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EXTENT OF PARTICIPATION IN THE STRATEGIC PLANNING PROCESS BY EXECUTIVE NURSES IN VIRGINIA'S ACUTE CARE HOSPITAL

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This is to certify that the thesis prepared by

Mary R. Pippin entitled <u>Extent of Participation in the Stra-</u>

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EXTENT OF PARTICIPATION IN THE STRATEGIC PLANNING PROCESS
BY EXECUTIVE NURSES IN VIRGINIA'S ACUTE CARE HOSPITAL

A thesis submitted in partial fulfillment of the
requirements for the degree of Master of Science
at Virginia Commonwealth University

By

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ABSTRACT

EXTENT OF PARTICIPATION IN THE STRATEGIC PLANNING PROCESS BY EXECUTIVE NURSES IN VIRGINIA'S ACUTE CARE HOSPITALS

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The purpose of this study was to determine the extent to which executive nurses participate in strategic planning for their institutions, and the extent to which these executive nurses utilize the strategic planning process for their nursing departments. The effects of ownership, size, and educational level of the executive nurse on the extent of participation in institutional strategic planning and the utilization of the strategic planning process for their nursing departments was also examined.

The population of the study included all executive nurses employed in short-term, nonmiltary, Virginia hos- pitals, which were members of the Virginia Hospital Associa- tion. Questionnaires were mailed to 114 executive nurses, 60 returned the survey with a response rate of 53 percent. The 60 hospitals included: 14 small institutions (< 99 beds), constituting 24 percent of the sample; 30 medium-sized insti- tutions (100-399 beds), comprising 58 percent of the sample;

and 11 large institutions (> 400 beds), constituting 18 per-
cent of the sample. There were 48 not-for-profit institu-
tions constituting 80 percent of the sample, and 12
for-profit (investor owned) comprising 20 percent of the
sample.

The typical nurse executive in this study held a
master's degree, had 21-25 total years of nursing experience
of which one to five years was at the executive level, and
had been in his/her present position one to five years.
Slightly over half of nursing departments had long-range
plans covering three years or less. The majority of
long-range plans for the department of nursing were formu-
lated by the strategic planning process. Participation in
hospital strategic planning was influenced by the
institution's size and the nurse executive's educational
level. Utilization of the strategic planning process for
the department of nursing was influenced by neither size nor
ownership, only the executive nurse's educational level.

CHAPTER ONE

Introduction

Health care costs continue to accelerate in the United
States. In 1966, when Medicare and Medicaid were imple-
mented, total spending by individuals, insurance companies,
and the government was six percent of our gross national
product (GNP). By 1985, national health expenditures repre-
sented 10.6 percent of the GNP. This continued increase in
the cost of health care, combined with a societal belief
that all people have a right to health care, resulted in
various consumer groups directing pressure on hospitals to
become more cost effective.

The external demands for cost effectiveness along with
increased federal and state regulations forced hospitals to
begin responding to their external environment in a manner
similar to other service organizations. Hospitals, like
other organizations, must effectively manage the demands of
their external environment in order to survive (Pfeffer and
Salancik, 1978). External events that are currently having
an impact on hospitals (Coddington, Palmquist and Tollinger,
1985) include prospective payment instead of cost reimburse-
ment, decreased occupancy rates, competition, changing
relationships between hospital administration and physicians,

deregulation of hospital building, continued improvement in technology and equipment, difficulty in raising capital, and financial problems secondary to treating the indigent.

In order to prosper in today's turbulent environment, organizations must engage in methods that enable them to match their organizational strengths with opportunities in their external environments. Planning is one method that organizations have used to accomplish this.

Because the planning process has evolved continually since its inception, business planning has taken many forms. Over the years, various planning approaches to managerial problems were formulated: financial ratio analysis, management by objectives, capital budgeting, profit planning, long-range planning, strategic planning, issue analysis, and strategic portfolio analysis (Ansoff, Declerck and Hughes, 1976:41).

Planning by hospitals began with the implementation of the Hill-Burton Act of 1946, which allotted money initially for the building of hospitals, and then later, for renovation, special services, and nursing homes. Later, project planning was done in order to obtain money through the Comprehensive Health Planning Act of 1965, for development and monitoring of additional health care resources, such as the construction of new hospitals, specialty services, and nursing homes, through the creation of state and sub-state health planning agencies. Project planning evolved into

long-range planning by expanding the time frame from that necessary to complete just one proposed project to three-year planning in order to meet Medicare regulatory requirements.

Long-range planning in hospitals frequently was done by external consultants, was very expensive, and was very time consuming. The focus of the process was frequently on the generation of a plan to meet regulatory requirements. There was little flexibility once the plan was accepted and implementation begun. Long-range plans usually covered three to five years, and review of the plan once formulated generally occurred just prior to the generation of the next plan. Long-range planning tended to become a paper exercise for regulatory documentation rather than a process for both charting the hospital's future course and acting as an instrument to measure the progress of the hospital in meeting milestones toward future goals.

Traditionally, hospitals have adopted industry's planning processes because industries were confronted earlier than hospitals by external environment demands; therefore, industry had experience in formulating effective methods to manage the external environment. In order to be able to respond more rapidly to environmental changes, hospitals adopted from industry the strategic planning process.

Strategic planning is a method currently utilized to manage the boundary between the hospital and its external

environment. Strategic planning is the process by which hospitals assess the health care market and their true competitive position within the market. According to Bourgeois, "one can find among the many definitions that strategy has the two primary purposes of defining the segment of the environment in which the organization will operate and providing guidance for subsequent goal-directed activity within that niche" (1980:27). This process determines the hospital's future direction while concurrently addressing community needs and satisfying regulatory requirements (Domanico, 1981).

Like hospital planning, nursing service departmental planning has been an ongoing evolutionary process. Although planning is recognized as a fundamental part of good management, because of the heavy demands for immediate resolution of daily crises and a lack of knowledge and experience in establishing and utilizing a formal planning program (Fox and Fox, 1983), planning by nurse executives traditionally has been relegated to the last priority.

Several additional factors have also contributed to the late entry by nurse executives into the field of formalized planning. A cursory examination of hospital administration practices (Gugenheim, 1979) revealed a failure to solicit nursing input into significant policy-making decisions, program planning and design, and financial management. Specific

barriers identified for failure to solicit nursing input were: (a) failure of hospital administration, physicians, and some nurses to recognize and acknowledge a nurse's capability to fulfill a top management role, (b) reluctance on the part of nurse executives to accept and implement their roles in top management, and (c) longstanding difficulties in interprofessional collaboration (Gugenheim, 1979).

The first barrier to formalized planning by nursing prior to the 1980's was frequently the nurse executive's lack of educational preparation in administration. In 1977, 49.5 percent of nurse executives cited diplomas and 22.5 percent cited the associate degree as their highest degree (Aydelotte, 1984). These nurses graduated in an era when nurses were generally taught by physicians and nurses did not feel part of administration (Niederbaumer, 1979).

The accuracy of this perception was depicted in the late 1950's when a study of nursing leadership at various levels in 15 hospitals discovered that nurses did not perceive the executive nurse to be a leader in formulating ideas, long-range planning, or promoting nursing as a profession (Hagen and Wolf, 1961). Instead, the role of the executive nurse was seen primarily as directed toward acquiring nursing personnel, coordinating departments, enforcing hospital policies, providing for inservice training, and generally improving nursing services (Weisman, Alexander and Morlock, 1981).

Twenty years later, the trend continued at the administrator level when in 1977, a survey conducted by the Professional Services Committee of the Pennsylvania Hospital Association reviewed 145 sets of responses from Chief Operating Officers (COO) and Directors of Nursing Service (DNS) concerning the perceived role of the DNS (Hospital Topics, 1979). The study revealed: (a) half of COOs failed to view the DNS's formal position and title at the first level of management below the COO or viewed the DNS at one or even two levels below the first line, (b) the DNS was perceived by the COOs to have increasingly less authority as the subrole in which the DNS was functioning moved away from that of clinician to fiscal officer and then administration, i.e., the DNS was viewed as a nurse not an administrator, and (c) the DNS believed that the positions of DNS and director of medical service were equal, but they actually were not.

Additionally, in most institutions contributing to policy formation required being a member of the administrative executive staff, the hospital governing body, and the hospital long-range planning committee (Niederbaumer, 1979). Niederbaumer stated that in many institutions the DNS was unknown to the trustees and others in policy-making positions and she did not participate in hospital decisions. Therefore, the DNS was denied membership into groups responsible for organizational-environmental boundary management.

More recently, nurse executives are being included in hospital administration groups responsible for boundary management. In 1982, the American Society for Nursing Service Administrator's follow-up survey of its 1977 study revealed that the role of nurse executives had evolved to include increased participation in institutional governance and fiscal management and significant changes in reporting relationships.

According to Manson (1983), the nurse executive of the future must possess financial management skills, computer knowledge, marketing and public relations skills, and the ability to analyze data and formulate short and long-range plans based on economic and clinical information. Niederbaumer (1979) asserts that nursing participation in policy level decision-making is the only effective manner to plan, integrate and implement the hospital's goals.

Eventually nurse executives became involved in the process of long-range planning, and then finally in the early 1980's they began participating in the strategic planning process (Fox and Fox, 1983). Studies by Schultz (1972), Shortell, Becker and Neuhauser (1976), and Shortell and LoGerfo (1981) were the basis of Stuart's (1985) statement:

> Based on the research of participation by physicians, administrators and trustees in hospital decision-making, one might expect that increased participation by nursing would be associated with positive outcomes for hospital effectiveness and viability through increasing

the organization's command of its internal environ-
ment and resources. Thus suggested outcomes might
include decreased hospital costs and improved
quality of nursing care through the retention and
commitment of a professional nursing staff (p. 53).

Involvement in strategic planning offers nurse execu-
tives a method to increase professional practice and autonomy
through participation in hospital decision making. For
nursing, attaining autonomy means being able to define the
domain of nursing, being able to exercise control over
nursing practice and becoming more independent of medical
dominance (Stuart, 1985).

Today's environment of increasing technology, escalating
costs, consumer desire for additional community services,
increased competition, emergence of for-profit health care
organizations, and enactment of prospective payment has
resulted in changing roles of health-care organizations.
The evolving roles of health care organizations have in turn
mandated alterations in the role of the nursing administrator
(Hospital Topics, 1979). There is a need for executive
nurses and their subordinates to plan for the future, which
should include the construction of effective economic con-
trols for nursing (Swansburg, 1979; Monte, 1979; Poulin,
1984).

Strategic planning offers nurse executives a method to
increase management effectiveness by matching departmental
strengths with environmental opportunities. It can increase

effectiveness by delineating competencies which will promote professional nursing practice, the mission, and the long-range goals of the hospital. Strategic planning permits nurses to provide services that accurately align current and potential client needs with nursing's unique professional competencies (Fox and Fox, 1983; Lukacs, 1984). Strategic planning also promotes the managerial flexibility necessary to respond proactively to new information, thereby increasing long-term viability of organizational contributions and programs (Camillius, 1980). The proactive nature of strategic planning can assist nursing in avoiding future problems; because when using the process, the executive nurse considers both what nursing currently is and should be over the projected planning period.

The purpose of this study is to determine the extent to which executive nurses in Virginia hospitals are: (a) participating in the strategic planning process for their institutions, and (b) using the strategic planning process for the department of nursing. Results of this study will provide hypothesis generation for future research, practical guidelines for future education of nurse executives and hospital administrators, practical guidelines for incorporating the strategic planning process in the department of nursing, and knowledge to practicing nurse executives regarding the

current state of their peers' involvement in strategic
planning for both the hospital and the department of nursing.

Statement of the Problem

The intent of this study is to determine the extent to
which nurse executives are participating in the institutional
strategic planning process. A second purpose is to determine
whether or not the nurse executive is using the strategic
planning process in managing the department of nursing.

Research questions to be studied are:

1. To what extent are nurse executives participating
in institutional strategic planning?

2. Are nurse executives using the strategic planning
process in managing the department of nursing?

3. Does hospital size, ownership, or the nurse
executive's educational level have any impact on extent of
participation?

Operational Definitions

Executive nurse - the hospital's top nursing adminis-
trator who is responsible for directing nursing service for
the entire hospital. Usual titles include Director for
Nursing Service, Vice President for Nursing Service, or
Assistant Administrator.

Strategic planning - the existence of a planning process
for a time period of three to five years that is based on the

examination of the hospital's mission and environmental analysis; includes a listing of ranked objectives, and specific plans to achieve stated objectives, as determined by tabulating "yes" responses to questions on the participation questionnaire.

Extent of participation - the amount of participation in various strategic planning process activities as measured by positive responses on the strategic planning process questionnaire.

Short-term hospitals - hospitals in which the patient's length of stay is 30 days or less.

Conceptual Framework

Like other organizations, hospitals are influenced by their external and internal environments. According to Georgopoulos (1974:3), the hospital as an organization is a specialized community institution that is operating: (a) under the constraints of a health care delivery system that is invested with problems, and (b) within a turbulent social environment to which it must constantly relate and adapt. It is a highly complex organization founded on the mutual cooperation of a large and heterogenous number of inter-dependent professional, semi-professional, and nonprofes-sional members.

