and not other members of the other professions, such as medicine and engineering. In response, this barrister explained that apart from the law profession, no other one socializes their members to become an expert in almost all the fields of life. According to him, a lawyer should be able to discuss any case from all the angles like an expert, from medical, to political, to socio-economic angle, etc. According to Adebayo (2004), an administrator should possess the quality of thinking briefly and rapidly about many subjects and their interconnections, of combining political, social and; technical factors into specific judgment for consideration of policy makers.

What this implies is that a health administrator should develop a literary mind and create the habit of reading widely. It is not just the hospital or department that should have a good library but right in his / her home, he / she should own a reasonably good library; find time to buy and read daily and periodic newspapers as well as professional journals.

Imagination and perseverance: A good sense of imagination and perseverance are two essential attributes of a manager. A good administrator should possess the ability of abstract thinking and be able to persevere in any situation no matter how difficult. A health administrator should have the power of rapid analysis. He / she should be able to grasp all the facts in a complicated situation, to sort them out and to set them out in their proper relationship and to summarize them in the fewest possible words (Adebayo, 2004). Other attributes associated with the sense of imagination and perseverance include:

- The capacity to recognize the essential points in a situation however complicated. The sense of timing.
- The capacity to think less in terms of things as they are today but in terms of what is going to happen.
- Ability to show fine discrimination about the points to concede and the points on which to stand firm.

- The capacity not only to understand people but also to lead them -to be the conductor of the orchestra.

Good communication skills: A health administrator should possess the ability to communicate effectively using both verbal and non-verbal methods of communication. He / she must be a good listener and a careful observer.

Sense of humour: An administrator must have a good sense of humour in order to enhance the effect of the communication, create a friendly environment and make the interaction interesting and sustainable without losing the focus or the issues being discussed with the staff or client. Relaxation and sleep and a neat and decent way of dressing: A health administrator should be able to sleep well and relax after a busy day. He must learn not to fret or get rattled over every problem that arises during the day so as to avoid the problem of executive stress which might lead to insomnia and if care is not taken, hypertension. In order to appear presentable, an administrator should develop a neat and decent way of dressing, a dignified and calculated way of speech and always conduct him / herself in a decent manner.

According to Parkinson et al. (1998), the manager or administrator is the dynamic, life- giving element in an organization. His function is to coordinate effort, encourage initiative and keenness, use each man's abilities and develop a dynamic and devoted team that can function as a single entity. He should be endowed with delicate and sensitive perceptions so that he can understand the changing needs of the organization. He should possess knowledge, imagination, insight and foresight. He should have courage and faith. The administrator must be able to define clearly the objectives of the organization and then direct the activities of his men to the attainment of the objectives.

Other characteristics of an administrator or manager discussed by Parkinson et al. include: broad familiarity with the technology being used by the organization, being able to work with people, time management, concentration, practical approach to issues, being able to attempt the impossible, being action oriented, integrity and being able to calculate costs and benefits. Peretomode & Peretomode (2005) listed the essential qualities of a health administrator or manager as follows:

Good human relationship	Intelligent, persuasive and diplomatic	Potential for growth
Accessibility and approachability	Initiative and decisiveness	Ability to make sound professional judgment and suggestions to superiors
Patience, tolerance and endurance	Drive and efficiency	Ability to take suggestions from subordinate
Effective communication skills, including listening ability	Foresight and vision	Willingness to accept criticism and admit mistakes
Good sense of humour, cheerfulness	Flexibility and adaptability	versatility, energetic and enthusiastic
Physical, mental an emotional stability	A democratic attitude, be open-minded	Decisiveness
Honest, reliable and dependable character. Trustworthiness and good integrity	Be polite, courteous, thoughtful and tactful	Assertiveness

It is worthy of note that there are two ways of acquiring these qualities: through formal education and mainly through long-term experience on the job. According to experts in public administration, no person can acquire these qualities without having made himself the master of at least one branch of work.

4.0 CONCLUSION

Every worker even at the lowest level of the ladder, with time and pace will become a leader tomorrow. However, since there are always few administrative positions, not everybody can become a leading administrator and those privileged to become a leader must manifest some characteristics that will make them unique in the organization so that they can successfully lead while others will follow in order to achieve the purpose of the organization.

5.0 SUMMARY

You as the students have been taken through the basic characteristics that a leader or health manager must exhibit and wherever you find yourself as a manager if your worth must be realized and felt by the society where you serve.

6.0 TUTOR- MARKED ASSIGNMENT

List and discuss any five characteristics a health manager must exhibit if he must be a successful manager.

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UNIT 13 INTERPERSONAL RELATIONSHIP IN SHIFTING SYSTEM

CONTENTS

1.0 Introduction
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    3.2 Variables of Interpersonal Relationship
    3.3 Techniques of Interpersonal Relationship
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1.0 INTRODUCTION

Interpersonal relationship is a form of communication which occurs between two people or within a small group. It is often face to face, healthy and most frequently used in hospitals which allows for problem solving, sharing of ideas, decision making and personal growth.

Interpersonal relationship is a major tool for effective Health care delivery encounter with clients such as carrying out any procedure requires exchai1ge of information. The workers understanding of the communication skills will also assist in relating with other staff members who may have different opinions and experiences. A meaningful interpersonal relationship offers a great deal of help by the health worker to a client.

This unit will examine the interpersonal relationship and its effect on the therapeutic management of clients.

2.0 OBJECTIVES

At the end of this unit, the learner will be able to:

- Describe the concept of interpersonal relationship and its application to health care delivery system.
- Discuss the phases of a therapeutic helping relationship.
- Explain the variables of interpersonal relationship and the applied models.

3.0 MAIN CONTENT

3.1 Interpersonal Relationship

Communication begets relationship. Without it, there is no organization as this is the only means of influencing the behaviour of the individual.

Interpersonal communication / relationship goes on directly between individuals (nurse and client), either verbal or non-verbal.

Verbal: Words that we hear or see in writing.
Non-verbal: Sounds, sight, odor and touch.
Pre-verbal: Precedes the ability to form words e.g. screams in babies.

Interpersonal relationship is utilized in nursing activities such as counselling, collecting a blood specimen, taking a medical history, group situations like classroom, committee meeting, intra professional dialogue, with physicians, social workers, therapists and even relatives of patients. These help the workers later to develop an intra-personal thought to develop measures of assisting in the care of the client.

3.2 Variables of Interpersonal Relationship

There are variables in interpersonal relationship. These include referent, sender, message, channels, receiver and feedback. A careful understanding of these (knowing that communication is complex, involving many verbal and non verbal symbols and messages exchanged between persons) is crucial as any slight change or modification can affect the overall expected result.

Referent: This represents the stimulus, which motivates a person to communicate with another. It may be an object experience, emotion, idea or act. It is what ignites the relationship.

Sender: This is the encoder, the person who initiates the interpersonal relationship. The sender now may be the receiver later.

Message: This is the information being sent or expressed by the sender. It must be clear and organized no professional jargon while relating with the patient. If symbols are being used, it must be concise and not mixed up.

Channels: This represents the medium through which it is being sent. This can be auditory, visual and tactile sense. The placing of a hand on an individual while relating depicts the use of touch as a channel.

Receiver: This is the decoder, the one to whom the message is sent. But the receiver and sender have so much in common as they can interchange their roles in the relationship processed.

Feedback: This is the message returned to the sender. It helps to reveal whether the meaning of the message is received.

The nurse in interpersonal relationship with client assumes major responsibility unlike in the social relationship when both persons involved assume equal responsibility for seeking openness and clarification.

3.3 Techniques of Interpersonal Relationship

The workers send messages in the verbal and non-verbal modes, which are closely bound together during interpersonal interaction with clients and relations. During the art of speaking, we express ourselves through movements, tone of voice, facial expressions and general appearance. As the worker learns the skills communication, is also expected to master the techniques, these include:

* *Clarity and brevity*

  Effective communication should be simple, short and direct. Fewer words spoken results in less confusion. A nurse taking patient history starts with bio-data, what is your name? Where do you come from? Because of the variables involved, clarity is required to get the appropriate answer. Using examples can even make an explanation easier to understand. Repetition also makes communication easier. Brevity is best achieved by using words that expresses an idea simply "tell me where you feel the pain most" is better than "describe to me the location of the discomfort." This is necessary especially while eliciting information from patient or relation on arrival at the hospital.

* *Vocabulary*

  Lack of understanding of the sender's words and phrases the receiver can make communication unsuccessful thereby affecting relationship. Nurses should avoid professional jargon while relating with patients as they may become confused and unable to follow instructions. The first expression and outlook can frighten the patient.

* *Denotative and connotative meaning*

  Single words do have different meanings. While denotation meaning is one shared by individuals who use a common language, connotative meaning is the thought feelings or ideas that people have about the word. The expression, of "The condition is serious" may suggest to families that clients are close to death, but a nurse does proper things that way. When nurses communicate with clients, they should carefully select words that cannot be easily misinterpreted. This is important when explaining conditions, treatment, or purpose of therapies to patients and relatives.

* *Pacing*

  Interpersonal relationship gives credence to pace or speed. Talking rapidly, using awkward pauses and speaking too slowly can convey an unintended message. The nurse should avoid awkward pauses during an explanation instead using proper pacing by thinking about what to say before saying it. The nurse should also observe for non-verbal cues from the client that might suggest confusion or misunderstanding.

* *Timing and relevance*

  The nurse must be sensitive to the appropriate time for discussions. The best time for interaction is when a client expresses an interest in communication. Individual's interest and needs are considered alongside with appropriate timing in order to achieve optional results.

* *Humour*

  Humour is a powerful tool in promoting well-being. Laughter helps relieve stress-related tension and pain, increases the nurses effectiveness in providing emotional support to clients, and humanizes the experience of illness. Humour has been shown to stimulate the production of catecholamines and hormones that enhance feelings of well being, improve pain tolerance, reduce anxiety, facilitate respiratory relaxation, and enhance metabolism.

The workers can use humour in conversations with clients by cracking jokes, sharing humorous incidents or situations. This procedure allays the fears of an emotionally grieved and tense patient. Humour opens up a patient to share their grief and be more self-disclosing. It is an

effective approach in helping clients to interact more openly and honestly.

