Staff Rostering
(Rostering Of Nursing Staff)

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OPSOMMING

Personeeltoewysing beklee 'n sleutelposisie in verpleegbeheer, maar die stelsel van verpleging wat personeelvoorsiening as doelwit het, funksioneer nie in 'n lugleegte nie.

Die benadering tot personeeltoewysing moet dus deurlopend met personeelkeuring, — oriëntering en evaluering geskied, wat almal op die doelwit gebaseer en daarmee deurdrenk is.

INTRODUCTION

STAFF rostering is a key factor in nursing management with potential to bring life to, or to paralyse the system. This places immense responsibility on those in charge of rostering, and an all but intolerable load if the task is incumbent upon any one person. Nurse administrators (managers) who have handled such a task, are to be congratulated on the order they have created out of potential 'chaos'. It would seem, however, that the time is surely ripe for regular appraisals of the situation with a resultant increased participation in the policy and decision-making process.

The origin of the word "roster" is both military and naval and, according to Webster's Dictionary[1], is ". . . a register showing or fixing the rotation and assignments in which individuals, companies, regiments, etc., are called on to serve" and . . . "any list; or roll".

This definition assumes that planning is necessary in order to accomplish the assignments on hand, but the extent or nature of the planning is not specified. A list or a roll is meaningless unless it is an expression and result of the life of the whole system. In other words, **rostering cannot be seen in isolation, divorced from the other components of the health care system, but as an integral part of it.**

The approach to rostering must thus be within the framework of, and continuous with, that of personnel selection, orientation and evaluation, all of which are patterned on and permeated by established objectives (based on desired results).

In order to view rostering in relation to these aspects of personnel administration each subject will be dealt with, of necessity somewhat superficially.

OBJECTIVES

Redding[2] defines objectives as **"effectiveness standards which are as specific, as time-bounded and as measurable as possible".**

He devotes considerable attention to clarifying effectiveness, particularly in relation to efficiency and this is noteworthy.

"Effectiveness is the extent to which a manager achieves the output requirements of his (her) position".[3] In short, the job of the manager is to be effective. **Effectiveness is directly related to OUTPUT (results) and is not the automatic outcome of correct activities.** It can not thus be judged by observation of behaviour alone, but must be evaluated in terms of whether or not it is achieving the output

requirements of the job.

In contrast, efficiency may be seen as the ratio of output to input, which means that if both input and output are low, efficiency could still be 100 per cent.

The example[4] below illustrates a few differences between the efficient and the effective administrator.

Efficient	**Effective**
Does things 'right.'	Does right things.
Solves problems.	Produces creative alternatives.
Safeguards resources.	Optimises resource utilisation.
Discharges duties.	Obtains results.

Efficiency and effectiveness are not mutually exclusive, but it is important constantly to be alert to the fact that efficiency does not necessarily mean effectiveness.

Having stated that objectives are standards of effectiveness (both general and specific), it is now necessary briefly to establish the nature of these areas of effectiveness.

Stating objectives for a specific member of staff and making plans to ensure these are met, is no easy task and requires considerable personal effort, time and expertise, but the dividends in both the short-and long-term are such as to make the initial investment infinitely worthwhile.

When commencing this task it is helpful to consider the areas or spheres in which a nurse functions, and in which she is required to be effective. These areas apply in varying degrees to all categories of nursing staff, and the priorities need to be placed according to the function (position) of the nurse.

— personal growth
— health care (i.e. community, family, patient needs) at the primary, secondary or tertiary level
— professional sphere (including education)
— organisational sphere (division, department, hospital, community-based clinic, etc.)

Objectives should first be set for the most senior administrative positions and these objectives must reflect both the nurse-executive's (and her subordinates') level of experience, training, skill, capability and motivation as well as the resources on which the nurse-executive can draw — in other words **objectives must be realistic.**

To standardise expectations of staff without any reference to the circumstances in which they work is obviously unwise.

Objectives are best formulated together with the superior, subordinate and incumbent. (In the main this pattern can be repeated irrespective of the position under review). Principal objectives usually number six to eight.