Changes in the role of the hospital as a health care center within the overall care delivery system have been noted (Georgopoulos, 1974). This redefinition of roles is occurring in the context of major societal trends concerning community demands, national health priorities and goals, and health care conceptions by both the public and its representatives (Georgopoulos, 1974).

With the advent of accelerated post-Medicare cost increases, national health policy has essentially been modified from one promoting equal access to health care to one of equal access under cost control measures. The National Health Planning and Resources Development Act of 1974 was one such cost control measure. For example, P.L. 93-641 through certificate of need requirements, attempted to curtail the costs of health care by restricting unnecessary expansion of health care facilities. Unnecessary expansion and services were restricted by placing legal prohibitions on unnecessary capital investment, and establishing financial controls by making an institution's eligibility to receive capital or operating funds dependent upon the approval of designated planning agencies (Salkever and Brice, 1976). Additional legislation in the form of prospective payment in 1983 provided financial cost control incentives to health care institutions through prospective reimbursement for hospitalized Medicare patients. These legislative acts comprise only one

element in the hospital's external environment.

Organizations may be viewed from Chin's (1961) system theory in which change is an ongoing and dynamic process caused by interactions between all the elements both internal and external to the organization. Internal elements for a hospital include such items as the number, type and educational level of personnel, condition and adequacy of physical facilities, inter- and intra-departmental relationships, type and quality of professional services being provided, operating funds, and institutional reputation. A hospital's external environment is comprised of elements arising from the political, social and economic arenas such as competition, local, state and federal regulatory requirements, availability of supplies and equipment, new technology, and societal demands for high quality and cost contained health care. All systems have inputs, transformation processes and outputs.

For input, organizations bring in a variety of material and nonmaterial resources and facilities from the environment. Hospitals import, combine and then transform such inputs as new personnel, technology, knowledge, and equipment into outputs such as advanced technology, additional knowledge, expanded services and improved health care. Organizations import raw materials, supplies, equipment, funds, labor, and information in order to reduce uncertainty and

fight entropy--the trend for systems to become disorganized, break down and disintegrate.

Organizations import the above resources and transform inputs into outputs. Organizational outputs vary according to the purpose of the organization. For manufacturing organizations, they are usually physical products like watches or cars. Educational and research organizations provide educated individuals and new information as their output. The third type of system, service organizations, produce various services to society, such as health care.

An organization is an open system because there is a constant exchange of information, matter, and energy between the organization and its environment. The open system is in continual interaction with its environment and achieves a "steady state" or a dynamic equilibrium while still retaining its capacity for work or energy transformation. The organization balances maintenance activities such as purchase, maintenance of equipment, recruitment and training, and rules and regulations with adaptive activities of planning, marketing, and research and development (Robbins, 1983:12). The open system adapts to its environment by changing the structure and processes of its internal components.

Human organizations are constantly subject to external forces, pressures, and stimuli that significantly influence behavior within the system, and vice versa (Georgopoulos,

1972). During the process of simultaneous stimulation, organizations are affecting the environment and are in turn affected by it. Through continual interchange and negotiation with the environment organizations preserve their basic integrity and internal adjustment while coping with external change. Human organizations are dynamic open systems, whose boundaries are relatively elastic and permeable rather than fixed. They are sufficiently open to allow the input-output transformations of matter, energy and information with the external environment that are vital to the existence and functioning of the system.

The hospital as a human organization is an open system which is influenced by many different sectors in the external environment. In return, the hospital influences the external environmental sectors, primarily through political and client interaction processes. The hospital is also influenced by its internal environment such as the quality, productivity, and efficiency of its professional staff, and influences its professional staff through the enactment of performance standards, bylaws, and reward systems. Because the hospital is an open system there is constant interaction between it and its environments.

Strategic planning is one method for effectively managing the organization's open system environment in which change is an ongoing and dynamic process secondary to

interactions among elements both internal and external to the organization. The process of strategic planning includes the assessment of the external and internal environments, establishment of goals, formulating alternatives for achieving the goals, selection and implementation of strategic choices and ongoing evaluation and adaptation as new information becomes available. For example, if a hospital has a low occupancy rate, its medical staff is primarily general practitioners, and the community lacks skilled nursing beds, the hospital might consider opening a skilled nursing unit for patients who no longer require acute hospital care, but who are not ready to be discharged to home or to a long-term care facility. By focusing on the institution's strengths and weaknesses in combination with threats and opportunities presented by the external environment, strategic planning enables a hospital to link the organization with its external environment.

Because the hospital is an open systems environment, nursing can contribute to the institutional strategic planning and employ the strategic planning process in managing the boundary between nursing, the hospital and the community. Nurse executive involvement in the strategic planning process can enhance professional practice and autonomy while simultaneously contributing to the organization's efficiency and effectiveness.

CHAPTER TWO

Literature Review

Planning in Business Organizations

Participation in strategic planning by organizations began in the manufacturing industry and was later adopted by service industries. Bourgeois (1980:27) asserts that among the many definitions of strategy two primary purposes can be identified: (a)"define the segment of the environment in which the organization will operate," and (b)"provide guidance for subsequent goal-directed activity within that niche." Steiner (1979:37) states that strategic planning has seven elements: (a) it simulates the future, (b) it applies the systems approach, (c) it forces the setting of objectives, (d) it reveals and clarifies future opportunities and threats, (e) it provides a framework for decision-making throughout the company, (f) it is a basis for other management functions, and (g) can be used to measure performance.

However, Steiner (1979:37) also identifies some limitations of strategic planning: the environment may prove different from that anticipated; there may be internal resistance; planning is expensive and does not manage crises. In addition, planning is difficult, and completed plans can limit choice. Kiechel (1982) after reviewing actual actions

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to planned strategies, estimated that 90 percent of all
American companies had failed to successfuly implement
their strategies.

In the middle 1950's many American firms experienced a
leveling off of their market demand, a decreased demand
secondary to substitutive products by new technologies and
increased market share by foreign competitors (Ansoff, et al.,
1976:41). Additional environmental changes affecting
industry included anti-trust legislation, safety legislation,
consumer pressures, pollution constraints, and price and wage
controls. Manufacturing firms, followed by other types of
organizations, increasingly became concerned about their
"mal-adjustment with the environment." The cause, which was
labeled the "strategic problem," was thought to be secondary
to a techno-economic mismatch between the products of the
firm and the demands of its market (Ansoff, et al., 1976:1).

Strategic planning was developed as a solution. Strate-
gic planning was formulated to furnish management a tool that
would enable a rational analysis of both the threats and
opportunities provided by the environment and the strengths
and weaknesses of the firm. The analysis would then be
followed by a selection of a "match" or strategy between the
firm and its environment which would meet the objectives of
the firm (Ansoff, et al., 1976:11).

Initially, strategic planning included only the techno-
logic, economic and informational variables; excluded were
the political and social dynamics both internal and external
to the organization. Ansoff, et al. (1976), however, pre-
dicted that psychological, social and political variables
would become the most important variables in the 1980's.
Because of the importance of the excluded variables, they
were eventually included as a total package in the strategic
management process.

In 1982, Armstrong conducted a review of empirical
research to determine the value of formal planning for stra-
tegic decisions. He examined 12 studies to determine what
aspects of formal planning were actually used, in what situa-
tions formal planning was used, and what the results of for-
mal versus informal planning were. Several difficulties were
encountered. First, 60 percent of the studies did not pro-
vide adequate information on the nature of the planning pro-
cess. Second, 70 percent of the studies did not include
information to determine the situation in which formal
planning was used, and finally, 80 percent of the studies
limited the results of strategic planning only to the finan-
cial impact of planning upon the stockholder's return on
investment, rather than evaluating the entire efficiency of
the firm. However, in spite of the limitations, a pattern
could be identified. When improved performance was used as the

evaluating criteria, informal planning was superior in two
comparisons, but neither was statistically significant; for-
mal planning was superior in 10 of 15 comparisons in the 12
studies, with five comparisons being statistically signifi-
cant. It was also noted that formal planning tended to be
more useful where major changes such as new product intro-
ductions or high rates of technological innovations were
involved.

In reviewing the literature concerning the impact of
formalized strategic planning on the financial performance of
small organizations, conflicting results were found. Ansoff,
Ayner, Brandenburg, Portner and Radosevich (1970) examined
the influence of planning on successful acquisitions in 93
American firms from 1946-1965. Planners significantly out-
performed nonplanners when using economic criteria of sales,
earnings, earnings per share, and return on common equity.

Thune and House (1970) investigated the impact of
long-range planning on the economic performance of 36 firms
in six industries. Economic criteria used were: sales,
stock prices, earnings per share, return on common equity,
and return on total capital employed. Formal planners sig-
nificantly outperformed informal planners in the drug, chemi-
cal, and machinery industries, but no significant relation-
ships were found in the food, oil, and steel industries.

Herold (1972) expanded Thune and House's study by
including pretax profits when measuring economic performance.
Five formal planners in the drug and chemical industries out-
performed five informal planners in the same industries.

Rue (1973) investigated the associations between
long-range planning and the economic performance of 386 firms
in the nondurable, durable, and service industries. In the
durable industries, planners outperformed the nonplanners; in
the service industries, nonplanners outperformed planners;
but in the nondurable industries, no consistent differences
were found.

Karger and Malik (1975) evaluated the impact of formal
integrated long-range planning on economic performance for
38 firms in the chemical, drug, electronic, and machinery
industries. Planners outperformed nonplanners on 10 of 13
economic measures, including net income, sales, earnings per
share, and return on net worth.

Robinson and Pearce (1983), in the study of 50 small
United States banks, also found empirical support for a
positive relationship between strategic planning and perfor-
mance in large organizations. However, there were also some
contradictions noted in two studies.

First, Grinyer and Norburn (1975) investigated the
relationships between characteristics of the strategic
planning process and financial performance in 21 United

Kingdom companies using return on net assets as the measure
of profitability. They were unable to find a significant
relationship between formal strategic planning and financial
performance.

Second, Kudla (1980) investigated the effects of stra-
tegic planning on returns to shareholders in 328 companies.
No significant differences in returns to shareholders by
planning and nonplanning firms were found.

Methdological concerns were expressed regarding the
negative studies, i.e., those studies which did not support
the beneficial impact of formal planning. Kudla (1980) dis-
covered in previous studies that no attempt had been made to
control for extraneous independent variables, such as general
market conditions, industry differences, and government fac-
tors, which could have affected the outcome of the studies.
These studies also did not control for inter-industry dif-
ferences. Rue (1973) found no significant differences
between planners and nonplanners in the nondurable indus-
tries, but that nonplanners outperformed planners in service
industries. Leontiades and Tezel (1980) expressed concern
that the methods for operationalizing formality of strategic
planning in previous studies had been too simple, arbitrary,
and reflected the researcher's opinion rather than the true
character of the planning system, i.e., whether or not the
planning system was really one of strategic planning.

An additional concern regarding the studies, regardless
of whether the results were positive or negative, was that
the samples were of large organizations. Lindsay and Rue
(1980) discovered that there were significant differences
between the organizational environment of large and small
firms, and therefore it was necessary to control for this.
They found that firms tended to adopt more complete formal
long-range planning processes as the complexity and
instability of the business environment increased. Lindsay
and Rue stated:

> Another finding was that the degree of openness
> in long-range planning processes is directly
> related to the degree of environmental complexity
> for large firms, but inversely related for small
> firms....The evidence obtained from this study
> suggests that large business firms in a variety
> of industries are attempting to fit their
> long-range planning processes to their perceived
> environmental conditions,...and that small firms
> should be considered as a separate class in this
> and future related studies (1980:402).

Lindsay and Rue (1980:402) stated that possibly:

> top management in small firms tended to centralize
> planning under adverse conditions and to trust more
> in their own judgments, but that managers in large
> firms tended to be more open to information from
> as many sources as possible.

Because the degree of openness in the long-range planning
process may vary, Lindsay and Rue (1980) advise that firm
size is a significant independent variable to consider when
designing an effective strategic planning process.

    In prescriptive literature, Buchele (1967), Cohen and
Lindberg (1972), Gilmore (1971), Robinson (1980), Steiner
(1967), and Still (1974) stated that outsiders, short-time
horizons, minimum emphasis on goal identification, and
informality were four key components of an effective small
firm planning process. Robinson and Pearce (1983:198)
stated that while the above variables were attributed to
planning, these same variables may have reflected charac-
teristics of flexibility, efficiency and centralized decision
making which allowed small firms to survive in a particular
industry segment.

    Empirical research examining the relationship between
strategic planning and performance in small organizations is
sparse. Strategic planning improved small firm effectiveness
when the systematic utilization of consultants was part of
the planning process (Robinson, 1982). In 1983, Robinson and
Pearce studied 20 randomly chosen small banks from a sample
of 85 federal and state-chartered bans in South Carolina to
determine the impact of formalized strategic planning on
financial performance in small organizations. Question-
naires concerned the formality of the bank's strategic
planning, and the degree to which the bank's strategic
decision making incorporated six basic dimensions of stra-
tegic management commonly found in the literature. The
length of time the strategic planning process had been in

place was not considered. Performance data on profit margin, return on assets, loan growth, and return on equity were obtained for three years (1977-1979) on each bank, and all banks were ranked on each performance measure.