4.0 CONCLUSION

The worker uses skills of interpersonal communication to develop a relationship with clients that allows understanding of them as total persons. This helping relationship is therapeutic, promoting a psychological climate that brings positive client change and growth. The relationship also focuses on meeting the clients' needs. Although the worker is expected to gain much satisfaction from the relationship in order to carry out his expected role to the clients, clients should be the primary recipient and determiners of benefits.

Interpersonal relationship seeks to provide physical and psychological comfort to the client. The worker's action considers the client's preferences. A helping relationship between the worker and client does not just happen; it is built with care as the worker uses therapeutic communication techniques. The characteristics involved in the interaction are trust, empathy, caring, autonomy and mutuality.

5.0 SUMMARY

This unit has examined interpersonal relationship in hospitals with information on variables and techniques of interpersonal relationship.

6.0 TUTOR- MARKED ASSIGNMENT

1. (a) List the six variables of interpersonal relationship.
   (b) List and comment on the importance of the five (5) techniques employed in interpersonal relationship.

7.0 REFERENCES/FURTHER READINGS

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UNIT 14 THE HUMAN ENVIRONMENT

CONTENTS

1.0 Introduction
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3.0 Main content
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    3.2 Types of Environment
    3.3 Effects of Environment on Man's well-being
        3.3.1 Physical environment
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        3.4.2 Structures supporting homeostasis
        3.4.3 Conditions of homeostasis
    3.5 Health worker's responsibility towards promoting a safe environment
4.0 Conclusion
5.0 Summary
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1.0 INTRODUCTION

We have been examining the structure and management of health care delivery for meeting the health needs of man within his environment. This unit will discuss human environment in totality.

Human beings are constantly interacting with their environment. The environment influences human beings and vice versa. The relationship between human beings and the environment is a dynamic one, never static. The environment greatly influences the quality of life one enjoys. People need the environment that they can constantly manipulate so that they can develop their potentials. An environment that stifles may result in abnormal personality. The importance of the environment has been demonstrated in an account of creation. The Garden of Eden provided an environment that was physically pleasing with soil that supported all plants and animals in symbiotic relationship. Adam and Eve provided social supports to each other and were spiritual in harmony with God. Everything was beautiful and peaceful. From this scenario, it could be deducted that the environment assumed the three dimensions of the physical, the psychosocial and the spiritual, the three being inter-related

and inter-dependent. Any disruption in one area would affect the other areas. Adam and Eve's problems started with social disharmony, which affected the other two parameters. One could see the concepts of adjustment and adaptation at work.

What started millions of years ago in terms of equilibrium among the elements in the universe remain with us till today. This unit will discuss the importance of a conducive environment in the promotion and maintenance of good health.

2.0 OBJECTIVES

At the end of this unit, each learner should be able to:

- Define 'environment'
- Describe briefly the components of the environment
- Describe at least two ways by which the environment can affect man's health

3.0 MAIN CONTENT

3.1 Definitions of the environment

The environment may be defined as the aggregate of human beings, things, conditions or influences surrounding human beings. It is all of the many physical, socio-cultural, socio- economic, and physical and psychosocial factors that influence or affect the lives and survival or people. The promotion and maintenance of a wholesome environment is a major concern of most world governments including Nigeria.

A principle concerning human beings and their environment implies that any environmental condition that interferes with the being is a threat to the human organism when he is no longer able to cope with it sufficiently well. Some people tolerate their environment better than others do. Also each individual may experience variations in ability to tolerate certain conditions depending on other factors in the situation. Concern for the physical as well as the sociological environment is global in nature. Nigeria is part of the global movement to make the world a safer place to live in. there is an agency in Nigeria, specifically for responsible for monitoring the environment and implementing measures that would make it safe, the Federal Environmental Protection Agency (FEPA).

Here are some examples that violate a wholesome environment. The human organism enjoys optimum functioning when the air breathed is

sufficiently free of physical and chemical pollutants so that irritation to the tissue is absent or at least negligible. But exhaust fumes from vehicles on our roads cause so much irritation to the eye and respiratory tissues. The noise emanating from music sheds and shops and every residence endanger our hearing mechanism. In recent years, Nigeria and the world population growths, and rural urban migration are leading to unprecedented congestion. Every where is being built up with temporary sheds which often become permanent structures. Human welfare is being compromised due to lack of access to nature and beauty. All these should be of concern to nursing. Instability at the physical level can eventually affect the totality of well-being.

3.2 Types of environment

The environment can be classified into two major types: External and internal. The
External Environment consists of:

- Biological environment, which considers all living things such as plants, bacteria etc.
- Social environment, this is unique to human beings. It is concerned with the relationship between human beings and their environment.
- Physical environment consists of non-living portions of the environment such as air, water and land.

3.3 Effects of environment on well-being

Now that the types of environment are identified, you will now proceed to learn how each type affects the well-being of individuals.

3.3.1 Physical environment

The type of physical environment in which a person lives can lead to an increased incidence or certain health problems. For example, people living in urban areas with heavy industries are exposed to smoke and air pollution. People who live in rural areas are less likely to have this type of health concern, but they may experience other problems such as snake bites, contaminated water supply, and decreased access to healthcare.

The environment may restrict daily activity. The hustle and bustle in our cities has restricted the daily activities of many older adults. This has a negative consequence on the conditions of bones and joints. Women in their post-menopausal years are known to suffer from osteoporosis a result of long-term reduced physical activity.

The environment in which one works and the type of physical activity engaged in, in terms of occupation, affect individual well being. Those who work in a coal mines, cement factories, flour mills, and tobacco factories are subjected to environments that make them prone to lung disease. Those who work in rice paddies (wet land in which rice is grown) are known to be more prone to guinea worm infection. In short, what you should learn from the discussion is that the environment affects the lifestyle of the inhabitants.

3.3.2 Socio-cultural environment

Each culture defines health and illness in a manner that reflects its previous experience. You will recall from the course that culture was defined as the sum of traditions, practices; beliefs and values developed by a group of people and passed on most often by the family from generation to generation. Cultural factors determine which health behaviour people perceive as 'normal or abnormal'. Cultural influence also determines whether or not a person seeks health care, and how a person seeks such care. Health practices are also based on cultural beliefs. Let us look at one or two examples.

You must have heard or read about female circumcision being practiced by some cultural groups in Nigeria. The reason proffered is that it would deter sexual promiscuity as the girls grow up. While there is virtue in discouraging promiscuity, the method being employed has left many women grossly incapacitated for life. What a price to pay for being born into such a cultural environment! Take another cultural practice that forbids meat and eggs to be fed to children because the children will grow up stealing. While the rationale appears to be morally acceptable but the child is being deprived the right to good health through good nutrition from being born into a particular socio-cultural environment.

3.3.3 Socio-economic environment

In many countries of the world, economic status is a major determinant of the quality of the physical and psychosocial environment available to individuals. We see that persons in the low-income group tend to congregate in the crowded inner city slums, where cleanliness and sanitation are poor, air polluted by stench from public drains and Refuse Mountains. All these endanger well-being and often lead to high incidence of communicable and infectious diseases. The picture is more dismal when the people in these areas are outside the health care system because they could not afford the cost of healthcare.

On the other hand, people of high socio-economic status could afford to locate themselves in healthy environments; and could afford good medical care. But in spite of the problems of adjustment and adaptation, human beings continue to find solutions to problems created by his environment.

3.3.4 Spiritual/religious environment

Spirituality refers to person's beliefs about a divine or a higher power or force, and related practices. Religion is an organized system of worship often directed towards the divine being, power or force. Spirituality and religion can affect a person's views of and actions towards health, illness and health care. For example, some religious groups regard illness as a form of punishment from God, and therefore refuse medical treatment or prevented care from being given. Some religious groups ban the use of drugs and alcohol for whatever reason. Being born and socialized into this type of environment means denying oneself or cause to be denied the rights to health care.

Conditions or circumstances in the external environment can be classified as life supporting or as hazardous. On the agents essential to survival are air, water, nutrients and shelter. Other agents favouring survival include people and a variety of other living organisms, from microorganisms to highly complicated multi-cellular organisms of both plant and animal origin. Even essential agents may be harmful when exposure is excessive or unbalanced. As an example, oxygen is required for survival. However, continued high concentrations of oxygen damage the respiratory membrane, and can cause blindness in newborn babies.

You have learnt about the external environment and some of the adverse effects it could have on health. The next emphasis is on the internal environment. By the end of this section you would have come to appreciate the inter-relatedness and interdependency of the external and internal environment; and that Man is not so easily dissected.

3.4 The Internal environment

The environment listed in 3.3 above lies outside the body and is in contact with the skin, mucous, membrane, and the sense organs. The internal environment is made up of the fluid surrounding the cells and carrying material to and from them.

Similar to the dependence of health on stability within the external environment, health is also dependent on the maintenance of relative stability of the physical and chemical characteristic of the fluid

comprising the internal environment. Survival of the cells and maintenance of their functions are dependent on conditions in the cell's immediate fluid environment. It is from this environment that the cell obtains a continued supply of nutrients and into which it discharges its wastes. For all cells, this immediate environment is a pool of water in which a variety of substances such as sodium chloride and glucose are dissolved. For a unicellular organism such as the amoeba, the fluid environment is a pond or puddle of water.

Human beings and other multi-cellular organisms, the fluid environment consists of blood, lymph, and interstitial fluid form the immediate environment of the cells. These fluids are known as the internal environment. The fluids composing the internal environment not only serve individual cells as such, but are the medium by which all body cells are united and affected by the activities of all other cells within the entire organism.

The physiological process which maintains most of the steady states is termed homeostasis, which implies variations within limits as long as the individual is capable of making appropriate adaptations to change.

3.4.1 Maintenance of homeostasis

The maintenance of homeostasis depends on a variety of elements. Substance required by cells must be available in adequate quantities. Material supplies include water, oxygen, and a variety of nutrients, including sources of calories, tissue-building materials, electrolytes and regulators not synthesized or present in the body. The intake, storage and elimination of excess supply are regulated so that the level of each substance is maintained within well-defined limits.

