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NOTES ON MANAGEMENT IN A HOSPITAL

By me

Well here I am, flat on my back literally and in other ways, right ankle resting on three pillows. Gravity is vital to treatment.

My nurse of the moment (R.N.) came in at about 1 o'clock to wrap my leg from the knee down in a hot towel and insulator. As a first step, she turned on the hot water in the wash bowl, as she needed hot water for the towel; departed. "I'll be right back." (Some nurses use the microwave oven for this purpose.) Anyway, a social worker dropped in about a half hour later. I asked her if she would mind turning off the hot water to avoid more waste of water and energy. She did. In another half hour, the nurse came back to put on the hot towel, but she needed hot water, therefore turned on the hot water. This time she actually returned and completed the task.

Dr. Sch ordered from the drug store (in the hospital) a paste for the itch that had set in in Minneapolis. The drug store was out of one of the ingredients: must order it from the wholesaler, and can not make it up till Monday, as this is Saturday, no delivery from the wholesaler till Monday. I need it tonight. On prodding from Dr. Sch, the drug store sent someone out to another drug store to fetch the missing ingredient. The paste came up that evening.

Unbelievable: the same scenario took place some days later My nurse of the afternoon ordered from the drug store a refill for the paste for itch. No problem, except that there would be a delay, as (again) the drug store would have to order from the wholesaler one of the ingredients. Tomorrow will be Saturday, next day Sunday; Monday they would have it. I hope to be on the way out by then. Meanwhile, they would send up a substitute, which would be in the form of a lotion, not paste. Actually, I'd prefer the lotion, but the paste came too, same evening. The drug store had again, on Dr. Sch's prodding, sent out for the missing ingredient.

On another day, my nurse of the moment (R.N.) came in three times between 0830h and 1000h to say that she would be right back to make my bed. I offered to get out of it so that she could make it up straightaway, but she may not have heard me. Each time, "I'll be right back." Anyhow, near noon she came and actually did the job. Of course, I'll live, bed made or no.

I wonder why is a registered nurse making beds? It seems to me that making beds is not good use of her time. Her education and skills could be put to better use, so it seems to me. Are there not helpers to do this kind of work? Maybe there are good reasons for what I don't understand.

All the while, nurses are on a dog-trot, panting for breath, working at top speed, losing time, not for start-up, but for no start. I know all about it; this is my way.

I was wondering about these thermometers, heavy electric cord attached. Speedy, yes, but impossible for a patient to hold correctly because of the heavy cord. The patient can only hold the thermometer against his cheek. The reading could be a whole degree low, I surmise. The aide that records temperature seemed to be totally indifferent: a reading is a reading.

The wash basin in my room has not enough space on it for a shaving mug, barely enough for a shaving brush. Bought at lowest price tag, I surmise.

The man that designed the shower had obviously never used one. The shower head, when not held by the hand, can only dangle and flood the floor. There is a tiny shelf in the shower only big enough to hold a wafer of soap. There is only one bar to hold on to. Use of this shower would be a risky business without a friend close by for rescue. Somebody sold somebody a bill of goods.

Intravenous diffusion due at 0600. The nurse came at 0505 to insert the needle into the more or less permanent spigot in my left arm, known as a Heparin Lock, departed. The infusion would run around 90 minutes. Meanwhile, some time after she left, in reaching for something on the shelf, I reached too far and pulled the needle out of the Heparin Lock. The nurse, when she came in around 0600, saw what had happened; was startled, but said not a word; merely carried everything away, liquid and tube. I supposed that she would return, and start over. Time went on; no return.

At 0830h I reported to Meg, head nurse in charge on the shift, that the intravenous diffusion due at 0600h had not been given. It was important to me, and important to Dr. D., else why bother with it? Her first impulse was to call (at home and maybe asleep) the nurse that left the job undone. It seemed to me, I told her, that it matters not what the nurse might say: I know what happened, and what did not. I called Dr. Sch. His secretary said that she would notify him at once and that he would call Dr. D.

The infusion came straightaway. The head nurse returned to say that the nurse that was to give the infusion at 0600 had recorded the infusion as given. It is possible that she recorded it in advance, with the intention to give it, and did not correct the record. Is this the regular procedure, to record intentions? Who would know?