No significant differences in performance rankings were noted on any of the four performance measures. Therefore, the performance of small banks using formal strategic planning was not significantly better than nonformal small bank planners. Formal and nonformal planners placed similar emphasis on scanning the environment, identifying distinct competencies, aligning organizational structure, deploying internal resources, and monitoring/controlling implementation in the strategic planning processes. However, formal planners placed significantly greater emphasis on concern for formulating goals and objectives than did nonformal planners. This study contradicts the findings of Wood and LaForge (1979) concerning the value of formal strategic planning in organizational performance, and suggests that there may be different determinants of effectiveness in small firms.

Planning in Hospitals

Strategic planning has only recently come to the hospital industry. To investigate the nature of existing long-range planning efforts, Perlin, in 1972, conducted a nationwide survey of 614 nonfederal, short-term, general hospitals. Perlin (1972) found that although 96 percent of

the hospitals stated they were engaged in long-range planning and two-thirds had a continuous planning process, about one-third of these efforts were one-time exercises and were not part of an ongoing process. Additionally, differences in hospital goals, organizational mechanisms, participation in the planning process, and constraints to effective planning were identified. In three-fourths of the hospitals studied, long-range planning was primarily the responsibility of the chief executive officers, most of whom spent only one-eighth or less of their time on planning (Perlin, 1972).

Prompted by legislation enacted in the 1970's, the 1980's has brought to the hospital industry a greater need for external environmental scanning. Certificate of need legislation, enacted in 1974, meant that institutions could establish new services only with an approved certificate of need granted by the Health Systems Agency (HSA). Applicants would receive grants, contracts, loans, or loan guarantees under specified federal public health programs for resource development only after approval by the HSA.

On July 7, 1972, through Medicare/Medicaid amendments, the Social Security Administration mandated limited institutional planning as a requirement for participation. Under P.L. 92-603, hospitals were required to prepare an overall plan and budget which provided for an annual operating budget and a capital expenditure plan. The capital expenditure plan

covered a three-year period and the overall plan was reviewed and updated annually.

Regardless of the legislation enacted, many hospitals continue to be involved in little, if any, comprehensive strategic planning. Mankin and Glueck (1977), surveying 15 Missouri hospitals, reported that only 40 percent of hospital administrators systematically appraised the external hospital environment. Bander (1980) surveyed 10 urban, not-for-profit hospitals and found that only two hospitals were actively utilizing strategic planning. Breindel (1980) reviewed the planning process of 71 Virginia hospitals. He found that 38 percent did not have long-range plans, and of those institutions having long-range plans only 5.6 percent had a formal organized planning department.

· The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) restricted the growth rate in hospital costs, as measured against an institution-specific base-year cost. The following year, additional legislation phased out the TEFRA provisions for acute care hospitals and introduced a new system that over a three-year period shifted hospitals from regional to national peer-group rates. In 1984, new regulations reduced the permitted annual increase in regional and national peer-group rates to a level below that expected by many hospitals (Anderson, 1985).

In 1983, prospective payment for Medicare was insti-
tuted. All hospitals, except for psychiatric, long-term
care, pediatric, and rehabilitation hospitals, are paid a
fixed amount determined in advance for each case in a diag-
nosis related group (DRG). Hospitals cannot claim higher DRG
payments or charge beneficiaries more than the statutory
deductible or coinsurance; but if the hospital's operating
expenses are lower than the payment, the hospital may keep
the difference (Davis, 1983). In addition to various legis-
lative enactments, the hospital industry itself has been
changing and becoming increasingly competitive. Health main-
tenance organizations are an example of this competitiveness.

In the 1930's Kaiser developed the health maintenance
organization (HMO), which is a prepaid group practice health
care delivery system. In 1983, HMO's served six percent of
the population (Friedman, 1984). However, with the enactment
of prospective payment in 1983, industry's concern with the
cost of health benefits, and greater cost sharing by con-
sumers, the number and memberships in HMO's are expected to
increase.

During the 1960's, hospitals saw the entry of major
proprietary chains. The advantages of proprietaries listed
by CEO's are "management based on the industry model,
corporate structure and diversification of product lines, the
ability to make rapid decisions, an access to large amounts

of capital, and the use of marketing research" (Sussman, 1985:23). Although the number of hospitals in the United States has remained fairly consistent, in the past decade the number of hospitals which are affiliated with investor-owned chains has increased by 80 percent (Watt, Derzon, Renn, Schramm, Hahn and Pillari, 1986). Finally, the growing trend of multi-institutional hospital firms, for-profit institutions, increased use of ambulatory care centers and the increased number of aged have all contributed to the necessity for increased external environmental scanning by health care facilities.

Pitts and Wood (1985) reviewed and critiqued the strategic management literature on not-for-profit community hospitals. They found that over half of the articles were prescriptive in nature: in other words, there was no empirical evidence to support the positive impact of strategic management in community not-for-profit hospitals. Several studies found by Pitts and Wood that a large percentage of hospitals had strategic plans, but as of 1982 Kropf and Goldsmith (p. 5) "noted a minimal use of sophisticated analytical techniques along with little innovation in hospital plans." Pitts and Wood found no studies that correlated the value of strategic planning with performance or the appropriateness of specific strategies.

In 1983, Pitts studied 34 Virginia hospitals to deter-
mine whether or not planning changed performance. Perfor-
mance was viewed from the perspective of occupany rate,
personnel expense per operating bed, total expense per
operating bed, number of personnel per operating bed, and
relative market share. Strategic planning intensity was
determined by total scores on the questionnaire. Areas
addressed in the questionnaire were: the existence of a
written plan, the plan's contents, the existence of a
planning department, a staff planner, and a board and/or
administrative planning committee. Pitts found that 70.8
percent of the hospitals had long-range plans; most of the
hospitals had plans for the past five years; plans usually
were generated for three to five years; and the plans were
updated yearly.

Weaknesses identified by Pitts in the long-range plans
were: lack of plan content, lack of goal documentation, lack
of a marketing plan, and only 29 percent had a financial
plan. Typically, the planning document was done internally
and approved by the board of trustees. The size of the hos-
pital had little relationship to planning. Employees had
some input into the plan but little access to the completed
document and the chief executive officer was the main player.

Additional findings were that urban high formal
planners, as measured on a planning intensity scale, were

better at controlling expenses, while urban less formal planners gained more market share. Rural less formal planners, as measured on a planning intensity scale, were better at controlling expenses, while rural more formal planners gained more market share. High implementation and formal planners never produced the highest performance. Changes in the environment did cause changes in planning, but not necessarily better planning. Planning had little effect on marketing and no effect on occupancy. Pitts' study clearly demonstrated that strategic planning is being done in the majority of Virginia community hospitals. However, a clear link to formal planning and high performance was not demonstrated. Therefore, while industry studies have demonstrated a positive effect on performance through the use of the strategic planning process, hospital studies have not as yet demonstrated such a direct effect.

Nurses Participation in Planning

Nursing administrators have often been promoted into their executive positions with little or no previous management experience or training (Stein, 1980) and have lacked the knowledge and experience necessary to implement formal planning processes (Fox and Fox, 1983). Lack of knowledgeable expertise combined with nonrecognition of DNSs by both peers and CEOs as a valuable contributor to planning, delayed executive nurses' involvement in formalized planning. The

extent to which executive nurses have been participating in strategic planning has been discussed in the literature for approximately the last five years.

In 1971, Poulin investigated how nurse executives "viewed their positions in an increasingly complex and changing situation" (1984:9). In 1980, Poulin replicated her study and investigated "the structural and functional components of the nurse executive's position as perceived by selected incumbents" (1984:9). A nonrandomized sample of 12 nursing administrators was selected based on their peers' recognition of the nurse executives' administrative compe- tence and/or reputation for progressive delivery of nursing care. A profile of these nursing administrators emerged: a single woman between the ages of 50 and 59 years, has a master's degree, has been in her present position for 5.3 years, has been in nursing for 25 years, employed in a general hospital of 400 to 599 beds, assisted by 11 employees reporting directly to her, reports directly to the chief executive officer, and holds a corporate title that places her at the top level of the organizational hierarchy. The majority listed the chief executive officer as the person who most influenced them in their present position. The execu- tive nurses stated that their primary responsibility in nursing care was: "(a) the setting and implementation of standards and goals, (b) ensuring control mechanisms,

(c) provision of personnel, and (d) the facilitation of staff functioning" (1984:11). Respondents identified their main responsibility in personnel functions as the development and dissemination of policy, particularly the development of budget and salary scales. Terms which reflected a change from centralized nursing to decentralized included self-governance committees, task forces, individualized career development, leadership development and head nurse decisions. Educational responsibilities were also considered an integral part of the nurse executive role. Participants functioned as preceptors for students, taught classes, were guest lecturers, and were members of advisory councils to schools. Responsibility for nursing care had broadened from inpatient care to ambulatory care, home health agencies, alcohol rehabilitation, outreach programs, and nursing departments of other facilities. Outside of the nursing department, executive nurses were involved with the hospital's budget and policy development and interdepart-mental relations.

Based on the taped interviews with the 12 nursing administrators, Poulin (1984) reached five conclusions which can be related to organizational-environmental boundaries. First, the scope and responsibility of the executive nurse was shifting from a focus on the internal direction of nursing service to a broad social concern for meeting the

nursing needs of society. Second, the degree of authority
nursing has and the influence it exerts in the hospital's
total program are directly related to the executive nurse's
position in the organizational hierarchy. Third, the execu-
tive nurse deals with a variety of individuals and groups
outside the nursing directorate, resulting in a complex
pattern of interactional behaviors. Fourth, the role of the
executive nurse in the organization's power structure will
change from a medically based to a multiprofessionally based
system to accommodate a broader spectrum of health services
in keeping with consumer demands. Fifth, if present trends
continue, the role of the executive nurse will become more
coordinating and less directing as the organization becomes
more decentralized and nursing becomes more professionalized.

In 1982, the American Society for Nursing Service Admin-
istrators surveyed 361 of its members to update its 1977 Sur-
vey of Nursing Service Administrators. Of particular
interest were changes in salary and benefits, role, functions,
responsibility, and accountability that had occurred since
1977. In 1977, "director of nursing" was the most frequently
used title (77.1%), and 1.6 percent of executive nurses were
titled "vice president." The title "assistant administrator"
was not included in the 1977 survey. In 1982, however,
36.7 percent of nurse executives used the title of
"director of nursing," followed by "assistant administrator"

(19.1%), and "vice president for nursing" (17.3%). Aydelotte
also found that 21 percent of nurse executives participated
in hospital governance, of these 3.9 percent were voting mem-
bers of the governing board. Half of the nurses surveyed
were members of board committees and were members of the
Medical Executive Committee, with eight percent being voting
members. Nursing service administrators reported to the top
administrative officer 81.6 percent of the time, with 14 per-
cent reporting to the second level. Nursing administrators
participated in planning the overall hospital budget in 82.6
percent of the institutions as compared to 50.8 percent in
1977. Seventy-seven percent of nurse administrators assisted
in establishing budget priorities in 1982 as compared with
48 percent in 1977. Ninety-three percent of the nurse
administrators established the nursing budget in 1982 as com-
pared to 56.1 percent in 1977. The evolving role of the
nurse executive is reflected by increased participation in
institutional governance and fiscal management, and through
significant changes in reporting relationships.

In Simms, et al. (1985) study to determine precise func-
tions of nurse executives and how they differ among practice
settings, 30 nurse executives were interviewed. Twenty of the
30 administrators in acute care hospitals and home-care insti-
tutions held master's degrees. These 20 nurse administrators
were all involved in long-range planning, financial

management and policy-making. The sample of 30 nursing administrators were employed in a variety of institutions: 10 were in acute care institutions (five from 200-500 bed institutions, five from greater than 500 beds). Ten nursing administrators were employed by home care agencies which served approximately 100,000 people; and 10 nursing administrators were from long-term facilities with over 100 beds. Simms' sample is not truly representative of nurse administrators in general because the average hospital is about 150 beds. Also in 1985, R. M. Anderson stated that of 61,000 nurses in administrative positions across the United States, only 18 percent had master's degrees as compared to Simms, et al.'s 66 percent.

As cited in Aydelotte's repeat study of 1982, the majority of nurse executives are establishing their own departmental budgets and assisting with developing the hospital's budget as well as taking a more active role at the executive administrative level for the hospital. Stuart (1985), in her study of participation in hospital decision making by nurses, demonstrated that nurse administrators desired greater participation in top level decision making. However, the question of the extent to which executive nurses are participating in organizational-environmental boundary management through strategic planning has not been answered.

CHAPTER THREE

Methodology

The purpose of this study was to determine the extent to
which nurse executives are participating in the institutional
strategic planning process. A second purpose was to deter-
mine whether or not the nurse executive is using the strate-
gic planning process in managing the department of nursing.

Research questions which were studied included:

1. To what extent are nurse executives participating
in institutional strategic planning?

2. To what extent are nurse executives using the
strategic planning process in managing the department of
nursing?

3. Does hospital size, ownership, or the nurse
executives' educational level have any impact on extent of
participation?

Design

A descriptive ex post facto design was used for this
study. According to Polit and Hungler (1983):

> The basic purpose of ex post facto research is
> essentially the same as experimental research:
> to determine the relationships among variables.
> The most important distinction between the two
> is the difficulty in inferring causal relation-
> ships in ex post facto studies because of the
> lack of manipulative control of the independent
> variable (p. 170).

The nature of the independent variables of ownership, size, and nurse executive educational level were not able to be manipulated.