3.4.2 Structure supporting homeostasis

The healthy organism is capable of responding to disturbances in such a manner that damage is prevented or repaired. The kinds of structures that fulfill this function include the following:

- Structure where required substances are absorbed from the external environment and when necessary, modified so that they can enter the internal environment. For example, oxygen is absorbed into the blood unchanged. The air, from which oxygen is taken, however, requires conditioning. Nutrients usually require reduction to simpler forms before they can be absorbed and provision for the elimination of indigestible substances is also necessary.

- Materials enter or leave the external environment through semi-permeable membranes that separate the internal from the external environment. These semi-permeable membranes act to protect the internal environment from too rapid a change or from the entrance of potentially harmful or unusable particles.

- Structures to transport materials from point of entry to cells and from cells to points of elimination or exit such as the heart and blood vessels.

- Structures that store or eliminate excesses of intake and by-products of metabolism. For example, glucose is stored as glycogen in the liver and muscles, much of the excess is stored as fat. Excess sodium is normally excreted in the urine.

- Structures that make movement in the external environment possible. They enable the individual to seek food and water, to alter the environment to suit his needs, to overcome or avoid danger and to find a partner.

- Structures that reproduce themselves to replace worm-out cells, to repair injury or to produce a new organism.

- Structures that protect the organism from injury.

- Finally, structures that regulate and integrate the activities of all individual cells and aggregates of cells so that the organism functions as a whole.

3.4.3 Conditions of homeostasis

Conditions that must be maintained within limits include:

- Osmolality
- Blood pressure
- Cation-anion balance and concentration,
- Hydrogen ion concentration, and
- Body temperature

Conditions in the external environment must be within the limits to which human beings can adapt. For example, the capacity to adapt to extremes of temperature, high altitude, water and food supply, and physical trauma is limited. However human beings are liable to live in some hostile environments the nurse must set exemplary examples by

her personal behaviour. The practice of washing hands thoroughly indicated in order to control the spread of infection. The nurse knows that oxygen supports combustion, so she takes appropriate measures to decrease the likelihood of fire in the room of someone receiving oxygen therapy. Public education directed towards safe environment both in the healthcare institutions and homes watching electrical cords and connections, medications, house cleaning solutions and so on.

Water supply, good ventilation and clean air, balanced food, personal hygiene and environmental sanitation are all concerns of health workers. Florence Nightingale in her treatise on what nursing should do, wrote: "nursing ought to signify the proper use of fresh air, light, warmth, cleanliness, quiet, and the proper selection and administration of diet-all at the least expense of vital power to the patient". All these are vital elements in the external environment that are necessary for homeostasis in the internal environment.

3.2 Shift work, health, the working time regulations and health assessments

Changes of alertness and cognitive efficiency has been suggested in people on night or shift-work, that cognitive functioning tends to be impaired by a long-term exposure to shift work and neuropsychological performance tends to decrease with the increases in the duration of exposure to shift-work.

There is interaction between shift work, health, working time regulations and health assessments and it is expected that in your various studies, you must have learnt about health, work time regulations especially Labour Law in Nigeria Cap 432 and health assessments.

Shift work and night work in particular have been associated with sleep difficulties, general malaise, fatigue, peptic ulceration, ischaemic heart disease, cigarette smoking and adverse pregnancy outcome. The medical conditions previously regarded as making individuals unsuitable for shift work show wide ranging patho-physiological activity and there is no published evidence for any such condition to be regarded an absolute reason to exclude an individual from shift work. The fulfillment of the legal obligations of the Working Time Regulations 1998 is neither prescribed nor constrained in any way. It is advisable therefore to build on existing health procedures where they are in effect. Periodic health questionnaires can offer health professionals an opportunity to detect any disorder likely to be aggravated by shift work or by a combination of shift work, job demands and workplace conditions. A further purpose

of the questionnaire is the assessment of ability to undertake shift work duties. However, health questionnaires are neither sensitive nor specific enough to be used to select applicants or employees for shift work, since they do not consistently predict tolerance of shift work or subsequent health problems. Whether employers should offer anything more than a simple questionnaire will depend on the culture of the company and accessibility of health services. Screening programmes affect many people relative to the few who benefit and with existing knowledge; periodic general health examinations performed in asymptomatic subjects have limited predictive or preventive value.

4.0 CONCLUSION

Environment is all of the many physical and psychosocial factors that influence or affect the life and survival of the individual. Environment is subdivided into external and internal. External environment lies outside the body and is in contact with the skin, mucous membrane and the sense organs. The internal environment is made up of the fluid surrounding the cells and carrying to and from them. Similar to the dependence of health on the stability within the external environment, health is also dependent on the maintenance of relative stability of the physical and chemical characteristics of the fluid comprising the internal environment. For human beings and other multi-cellular organisms, blood, lymph and interstitial fluid form the immediate environment of the cells. Materials utilized in the internal environment come from the external environment through specialized structures.

Therefore, the quality and state of the external environment determine the state of the internal environment. For man to be in a healthy state, there should be equilibrium between the external and internal environment. Hence a safe external environment determines the quality of the internal government. Conditions in the external environment must be within the limits to which an individual can adapt to.

Night work and shift work are related to a wide range of health effects, the evidence for the risk of cardiovascular morbidity being the strongest so the manager must always be aware of the inter relatedness of shift, health, hours of work regulation and health assessments.

5.0 SUMMARY

You have learnt how human beings and their environment are constantly interacting and influencing each other, how the relationship is dynamic and how human beings manipulate their environment to meet their needs as well as the inter-relatedness of shift work, health, the working time regulations and health assessments in this unit.

6.0 TUTOR- MARKED ASSIGNMENT

List the effects of the environment on the human being.

7.0 REFERENCES AND FURTHER READINGS

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UNIT 15 PARTICIPATIVE HEALTH CARE

CONTENTS

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1.0 INTRODUCTION

Organizations are made up of people-men and women-the employees who carry out assigned functions for the smooth functioning of the organization. The corporate output and performance of the organization are therefore the collective responsibility of those people that are working in the organization. An organization cannot therefore be better than the people that make it up. The success or failure of an organization depends on the quality of the people. The human resources of the organization, the efficient and effective utilization of these people, will contribute substantially to the growth and development of the organization. In effect, the collective willingness of the people to contribute their best to the organization will determine the success of the organization.

There is a popular saying that two heads are better than one, if they agree. This illustrates the concept and importance of participative decision-making in organizations.

This unit deals with the participative Health Care Principles and Practice in Nigeria the objectives, factors that contribute to the increasing

demand for participative management and differences between workers participation and collective bargaining.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- Explain the concept of workers' participation
- List the objectives of workers participation
- State in clear terms the factors contributing to the increasing demand for participative management
- List the kinds of workers' participation.
- Distinguish between workers' participation and collective bargaining.
- Discuss the conditions necessary for workers' participation and its benefits.

3.0 MAIN CONTENT

3.1 Meanings of the concept of Workers Participation

According to Beach (1970), workers' participation is a process by which workers contribute ideas towards the solution of problems affecting their organization and their jobs, thus exercising some degree of influence on the decision-making process. The British Institute of Management (BIM), in its 1977 publication, defined workers' participation as a practice in industries whereby:

Employees take part in management decision based on the assumption of a community of interests between the employer and the employees in furthering the long-term prospects of the enterprise and those working in it.

The Institute also distinguished between the concepts of workers' control from the concept of workers' participation. This distinction revolves on the fact that their objectives differ. While workers' control seeks to establish workers' ownership and workers' self-government in industry, employee participation simply seeks to be involved in influencing and partaking in decisions on issues affecting them and their work.

Describing workers' participation, Marsh (1970) once explained it as:

> Any theory or scheme as long as it is based on a genuine concern for the rights of workers in industry, particularly the rights to share in the control of industrial decisions.

Marsh went further to say that workers' participation is a form of industrial democracy that is short of workers' control I take over of running the industry. As for Brannem and his colleagues (1976), workers' participation is an upsurge of interest and agitation for changes in industry to allow employees to have more control over the conditions of their working lives.

Workers' participation was described as:

Any set of social or institutional devices by which subordinate employees either individually or collectively become involved in one or more aspects of organizational decision- making within the enterprises in which they work.

Workers' participation from the standpoint of management means seeing workers and the government as parties to industrial relations. According to them, management considers workers' participation as a joint consultation to be conducted prior to decision-making; and, for the workers, it means co-determination; and, for the government, it is an association of labour with management to hold decisions without the final authority to take decision. Also, workers' participation was described as:

> A new means of ensuring the co-operation and commitment of workers and a new system of protecting their interests, not at the bargaining table but from inside, by participating in decision-making and having common responsibilities.

However, workers' participation can be viewed as a "'concept and practice whereby employees seek and are allowed to partake in decision-making directly as individuals or indirectly as a union representative so as to ensure that their interests are protected in the management of their workplace.

Under participative management, the employees "confer" with management over decisions that affect them and their work. One of the earlier writers of this concept was Douglas McGregor (1960) who recognized that people tend to work harder when they feel that they are part of the total organization. This is unduly recognized as desirable, since people develop a sense of commitment when they participate in planning and making choices. He, however, concludes that one major drawback to the amount of participation is time spent at meetings and conferences. Also, whenever group decisions are made, tensions can develop among those who do not agree with the majority. The

researcher seems to agree with the views of the above author, but would want to state that participative decision-making may have advantages which may outweigh its disadvantages; as workers' involvement in decisions seem to recognize the human asset factor in an organization.

Participation of workers in development has been recognized as one of the ways of ensuring proper and good labour relations in an organization. Management is concerned essentially with the utilization of human and material resources for the production of goods and services. In the performance of this function, management exercises some degree of authority over workers. Employees however expect some degree of freedom in the workplace, especially with the continued agitation for democracy in the larger society. Participative management could be seen as a variant of democracy, i.e., it is industrial democracy. When an employee is really involved in the planning and setting of policy in an organization, he becomes efficient, effective, loyal and committed (Drucker, 1976).

Before now, employees were virtually at the mercy of their employers who possessed the unquestionable right. The Industrial Revolution of the 18th and 19th centuries changed this situation in the world.