Attempts should be made to link the objectives with those of other relevant positions. For example, it is important that the objectives of the matron should bear relation to those of the medical superintendent; that the objectives of a surgical ward sister should be linked to those of the intensive care unit sister; the nurse-educator with the nurse-administrator, etc.

Objectives, once agreed upon by the superior require a plan to ensure their realisation. The plan is the responsibility of the incumbent, e.g. that which a ward sister is to achieve needs the approval of the appropriate nurse-administrator, how she does it is her responsibility (assuming certain safeguards).

In addition to facilitating linking of objectives, the setting of objectives should be such as to allow measurement, control and regular review. However, it is important to state that the strength of nursing management by objectives is in motivation, planning and integration of the organisation and is not merely a tool of control and appraisal.

It is ultimately envisaged that job effectiveness descriptions (resulting from the objectives) will exist for each nursing administrator whether she (he) be in the clinical, educational or administrative role; and, that objectives will exist for each department, ward, unit, etc., formulated by the relevant multi-disciplinary team. This would naturally be a long-term goal.

Objectives are dynamic and therefore subject to variations in detail and application but once the basic objectives are assimilated and found to be of value by the staff, these will find expression in attitudes and actions.

Objectives must not be relegated to being another administrative burden . . . another piece of paper, but must be a vibrant part of the organisation.

PERSONNEL SELECTION

In the discussion on objectives the point was made that job effectiveness descriptions (based on general and specific objectives) are required for each nursing administrator irrespective of her position on the hierarchical ladder. This description is an invaluable guide to the nurse responsible for personnel selection, particularly at registered nurse level and, where possible, new staff should be chosen with a specific position in view. (However, the job description is to be used with flexibility, and may well require minor, or even major adjustments, to the mutual benefit of both the employee and the organisation).

By using job effectiveness descriptions both employer and prospective employee are in a position to assess the candidate's expectations and expertise *vis-á-vis* the vacancy in question. Thus the need of the organisation for an employee to be effective, and the need of the employee to have certain expectations realised will be covered.

Considering an employee's expectations and goals from the start, should be a motivating factor. Equally, and perhaps more important is the recognition by the employee that she is viewed as an individual with a specific contribution to give to the organisation, as well as receiving opportunities and resources to meet the mutually established goals.

It would be most beneficial if the immediate superior of the prospective employee was involved in the later stages of the selection process, so that initial contact is established prior to commencement of employment and out of the specific work environment, where roles are less rigidly defined.

The above procedure applies equally, whether the recruitment is from without or from within the organisation.

Where selection involves more junior categories of staff, particularly student nurses, the job effectiveness description is less specific but the principle of goal-setting, responsibility and accountability still apply. Attention needs to be given to establishing expectations as these are frequently somewhat unrealistic and need to be carefully handled at grass-root level. (Failure to do this may well be one of the major causes of drop-out).

In all instances a start should be made towards crystallising the long-term goals, particularly professional goals. This process needs to be continued by the immediate superior from time to time but an interview with a more senior nurse-executive at 12 — 18 month intervals could prove most fruitful.

In summary, recruitment is based on a systematic assessment of candidates rather than on the presence of an R.N. (or matriculation) suffix, and it goes without saying that where quality is recruited, quality is to be utilised.

PREPARATION OF PERSONNEL

Much progress has been made during the past two or three years in the area of orientation programs but a few points are worthy of mention.

Active orientation 'programs' I believe, need to start prior to commencement of work, e.g.:-

— interview/s
— brochures and information sheets giving adequate details of the organisation in general and the specific job in particular (including job effectiveness descriptions and conditions of service)
— information booklets/brochures, etc. for living-in and up-country staff covering aspects of everyday life (e.g. transport, postage, banking, library, cultural and recreational facilities, etc.) as well as facilities provided within the residence and hospital.

The problem is seldom one of a surfeit of information, rather the reverse.

The benefit of sufficient information should not be underestimated for it does much to allay fear and minimise insecurity and thus facilitate the realisation of objectives.

Although many institutions rightly consider a fixed number of weeks or months as the orientation period, nurse-supervisors (administrators) need constantly to be attuned to the individual nurse. No two people adapt at the same rate, nor does one person make multiple and diverse changes in behaviour patterns concurrently.