The weaknesses of ex post facto research (Kerlinger, 1973) include: (a) the inability to actively manipulate the independent variables, (b) the inability to randomly assign individuals to experimental treatments, and (c) the possibility of faulty interpretation of study results.

Design strengths include the ability to collect large amounts of data in an efficient and effective manner, its use in field settings, and the appropriateness of its use in many health related studies where manipulation of variables would be unethical or impractical (Polit and Hungler, 1983: 181-183). This design was selected both because it enabled large amounts of data to be collected within the hospital and because manipulation of the independent variables was impractical.

While this is not a quasi-experimental design, threats to validity include inexperience of the researcher, instrument problems, and that the findings of extent of participation in strategic planning may not be generalizable to non-short-term health care institutions.

Population and Sample

To study the question regarding extent of participation by Virginia executive nurses in strategic planning, all

Virginia Hospital Association executive nurses were asked to
participate in the study. By including all Virginia hospital
executive nurses, the hospitals represented various sizes and
types, both proprietary and nonproprietary, as well as
teaching and nonteaching institutions.

The target population consisted of all Virginia acute
care hospital executive nurses. The accessible population,
short-term hospitals, was drawn from a list of hospitals
which were members of the Virginia Hospital Association.
All short-term hospitals were included in the study. Nurse
executives of short-term care hospitals (i.e., with lengths
of stay less than 30 days), with the title of Director of
Nursing Service, Vice President for Nursing, or Assistant
Administrator, who were members of the Virginia Hospital
Association comprised the accessible population.

Data Collection Procedure

A list of Virginia short-term care hospitals was
obtained from the Virginia Hospital Association. All
short-term care Virginia hospital nurse executives were
asked to participate. In order to insure confidentiality,
questionnaires were numbered in the same order as the
researcher's list of executive nurses who were being
requested to participate in the study. Coded question-
naires with cover letters explaining the purpose of the
study were sent to Virginia executive nurses; returned

completed questionnaires signified participation consent.
Responses of returned questionnaires were tabulated and data
analyzed.

A mailed survey was chosen because of the large geo-
graphic area involved in the study and time constraints of
the researcher. Strengths of a mail survey include
expediency of gathering data from a large sample. In
addition, the anonymity of the mail survey increases the
freedom of the respondent to answer questions. The weak-
nesses of a mail survey include lower response rate, some-
times resulting in response bias (Babbie, 1973). Another
weakness is the possibility of superficial responses in com-
parison to data collected in personal interviews. These
weaknesses may make generalizing the results of the study
inappropriate. When a low response rate is experienced, if
respondent geographic characteristics are similar to the
target population characteristics, the presence of a serious
bias can be negated (Babbie, 1973).

Development of Survey Instrument

In order to measure the extent of participation in stra-
tegic planning and the use of the strategic planning process
in the department of nursing, a scale based instrument was
chosen as the best tool to assess the range of participation.
Because the strategic planning process is relatively new to

the hospital industry, an instrument which allowed a range of responses rather than an all or none response was deemed more appropriate for the research. The value of such a format is the "unambiguous ordinality of response categories" (Babbie, 1973:269). A scale confines the respondent to a set of responses and allows the researcher to evaluate the relative strength of participation. The Likert method is founded on the assumption "that the overall score based on responses to the many items, seeming to reflect the variable under consideration, provides a reasonably good measure of the variable" (Babbie, 1973:270). Overall scores can be used to analyze individual items in order to determine the best indicators of the variable; and only these items are included in the index ultimately used for analyses of the variable.

For this study a Likert scale was employed with the range of responses of: 1 = not at all, 2 = very little, 3 = somewhat, 4 = to a great extent, and 5 = to a very great extent. Scores were totalled and averaged for each section relating to strategic planning for both the institution and the department of nursing (sections II A-F and III A-F).

After the tool was formulated by the researcher, content and face validity were established by nurse and hospital administration strategic planning experts reviewing the instrument. Following incorporation of suggested changes, the instrument was again reviewed by the thesis committee; and

after approval, the questionnaire was mailed to all Virginia hospital nurse executives. No quantitative measures of reliability or validity were calculated.

The following section provides information regarding which questions were used to determine participation in each segment of the strategic planning process.

Extent of Participation in Hospital Strategic Planning

The extent of participation was determined by analyzing the executive nurse's involvement with the five phases of strategic planning (Luke and Kurowski, 1983).

Environmental analysis involves both the external and internal environments.

External environmental analysis refers to scanning the environment for threats and opportunities to the hospital (Mankin and Glueck, 1977). Extent of participation in hospital external environmental analysis is assessed with items II, Section A, questions 1-4.

Question 1: To what extent do you participate in gathering and analyzing information regarding the local, state, and/or national economic environment which could influence the way business is conducted, or the services which are offered? For example: information might relate to new insurance coverage, reimbursement rates for third party payers or the opening/closing of a community industry.

Question 2: To what extent do you participate in gathering and analyzing information regarding the local, state, and/or national political environment which could influence the way business is conducted, or the services which are offered? For example: possible union formation, proposed legislation or regulation, or a local competitor's plans for a new service or facility.

Question 3: To what extent do you participate in gathering and analyzing information regarding changes in health care and/or information management system technology which could influence the way business is conducted or the services which are offered? For example: installation of an automated patient care information system, or the need for home health care services.

Question 4: To what extent do you participate in gathering and analyzing information regarding the local, state, and/or federal social policy which could influence the way business is conducted or the services which are offered? For example: minority needs, community activities, or consumer profiles.

Internal environmental analysis refers to elements and conditions present in the institution itself which comprise institutional advantages and disadvantages (Mankin and Glueck, 1977; Luke and Kurowski, 1983). Extent of participation in hospital internal environmental analysis is assessed with items II, Section B, questions 1-6.

Question 1: To what extent do you participate in gathering and analyzing information regarding the hospital's human resources, such as the number, quality, knowledge and skill levels, or productivity of personnel.

Question 2: To what extent do you participate in gathering and analyzing information regarding the financial status? For example, hospital's income and balance sheets, financial ratio analysis, or cost containment measures.

Question 3: To what extent do you participate in gathering and analyzing information regarding productivity? For example: variance analysis.

Question 4: To what extent do you participate in gathering and analyzing information regarding the physical facility? For example: space requirements, equipment efficiency or effectiveness, or repair/maintenance needs.

Question 5: To what extent do you participate in gathering and analyzing information regarding the hospital's current <u>health care delivery, or its existing information management system's technology</u>. For example: new products/procedures, or additions to or replacement of the current information management system.

Question 6: To what extent do you participate in reviewing and revising the hospital's <u>mission</u> statement?

<u>Formulating goals and objectives</u> refers to establishing goals and objectives or priorities that the hospital wants to achieve based on matching the hospital's strengths with environmental opportunities (Mankin and Glueck, 1977; Luke and Kurowski, 1983). Items which assess participation in formulating goals and objectives or establishing priorities for the hospital are in II, Section C, questions 1-6.

Question 1: To what extent do you participate in formulating <u>goals/objectives</u> based on the hospital's <u>internal</u> environmental analysis?

Question 2: To what extent do you participate in formulating <u>goals/objectives</u> based on the hospital's <u>external</u> environmental analysis?

Question 3: To what extent do you participate in ranking the goals/objectives?

Question 4: To what extent do you participate in formulating priorities based on the hospital's internal environmental analysis?

Question 5: To what extent do you participate in formulating priorities based on the hospital's external environmental analysis?

Question 6: To what extent do you participate in ranking the priorities?

Strategic analysis and choice refers to considering strategic alternatives and choosing the strategy(ies) (Mankin and Glueck, 1977). Items addressing strategic analysis and choice for the hospital are in II, Section D, questions 1-4.

Question 1: To what extent do you participate in formulating possible strategies for the hospital's long-range plan?

Question 2: To what extent do you participate in analyzing the costs/benefits (financial, human resources, public image) of the proposed strategies to meet the defined goals/objectives/priorities?

Question 3: To what extent do you participate in evaluating the advantages and/or disadvantages of proposed strategies relevant to the resources, competence and preferences of the organization?

Question 4: To what extent do you participate in selecting from the proposed strategies the strategic choice(s) which will be implemented?

Strategy implementation refers to developing policies, plans and assigning human, material, financial, and ideational resources required by the strategy (Mankin and Glueck, 1977). Items which assess participation in hospital strategy implementation are contained in II, Section E, questions 1-4.

Question 1: To what extent do you participate in developing policies for implementing the strategic choice(s)?

Question 2: To what extent do you participate in developing plans for implementing the strategic choice(s)?

Question 3: To what extent do you participate in identifying individuals who will be responsible for implementing the strategic choice(s)?

Question 4: To what extent do you participate in selecting individuals who will be responsible for implementing the strategic choice(s)?

Strategy evaluation refers to participation in assessing the success for implementing the strategy and the success of the strategy in meeting the institution's goals, objectives or priorities (Mankin and Glueck, 1977). Items which address hospital strategy implementation are contained in II, Section F, questions 1-4.

Question 1: To what extent do you participate in developing performance measures for monitoring and controlling implementation of the strategic choice(s)?

Question 2: To what extent do you participate in analyzing the performance measures' results?

Question 3: To what extent do you participate in evaluating the success of implementing the strategic choice(s)?

Question 4: To what extent do you participate in re-evaluation of current goals/objectives, priorities, and strategies in light of new elements in the external or internal environments, or a change in the mission?

Strategic Planning Process Use by the
   Executive Nurse

The extent of strategic planning process use for the
department of nursing was determined by analyzing the execu-
tive nurse's utilization of the five phases of strategic
planning (Luke and Kurowski, 1983):

Environmental analysis involves both the external and
internal environments.

External environmental analysis refers to scanning the
environment for threats and opportunities to the department
of nursing (Mankin and Glueck, 1977). Utilization of exter-
nal environmental analysis is assessed with items III,
Section A, questions 1-4.

Question 1: When preparing nursing's long-range plan,
to what extent do you gather and analyze information
regarding the local, state, and/or national
economic environment which could influence the way
business is conducted in the department of nursing, or
the services which are offered? For example:
information might relate to new services or proce-
dures which the hospital or department of nursing could
offer, direct reimbursement for nursing services, or
separation of nursing service charges from hospital
bed and board charges.

Question 2: When preparing nursing's long-range plan, to what extent do you gather and analyze information regarding the local, state, and/or national political environment which could influence the way business is conducted in the department of nursing, or the services which are offered? For example: possible union formation, proposed legislation or regulation, or changes in the nurse practice act.

Question 3: When preparing nursing's long-range plan, to what extent do you gather and analyze information regarding changes in health care and/or information management system technology which could influence the way the department of nursing conducts its business or the services which are offered? For example, improvement of automated nurse staffing and scheduling systems, or the need for home health services.

Question 4: When preparing nursing's long-range plan, to what extent do you gather and analyze information regarding the local, state, and/or national social policy which could influence the way business is conducted in the department of nursing, or the services which are offered? For example: minority needs, community activities, or consumer profiles?

Internal environmental analysis refers to elements and
conditions present in the department of nursing itself which
comprise nursing advantages and disadvantages (Mankin and
Glueck, 1977; Luke and Kurowski, 1983). Use of internal
environmental analysis is assessed with items III, Section B,
questions 1-6.

Question 1: When preparing nursing's long-range plan,
to what extent do you gather and analyze information
regarding the department of nursing's human resources,
such as the number, quality, knowledge and skill levels,
or productivity of personnel?

Question 2: When preparing nursing's long-range plan,
to what extent do you gather and analyze information
for the department of nursing regarding its
financial status? For example: variance analysis,
number of patient care hours needed per patient classi-
fication category, or skill mix.

Question 3: When preparing nursing's long-range plan,
to what extent do you gather and analyze information for
the department of nursing regarding its productivity?
For example: variance analysis.

Question 4: When preparing nursing's long-range plan, to what extent do you gather and analyze information for the department of nursing regarding the physical facility? For example: space requirements, equipment efficiency or effectiveness, or repair/maintenance needs.

Question 5: When preparing nursing's long-range plan, to what extent do you gather and analyze information regarding the nursing department's current health care delivery, or its existing information management system's technology? For example: new products/ procedures, or additions to or replacement of the current information management system.

Question 6: When preparing nursing's long-range plan, to what extent do you review and revise nursing's mission statement?

Formulating goals and objectives refers to establishing goals and objectives or priorities that the nursing depart- ment wants to achieve based on matching nursing's strengths with environmental opportunities (Mankin, et al., 1977; Luke and Kurowski, 1983). Items which assess utilization of formulating goals and objectives or establishing priorities for the nursing department are in III, Section C, questions 1-6.

Question 1: When preparing nursing's long-range plan, to what extent do you formulate goals/objectives based on nursing's internal environmental analysis?

Question 2: When preparing nursing's long-range plan, to what extent do you formulate goals/objectives based on nursing's external environmental analysis?

Question 3: When preparing nursing's long-range plan, to what extent do you rank the goals/objectives for the department of nursing?

Question 4: When preparing nursing's long-range plan, to what extent do you formulate priorities based on nursing's internal environmental analysis?

Question 5: When preparing nursing's long-range plan, to what extent do you formulate priorities based on nursing's external environmental analysis?

Question 6: When preparing nursing's long-range plan, to what extent do you rank priorities?