Initially, participation of workers was limited to issues of fixing wages and hours of work, and the protection of the life and health of workers. Prior to this new period, these issues were discussed on a personal basis; that is, individual bargaining as against collective bargaining. Balfour recognized the organization of labour, which is as a result of the foregoing, as representing "the most single potent force of change in the industrial relations situation". According to him, the main reason behind the setting up of union is an attempt at improving the human relations in industry by protecting the status of labour against the willful and autocratic act of management and attempting for labour a larger and more equitable share of the proceeds of industry.

Beach (1970) talks of workers' participation as "the term used to designate the process by which people contribute ideas towards the solution of problems affecting the organization and their jobs. The people exercise some degree of influence in the decision-making process. It includes not only the physical contributions of the worker but also his intellectual and emotional involvement in the affairs of the organization". In Davis' view, participation requires the mental and emotional involvement of a person in a group situation, which encourages him to contribute to group goals and share responsibilities on them. It is thus the employee's psychological result of supportive management.

Akpala (1987) sees workers' participation in management as "any process whereby workers, whether as individuals or through a union or other organization, have a share in the reaching of management decision in the enterprise." This may be through such methods as collective bargaining, consultation, appointment of workers; directors, autonomous work groups, and particular styles of management.

Stephen J. Carrol, and Henry L. Tosi (1973) are of the belief that an individual that had an influence on a decision can in effect be said to have participated in making that decision. Douglas MacGregor finds a link between management by integration and self-control (his theory 'V') and participation. He considers participation to consist of "basically creating opportunities under suitable conditions for people to influence decisions affecting them." Commenting further, he says " Is a special case of delegation in which the subordinate gains greater control, greater freedom of choice with respect to his own responsibility". It is where all members of a (work) group contribute, share or are influenced by the interchange of ideas and activities towards problem-solving or decision-making within the organization.

It is a form of management in which the participation of employees in decision-making in an organization is developed either individually or through representative democracy at the boardroom level to influence or to make decisions in the organization. In other words, it involves the total democratization of an organization, such that subordinates in the organization are involved directly or indirectly in the process of planning, organizing, directing, staffing and controlling such organization in order to achieve organizational harmony as well as societal and individual goals.

Davis (1977) contends that participative managers are neither autocratic nor do they shirk ultimate responsibility with those who perform the work." He stresses further that workers are, in such a situation, activated to make inputs into the decision-making process and therefore share a sense of responsibility for such decision.

Damachi (1982) opines that participation could take place in two ways - ascending and descending order. The former, according to him, exists "... at levels above their own". The latter "... on the other hand, involves managerial functions being pushed down the hierarchy and carried out at the workers' own level." Damachi further buttresses his point by listing out some principal perspective from which workers' participation in management may be seen. They include:

(a) A means of advancing the interests of workers; that is, the defence and promotion of workers' interests.
(b) A means of distributing powers within the- enterprise more equally, and of handling conflicts of interest by democratic procedures; that is, industrial democracy.
(c) A means of contributing to practical efficiency.
(d) A remedy to industrial conflict.
(e) A means of improving the quality of workers' life on the job by helping to harmonize it.
(f) A means of providing workers the opportunity to arrange their social needs and welfare.
(g) An illegitimate intrusion upon managerial prerogatives.

Conversely, some other scholars were of the view that participative management is useful beyond Damachi's horizon. For instance, Maslow (1954) had contended that workers' participation allows for the satisfaction of the workers' higher needs: the needs for self-esteem and self-actualization. This perspective has been elongated by Turner and Lawrence (1965) and Goldthorpe and his collaborators (1968). In the perception of these management scholars, workers' participation in management is beneficial in the sense that it brings about heightened workers' morale, increased job satisfaction, increased efficiency and, consequently, the enlargement of organizational output and profit. In other words, workers' participation is a motivational variable which management could manipulate effectively to achieve desirable organizational outcomes.

3.2 The Objectives of Workers' Participation

The objectives of advancing workers' participation in decision-making were raised by Arthur Marsh (1975). He said that the main aim had been to break up the concentration of industrial power on management alone, as a safeguard against self-interest and arbitrary action, and on the need to increase social and material satisfaction of workers in industry. Another objective is to encourage opposition to the authorization tendency of management and, by so doing, bring management and employees closer to understand each other. The objective is also to encourage personnel development and job satisfaction among employees.

In furthering the objectives of advancing workers' participation, the International Labour Organization (ILO) (1986) in its publication, the "World Labour Report", made it clear that the intentions are: (i) to promote the personal development of the workers; (ii) to achieve industrial democracy, that is, to give workers more influence on

economic decisions, and (iii) to create an atmosphere of peace and co-operation that is conducive to greater productivity and efficiency in the enterprise.

3.3 Factors that Contribute to the Increasing Demand for Participative Management

In a study of this nature, one can probably identify the factors that have contributed to the increasing demand for participative management in the contemporary work environment. These factors include:

(1) The increasing complexity of the environment. In contemporary organizations of today that operate in dynamic environments, tasks to be performed and decision-making are becoming too complex to be managed without the active participation of employees.

(2) The changing attitude of subordinates towards their jobs. Employees are no longer satisfied with extrinsic rewards such as pay and fringe benefits; they are interested in having challenging jobs, and increasing responsibilities, autonomy and the right to influence the decisions affecting their jobs, and their personality. This necessitates the institutionalization of participative management.

(3) Workers are getting better educated and more knowledgeable, and they want to assert their rights on certain management issues. The formal old autocratic leadership style of management is therefore becoming ineffective and costly to contemporary organizations. A change to more participative styles seems to be taking place nowadays.

(4) The development of new technologies, automation and information systems, tends to call for shared ideas in the acquisition and use of these technologies. The effective development and use of these new technologies necessitate shared ideas and decision- making, hence, the need for workers' participation.

(5) Organizations now operate in turbulent environments characterized by political instabilities, and increasing interest groups that make demands on corporate organizations. There are sophisticated customers that seek to assert their rights in the consumption of the output of organizations, and there is the ever-increasing government legislations. These challenges require that management demands for the opinions and suggestions of workers in dealing with them.

(6) The increasing depletion of natural resources poses threats to raw materials being used in the production process. The need to

search and develop alternative sources of raw materials demands that management seeks for ideas even in a subtle way from the workers. This is a form of participative management.

(7) There is an increasing democratization of the political system and governance on a global scale. This development tends to challenge the status quo in corporate organizations. The fact that organizations now operate in democratic political environments tends to influence their decision-making process in the work environment.

(8) Participative management has been accepted as a good system for organizational effectiveness in some advanced industrialized countries. Its adaptation in the developing countries is being advocated as a system for accelerated economic growth and social transformation.

3.4 Forms of Workers' Participation

Participative management could take different forms, depending on the situation and circumstances. We discuss here some of the forms that are commonly used in organizations.

(i) *Briefing Groups:* This is a form of workers' participation that is customary and is a systematic form of transmitting information through the work organization. It is a work unit form of periodic meetings for the passing out of information, briefing subordinates and getting feedbacks from them. it has been criticized as not truly participatory but a mere device for managerial control of information and a channel for issuing orders.

(ii) *Individual Contacts*: This form of participation is most common and very informal; it is a form of participation whereby managers, among themselves, and among their subordinates, exchange opinions and experiences on a daily basis and on a person-to- person basis as regards their jobs and the company.

(iii) *Group Discussion:* It is a form of democratic system whereby employees are allowed to participate in group discussions about their collective problems and arrive at joint decisions moderated by a discussion leader who is usually a head of department. It serves as a useful forum for brain-storming, information giving and gathering, appraising and commending work programmes, developing common work goals, work requirements, setting production standards and assisting the work group leaders in solving problems.

(iv) *Works Committee:* Works committees also serve as a forum for workers' participation in decision-making. They are set up on the workshop floor to tackle different tasks. They are task-oriented committees. Examples are: safety committee, quality control committee, production / productivity committee, labour / management committee, etc.

(v) *Consultative Management*: It is a form of participation, which requires managers to consult their subordinates with the intent of encouraging them to think about issues that can improve their job, initiate new ideas and be willing to present their position on all matters for which they are being consulted. However, after consultation, the manager has the prerogative to make his final decision after considering the positions of his subordinates.

Beach (1970) calls it consultative supervision, a system of management whereby the supervisor (manager) calls a meeting of his subordinates, whenever the situation requires it in order to obtain their questions, suggestions, ideas and criticisms. According the Beach, suggestion plan is a formalized system established by an employer to encourage employees to submit ideas that will result in improvement for the business of the work organization. It entails the installation of opinion / suggestion boxes in the various locations in the workplace.

(vi) *Middle Management Committee*: This is a form of workers' participation among middle management manpower. Davis (1977) describes it as multiple management, while Beach (1970) sees it as a junior board of executives. It is usually a standing committee of junior managers who are authorized to carry out studies and make recommendations to senior managers concerning specific issues for final decision.

(vii) Collective Bargaining: It is a form of participation programme, which is not initiated by management but by employees' union. Whereas other forms of participation are at the management discretion, collective bargaining is at the employee / union's discretion. It is a form of participation whereby employees negotiate with their employer and jointly take decisions concerning their conditions of service. The bargaining relationship arises as a result of union's agitation and campaign for negotiation over the terms and conditions of employment.

(viii) Joint Consultation: This is a form of participation, which entails regular discussion between management and workers in a

workplace concerning matters of common interest, which are not items for negotiation. in Nigerian industrial relations circles, it is known as joint consultative council (JCC). Beach describes it as union-management co-operation.

(ix) Worker-Directors: It is the highest form of participation that is accorded workers in their workplace, whereby some workers are nominated / selected into their company's board to represent employees' interests.

3.5 Differences between Workers' Participation and Collective Bargaining

The International Labour Organization (ILO) (1986), tried to make some distinctions between workers' participation and collective bargaining. Their viewpoints are very relevant to this study. They include the following:

(i) That, traditionally, collective bargaining is considered to be the exclusive prerogative of the trade unions, which represent, as a rule, only the unionized workers, whereas the workers' representatives on the various participatory' bodies represent all the workers of the enterprise, whether they belong to the union or not. The consequence of this is that the unions tend to be suspicious of participation when they have reason to believe that it will be used to encroach on their collective bargaining powers.