Thus, while a nurse may have apparently 'adapted professionally' she may well be lagging far behind in emotional or social adjustments. It is the difficult task of the nurse-supervisor to discern the individual nurse's threshold for change and accordingly to select one or two behaviours for alteration at any one time.

Such 'sensitivity' is not born overnight and nurse executives need to set the example, and also ensure that their administrators at all levels are trained and nurtured, in order to develop such assessment skills.

An approach such as this, with regular informal communication does much to speed up the adaptation process, minimise strain and improve the standard of work and job satisfaction obtained.

PLACEMENT OF PERSONNEL (STAFF ROSTERING)

At the outset it was stated that rostering of nursing personnel is a basic component of any organisational system and should be structured on the common framework of established objectives (effectiveness standards). Thus, however many units are involved in the rostering they are united by a common set of objectives, ensuring a relationship of responsibility and accountability — a fundamental management principle.

Staffing the nursing service is a difficult and often critical problem, not only because it represents the single most costly component of hospital expenditure, but also because it has, amongst other things, a direct bearing on the quality of patient care. There is, however, no universal panacea to the problem of staff rostering; each situation is unique and thus brings with it its individual strengths and weaknesses.

Excellent literature [6] — [12] is available detailing the various scientific methods which have been developed and successfully used in improving the prediction of nurse-manpower needs, by taking cognisance of the multiplicity of variables affecting manpower planning. These methods are indeed of considerable value, they can be neither overlooked nor underestimated, for they have contributed in no small measure to the relatively stable staff establishments which are the pattern today. But, important as they may be, these methods alone do not ensure an effective system.

A rostering system, I believe, does not primarily stand or fall by the balance or imbalance of numbers of personnel or available resources to the situation in hand but rather by the **quality of the relationships which exist throughout the organisation and specifically with nursing management.** Thus, at the risk of being considered too fundamental or perhaps too idealistic, I shall now focus on this area of relationships. It is the component common to all nursing systems, and in the final analysis rostering involves individuals who share certain basic needs.

The prerequisites essential to any good relationship are communication, loyalty and trust. These are easy to list but difficult to achieve. Success requires a continuous and concerted effort on the part of each staff member, not only to establish relationships but also to maintain them.

What then is the basis for acceptance within nursing? I believe, to the detriment of our professional and interpersonal relations, this has been 'perfection' or 'apparent success'. In other words acceptance has been based on 'how right and self-sufficient I am' and 'how few mistakes I make' — therefore, I never expose my weaknesses nor my needs. So, to a great extent we have a profession which is clad in masks. A masked 'me' relates to a masked 'you' and therefore we are conversing across a barrier which only serves to widen the communication gap. There is a right time and place for such admissions and one must be willing to make them at these times and face the genuine risks involved in being real (in being oneself). This involves us all — it is costly but the final results are beyond measurement!

This is not to advocate an unnecessary or unseemly 'baring of souls;' but rather is a recognition that, if adequate verbalisation of increasing stress, or failure in any particular area, is to occur, and be dealt with in a timely and satisfactory way, lines of communication need to be sufficiently open.

The basis for relationship and acceptance is a respect for the individual person and a concern for her growth and wellbeing and this should be the message communicated at all times, not least in the specific objectives.

The policy relating to such aspects of service as:-

— places of work
— training courses
— leave privileges
— communication channels, etc.

need to be stated in writing and reinforced verbally, at the time of appointment and any unexpected or major changes in plans (particularly in relation to the staff roster) should be communicated **personally**, and prior to publication of the roster. If the downward information flow is slow and faulty, misunderstandings, frustration and apathy result. The same applies to the upward flow of information. The result in either instance is division.

It is easy to use the roster as a means for 'coping' with a problem member of staff, **but** changing the place of work does not necessarily solve the problem — whatever the solution a personal discussion is essential. The success of staff rostering is readily revealed at ward, unit or clinic level and it is here that the ward sister and her immediate superior (e.g. clinical matron) are of paramount importance. They are in a position to gauge pressures and pace of work and to change routines in order to relieve strain while still maintaining objectives. A useful guide to the priorities of the shift (be it day or night) is to consider what functions, needs, tasks are:

a) important and/or urgent (i.e. the treatment without

which the patient would suffer).

b) necessary (i.e. ordinary hospital/nursing routine).

c) desirable (i.e. the extras which go beyond routine functions).