Strategic analysis and choice refers to considering strategic alternatives and choosing the strategy(ies) (Mankin and Glueck, 1977). Items addressing strategic analysis and choice for the nursing department are in III, Section D, questions 1-4.

Question 1: To what extent do you formulate possible strategies for nursing's long-range plan?

Question 2: To what extent do you analyze the costs/ benefits (financial, human resources, public image) of the proposed strategies to meet the defined goals/ objectives, and priorities?

Question 3: When preparing nursing's long-range plan, to what extent do you evaluate the advantages and/or disadvantages of the proposed strategies relevant to the resources, competence, and preferences of the organization?

Question 4: When preparing nursing's long-range plan, to what extent do you select from the proposed strat- egies the strategic choice(s) which will be implemented?

Strategy implementation refers to developing policies, plans and assigning human, material, financial, and ideational resources required by the strategy (Mankin and Glueck, 1977). Items which assess utilization of strategy implementation for the department of nursing are contained in III, Section E, questions 1-4.

Question 1: When preparing nursing's long-range plan, to what extent do you develop policies for implementing the strategic choice?

Question 2: When preparing nursing's long-range plan,
to what extent do you <u>develop plans</u> for implementing
the strategic choice?

Question 3: When preparing nursing's long-range plan,
to what extent do you <u>identify individuals</u> who will be
responsible for implementing the strategic choice?

Question 4: When preparing nursing's long-range plan,
to what extent do you <u>select individuals</u> who will be
responsible for implementing the strategic choice?

<u>Strategy evaluation</u> refers to assessing the success both
of implementing the strategy and the success of the strategy
in meeting nursing's goals, objectives or priorities (Mankin
and Glueck, 1977). Items which address strategy implementa-
tion are contained in III, Section F, questions 1-4.

Question 1: When preparing nursing's long-range plan,
to what extent do you <u>develop performance measures</u> for
monitoring and controlling implementation of the
strategic choice(s)?

Question 2: When preparing nursing's long-range plan,
to what extent do you <u>analyze</u> the performance measures'
results?

Question 3: When preparing nursing's long-range plan, to what extent do you <u>evaluate</u> the success of implementing the strategic choice(s)?

Question 4: When preparing nursing's long-range plan, to what extent do you <u>re-evaluate</u> current goals/ objectives, priorities, and strategies in light of new elements in the external and internal environments, or a change in the mission?

Hospital Demographic Data

Hospital demographic data was obtained for correlation with the strategic planning process for both the institution and the department of nursing. Demographic data concerning the hospital's size and ownership are contained in items I, A and B.

Item IA: Your hospital is:
  _____ 0- 99 beds
  _____ 100-399 beds
  _____ 400 beds or more

Item IB: Your hospital is classified as:
  _____ nonprofit
  _____ for profit

Demographic data concerning the hospital's planning process and the content of the plan is contained in items I, C-H.

Item IC: Does your hospital have a long-range plan?

Item ID: If your hospital has a long-range plan, is
it written?

Item IE: What is the time period covered by the
long-range plan?

_____ less than 3 years _____ 5 years
_____ 3 years   _____ greater than
_____ 4 years   5 years

Item IF: Which of the following are included in
the long-range plan?

_____ mission statement
_____ master facilities plan
_____ financial plan
_____ capital budget
_____ marketing plan
_____ operating budget
_____ contingency plan
_____ external environment analysis
_____ internal environment analysis
_____ formulating goals/objectives
_____ formulating priorities
_____ ranking goals and objectives
_____ ranking priorities
_____ formulating strategies to meet
        goals/objectives
_____ formulating strategies to meet
        priorities
_____ selecting strategies
_____ implementing strategies
_____ evaluation

Item IG: In what year did your hospital first prepare
a long-range plan? 19__

Item IH: If your hospital has a long-range plan, is it
formulated similar to the process described
in the definition of strategic planning
process?

Nursing Department's Demographic Data

Nursing demographic data was obtained for correlation with the strategic planning process for both the institution and the department of nursing. Demographic data regarding nursing's planning process and the content of the plan is contained in items III, A-G.

Item IIIA: Does the department of nursing have a long-range plan?

Item IIIB: Is the department of nursing's long-range plan written?

Item IIIC: What is the time period covered by the long-range plan?

____ less than 3 years   ____ 5 years
____ 3 years   ____ greater than
____ 4 years   5 years

Item IIID: In what year did the department of nursing first prepare a long-range plan? 19__

Item IIIE: Is the nursing department's long-range plan prepared similar to the process described in the definition of strategic planning?

Item IIIF: Is the nursing department's long-range plan part of the hospital's long-range plan?

Item IIIG: Which of the following are included in the

long-range plan?

_____ mission statement
_____ master facilities plan
_____ financial plan
_____ capital budget
_____ marketing plan
_____ operating budget
_____ contingency plan
_____ external environment analysis
_____ internal environment analysis
_____ formulating goals/objectives
_____ formulating priorities
_____ ranking goals and objectives
_____ ranking priorities
_____ formulating strategies to meet
        goals/objectives
_____ formulating streaties to meet
        priorities
_____ selecting strategies
_____ implementing strategies
_____ evaluation

Executive nurse demographic data concerning work history and educational background is contained in items IV, A-D.

Item IVA: How many total years of nursing experience

as a registered nurse do you have?

Item IVB: How many years of nursing administration

experience at the executive level (Director

of Nursing or comparable highest nurse

administrator only), do you have?

Item IVC: How many years have you been employed by

this hospital in your present position?

Item IVD: What is your highest degree?

____ associate degree in nursing
____ diploma in nursing
____ bachelor's in nursing
____ bachelor's in another field
____ master's in nursing administration
____ master's in clinical nursing
____ master's in another field
____ doctorate in nursing
____ doctorate in another field

Nurse executive participation in decisions regarding hospital policy is contained in IV, E.

Item IVE: Do you participate in hospital policy decisions such as new services to be provided, facility expansion, or cost containment measures?

The data generated from the above survey instrument were then analyzed using descriptive measures, Analysis of Variance, and Duncan's Multiple Range Test.

Data Analysis

Data were analyzed using descriptive measures. First, responses were tabulated for the extent of participation in strategic planning for each size hospital, ownership, and educational level of the executive nurse. Means and standard deviations were obtained.

Second, demographic data for both the hospital and the department of nursing were analyzed regarding: (a) presence

or absence of a plan, (b) whether or not the plan was written, (c) the time period covered by the plan, (d) the year the plan was first generated, (e) whether or not the plan was formulated in a manner similar to the process described in the definition of strategic planning, (f) the planning process, and (g) the plan content. Demographic data regarding the executive nurse included the total years of nursing experience, years of experience as an executive nurse, years employed by the hospital in their present position, their highest degree held, and whether or not they participated in hospital policy decision-making. Means and standard deviations were calculated for the years of nursing experience, years of nursing administration experience, and years in their present position. Demographic data for the hospital included the size and ownership.

Third, mean participation scores for each section of the process of strategic planning and overall mean score for strategic planning were calculated for all hospitals and all departments of nursing.

Fourth, analysis of variance (ANOVA) was performed on the extent of participation in strategic planning by both the institution and the department of nursing in comparison with size, ownership, and educational level to determine whether or not there were significant differences in the

variables of interest. Duncan's Multiple Range Test was also performed to enhance the results of the ANOVA by separating like from unlike variables.

CHAPTER FOUR

Findings

Data Analysis

The purpose of this study was to determine the extent to
which Virginia executive nurses participate in strategic
planning for their institution, and the extent to which these
executive nurses utilize the strategic planning process for
their nursing departments. The effect of ownership, size,
and educational level of the nurse executive on the extent
of participation in strategic planning was also studied.

Characteristics of Surveyed Hospitals

All executive nurses of Virginia short-term nonmilitary
hospitals, who are members of the Virginia Hospital Assoc-
iation, were asked to participate in the study. Of the 114
executive nurses, 60 returned the survey, a response rate of
53 percent. The 60 hospitals included: 14 small institutions
(< 99 beds), constituting 24 percent of the sample; 35
medium-sized institutions (100-399 beds), constituting 58
percent of the sample; and 11 large institutions (> 400 beds),
constituting 18 percent of the sample. There were 48 not-for-
profit institutions comprising 80 percent of the sample, and
12 for-profit (investor owned) comprising 20 percent of the
sample. These characteristics are displayed in Table 1.

Table 1

Characteristics of Hospitals (N=60)

	n	%
Size of Hospital		
Small (0- 99 beds)	14	24
Medium (100-399 beds)	35	58
Large (>400 beds)	11	18
Ownership of Hospital		
Not-for-Profit	48	80
For-Profit	12	20

Characteristics of Surveyed
  Executive Nurses

The typical executive nurse responding to the question-
naire had between 21 and 25 years of total nursing experience,
with one-five years of that time being in nursing adminis-
tration. The majority of nurse executives managed depart-
ments of nursing in medium-size (100-399 beds) not-for-profit
institutions. In contrast to Aydelotte's (1984) report about
the educational level of nursing administrators in which 60.8
percent held master's degrees, slightly less than half of
this sample (47.4%) held a master's degree, either in
nursing or in another field. All nurse executives (59), who
responded to the questionnaire participated in hospital policy
decisions. Table 2 provides further information about the
characteristics of the sample.

Table 2

Description of Sample (N=60)

	n	%
Years of Nursing Experience		
$\bar{X}$ = 21 years		
SD = 6.56 years		
1- 5 years	2	3
6-10 years	1	2
11-15 years	10	17
16-20 years	16	27
21-15 years	17	28
26-30 years	9	15
31-35 years	3	5
> 35 years	2	3
Years of Nursing Administration Experience		
$\bar{X}$ = 7 years		
SD = 4.73 years		
1- 5 years	29	48
6-10 years	20	33
11-15 years	8	13
16-20 years	3	5
Years in Present Position		
$\bar{X}$ = 6 years		
SD = 5.68 years		
1- 5 years	33	55
6-10 years	17	28
11-15 years	7	12
16-20 years	2	3
21-25 years	1	2
Highest Degree Held		
Associate in Nursing	1	2
Diploma in Nursing	18	31
Bachelor's in Nursing	9	13
Bachelor's in Another Field	3	5
Master's in Nursing Administration	10	17
Master's in Clinical Nursing	8	14
Master's in Another Field	10	17

Table 2 continued

	n	%
Participation in Policy Decisions		
Yes	59	100
No	0	0
Educational Level		
No BS	19	32
Any BS	12	20
Any Master's	28	48

Planning Data

Fifty two, or 87 percent, of hospitals had a long-range plan for the hospital, of which 92 percent were written plans. Thirty-one, or 52 percent, of nursing depart-ments had long-range plans. Eighty-one percent of these plans were written.

Almost all (96%) of the hospitals with long-range plans used the strategic planning process in formulating their plans. Sixty-nine percent of nursing departments with long-range plans used the strategic planning process for formulating their long-range plans.

The majority of the hospitals' long-range plans (62%) covered four years, with three percent initiated before 1965, and 46 percent begun after 1982. Sixty-nine percent of nursing's long-range plans covered three years or less, with four percent initiated before 1965, and 61 percent begun after 1982. Twenty (69%) of the nursing departments' long-range plans were part of the hospitals' long-range plan. Planning data for the hospitals are shown in Table 3, and for the nursing departments in Table 4.

Table 3

Hospital Planning Data

	Yes		No	
	n	%	n	%
Presence of Plan	52	87	8	13
Plan is Written	49	92	4	8
Use Strategic Planning Process	49	96	2	4
Years Covered by Plan				
<3 years	9	17		
3 years	6	11		
4 years	32	62		
5 years	5	10		
Year Plan Initiated				
Before 1965	1	3		
1965-1968	1	3		
1970-1974	2	5		
1975-1979	4	10		
1980-1984	20	51		
After 1985	11	28		

Table 4

Nursing Planning Data

	Yes		No	
	n	%	n	%
Presence of Plan	31	53	28	47
Plan is Written	26	81	5	19
Use Strategic Planning Process	20	69	9	31
Years covered by Plan				
<3 years	13	45		
3 years	7	24		
4 years	3	10		
5 years	5	17		
>5 years	1	4		
Year Plan Initiated				
Before 1965	1	4		
1965-1969	1	4		
1970-1974	0	0		
1975-1979	2	7		
1980-1984	12	43		
After 1985	12	43		
Plan Part of Hospital's Plan	20	69	9	31

Elements and Processes Included in
  Long-Range Plans

Three-fourths of the hospitals included the elements of
mission statement (86%), master facilities plan (83%), and
marketing plan (76%) in their long-range plans. The majority
of nursing departments included the elements of mission state-
ment (87%), capital budget (67%), and operating budget (63%).
Additional information is contained in Table 5.

Three-fourths of the hospitals included the processes of
analyzing the external environment (81%), analyzing the
internal environment (79%), and formulating goals and objec-
tives (77%) in their long-range plans. These processes were
closely followed by formulating strategies for goals and
objectives (73%), selecting strategies (69%), and imple-
menting strategies (69%).

Three-fourths of nursing departments included the pro-
cesses of formulating goals and objectives (97%), formula-
ting strategies for goals and objectives (93%), selecting
strategies (87%), implementing strategies (87%), formulating
priorities (83%), evaluation (80%), and formulating stra-
tegies for priorities (77%). Additional information on
processes included in long-range planning is contained
in Table 5.