(ii) That, in participation, workers can obstruct a decision only in few cases like in workers' self-management, co-determination, and not in workers' council, joint consultation committees; whereas, at collective bargaining, workers can always obstruct decisions. In effect, there must be consensus before a decision is taken at a collective bargaining, being a product of consultation.

(iii) That collective bargaining deals with matters of conflict-mainly wages, fringe benefits, and other basic conditions of employment -whereas the machinery of participation deals with issues on which employers' and workers' interest tend to converge, such as the economic and financial management of the enterprise.

3.6 Conditions Necessary for Workers' Participation

Generally speaking, participation of workers in the decision-making process does not work out in all situations. It has conditions or prerequisites that must be met for it to take place and be an effective tool

for managing the work force. These conditions are examined here to help us determine why certain issues are the way they are in the course of this study.

(1) The employees, as a condition for effective participation, must have strong desire to express themselves in their work, to exercise their own judgment, assert themselves in their rights and be willing to influence matters. The employees must be people who are interested in both their career and their organization.

(2) In his research, Vroom (1964) identified an essential prerequisite for workers' participation which explains that subordinates who have strong needs for independence are prone to have zeal for participation in decision-making. He saw the desire for independence, which, according to him, meant a strong drive to express oneself and figure out things for oneself, as a necessary condition for effective participation among workers.

(3) The employees must have the ability, the intelligence and the knowledge of the subject matter involved. That is, they must have the capacity to contribute meaningfully and freely.

(4) It is also necessary that the subject for participation be relevant to the participant's work organization. It must also be of interest to the participant workers, and they must have common language for effective communication.

(5) Another important condition is that neither the workers nor the managers should feel that their positions are threatened by participation of workers in decision-making. This is crucial because, if workers think that their status would be affected adversely, they might withdraw from active participation. In the same manner, if managers feel that their authorities are threatened by workers' participation, they would refuse to encourage participation among their subordinates. Also, some union leaders resist participation when they feel that it would reduce their bargaining position.

(6) The problems to be discussed at participation must be appropriate. Participation should be on those situations and problems that have direct impact on the workers involved. A manager should not waste the time of all his subordinates if the issue clearly concerns only a few of his workers; only those concerned and those that have legitimate interest should be involved.

(7) Managers and workers alike must be trained concerning the need for participation to be taken seriously and what it demands to carry out participation schemes. Managers need to learn how to delegate, consult, lead, confer, and encourage suggestions, etc. Also, employees need to learn how to work co-operatively in participative management situations. The workers must be taught about what is expected of them in participation.

(8) Managers should invite their subordinates to participate in deliberating on only problems and cases within their sphere of authority and competence.

(9) Matters of emergency situations are not effective issue~5 for participation. This sense of urgency precludes consultation with subordinates in cases like a decision to rush shipment of goods, tactical actions to arrest impending strike or to avert damage to equipment or injury to workers or industrial accident. Such situations are not allowed to be matters for participation.

(10) Finally, on no condition should financial cost of participation be allowed to exceed the values derivable from it. It must be cost-effective. Workers cannot be allowed to waste their productive items in the name of participation in decision-making.

3.7 Benefits of Participative Management

McGregor (1960) considers participation as an employee development device, which sees subordinates on the path of growth, and peps up their willingness to accept responsibility. Ubeku (1983) seems to agree with this position. He feels the manager's duty to develop his subordinates could in part be discharged by increasing their responsibilities which, of course, cannot be facilitated if he keeps "....the whole decision-making process to himself'.

Odiorne (1973) contends that there is an association between participation and increased employee morale, reduced labour turnover, and employee willingness to accept change. He claims that some research correlates participation with job, and status contentment.

There is an argument that participation seeks to satisfy ethical, politico-social, and economic objectives. The ethical consideration argument derives from man's natural right to develop his personality without any impediments. The political and social goals are meant to extend man's political rights in a democratic state to the industrial setting, while the

"economic" consideration stems from the belief that workers are indispensable in the march towards industrial efficiency and harmony. Non-consultation of workers on matters that affect them has been identified as a source of discontent, and a cause of alienation of workers in our organizations. Since decision-making helps create an atmosphere of mutual trust between management and the rest of the work force, it is considered helpful in efforts to achieve industrial peace and harmony. Individuals work more readily and effectively when they know that they will be consulted upon, more especially before changes which will affect them are ratified. More salutary effects are derived when they envisage that their suggestions will be treated seriously.

Beach (1970) is of the view that any system that crates opportunities for workers to influence decisions tends to generate an atmosphere of friendliness and dispute resolution.

The benefits of participative management can be summarized as follows:

(a) There is ease in implementing decisions within the organization.
(b) There is avoidance of costly mistakes.
(c) There is reduced employee resistance to ideas.
(d) There is improved job performance at all levels.
(e) There is enhanced flexibility in the organization.
(f) There is higher employee morale.

3.8 Factors Influencing Workers' Participation

It is reasonable to consider the possible factors that affect participative decision-making in organizations. It will throw some light on our study concerning the factors that have encouraged and discouraged workers from participating in the decision-making process.

Beach (1970) identified three factors that can influence workers' participation, namely: the organization, the manager and the employee. Also, in their research report, Clarke (1977) and his colleagues enumerated four factors that influence workers' participation in decision-making as: the degree of unionization, the size of the enterprise, the type of industry, and the form of ownership of the enterprise. Rosenstain (1977) also identified education as a crucial factor that affects the extent of workers' participation. These factors are hereby discussed.

(i) *The Organization*: A conducive psychological climate for participation and honest zeal to encourage participation must be the nature of an organization. The organization's attitude towards

its employees has a direct bearing on the employees' interest in participation. The organization has to make its employees feel that their opinions and ideas are cherished and valued by the organization, for the organization to influence the level of participation positively.

(ii) *The Manager*: A manager's perception of what workers' participations stands for goes a long way to affect the extent of workers' participation. He needs to perceive participation as: a good managerial tool for effective delegation of duties; a means of making effective use of subordinates; a means for training subordinates; a true morale-booster; and a medication for treating the problem of alienation. These perceptions make a manager a positive factor to influence workers' participation. On the contrary, if a manager perceives participation as an activity that erodes his authority and challenges his control over his subordinates, in this case, he becomes a factor that affects participation negatively.

(iii) *The Employee*: The nature of an employee in terms of his learning, knowledge, training, general background and exposure, determines him as a factor influencing the level of participation. If an employee has background knowledge on the subject being discussed or found himself incompetent in handling the problem being tackled; all these will affect him to either be a negative or positive factor influencing participation.

(iv) *Degree of Unionization*: The degree of unionization is clearly a factor or major importance in determining the pattern of participation within an enterprise. The more highly unionized a plant, the more likely that a range of decisions will be made through the collective bargaining process. Furthermore, the higher the degree of unionization, the more likely the workers at the shop floor must have ceded some of its rights to the shop floor and their shop stewards (local union leaders) to decide on specific matters.

(v) *The Size of the Enterprise*: The effect of size of an enterprise would seem to be of special importance since it is amply substantiated that, in very small units of work organizations, there are very close contacts between workers and managers, more mutual understanding and less institutionalized conflict. This is so because it is easier to develop mutual confidence and issues are speedily resolved due to close personal contacts. As the level

of personal contacts is determined by the size of the enterprise, so also the size of an enterprise influences the level of participation.

(vi) The Type of Industry: The type of industry, whether service or manufacturing, also determines the change of workers' participation in decision-making in the manufacturing industry. For example, where there is complex production process, with a large work force, management has to constantly involve the employees in the decision-making process so as to achieve the production target.

(vii) The Form of Ownership of Enterprise: The form of share ownership of an enterprise goes a long way to determine the level of workers' participation. In fact, it is an influencing factor over participation. In firms where workers have a substantial portion of the share, their participation in decision-making is very high, whereas, where the workers have no share interest; their level of participation is very low.

3.9 Limitation to Workers' Participation

There is need to consider the limitations of workers' participation in decision-making: that is, those elements that impinge on employees' ability to participate in the decision process in their workplace. Beach (1970) identifies the following limitations to workers' participation in decision-making: the power structure of the organizational hierarchy, the manager of the authoritarian personality, and the pressure to conform to the customary beliefs of the group. Monappa and Saiyada (1970) also gave an account of what they called "the cause of relative failure in participatory schemes." These include:

(i) *The Power Structure of the Organizational Hierarchy*: The power, authority, and influence of most superiors over their subordinates are strong limitations over the freedom of workers to participate actively in decision-making for fear of victimization when they express their opinions. Being aware that their superiors have the power and authority to decide on their increment, promotions, transfers and work schedules, they are restrained to participate freely in discussions and decisions.

(ii) *The Authoritarian Personality*: In departments where managers have authoritarian personality, it is a constraint to participation because such managers do not believe that their subordinates are capable of doing things worthwhile. They do not tolerate any idea from their subordinates that might challenge their point of view,

no matter how bright the idea is. Their subordinates are simply meant to obey orders. This is a strong limitation to participation.

(iii) *Conservatism*: In work organizations where there are strong informal groups with their customs, there is always pressure on members (workers) to conform to the norms of the group. The individuality and creativity associated with participation is often seen by the work group as a threat to their collective interests. As a result, workers are informally compelled to participate within the perception limits of their work group. This causes limitation to participation arising from conservatism of the work group.

(iv) *Workers' Involvement beyond Area of Competence*: Often in the participatory scheme, difficulties arise when employees make proposals in areas where they are not competent or not allowed by collective agreement to participate. As employees try to participate in those areas meant for management, contrary to the collective agreement, management resists them. As a protest move, the employees in turn refuse to co-operate with management. Here, the union wants to be consulted on all matters, including those that are managerially and technically beyond their competence. Such situation is 'a strong limitation to active participation, since the management would be influenced to be resentful to workers' participation as a result of its experience.

(v) *Trade Union Participation*: The problem of participation through workers' representatives had become a strong limitation to workers' participation. It restrains the individual from active participation, since participation is by proxy. Workers are no longer in face-to-face relationship with their representatives; as union bureaucracy grows, workers and their representatives have been made wider. This means that the union becomes less responsive to the popular demands of the rank and file. In this case, the indirect participation through the union becomes effective and problematic.