Those who fall into category (a) are completed first and usually those in category (b) second, but, if a high standard of patient care **and** job satisfaction are to be achieved the individual nurse must be given some freedom to choose between (b) and (c). The 'clinical matron' is in a unique position to advise the nurse-executive (in charge of staff rostering) when changes or additional assistance are required in any particular sphere, in order to protect the ward sister from excessive pressures. It is crucial that the nurse-executive should have her finger on the pulse (!) of the ward sister (registered nurse) for she is the cornerstone of the nursing service and errors of judgement, as to her health and needs can only be detrimental to the service.

Finally the pattern of rostering for nurses in training needs to be designed in order that their clinical experience is as near optimal as possible in relation to their educational program and their level of training. This will require that certain wards are staffed with a greater proportion of registered nurses and others with additional assistant nurses thus making the required wards/units available to students in training for the necessary periods.

PERFORMANCE APPRAISAL (Evaluation)

In the past performance appraisal has been viewed with considerable scepticism and rightly so, for it placed the supervisor in the untenable position of judging the personal worth of her subordinates, and of acting on these judgements. It was seen as an isolated entity, as an end in itself and bore little, if any, relationship to the total system.

What is the answer to the performance appraisal as a means. One must ask, a means to what end? The end may be different for different nurse-executives and different institutions. Once this is defined (viz. objectives/output requirements) performance appraisal shrinks to appropriate size, becoming part of a bigger system designed to meet the desired end.

A sound approach places the major responsibility on the staff member for establishing performance goals (in conjunction with her supervisor and possibly subordinate) and appraising progress towards them, e.g. at the end of a three or six month period the staff member makes her **own** appraisal of what she has accomplished relative to the targets she had set earlier. She substantiates it with factual data wherever possible. The interview is an examination by the evaluator (supervisor) and staff member together, of her self-appraisal, and it culminates in a resetting of targets for the next six months. Thus no longer is the supervisor examining the staff member, rather the staff member is examining herself in order to define not only her weaknesses but also her strengths and potential. The focus is thus on the future rather than the past. "Effective development of staff members calls for **creating a relationship** within which a person can take responsibility for developing her own potential, plan for herself, and learn from putting her plans into action. The proper role of the supervisor, then, is the one that falls naturally to her under the suggested plan, helping the staff member relate her career-planning to the needs and realities of the organisation. In the ongoing discussions, the supervisor (evaluator) can use her knowledge to help the staff member establish targets and methods for achieving them which will (a) lead to increased knowledge and skill, (b) contribute to organisational objectives, and (c) test the staff member's appriasal of herself."

Throughout this process it is necessary for the supervisor to coach and encourage the staff member to determine priorities and focus on these, as well as to develop an innate sensitivity to the signals of her own state of wellbeing (i.e. emotional and professional thresholds) and to be able to alter her pace accordingly. Under such circumstances the opportunities for learning and for genuine development of both parties are maximal, and the organisation, the supervisor and the staff member all stand to gain.

It is clear that more managerial skill and the investment of a considerable amount of time are required. Reaction to these costs will undoubtedly vary. The administration that considers the development of its human resources to be the primary means of achieving the objectives of the organisation, will not be perturbed. It will regard guidance and coaching as among the most important functions of every person in a supervisory position.

CONCLUSION

As effectiveness, rather than efficiency, is seen to be the goal, the evasion of personal development and adaptation behind a mask of efficiency is to be avoided. This will involve better personal caring for the individual nurse as the ultimate asset (instead of an 'exclusive' emphasis on knowledge and techniques) than has, perhaps, been the case so far. If it is true, however, that 'to care for the nurse is the most effective way of achieving optimum patient care,' then it is a totally commendable shift of emphasis.

One would hope and indeed expect that it would result in the successful realisation of job effectiveness descriptions by nurses at every level, and an achievement of job satisfaction and personal fulfilment that should aid both the general health service and those working in it.

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