Table 5

Elements and Processes Included in Long-Range Plans

	Yes		No	
	n	%	n	%
Hospital Elements				
Mission Statement	45	87	7	13
Master Facilities Plan	43	83	9	17
Financial Plan	38	73	14	27
Capital Budget	32	62	20	39
Marketing Plan	40	76	12	23
Operating Budget	24	46	28	54
Contingency Plan	22	42	30	58
Hospital Process				
Analysis External Environment	42	81	10	19
Analysis Internal Environment	41	79	11	21
Formulating Goals and Objectives	40	77	12	23
Formulating Priorities	41	79	11	21
Ranking Goals and Objectives	31	60	21	40
Ranking Priorities	36	69	16	31
Formulating Strategies for Goals and Objectives	38	73	14	27
Formulating Strategies for Priorities	35	67	17	33
Selecting Strategies	36	69	16	31
Implementing Strategies	36	69	16	31
Evaluation	32	62	20	39
Nursing Elements				
Mission Statement	26	87	4	13
Master Facilities Plan	13	43	17	57
Financial Plan	15	50	15	50
Capital Budget	20	67	10	33
Marketing Plan	14	47	16	53
Operating Budget	19	63	11	37
Contingency Plan	11	37	19	63

Table 5 continued

	Yes		No	
	n	%	n	%
Nursing Process				
Analysis External Environment	11	37	19	63
Analysis Internal Environment	15	50	15	50
Formulating Goals and Objectives	29	97	1	3
Formulating Priorities	25	83	5	17
Ranking Goals and Objectives	21	70	9	30
Ranking Priorities	20	67	10	33
Formulating Strategies for Goals and Objectives	28	93	2	7
Formulating Strategies for Priorities	23	77	7	23
Selecting Strategies	26	87	4	13
Implementing Strategies	26	87	4	13
Evaluation	24	80	6	20

Extent of Participation in Strategic
  Planning

Mean scores for each segment of the strategic planning
process were totalled, and then from the total score a mean
score for overall participation in strategic planning was
derived. A mean score for each segment of the strategic
planning process was also calculated. The possible range of
scores for either overall participation or for each process
segment was one to five.

The nurse executives' overall mean score for participa-
tion in hospital long-range planning was 3.25 (somewhat
involved). Except for the nurse executives' participation
in external environmental analysis (2.74 = very little
involved), there was little difference in the scores for the
other segments of the strategic planning process. The mean
scores for the remaining strategic planning segments ranged
from 3.19 for evaluation to 3.42 for analysis of the internal
environment. These results are illustrated in Table 6.

These nurse executives' mean overall participation
score for using the strategic planning process for the
department of nursing was 4.18 (to a great extent involved).
Just as with the scores for participation in hospital stra-
tegic planning, except for the nurse executives' involvement
in external environmental analysis (3.79 somewhat involved),
there was little difference in the mean scores for other
segments of the process. Mean scores for utilizing the other

Table 6

Extent of Participation in Strategic Planning (N=53)

	n	$\bar{X}$	SD
Hospital Process			
External Environment Analysis	53	2.74	1.02
Internal Environment Analysis	53	3.42	0.9
Establishing Goals/Priorities	53	3.41	0.99
Strategic Analysis and Choice	53	3.36	1.03
Implementing Strategic Choice	53	3.39	0.92
Evaluation	53	3.19	1.07
Total	53	3.25	0.86
Nursing Department Process			
External Environment Analysis	29	3.79	1.05
Internal Environment Analysis	29	4.38	0.56
Establishing Goals/Priorities	29	4.23	0.69
Strategic Analysis and Choice	29	4.28	0.65
Implementing Strategic Choice	29	4.32	0.71
Evaluation	29	4.05	0.86
Total	29	4.18	0.66

strategic planning process segments ranged from 4.05 for evaluation to 4.38 for internal environmental analysis. Details for extent of participation in the strategic planning process for the department of nursing are contained in Table 6.

Analysis of Variance for Participation in Strategic Planning

The independent variables of size, ownership, and educational level of the nursing administrator were analyzed with regard to their impact on the extent of participation in the strategic planning process for the hospital and the department of nursing. Analysis of variance (ANOVA) was performed on the mean of the three variables. After the ANOVA was performed, Duncan's Multiple Range Test was also performed. Duncan's Multiple Range Test separated the categories in each variable to isolate significantly dissimilar means from similar means.

ANOVA revealed that size had a significant impact on the extent of participation in hospital strategic planning ($F = 6.74$, $p < .01$) with nurse executives in medium-size hospitals being significantly more involved in strategic planning than nurse executives in either small or large institutions. Ownership did not have a significant impact on participation in strategic planning for either the hospital or the department of nursing. The educational level of the

nurse executive was highly significant, with the master's level nurse being more involved in strategic planning for both the institution and the department of nursing. Details of the analysis are contained in Table 7.

Table 7

Results of Analysis of Variance in Strategic Planning by Size, Ownership, and Educational Level (N=60)

	n	SS	MS	DF	F	P
Variables for Hospital						
Size	53	38.41	4.08	2	6.74	.0026**
Ownership	53	38.41	0.81	1	1.11	.298
Education Level	52	38.36	5.21	2	9.14	.0004***
Variables for Nursing						
Size	29	1.15	1.15	1	2.82	.1044
Ownership	29	12.13	0.21	2	0.46	.6370
Education Level	29	12.14	1.25	2	3.39	.0481*

*P < .05
**P < .01
***P < .001

Duncan's Multiple Range Test groups like means together, thereby isolating significant categories within a variable. Medium size and master's educational level were significant in determining participation in hospital strategic planning. No category was identified as significant for participation in strategic planning for the department of nursing. Details of the Duncan's Multiple Range Test are contained in Table 8.

Table 8

Duncan's Multiple Range Test for Independent Variables

	Grouping	Mean	n	Level
Size				
Hospital	A	3.566	32	Medium
	B	2.893	9	Large
	B	2.686	12	Small
Nursing	A	4.430	5	Small
	A	4.151	19	Medium
	A	4.05	5	Large
Ownership				
Hospital	A	3.481	12	For-Profit
	A	3.185	41	Not-For-Profit
Nursing	A	4.571	6	For-Profit
	A	4.080	23	Not-For-Profit
Educational Level				
Hospital	A	3.688	25	Any Master's
	B	3.069	12	Any BS
	B	2.659	15	No BS
Nursing	A	4.395	19	Any Master's
	A	3.777	5	No BS
	A	3.775	5	Any BS

Summary

The typical nurse executive in this study held a master's degree, had 21-25 total years of nursing experience of which one-five years was at the executive level, and had been in his/her present position one-five years. Slightly over half of nursing departments had long-range plans covering three years or less. The majority of long-range plans for the department of nursing were formulated by the strategic planning process. Participation in hospital strategic planning was influenced by the institution's size and the nurse executive's education level. Utilization was influenced by neither size nor ownership, only the executive nurse's educational level.

CHAPTER FIVE

Summary and Implications

The purpose of this study was to determine the extent to which hospital nurse executives are participating in strategic planning for the institution, and the extent to which they are using the strategic planning process in their departments of nursing. The effect of hospital size, ownership, and the executive nurse's educational level on both the extent of participation in institutional strategic planning and utilization of the process in nursing departments was also examined.

The following findings of the research are summarized with an emphasis on interpretation and implications for nursing administration. Limitations of the study and suggestions for future research are also included.

Survey Findings

The typical nurse executive in this study held a master's degree, had 21-25 total years of nursing experience of which one-five years was at the executive level, and had been in his/her present position one-five years. Fifty-three percent of nursing departments had long-range plans generally covering three years or less. The majority of plans were written (81%) and formed by the strategic planning process (69%).

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Participation in institutional strategic planning was influenced by the hospital's size and the executive nurse's educational level, but not ownership. Nurse executives who generally participated in institutional strategic planning were more likely to be in medium-sized hospitals (100-399 beds) and to hold a master's degree. Utilization of the strategic planning process for the department of nursing was influenced by neither hospital size, nor ownership, but the executive nurse's educational level was significant.

Interpretation

Presence of a Long-Range Plan

It is not surprising that hospitals in this study had a higher percentage of written long-range plans than did their nursing departments. While federal legislation (Hill-Burton) as early as 1946 has required hospitals to have written plans of one kind or another in order to participate in the federal programs, there are no legislative requirements for planning by departments of nursing. According to Niederbaumer (1979), the nurse's lack of educational preparation in administration is a major barrier to planning by nurse executives. Additional barriers include the failure to solicit nursing input, and a lack of recognition and acknowledgement of the nurse's capacity to fulfill a top management role by hospital administration, physicians, and some nurses (Hagen and Wolf,

1961; Hospital Topics, 1977; Gugenheim, 1979).

The effect of early mandated emphasis on hospital
planning is again reflected in the utilization rate of the
strategic planning process in formulating long-range plans.
While 96 percent of hospital long-range plans were generated
by the process of strategic planning, only 69 percent of
nursing departments used the process. The lower rate by
nursing can probably also be explained by the lack of
knowledge and exposure to the process of strategic planning
(Fox and Fox, 1983). While the literature abounds with
articles on strategic planning for hospitals, few articles
are available for nursing on adapting the strategic planning
process for their purposes.

Planning Elements

There are many elements which can be included as a basis
for the hospital or departmental long-range plan. These
elements can include: mission statement, master facilities
plan, financial plan, capital budget, marketing plan,
operating budget, and contingency plan. In this study, nurse
executives were requested to identify those specific elements
which were in fact included in their own hospital's long-
range plan, as well as in the long-range plan for the
department of nursing. According to the nurse executives,
while most elements included in both the hospital as well as
the departmental long-range plans were the same, there were

some differences. For example, although 87 percent of
hospitals' and 87 percent of nursing departments' long-range
plans included the mission statement, only 43 percent of
departmental long-range plans included the master facilities
plan, while 83 percent of hospital long-range plans included
this same element. There are several reasons which may
explain the differences.

One reason is that different elements of the plan may
have been more or less critical to the hospitals' or the
nursing departments' strategic planning process. For example,
76 percent of the hospitals' long-range plans incorporated a
marketing plan, while only 47 percent of the nursing depart-
ments included this element. In today's competitive environ-
ment more and more hospitals are relying on marketing infor-
mation in order to increase their share of the health care
market. This is reflected in the fact that three out of four
hospitals with long-range plans indeed had marketing plans.
Yet only 47 percent of departmental plans included marketing
plans. Perhaps nursing does not view itself as a revenue
generating department and therefore did not place great
importance on a marketing plan for nursing.

Another reason is that because of the differing pos-
ture and visibility of the nurse executive in the strategic
planning process, she/he may not have been completely
knowledgeable about the elements included in the hospital's

long-range plan. This cannot be determined since the
questionnaire did not allow for a "do not know" response.

Planning Process

In addition to identifying the elements that were
included in the long-range plans, nurse executives were
requested to designate which of the segments of the strategic
planning processes were included in formulating the long-range
plans. These processes included: analysis of external
environment, analysis of internal environment, formulating
goals and objectives, formulating priorities, ranking goals
and objectives, ranking priorities, formulating strategies
for goals and objectives, formulating strategies for
priorities, selecting strategies, implementing strategies,
and evaluation. Just as the elements included in the plans
were similar, so generally were the process segments used to
formulate the plans also alike.

However, there were also some differences. Of partic-
ular interest was the difference in the use of external and
internal environmental analyses. While nurse executives
identified these processes to a great extent as being used to
formulate the institution's long-range plan (81% and 79%,
respectively), the rate of use was much lower (37% and 50%,
respectively) for these processes in the department of
nursing's long-range plan. The reasons for the differences
in the identified elements and the reasons for the

differences in the identified process segments are not the
same.

When reviewing the planning elements contained in both
the hospital and departmental long-range plans, the dif-
ferences could be understood at least in part by the possi-
bility that the nurse executive was not fully aware of the
elements included in the hospital's long-range plan.
However, this is not true for the differences in the identi-
fied process segments. Although the nurse executives identi-
fied the process segments of external and internal environ-
mental analyses as being used to a great extent in the
hospitals' long-range plan (81% and 79%, respectively), they
did not use them when formulating the nursing departments'
long-range plan (37% and 50%, respectively). The variance
in the scores may reflect the lack of significance the execu-
tive nurse places on boundary management for the department
of nursing in comparison to the institution. Also, the
nurse executives may lack the expertise necessary for applying
these segments of the strategic planning process to their
nursing departments. In addition to the degree of importance
placed by the nurse executives on these particular processes
for the department of nursing, the differences in the identi-
fied processes may be semantic.

Another interesting finding was the apparent discrepancy
between usage rates and extent of participation. For
example, only 37 percent of nurse executives reported that

they used "external environmental analysis" when formulating nursing's long-range plan. Yet, when asked the extent to which they participated in activities which are a part of external environmental analysis for the nursing department, the nurse executives had a mean score of 3.79 on a 5.0 scale, indicating a fairly high level of involvement. It is possible that this sample, while in fact quite involved in the activities which constitute strategic planning, were not familiar with the technical language used to describe the process.