4.0 CONCLUSION

Hospital being a complex social institution require participative management if it has to meet up its obligations to the society as every individual, group, department and specialty is important; in fact needed to play its unique role and for this reason every one must take active part in the service delivery.

5.0 SUMMARY

The student must have learnt in this unit the significant role of every worker; be it skilled or unskilled in the health delivery system so the need for active participation can not be undermined.

6.0 TUTOR- MARKED ASSIGNMENT

Why is workers' participation relevant in the health care delivery industry?

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UNIT 16 GROUP DYNAMICS IN HEALTH CARE SYSTEM

CONTENTS

1.0 Introduction
2.0 Objectives
3.0 Main Content
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    3.2 Essential Properties of a group
    3.3 Principles of Group Dynamics
    3.4 Types and Levels of Groups
4.0 Conclusion
5.0 Summary
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7.0 References/Further Readings

1.0 INTRODUCTION

Group dynamics is essential for the successful health care delivery in Nigeria as every member in the health system is important, interrelated and interdependent, the inefficiency or inaction of a member of the group will have adverse effect on the entire group system hence the importance of the group dynamics can not be undermined.

This unit will focus on group dynamics and will point the students to the fact that each of them is important in the various groups he / she belongs.

2.0 OBJECTIVES

At the end of this unit, the students should be able to:

- Explain the concept of group dynamics
- List the essential properties of a group
- State some principles of group dynamics
- Discuss the various types and levels of groups in the society.

3.0 MAIN CONTENT

3.1 Introduction

The term group has been variously defined in standard dictionaries. The definition germane to the aims and objectives of guidance and

counselling is that a group is the collection of individuals who interact psychologically with a purpose to pursue or achieve a common goal. The group members join the group towards realizing the group's objectives. In counselling, a group consists of two or more persons who voluntarily have contact and interaction intended to produce change in each member. Due to voluntary participation, members interact with and influence each other.

Group dynamics refers to a sort of political ideology concerning the ways in which groups should be organized and managed. The ideology emphasizes the importance of democratic leadership, the participation of members in decisions, and the gains both to society and do individuals to be obtained through cooperative activities in groups. The critics of this view have sometimes caricatured it as making "togetherness" the supreme virtue, advocating that everything be done jointly in groups which have and need no leader because everyone participates fully and equally.

Group dynamics according to Shertzer and Stone (1976) is the interacting forces within groups as they organize and operate in order to achieve their objectives. The forces in the group which enhance the effectiveness of the group are varied and these fall under the category of group dynamics. These forces or mechanisms in a group may be in the form of leadership style, role playing, observation as well as feedback to the group members' interaction, nature of the goal, ways and means of achieving these goals and other related forces. Group dynamics involves the forces which account for group cohesion whereby members work out the group norms and interact meaningfully and purposefully to achieve the objectives of the group.

3.2 Essential properties of a group

As earlier mentioned, a group refers to a number of persons who communicate with one another often over a life span of time and who are few enough so that each other is able to communicate with all the others, not at second hand, through other people, but face-to-face. Some of the essential properties of a group are as follows:

(a) A dynamic interaction: If members will learn from each other, there must be some kind of relationship and subsequent interaction base on which this relationship will develop. In short, the members must be interacting with one another.

(b) A common goal: For the group to have a common goal, members should be willing to give feedback willingly to each other.

(c) Volition and concept: Members should not be forced to belong to a group, but rather, they should join groups voluntarily having the idea of what the group stands for. Members who are forced to join a group may not be able to tap the potentialities of the group they belong.

(d) An appropriate number of members: There should be an appropriate number for the proposed function. The number of size of a group will determine to a great extent the effectiveness of the group, because the feelings will easily come out. The smaller the size of a group, the greater the relationship or interaction.

(e) Capacity for self-direction: Members should be alive to their responsibilities. If the group is voluntary and meaningful, the willingness to govern and control will evolve and the group will move in terms of self-direction.

3.3 Principles of Group Dynamics

It has been discussed hitherto that group dynamics refers to the forces operating in groups which give rise to them and the consequences which these forces have on the modification of the behaviour of the members of the group. Group dynamics that is oriented towards change in behavioural adjustment can be viewed in three ways: firstly, the group can be seen as a source of influence over its members; secondly, the group itself may be a target of change. In order to assist the individuals to change or modify their behaviour, it may be necessary to change the standard of the group, the leadership style, the emotional atmosphere, and even some of the group's objectives; thirdly, assistance to individuals through groups can be done effectively through the organized efforts of groups as agents of change.

Some of the principles of group dynamics that are applicable to guidance and counselling are as follows:-

a. Principle of shared responsibility: Whenever a change is to be effected the group goals, information plans and effects must be shared by the group members.
b. Principle of attractiveness of the group: The degree of attractiveness of a group to the members will determine the influence of the group.

c. Principle of sense of belonging to the group: Members should show some signs of commitment to the group. This will enhance their active participation in group activities.
d. Principle of individual member's status: It is obvious that if one of the members of the group is highly respected by other members, he would have great influence on the other embers of the group.
e. Principle of behavioural censorship: Here activities that will make members deviate from the norms of the group are usually rejected by members of the group because of the attendant sanction.
f. Principles of readjustment: A change in a section of a group will likely produce a strain in others. The solution to this is for members to readjust in other sections.

3.4 Types and levels of Groups

Different groups originated in America in relation to group dynamics. They are as follows:

1. *The T-groups*

T-Groups originated in the U.S.A in 1947. T stands for training. It aims, through workshops and conferences, at educating the participants about human relations, enhancement of interpersonal skills and the development of individuals equipped to provide leadership in changing organizations. Hence, the primary focus is on inter-personal interaction and on group dynamics as revealed by member functioning. Participants of this group are involved in experiences designed to help them learn from their own behaviours and others.

T -Groups are involved in an experience in which they learn from their behaviour. Group members learn to recognize the effect they have on others and how others see them. The objective of this group is to learn by use of group process rather than facilitating personal growth.

2. Sensitivity Training Groups

This group is experienced-based and interactive designed to facilitate development and self-change. Sensitivity training is a generic name that was coined to refer to the small group training conducted by the National Training Laboratory. Its primary focus is on members' interpersonal behaviours. Attention is paid to group role and processes only as this illuminate on personal dynamics. The outcome of this group includes clarification of life values, increased sensitivity to and

acceptance of self and others, and overall improvement in personal adequacy.

Goals of sensitivity training groups include facilitating personal, increased sensitivity to the feelings of the individual sometimes a trained psychotherapist.

3. Laboratory Training Groups

The term refers to an educational method which emphasizes experience -based learning activity. The word laboratory connotes the fact that the learning environment is experimental in that participants go beyond their usual pattern of interacting with individuals and groups. It presents the learner with a situation in interpersonal group or organizational system encounter in daily life.

4. Personal Growth Groups

This group is designed to strengthen the individual's ability to experience people and events more accurately. Emphasis shifts from the group itself to a Rogerian conception of the individual within the group. The leader's attention centers on the expression of feelings by the group members. It is meant not for the disturbed but for normal people who are seeking further personal development, hence, the term growth. The encounter group enhances the exploration of the individuals potentials and how best to eliminate block to the realization of their full potentials.

5. *Encounter Groups*

These are usually brief, intensive, face to face interaction not necessarily restricted to verbal communication. Strong emphasis is on openness, honesty, and expression of strong feelings; self-disclosure and spontaneity (including physical expressions of feelings) are encouraged. Its therapeutic goals that are related to feelings range from those indistinguishable from goals of conventional counselling to those of consciousness raising greater expression, or simply the enjoyment of a mutual experience. They seek personal growth to rediscover and use the affective part of themselves.

6. *Marathon Groups*

Marathon group is the most intensive encounter group of all. It meets for a long time at a stretch of time. In some marathon groups, members may take short sleep periods but in others, this is discouraged, in the belief that prolonged contact and physical exhaustion accelerate and intensify

the interaction between group members and the expression of feelings that normally submerge. A high value is placed on self-expression, honesty, and aggressive confrontation between group members.

The group does not deal with anything except its chosen task, which usually is the expression and exploration of immediate feelings. The intensity of the marathon experience operates to bring about personality changes, in the direction of self-understanding and self-acceptance, which often endure.

7. *Group Therapy*

This is the application of therapeutic principles to two or more individuals simultaneously to clarify their psychological conflicts so that they may live normal lives. A psychiatrist or a clinical psychologist serves as a group leader. It finds its root in medicine, sociology and religion. Its innovative factors include imparting of information, installation of hope, communication of universality (patients learn that their illness is not unique), socializing techniques, interpersonal learning and group cohesiveness.

8. *Organization Development*

The origin of organization development was in the laboratory -training and T-Group procedure. It incorporates the variety of group strategies designed to bring about changes in an organization in order to increase its effectiveness and efficiency. Organization development focuses on the individual and the group assuming that changes there would bring about changes in the total organization.

Reasons for constituting a Group

a. Underachievement and the desire to motivate workers can bring about the formation of a group. However, studies have shown that the performi11i1ce of those who participate in this group has not been better than those who did not participate. One of the reasons cited is that the group meetings are few which may not make for much change. Some of the studies revealed that some of the participants even received lower grades, but showed increase in self-acceptance. In essence, the groups offered support and not motivation.

b. Hospital Administrators frequently structure groups to provide information that would reduce the anxiety and uncertainty experienced. Studies have revealed that participants of such

groups showed greater knowledge of requirements (entry) than those who do not participate, and they made more appropriate decisions.

c. Groups are also formed to facilitate developmental tasks. Some of the goals are how to establish group relations with peers, improving communication, developing social skills, and enhancing the self concept. While the rationale may differ from group to group, the emphasis is on the type of relationship in which case the group is small enough to provide for intimacy and extensive participation.

Stages of Group Development

Groups are complex social systems in which many variables change simultaneously. Hence, an individual entering a group unaware of all the dynamics of the situation may find the state of flux disturbing, confusing and embarrassing. Such an individual needs the help of an experienced administrator to discern order and patterns in the process. To provide the most meaningful experience for participants in the groups they lead, administrators must understand how groups develop and how they evolve through a systematic process.