An unsuspecting physician, looking at the record for his patient, would assume that the infusion had been given, and could draw wrong inferences about how the patient had been doing on the drug. In my case, as it turned out, no harm. But how would he know? A nurse, a physician has a right to suppose that the medication was delivered as ordered and as recorded.

Dr. Sch assured me that he is running this lapse down in every detail, and that nothing like it will ever happen again here--the usual supposition, actually only working on a defect, not on its cause.

Is it regular procedure in a hospital for a nurse to indicate on her record before she does it, that she has done it? Would she go back and change the record if she did not do it? Why should she? Who would know?

What is the purpose of the record? To inform the physician about intentions, or to tell him what happened?

A little figuring told me that insertion of the needle at 0505h, for infusion to start at 0600h (if she came back on time) would tie the patient in bed for over 2½ hours, the first hour tied in bed, then 1½ hours for the infusion, plus time added for the nurse to come to take the needle out of the Heparin Lock, and take the whole thing away. This long time in bed, with 3/4 cup of liquid infused, could create great discomfort for a patient.

She (R.N.) would "be back in 20 minutes," to take the wrapping off the hot towel and insulation that she had just wrapped my leg in, and would apply the cream prescribed. An hour and 5 minutes later, almost time for my IV, I rang the bell to call her. She returned in 15 minutes, unwrapped my leg, and started the IV just about on time.

The food is superb. The lasagna yesterday noon was the best that I've had since the days of Iacominni's Restaurant in Akron. The baked chicken today was superb: wing attached, browned to perfection, and the sweet potato, all steaming hot. Excellent beef and barley broth. Such food in a fine restaurant would cost $20. If only the food came on dishes here, or even on a white or light colored moulded pattern, instead of on battered brown. These trays were purchased on lowest bid, I surmise, or maybe were donated by a soup kitchen on purchase of new ones.

The Fettuccini Alfredo for dinner Monday night was the best ever, with three packets of parmesan cheese, as good as any Fettuccini Alfredo that I ever had this side of Rome. The broccoli soup was delicious. The beautiful looking apple dumpling was hot and tempting. I had already eaten enough food, but with one taste, just for trial, the dumpling was irrestible, so I finished it whether I needed it or not.

Fifteen hours elapse between dinner and breakfast. I was hungry in the middle of the night, first night; fortunately had candy bars on hand.

I have learned how to acquire and store up food like a squirrel if I get hungry during the night. I order for dinner milk as well as coffee, set the milk aside for use during the night. On hand, from friends, if needed, wonderful Scottish short bread from Scotland, Waverly crackers, candy bars. Also, I order a ripe banana for breakfast every day, put it in storage. I now have two bananas on hand, the number that I started with, but not the same bananas. FIFO, first in first out is my system.

An aide comes along around 9 o'clock to hand out juice or (I surmise) soft drinks, or milk, but I now have my own food.

The chair in this room is huge, would seat two people, takes up an exhorbitant amount of space, heavy to move. Somebody had good intentions. It can be adjusted to go back as a foot-board moves into place, but need it be so big and heavy? Why not have a movable chair?

The coat hangers here are that maddening kind, found in most hotels. How I wish that I had known about them before I sent that cheque to this hospital a year ago: I should have designated $10,000 of it to go for new racks and honest coat hangers in the rooms.

I had a new full size bar of good soap on the wash bowl. The girl that picks up trash must have thought that this kind of soap is not suited to my kind of skin. Anyway, the nurse of the moment brought to me for replacement a new bar of soap, small but appreciated.

My nurse of the moment put on a hot towel this afternoon. "I'll be back in 20 minutes, and if I don't come, please ring." Sixty-five minutes later I pressed the button. A helper came in; explained to me that this was not her kind of job, so she cancelled the light for the nurse, and went off. Thirty minutes later I rang again for the nurse. The same helper came and observed again that the job was not in her line of duty, so again she cancelled the light and went off. The solution was simple, for me, merely discard the towel and insulation myself, with the rules or against the rules. The same event recurred another day.