Effect of Education on Participation in Strategic Planning

Education was a major factor influencing the extent of involvement in hospital strategic planning. Nurse executives who held a master's degree were more involved in strategic planning than either nurses with bachelor's degrees or diplomas. One of the reasons for this difference may be that curricula of diploma, associate degree, and bachelor's degree programs generally concentrate on the planning of individual patient care and unit management, not strategic planning. Therefore, nurses in these programs have not been exposed to the process of strategic planning. This lack of formal exposure to strategic planning, combined with minimal information on strategic planning available in the nursing literature, has resulted in nurse executives without master's degrees

being unable to participate in strategic planning for either
the institution or the department of nursing.

In addition, the credentials of the nurse executives with
a master's degree may gain them recognition by hospital admin-
istration as being capable of participating in strategic
planning. Therefore, the nurse executives become part of the
group responsible for strategic planning, because they have
educational levels comparable with other hospital executives.

Effect of Size on Participation in Strategic Planning

Hospital size influenced the extent of nurse executive
participation in hospital strategic planning. Size did not
influence the extent of utilization of the strategic
planning process for the department of nursing. Nurse execu-
tives who worked in medium-sized hospitals (100-399 beds) were
more likely to participate in institutional strategic
planning than those who worked in small or large
institutions.

Greater participation in strategic planning in medium-
sized hospitals may be due to the higher number of nurse
executives with master's degrees in medium-sized hospitals
(57%) than in small hospitals (21%). Although 55 percent of
nurse executives in large institutions held master's degrees,
large institutions were not identified as a significant
variable for participating in strategic planning. Perlin

(1972) found that three-fourths of long-range planning was done by the chief executive officer, and Pitts (1984) discovered that in Virginia plans were done internally and approved by the board of trustees. Therefore, while nurse executives in large institutions may have been educationally prepared to participate in strategic planning, they may not have been included as a member of the group responsible for formulating, finalizing and approving the institution's long-range plan.

Effect of Ownership on Strategic Planning

Hospital ownership affected neither participation in hospital strategic planning nor utilization of the strategic planning process for the department of nursing. Perhaps ownership is not a significant variable because it is not the only factor in determining either where or by whom strategic planning will be accomplished.

Summary

In this study, ownership influenced neither participation in strategic planning for the hospital nor utilization of the strategic planning process for the department of nursing. Hospital size did effect the extent of nurse executives' participation in hospital strategic planning. The nurse executive's educational level significantly influenced both his/her participation in institutional

strategic planning and the utilization of the strategic
planning process for the department of nursing. Therefore,
when nurse executives have both the necessary knowledge and
the opportunity to participate in hospital strategic planning,
they will do so. Since nurse executives are responsible for
their own departmental planning, nurse executives are
restrained in the use of strategic planning for the depart-
ment of nursing only by their lack of knowledge in the stra-
tegic planning process.

Implications

The current turbulent environment in which hospitals
and nursing departments conduct their business has resulted
in a search for methods which will enable hospitals and
departments of nursing to prosper. Hospitals as human
organizations are dynamic open systems whose boundaries are
relatively elastic and permeable rather than fixed. One
method which enhances the chances of prospering, through
facilitating the matching of organizational strengths with
environmental opportunities, is planning.

Over the years, planning in hospitals has evolved and
taken many forms: management by objectives, capital
budgeting, long-range planning, and currently strategic
planning. Strategic planning is a method utilized to manage
the boundary between the hospital and its external environ-
ment. Bourgeois (1980) stated:

> One can find among the many definitions that
> strategy has two primary purposes of defining
> the segment of the environment in which the
> organization will operate and providing guidance
> for subsequent goal-directed activity within that
> niche (p. 27)

The process of strategic planning involves: assessing the external and internal environments, establishing goals based on this assessment, formulating strategies to achieve prioritized goals, selecting the strategy(ies) to be implemented, implementing the strategy(ies), and evaluating the success of the implementation and outcome of the strategic planning process.

Traditionally, both operational and strategic planning have been accomplished by the board of trustees and the hospital's chief executive officer without participation by the director of nursing service. In 1982, the American Society for Nursing Service Administrators' follow-up survey of its 1977 study revealed that the role of nurse executives had evolved to include increased participation in institutional governance and fiscal management. There were also significant changes in reporting relationships. Although nurses are participating in operational planning for both the institution and their departments (Stuart, 1985), no information regarding the extent of participation by the nurse executive in the strategic planning process for the hospital or utilization of the process by nurse executives for managing their departments of nursing can be found in the literature.

While hospitals use strategic planning to a great extent for managing the boundary between the institution and the external environment to enhance their chances of survival, executive nurses are not as actively involved in strategic planning. The reasons that many executive nurses continue to be not as actively involved in departmental planning may be as cited by Fox and Fox (1983), a lack of knowledge or experience for implementing formal planning, and the heavy demands for immediate resolution of daily crises.

In this study, executive nurses were more likely to be involved in strategic planning if they had a master's degree and/or were employed in a medium-size hospital. More education increases involvement in strategic planning because generally curriculums at lower educational levels do not include information on strategic planning. Nurse executives may not be as involved in strategic planning in large hospitals because strategic planning may be being accomplished by the chief executive officer and the board of trustees. However, nurse executives may influence strategic planning through their participation in other policy decision arenas and interactions with members of the group responsible for strategic planning. Involvement in strategic planning for smaller institutions may be limited because planning is accomplished by the chief executive officer and the board of trustees and/or the nurse executive at smaller hospitals

tended to have less education (22 percent had master's
degrees) than those at medium (56 percent with master's
degrees) and large institutions (56 percent with master's
degrees).

The failure of the nurse executive to participate in
strategic planning is a disservice to the institution as well
as to the department of nursing, because contributions which
could be made by the nurse executive are never solicited.
Nurse executives can participate in all phases of the stra-
tegic planning process. For example, by contributing infor-
mation gleaned via already established external channels of
communication with the public through interactions with
patients, their families, and other community members
(Lukacs, 1984), nurses can participate in the assessment of
strategic planning. Stuart (1985) stated that based on
studies by Schultz (1972), Shortell, Becker and Neuhauser
(1967), and Shortell and LoGerfo (1981):

> one might expect that increased participation by
> nursing would be associated with positive out-
> comes for hospital effectiveness and viability
> through increasing the organization's command of
> its internal environment and resources (p. 53).

Implications for Nursing Practice

Nurse executives, if they are to achieve greater
autonomy for the practice of nursing, must continue to
increase their involvement in strategic planning for both the
department of nursing and their institutions, and to set a

higher value on planning than has traditionally been placed
(Fox and Fox, 1983). Autonomy can only occur if executive
nurses have the knowledge and opportunity to support nursing.
Manson (1983) stated that the nurse executive of the future
must possess financial management skills, computer knowledge,
marketing and public relation skills, and the ability to
analyze data and formulate short and long-range plans based
on economic and clinical information. Niederbaumer (1979)
asserted that nursing participation in policy level
decision-making was the only effective manner to plan, inte-
grate and implement the hospital's goals.

All nurse executives in this study were part of the
decision-making process; and they must also become part of
the planning process in order to advance nursing practice as
well as improve organizational effectiveness through
aligning nursing's priorities, goals, and objectives with
the institution's, and through influencing the institution's
priorities, goals, and objectives. Only through management
of the boundary between the department of nursing, the
institution and the external environment can executive nurses
enhance effectiveness for both their departments and their
institutions. Strategic planning promotes the managerial
flexibility necessary to respond proactively to new informa-
tion, thereby increasing long-term viability of organiza-
tional contributions and programs (Camillius, 1980).
Pfeffer and Salancik (1978) wrote that external environments

must be effectively managed if organizations are to survive.

Increased involvement in strategic planning will occur only with increased education of the executive nurse and the opportunity to participate in strategic planning. Nieder-baumer (1979) stated that in many institutions the director of nursing was unknown to the trustees and others in policy-making positions.

This study has shown a relationship between education and participation in strategic planning for both the institution and the department of nursing. Executive nurses are involved in strategic planning if they have the knowledge to do so. Nurse administrators must be prepared at the master's level if they are to effectively participate in institutional strategic planning. When nurse executives are capable of participating in strategic planning they are most likely not only to be included in institutional strategic planning, but will utilize the strategic planning process for their nursing department.

Limitations

Limitations of the study include both technical and practical aspects. A specific design weakness of this study is that the instrument may not reflect that institutional planning is being done if planning is done external to the organization or by another process, i.e., participants would respond "no" to questions regarding presence of a plan,

and/or may not be aware that a long-range plan exists because it is generated by individuals who are not part of the daily management of the hospital. Responses to questions (IH) and (IF) on the questionnaire, which delineated the process of planning, provided insight as to how the plan was formulated, but not necessarily where the planning function was performed, i.e., done within the institution or external to the institution.

Another problem with the questionnaire was the technical language used to designate the strategic planning processes. This was identified by the discrepancy between the low rates of the strategic planning processes identified by the executive nurses as being used in formulating the long-range plans, and the nurse executives' relatively high mean scores for participating in the strategic planning processes. Attempts to pilot the questionnaire outside Virginia were not successful, and the researcher did not want to decrease the sample by using executive nurses from Virginia.

Practical weaknesses include that the study was only done in Virginia and included only those nonmilitary hospitals belonging to the Virginia Hospital Association. The sample was not random, there was a low response rate (53%), and reliability and validity of the tool were not determined. Another concern was the questions which were not asked and which might have provided additional insight. Such questions as: "Was the nurse executive a member of the group

responsible for formation and/or approval of the strategic plan" would have been helpful in analyzing the data. The data were not analyzed to determine the interrelationship among the executive nurses' educational level, the size of facility in which they were employed, and participation in strategic planning.

There are no norms for who should participate in which types of planning. The studies involving planning have generally focused on the presence or absence of planning and who is involved in the process, but no study has been conducted to identify the effect on the outcome of planning by the presence or absence of a particular individual. It is not known from this study who were the individuals responsible for strategic planning at each institution; the nurse executive may not have been the only member of the hospital executive team not participating in strategic planning.

Recommendations for Future Research

There are many difficulties in descriptive surveys when studying new areas such as strategic planning. The relationship between strategic planning and outcome effectiveness has not been clearly established for the hospital (Pitts, 1984), and no studies have been conducted involving strategic planning effectiveness for the department of nursing.

While replication of this study with a larger sample size would also be of interest, additional future questions

which could be studied include:

1. Are nursing departments with long-range plans more efficient and effective than those nursing departments without long-range plans?

2. Are departments of nursing with long-range plans generated by the strategic planning process more efficient and effective than nursing departments with long-range plans formulated by other planning processes?

3. Which elements included in long-range strategic plans result in the best outcomes?

4. Who or what level of personnel should be involved in nursing long-range strategic planning for the best outcome?

5. What levels of nursing personnel should be involved in which segments of the strategic planning process?

6. All of the above questions could be asked of non-hospital based nursing departments, as well as comparing and contrasting hospital based nursing departments with non-hospital based nursing departments.

A related set of questions regarding why having a master's degree is significant for participation in strategic planning include:

1. Are executive nurses with master's degrees more assertive than executive nurses without a master's degree?

2. Do executive nurses with master's degrees have a more positive self-concept than executive nurses without a master's degree?

Conclusion

The purpose of this study was to determine the extent to which hospital nurse executives are participating in strategic planning for the institution, and the extent to which they are using the strategic planning process in their departments of nursing. Additionally studied was the effect of hospital size, ownership, and the executive nurses' educational level on both the extent of their participation in institutional strategic planning and their utilization of the process in their nursing departments. This chapter has summarized the findings of a survey questionnaire mailed to nonmilitary hospital based Virginia executive nurses. Interpretation of these findings was made and implications for nursing adminis- tration were discussed. The limitations of this study and recommendations for future studies were suggested.

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APPENDIX A

COVER LETTER AND SURVEY QUESTIONS

Dear Colleague:

    I am a graduate student in nursing administration at Medical College of Virginia/Virginia Commonwealth University. To fulfill the thesis requirement, I am conducting a study of the executive nurse's participation in the strategic planning process. The study includes all acute care hospitals in Virginia. Executive nurses in these hospitals are being asked to participate in the survey. Your participation in this study would be greatly appreciated.

    Participation in this study is entirely voluntary. Your responses will be reviewed only by me and will be accessible to no others. Although responses will be coded to allow for questionnaire follow-up, procedures have been developed to protect your privacy and the confidentiality of the data. Neither your name nor your institution's name will appear on any data forms and will not be used in any report of the findings. All data will be reported as aggregate statistics only, so that no individual or institution will be recognizable in any results reported. The completion of this questionnaire and the return of it to me signifies your consent to participate in this study. You may withdraw at any time by notifying me of your wish to do so.

    If you have any questions, please contact me at ████████████ A copy of the study results will be provided to you if you so desire. Thank you for your support and participation.

                             Sincerely,

                             Mary R. Pippin, R.N., B.S.N.

SURVEY QUESTIONS

I. Hospital Information

    A. Your hospital is:

        _____ 0-99 beds
        _____ 100-399 beds
        _____ 400 beds or more

    B. Your hospital is classified as:

        _____ nonprofit
        _____ for profit

Definition of Strategic Planning

Strategic planning is a process whereby a plan is prepared by ana-
lyzing elements in both the external and internal environment,
deriving goals based on the analysis, formulating and then
selecting a strategy(s) to meet the goals, implementing the stra-
tegy, and finally evaluating the success of the plan. For example,
the analysis of your external environment may reveal a population
of young married couples and no obstetrical care being provided by
other local hospitals. The internal analysis of the medical staff
and your facility reveals one physician, age 66, who is providing
obstetrical care and an outdated and under-utilized obstetrical
unit. Based on the analysis the hospital formulated a goal of
providing obstetrical care for the community. Strategies included
recruiting two young obstetricians, modernizing the obstetrical
unit, and media promotion. Time frames were established for
implementing the strategies and the plan was frequently evaluated
and revised as necessary based on new elements in the external or
internal environment.