Stage 1: The Initiation of the Group

The behaviour of members during the initial stage is relatively related. Problems presented are usually discussed rationally and members of this group help them to formulate a concept of the role each member is expected to play in the group. Hence, the early stage of the group is thus characterized by a degree of caution and self-verification behaviour.

The primary task for the members in a new group is to determine a method of achieving their goals. This means, in part, that they must resolve their social relationships in the group. Frequently, individuals or under what is expected, how much of their selves will have to be revealed, and what type of commitment will have to be made to others. Only that which is safe to describe is revealed during this stage.

For a while a culture evolves in the group that maximizes the opportunity for most members to play their private roles. However, as time goes on, more and more reality begins to intrude into their perceptions of one another. Through this, there is a shared relationship. It is through the process of developing this change relationship that a new reality is formed which permits the members to confront one another. The first major concern of counsellors is to provide a situation

that reduces threat to the members, thereby permitting them further self-exploration. To be helpful to the group, a counselor should establish a relationship which is expected by the counsellors. This includes genuineness, experiencing of positive regard for members and expression of emphatic understanding.

Stage 2: Conflict and Confrontation

In this stage, members manifest dissatisfaction with the operation of the group. After initial acquaintance of stage 1, members are frequently frustrated in their attempt to evolve new patterns of behaviour through which to work towards group goals. The discrepancy between individuals' real selves and their stereotyped images of the group may lead to conflict. Group members may challenge other's reactions to them and insist on their rights. Conflict also arises when certain issues are discovered to be more complex than the group members originally perceived.

Confrontation is a technique used by the counselor to invite a member to examine his or her behaviour and its consequences more carefully. Confrontation is a challenge to the members to become integrated. It permits the counselor and other members to express real thought and feeling and provides a model to help the client learn to accept and express thought and feelings and to test perceptions against other members' reality. Through confrontation, clients learn to recognize and face the inter-and-intra personal discrepancies that are an inevitable part of life.

Confrontation can be beneficial or detrimental to the individual. Therefore, to achieve beneficial confrontation, counsellors should take cognizance of the following guidelines:

i. It should be offered in a spirit of accurate empathy.
ii. It should take place tentatively especially in the early stage of a group.
iii. It should be proportionate -to the relationship between the two individuals in the interaction.
iv. It should be used in successive approximation~'. This is like that issue of tentativeness.
v. Do not use commands, judgmental or accusing statements.

Stage 3: Cohesiveness

This refers to the sense of solidarity or "we-ness" or "group ness" of the group. It also refers to the attractiveness of the group for its members. It

usually follows the stage of conflict and confrontation as the group gradually develops feelings of cohesiveness. There is an increased mutual trust and group morale. The primary interest of the group is with its intimacy and closeness. In fact after a period of conflict, the group may want peace at all cost and may develop a false type of cohesiveness as a form of protection.

How can a leader's behaviour facilitate group cohesiveness? A 4-step approach is suggested as follows:

i. He must define operationally exactly what behaviours indicate the presence of cohesiveness.
ii. He should diagnose the level of cohesiveness in the group.
iii. He may intervene by modeling cohesive behaviour. Intervention here means that he can come in and demonstrate what it is. Then they may be asked to repeat it after he can reinforce them.
iv. He should assess the impact of his intervention. Here, he may record the same statement that was measured earlier to assess the level of cohesiveness.

In conclusion, many counsellors feel that when the group reaches a stage of cohesiveness it is successful and they permit the group process to stop.

Stage 4: Productiveness

When a group achieves some degree of stability in its pattern of behaviour, along working process begins. Members are now deeply committed to the group. They reveal more of themselves and their problems in living. The established group now directs itself towards individual as well as group goals attempting to produce something of a general and lasting value. At first, the group was dependent upon the letter for concepts and models, but now the members have developed some leadership skills.

At this stage, the administrator serves as one source of internal standard but not the only one. Interpersonal bonds are strong, so evaluation, criticism, discussion and re-evaluation can be undertaken. Greater objectivity, greater ease in making decisions and more flexibility in controlling group process results.

Stage 5: Termination

This is one of the most significant aspects of a group process. It is the tradition from the group to the members' daily lives. It is one of the

most difficult and emotionally involving processes for the members because it arouses feelings of separation, loss, dissolution, impotence, dependency, death and abandonment. But pleasant or not, termination is built into the group process from its very beginning because the intention of the members is to eventually leave the group. It is made easier if the leader has emphasized the importance of taking action and making changes in attitude and behaviour.

The common forms of termination are:

i. The termination of the unsuccessful client (member)
ii. The termination of the successful client
iii. The termination of the entire group.

Towards the end of termination, members anticipate the loss and feel the need for closure. They make various attempts to deny the full impact of their separation, some suppressed frustration, insecurity and anger may emerge before termination. Perhaps, these were unexpected or unheeded throughout the group sessions. Members often withdraw by first expressing their negative feelings about others, then their positive feelings.

Members frequently insist that the group would never end because each person will carry the group away with him or her. They seek confirmation that their choice to join the group was a good one. They thank one another for their contributions and they feel that the results will be evident after the group is over and they are on their own.

Preparation for the Group

There should be some preparation of the counsellor as well as of each member prior to actual initiation. The following points will form the basis of such situation -the setting, the size, selection, composition, open or closed group, duration, preparation for interview and structure.

1. *The Setting*

The counselor must locate an appropriate place for the group to meet and establish policy about the duration of the group, duration of each session, admission of new members, and the size of the group. The setting must afford some degree of comfort, awareness, privacy and must be free of distractions such as tables, chairs, carpeted floors, audio or visual recording equipment etc.

2. *The Size*

A consensus of the literature suggests that the ideal size for a group in counselling is seven or eight members, with a range of 5-10. The lower limit is determined by the fact that when the group is much smaller, it ceases to operate as a group and individual counselling seems to ensure within the group setting. Also opportunities for utilizing the dynamics within the group are reduced. Lastly, such a pressure is put on each individual that he or she cannot choose to remain silent and so the comfort level is reduced. The upper limit is determined by the fact that less time is available for working with individual problems where there are additional members. As the group becomes larger it becomes difficult for the less forceful members to express their ideas. The competition for "air time" becomes critical. An administrator might expect one or two members to drop out during the early stages.

3. *Selection*

An administrator can increase the chances of success within the group by careful selection of client. Clients should be thoroughly screened so that the counselor will understand as much as possible about them. The counselor may wish to review a history of the client's family background, childhood, and adolescent and other development areas, awareness of the medical history.

Success is certainly increased by selecting clients who volunteer the experience since they are then more open than to help an individual who are coerced by family and friends. The age span of members should be as small as possible, probably not more than 3 years for adolescents who have a large variation in maturation.

An important prerequisite for admission to a group is stated individual goals. There must be verbalized contact regarding personal change. All group members should have relationship with the therapist prior to entering the group. This is very important because there is always a great deal of anxiety associated with group membership in the early stages. This relationship will help members to handle the initial anxiety until they begin relation with other group members.

4. *Composition*

Should a counselling group be homogenous or heterogeneous? That is, should it comprise of one set, age, socio-economic level, of problem areas as opposed to varying these factors within the same group?

Whether or not to select homogeneous client is an issue that each administrator has to resolve personally.

Due to limited amount of research specifically relation group composition to group process and outcome, there are no firm rules available. However, the following guidelines regarding group composition are in order: when attempting to solve the issue of homogeneity /heterogeneity, it is helpful to look at the range of "patient / normal" interpersonal skills and behaviours of the members. Since group maintenance is an important issue in a patient.

Population of a more homogeneous group is suggested in order to decrease the initial discomfort and anxiety of the group members. When group members are "more normal", they can tolerate greater degrees of discomfort and conflict with less risk of premature dropouts.

Using the concept of compatibility rather than homogeneity is better. Compatibility would ensure personal attraction, cooperation and productive interaction among others.

5. *The Open or Closed Groups*

Before beginning a group, you have to make a decision as to whether open or closed group. A closed group does not admit new members and it meets for a pre-determined number of sessions or until the group decides to terminate. On the other hand, an open group replaces members as they leave the group so that it continues to function without a predetermined conclusion.

Differences between Open and Closed Groups

a. Time Perspective -The members of a closed group are given adequate notice of the time of the meeting. In the case of an open group, members are not aware of the transitory nature of their relationship.

b. Equilibrium -Equilibrium is concerned with adjustment needed in the group as membership changes. Disequilibrium is a basic shortcoming of an open group, and a constant state is non-functional. The counselor should maintain such a flow of members in and out of the group. This will ensure the retention of enough members and provide an appropriate heterogeneity to ensure a steady state of equilibrium.

c. Frame of Reference -Frame of reference means the ground against which the figure is perceived. In an open group, members have a larger population as a frame of reference with which to compare themselves than in a selected group.

d. The Changing Membership -This is the most obvious distinction between open and closed groups. Possession of powers by one member over another is a function of changing membership. Power is relatively permanent in a closed group. In an open group, any member may leave thereby changing the balance of power.

6. *Duration*

Most groups take considerable time to warm up to personal communication and to work through some of the major themes in the session. It has been suggested that it is difficult for groups to get personally involved and productive in less than one and half hours. Also they become less productive and reach a point of diminishing return after two hours. The number of times the group will meet is also important. Although some intensive groups meet two to five times a week, the majority of groups meet once a week.

Time limit can be used by some members to protect themselves and avoid getting involved in working through specific problem areas. A disadvantage arises when a group has not sufficiently worked through the stages of interaction to such a point that it has productively met group and individual goals. In such a case, the termination would be frustrating.

7. *Preparation Interview*

During the preparation interview, the counselor should inform members about meeting place, length of each meeting, number of group meetings per week and total number of meeting. Such interview can help clients to recognize and work through misconceptions, unrealistic beliefs and expectations of the group counselling.

8. *Structure*

There are different opinions in this area. There is structured atmosphere and unstructured atmosphere. An unstructured atmosphere is more relevant to clients needs. It is conducive to self exploration and the group can gain awareness of the psychological relationships among its members. However, distress and anxiety are inherent in it. So members

device their own structure through tasks, rules etc. and resort to some habitual ways of coping with anxiety by using defence mechanisms.

On the other hand, a structured environment enhances development of good behaviours that can group development and client improvement. It is strongly suggested that structured atmosphere be used in the early stages of group process.

4.0 CONCLUSION

Hospital as a group of health workers requires some degree of stability in its pattern of behaviour as a long working process is needed. For this reason, stimulating structured and unstructured atmosphere is required and enhanced stable / hospital policies.

5.0 SUMMARY

Attempt has been made in this unit to explain the concept "group dynamics", types and levels of groups including the stages of group development.

6.0 TUTOR- MARKED ASSIGNMENT

(a) Examine the stages of group development
(b) Attempt a definition of group dynamics. What are the principles of group dynamics?

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UNIT 17 STRESS AND ADAPTATION

CONTENTS

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4.0 Conclusion
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1.0 INTRODUCTION

Modern man is faced with the paradox of stress. Everyone experience stress from time to time and normally a person is able to adapt to long term stress or cope with short term stress until it passes. Stress places heavy demand on a person, and if the person is unable to adapt, illness can result.

Stress is an essential part of our lives providing us with the impetus for vitality, drive and progress. Stress is the body response to the daily or everyday pressure of the body reaction to excessive demand by the trying to maintain equilibrium among its internal process. Conversely, it is also stress which is the root of a multitude of sociological, medical and economic problem. Stress can be mild, moderate and severe with behaviours that decrease energy and adaptive responses. The leading cause of death today involves life-style stressor which precipitates stress with resultant effect on health-illness continuum. It is this cause and effect that this unit intends to examine stress and adaptation considering its concept, models of stress and stressor, factors influencing response to stress, adaptation and stress management for improved patients' care.

2.0 OBJECTIVES

At the end of this unit, the learner will be able to:

- Explain the concept of stress and stressor.
- Discuss four (4) models of stress as they relate to hospital practice.
- Describe stress-management techniques required for clients care.

3.0 MAIN CONTENT

3.1 Concept of Stress

There can be no stress without a stressor. Stress is any situation that can upset and prevent an individual from relaxing naturally. Stressor is the stimuli that precipitate the change in a man. Stress as a stimulus; do tax the adaptive capacity of the organism to its limits and which in certain condition can lead to a disorganization of behaviour and mal-adaptation which may lead to diseases.

Stress is common denominator of the adaptive reaction in the body. it is any situation in which a non-specific demand requires an individual to~ respond physiologically and psychologically as well as taken an action. Stress can lead to negative or counterproductive feelings or threaten emotional well being; threatens the way a person normally perceives reality, solves problems or think; threatens relationship and sense of belonging and a persons general outlook on life, attitude towards loved ones; job satisfaction, ability to problem solve and health status.

Response to stress is initiated by the individual's perception or experience of the major change.

The stimulus precipitating the response is called the stressor which may be physiological, psychological, social, environmental, developmental, spiritual, or cultural and represent unmet need. Stressors may be internal such as (fever, pregnancy, menopause and an emotion such as guilt; and external which originates outside a person such as marked change in environmental temperature, a change in family or social role or peer pressure.

3.2 Models of Stress and Stressor

Models of stress refers to classes of stress which are used to identify the stressors for a particular individual and predict that persons responses to them. These models are useful for planning individualized nurse care plan to help a client cope with unhealthy, non-productive response to stressors.

There are four (4) models of stress namely:

- Response Based Model (REM)
- Adaptive Based Model (ABM)
- Stimulus -Based Model (SBM)
- Transaction -Based Model (TBM)

3.2.1 Response Based Model (RBM)

REM states the particular response or pattern of responses indicating a stressor. Selye, S. (1976) in his classic research into stress identified two physiological responses to stress namely: The local adaptation syndrome (LAS) and the general adaptation syndrome (GAS). While LAS is a response of a body tissue, organ or part of the stress of trauma, illness, or other physiological change, the GAS is a defense response of the whole body to stress. Individual response to stress is purely physiological and never modified to allow cognitive influences, but RBM does not allow individual differences in response patterns (No flexibility).

3.2.2 Adaptation Based Model (ABM)

ABM states that there are four (4) factors that determine whether a situation is stressful or not. These are: ability to cope with stress; practices and norms of the person's peer groups; impact of the individual to adapt to a stressor; and the resources that can be used to deal with the stressor.

ABM is based on the fact that people experience anxiety and increased stress when they are unprepared to cope with stressful situation.

3.2.3 Stimulus-Based Model (SBM)

SBM focused on distributing or disruptive characteristics within the environment. The classical research of Holmes and Rahe (1978) identified stress as a stimulus resulting in the development of the social readjustment scale which measures the effects of major life events on illness. The following verdicts have been summed up for:

- Life changes events are normal.
- People are passive recipients of stress and their perceptions of the events are irrelevant.
- All people have a common threshold of stimulus, and illness results at any point after the threshold.

3.2.4 Transaction Based Model (TBM)

TBM views the person and environment in changing, reciprocal, interactive, relationship. It was developed by Lazarus and Folkman (1984) with a focus on the stressor as an individual perpetual response rooted in psychological and cognitive process.

3.3 Factors Influencing Response to Stressors

The response to any stressor is dependent on physiological functioning, personality, behavioural characteristics and the nature of the stressor. The nature of the stressor involves the following factors:

i. Intensity: minimal, moderate or severe.
ii. Scope: limited, medium, extensive.
iii. Duration: time lag
iv. Number and nature of other stressors

3.4 Sources of Stress

The common sources of stress are classified under the following headings:

(A) Stress problems at home: these include:

- Problem with co-tenants or neighbours
- F ear of attack by armed robbers
- Looking after dependants
- Problem with in-laws
- Problem of the aged
- Domestic demands

(B) Stress provoking situations in the society:

- Erratic supply of electricity water and fuel
- Reckless driving and traffic hold ups
- Insecurity
- Economic recession!
- Social demands
- Lack of employment opportunity
- Under employment

(C) Stress provoking situation at work:

- Having too much to do
- Frequent shifting
- Shortage of staff
- Too many patients
- High demands of the clients / patients
- Lack of good interpersonal relationship at work place
- Unfriendly hospital policies.

Adaptation is the process by which the physiological dimensions change in response to stress. The focus therefore in health care is on a persons family's or community's adaptation to stress because many stressors cannot be avoided. It involves reflexes, automatic body mechanisms for protection, coping mechanisms and instincts. Adaptation is an attempt to maintain optimal functioning. To do this, persons must be able to respond to such stressors and adapt to the required demands or changes. It requires an active response from the whole person (physical, developmental, emotional, intellectual, social and spiritual). Adaptation response can be physiological or psychological.

Physiological Response

This model of stress response can be either Local Adaptation Syndrome (LAS) or General Adaptation Syndrome (GAS). See 1 in 3.2. An example of LAS is reflex (pain) and inflammatory response. The GAS consists of alarm reaction, resistance and the exhaustion stage.

1st Stage -Alarm Stage

Mobilization of the defence mechanisms of the body and mind to cope with the stressors.

2nd Stage -Resistance Stage

Stabilization is attempted and success if achieved the body repairs damaged tissue that may occur if not exhaustion is the next stage.

3rd Stage

i. Recovery Stage

Repairs done, the body goes back to full functioning

ii. Exhaustion Stage

The body can no longer resist stress and if continues, death may occur.

i. Psychological Response

Exposure to stress threatens ones basic needs. The threat whether actual or perceived, provides frustration, anxiety and tension. The psychological response otherwise referred to as coping mechanisms is adaptive behaviours which assist the person's ability to cope with stressors. These behaviours are directed at stress management and are acquired through learning and experience as a person identifies acceptable and successful bebaviours. The behaviour includes:

ii. Task-Oriented behaviour

Use of cognitive abilities to reduce stress, solve problems, resolves conflicts and gratify needs. The 3 types of task-oriented behaviours are attack behaviour, withdrawal behaviour, compromise (by substitution or omitting the satisfaction of needs to meet other needs or to avoid stress).

iii. Ego Defense Mechanism

These are unconscious behaviours that offer psychological protection from a stressful event. It is used by everyone and helps protect against feelings of unworthiness and anxiety.

3.6 Management of Stress

The management of stress is classified into 3 headings for easy assimilation and understanding.

i. Reducing stressful situation through:
   a. Habit formation
   b. Change avoidance
   c. Time blocking
   d. Time management
   e. Environment modification

ii. Decreasing physiological response through:
   b. Regular exercise
   c. Humour
   d. Nutrition
   e. Rest
   f. Relaxation

iii. Improved behavioural and emotional responses to stress through:
   a. Support systems: family, friends, colleague, to be included in the stress management.
   b. Crisis intervention
   c. Enhancing self esteem.

4.0 CONCLUSION

Each person reacts to stress differently according 10 perception of the stressor, personality, prior expectations with stress and use of coping mechanism.

The stages of illness development in stress-related diseases are 7 in all.

Stage 1: short stress situation (no risk)
Stage 2: moderate stress situation (at risk)
Stage 3: severe stress situation
Stage 4: early clinical sign
Stage 5: symptom
Stage 6: disease or disability
Stage 7: death

At any of this stage, there may be physical complaints such as nausea, vomiting, diarrohea or headache. Physical appearance also changes. The identification of the mind-body interaction is crucial for predicting the risk of stress-related illness. A nurse by mere studying the effects of a stressful lifestyle or event in a client can also assess the coping mechanism required by the client.

5.0 SUMMARY

This unit has examined the concept of stress and its relationship to health and illness. The various models of stress were also highlighted to help the nurse understand the causes and response to stress. Stress management techniques directed at changing a person's reaction to stressors were also discussed to assist the nurse in the helping client manage stress carefully.

6.0 TUTOR- MARKED ASSIGNMENT

List and explain the sources of stress in the hospital and suggest ways to overcome these sources.

7.0 REFERENCES/FURTHER READINGS

Hoffman-La, F. (1991). Stress: sign, symptoms, sources solution. Switzerland: Edition Roche, Base.

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