    C. Does your hospital have a long-range plan?

        _____ Yes   _____ No

If your answer is "no," please go to Section III Planning Process
for the Department of Nursing on page 5.

    D. If your hospital has a long-range plan, is it written?

        _____ Yes   _____ No

    E. What is the time period covered by the long-range plan?

        _____ less than 3 years   _____ 5 years
        _____ 3 years   _____ greater than 5 years
        _____ 4 years

F. Which of the following are included in the long-range plan?

_____ mission statement
_____ master facilities plan
_____ financial plan
_____ capital budget
_____ marketing plan
_____ operating budget
_____ contingency plan
_____ external environment analysis
_____ internal environment analysis
_____ formulating goals/objectives
_____ formulating priorities
_____ ranking goals and objectives
_____ ranking priorities
_____ formulating strategies to meet goals and objectives
_____ formulating strategies to meet priorities
_____ selecting strategies
_____ implementing strategies
_____ evaluation

G. In what year did your hospital first prepare a long-range plan? 19__

H. If your hospital has a long-range plan, is it formulated similar to the process described in the definition of strategic planning process?

_____ Yes   _____ No

For the next section of the questionnaire, using the below scale, please answer the questions by placing the number which corresponds to your response in the space provided. Because little is known about who actually participates in strategic planning, there are no "incorrect" or "correct" responses.

    1 = not at all, 2 = very little, 3 = somewhat,
    4 = to a great extent, 5 = to a very great extent

II. Planning Process for the Hospital

Section A:

_____ 1. To what extent do you participate in gathering and ana-
            lyzing information regarding the local, state, and/or
            national economic environment which could influence the
            way business is conducted, or the services which are
            offered? For example: information might relate to new
            insurance coverage, reimbursement rates for third party
            payors or the opening/closing of a community industry.

(1 = not at all, 2 = very little, 3 = somewhat, 4 = to a great extent, 5 = to a very great extent)

_____ 2. To what extent do you participate in gathering and ana-lyzing information regarding the local, state, and/or national political environment which could influence the way business is conducted, or the services which are offered? For example: possible union formation, pro-posed legislation or regulation, or a local competitor's plans for a new service or facility.

_____ 3. To what extent do you participate in gathering and analyzing information regarding changes in health care and/or information management system technology which could influence the way business is conducted or the services which are offered? For example: installation of an automated patient care information system, or the need for home health care services.

_____ 4. To what extent do you participate in gathering and ana-lyzing information concerning local, state, and/or federal social policy which could influence the way business is conducted or services are offered? For example: minority needs, community activities, or consumer profiles.

Section B:

_____ 1. To what extent do you participate in gathering and analyzing information regarding the hospital's human resources, such as the number, quality, knowledge and skill levels, or productivity of personnel?

_____ 2. To what extent do you participate in gathering and ana-lyzing information regarding the financial status? For example: hospital's income and balance sheets, financial ratio analysis, or cost containment measures.

_____ 3. To what extent do you participate in gathering and ana-lyzing information regarding productivity? For example: variance analysis.

_____ 4. To what extent do you participate in gathering and ana-lyzing information regarding the physical facility? For example: space requirements, equipment efficiency or effectivness, or repair/maintenance needs.

(1 = not at all, 2 = very little, 3 = somewhat, 4 = to a great extent,
5 = to a very great extent)

_____ 5. To what extent do you participate in gathering and ana-
            lyzing information regarding the hospital's current
            health care delivery, or its existing information management
            system's technology? For example: new products/procedures,
            or additions to or replacement of the current information
            management system.

_____ 6. To what extent do you participate in reviewing and
            revising the hospital's mission statement?

Section C:

_____ 1. To what extent do you participate in formulating goals/
            objectives based on the hospital's internal environmental
            analysis?

_____ 2. To what extent do you participate in formulating goals/
            objectives based on the hospital's external environmental
            analysis?

_____ 3. To what extent do you participate in ranking the goals/
            objectives?

_____ 4. To what extent do you participate in formulating priorities
            based on the hospital's internal environmental analysis?

_____ 5. To what extent do you participate in formulating priorities
            based on the hospital's external environmental analysis?

_____ 6. To what extent do you participate in ranking the priorities.

Section D:

_____ 1. To what extent do you participate in formulating possible
            strategies for the hospital's long-range plan?

_____ 2. To what extent do you participate in analyzing the costs/
            benefits (financial, human resources, public image) of the
            proposed strategies to meet the defined goals/objectives/
            priorities?

_____ 3. To what extent do you participate in evaluating the
            advantages and/or disadvantages of proposed strategies
            relevant to the resources, competence and preferences of
            the organization?

_____ 4. To what extent do you participate in selecting from the
            proposed strategies the strategic choice(s) which will
            be implemented?

(1 = not at all, 2 = very little, 3 = somewhat, 4 = to a great extent, 5 = to a _very_ great extent)

Section E:

_____ 1. To what extent do you participate in developing policies for implementing the strategic choice(s)?

_____ 2. To what extent do you participate in developing plans for implementing the strategic choice(s)?

_____ 3. To what extent do you participate in identifying individuals who will be responsible for implementing the strategic choice?

_____ 4. To what extent do you participate in selecting individuals who will be responsible for implementing the strategic choice?

Section F:

_____ 1. To what extent do you participate in developing performance measures for monitoring and controlling implementation of the strategic choice(s)?

_____ 2. To what extent do you participate in analyzing the performance measures' results?

_____ 3. To what extent do you participate in evaluating the success of implementing the strategic choice(s)?

_____ 4. To what extent do you participate in re-evaluation of current goals/objectives, priorities and strategies in light of new elements in the external or internal environments, or a change in the mission?

III. Planning Process for the Department of Nursing

A. Does the department of nursing have a long-range plan?

_____ Yes   _____ No

If neither the hospital nor the department of nursing has a long-range plan, do not continue with the questionnaire, but please return this questionnaire by mail. Thank you for your participation. If your answer is "yes," please continue with the questionnaire.

B. Is the department of nursing's long-range plan written?

_____ Yes   _____ No

C. What is the time period covered by the long-range plan?

_____ less than 3 years
_____ 3 years
_____ 4 years
_____ 5 years
_____ greater than 5 years

D. In what year did the department of nursing first prepare a long-range plan? 19__

E. Is the nursing department's long-range plan prepared similar to the process described in the definition of strategic planning?

_____ Yes _____ No

F. Is the department of nursing's plan part of the hospital's long-range plan?

_____ Yes _____ No

G. Which of the following are included in the long-range plan?

_____ mission statement
_____ master facilities plan
_____ financial plan
_____ capital budget
_____ marketing plan
_____ operating budget
_____ contingency plan
_____ external environmental analysis
_____ internal environmental analysis
_____ formulating goals/objectives
_____ formulating priorities
_____ ranking goals and objectives
_____ ranking priorities
_____ formulating strategies to meet goals and objectives
_____ formulating strategies to meet priorities
_____ selecting strategies
_____ implementing strategies
_____ evaluation

Please answer the following questions using the below scale. Because little is known about who actually participates in strategic planning, there are no "correct" or "incorrect" responses.

1 = not at all, 2 = very little, 3 = somewhat, 4 = to a great extent, 5 = to a very great extent.

Section A:

_____ 1. When preparing nursing's long-range plan, to what extent do you gather and analyze information regarding the local, state, and/or national economic environment which could influence the way business it conducted in the department of nursing, or the services which are offered? For example: information might relate to new services or procedures which the hospital or department of nursing could offer, direct reimbursement for nursing services, or separation of nursing service charges from hospital bed and board charges.

_____ 2. When preparing nursing's long-range plan, to what extent do you gather and analyze information regarding the local, state, and/or national political environment which could influence the way business is conducted in the department of nursing, or the services which are offered? For example: possible union formation, proposed legislation or regulation, or changes in the nurse practice act.

_____ 3. When preparing nursing's long-range plan, to what extent do you gather and analyze information regarding changes in health care and/or information management system technology which could influence the way the department of nursing conducts its business or the services which are offered? For example: improvement of automated nurse staffing and scheduling systems, or the need for home health services.

_____ 4. When preparing nursing's long-range plan, to what extent do you gather and analyze information concerning local, state, and/or national social policy which could influence the way the department of nursing conducts its business or services which are offered? For example: minority needs, community activities, or consumer profiles.

(1= not at all, 2 = very little, 3 = somewhat, 4 = to a great extent,
 5= to a very great extent)

Section B:

_____ 1. When preparing nursing's long-range plan, to what extent do
you gather and analyze information regarding the department
of nursing's human resources, such as the number, quality,
knowledge and skill levels, or productivity of personnel?

_____ 2. When preparing nursing's long-range plan, to what extent do
you gather and analyze information for the department of
nursing regarding its financial status? For example:
variance analysis, number of patient care hours needed per
patient classification category, or skill mix.

_____ 3. When preparing nursing's long-range plan, to what extent do
you gather and analyze information regarding productivity
for the department of nursing? For example: variance
analysis.

_____ 4. When preparing nursing's long-range plan, to what extent do
you gather and analyze information regarding the physical
facility? For example: space requirements, equipment
efficiency or effectiveness, or repair/maintenance needs.

_____ 5. When preparing nursing's long-range plan, to what extent do
you gather and analyze information regarding the nursing
department's current health care delivery, or its existing
information management system's technology? For example:
new products/procedures, or additions to or replacement of
the current information management system.

_____ 6. When preparing nursing's long-range plan, to what extent do
you review and revise nursing's mission statement?

Section C:

_____ 1. When preparing nursing's long-range plan, to what extent do
you formulate goals/objectives based on nursing's internal
environmental analysis?

_____ 2. When preparing nursing's long-range plan, to what extent do
you formulate goals/objectives based on nursing's external
environmental analysis?

_____ 3. When preparing nursing's long-range plan, to what extent do
you rank the goals/objectives for the department of nursing?

(1 = not at all, 2 = very little, 3 = somewhat, 4 = to a great extent,
 5 = to a very great extent)

_____ 4. When preparing nursing's long-range plan, to what extent do
           you formulate priorities based on nursing's internal
           environmental analysis?

_____ 5. When preparing nursing's long-range plan, to what extent do
           you formulate priorities based on nursing's external
           environmental analysis?

_____ 6. When preparing nursing's long-range plan, to what extent do
           you rank priorities.

Section D:

_____ 1. To what extent do you formulate possible strategies for
           nursing's long-range plan?

_____ 2. To what extent do you analyze the costs/benefits (financial,
           human resources, public image) of the proposed strategies to
           meet the defined goals/objectives, and priorities?

_____ 3. When preparing nursing's long-range plan, to what extent do
           you evaluate the advantages and/or disadvantages of the pro-
           posed strategies relevant to the resources, competence, and
           preferences of the organization?

_____ 4. When preparing nursing's long-range plan, to what extent do
           you select from the proposed strategies the strategic
           choice(s) which will be implemented?

Section E:

_____ 1. When preparing nursing's long-range plan, to what extent do
           you develop policies for implementing the strategic
           choice(s)?

_____ 2. When preparing nursing's long-range plan, to what extent do
           you develop plans for implementing the strategie choice(s)?

_____ 3. When preparing nursing's long-range plan, to what extent do
           you identify individuals who will be responsible for imple-
           menting the strategic choice?

_____ 4. When preparing nursing's long-range plan, to what extent do
           you select individuals who will be responsible for imple-
           menting the strategic choice?

(1 = not at all, 2 = very little, 3 = somewhat, 4 = to a great extent, 5 = to a very great extent)

Section F:

_____ 1. When preparing nursing's long-range plan, to what extent do you develop performance measures for monitoring and controlling implementation of the strategic choice(s)?

_____ 2. When preparing nursing's long-range plan, to what extent do you analyze the performance measures' results?

_____ 3. When preparing nursing's long-range plan, to what extent do you evaluate the success of implementing the strategic choice(s)?

_____ 4. When preparing nursing's long-range plan, to what extent do you re-evaluate current goals/objectives, priorities, and strategies in light of new elements in the external and internal environments, or a change in the mission?

Please answer the following demographic questions:

IV. Executive Nurse Information

A. How many total years of nursing experience as a registered nurse do you have? _____

B. How many years of nursing administration experience at the executive level (Director of Nursing or comparable highest nurse administrator only), do you have?

_____ (years)   _____ (months)

C. How many years have you been employed by this hospital in your present position?

_____ (years)   _____ (months)

D. What is your highest degree?

_____ associate degree in nursing
_____ diploma in nursing
_____ bachelor's in nursing
_____ bachelor's in another field
_____ master's in nursing administration
_____ master's in clinical nursing
_____ master's in another field
_____ doctorate in nursing
_____ doctorate in another field

E.   Do you participate in hospital policy decisions such as new
     services to be provided, facility expansion, or cost contain-
     ment measures?

     _____ Yes   _____ No

Thank you for your participation.

Please indicate whether or not you would like a copy of the
results of this study.

_____ Yes   _____ No

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