This experience leads to questions. Why should an aide, unable to perform the task, cancel the light? The nurse on duty for that light would not know that her patient needed a nurse. What if a nurse were suddenly vital to a patient? If he were in a single room, he would be left stranded. His nurse would not know that he had rung for her. In a room with two patients, the other one might be able to fetch a nurse. Moral, if you are acutely ill, don't go into a private room unless you have your own private nurse on duty at all times.

Shirley, a registered nurse, came to see me as a friend. She made the remark that a Heparin Lock ought to be examined at the end of 48 hours and maybe changed. It has now been in eight days. I asked later one of the nurses how long it should stay in one place. A nurse came and changed it from left arm to right arm.

What is the moral of all this? What have we learned? One answer: the Superintendent of the hospital needs to learn something about supervision. Only he can make the changes in procedure and responsibility that are required.

Talks between physicians and nurses, even with the head nurse, accomplish nothing. The same problems that I have noted will continue. A physician can not change the system. A head nurse can not change the system. Meanwhile, who would know? To work harder will not solve the problem. The nurses couldn't work any harder.

Ceil my secretary runs back and forth from here to my study only a mile away, to try to keep work moving. I have accomplished work on manuscripts due soon, and have caught up with a number of letters that have been dangling, also with some reading and re-reading in Harper's Magazine, the Atlantic Monthly, and others. It is not easy to read and to write while in bed with leg up. I violate instructions now and then, in order to write or to sign a letter, sitting up on the side of the bed, leg dangling.

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I estimated, on my prescribed 4 walks per day up and down the corridor that from half to a third of the beds were unoccupied. Saturday and Sunday could have been even lower and with less bustle. Vacant beds raise the cost per patient.

Poll Warns of Hospitals' Financial Deterioration

By Spencer Rich
Washington Post Staff Writer

The Healthcare Financial Management Association, which studies hospital financial trends, warned yesterday that its 1986 survey of 2,000 hospitals shows "early warning signs of financial deterioration of the hospital industry."

The organization said its survey showed profits falling from 3.6 percent of revenue in 1985 to 3 percent in 1986, the average age of plant and equipment rising from 7.2 years to 7.3 years, and a number of other indicators suggesting the financial condition in the industry "is rapidly deteriorating."

The association, which consists of about 26,000 persons involved in health-care financial management, accounting and planning, said in its study of audited reports from about 2,000 of the nation's 7,000 hospitals that "we are not predicting the immediate financial collapse of the hospital industry."

But it said that the government and other payers, which have been squeezing the industry on rates, must understand that holding increases in rates to less than the inflation rate year after year will hurt the industry and "result in reduced access and lower quality."

The decline in profits as a percent of revenue (or operating margins, as the industry prefers to call them) is sure to generate new debate about the increase in Medicare payment rates now under consideration in Congress for fiscal 1988—1 or 2 percent, compared with an inflation rate of nearly 5 percent in the costs of things hospitals typically buy.

Government studies have suggested hospitals might have made as much as 14 percent to 15 percent on Medicare operations in 1984 and 1985, but the industry and the HFMA contend these numbers are artificial and misleading.

Ron Kovener, HFMA vice president, said, "Congress and other payers should be aware of the fact that the industry is not in fat city."

Other unfavorable numbers reported by HFMA yesterday were a decline in return on investment—from 5.2 percent in 1985 to 4.6 percent in 1986; and a decline in debt-repayment ability.

HFMA said these trends were partly counterbalanced by some favorable trends like improvement in liquidity.

The author of this article captured in a few lines the main content of my teaching.
- WED

MANAGEMENT

Wanted: Joyful Bosses

W. EDWARDS DEMING

W. Edwards Deming has been a worldwide management consultant for more than 40 years. He has authored nearly 200 papers and several books, including Out of the Crisis.

What will make for quality products and services as well as renewed leadership in the 1990s? The prime requisite for achievement of any aim, including quality, is joy in work. This will require change, and management's job is to accomplish this change.

My own estimate is that today only two in 100 people in management take joy in their work. The other 98 are under stress, not from work or overwork, but from nonproductive work—churning money, battling for or against takeover and so on. Most of the 98 have their eyes on a good rating and don't dare contribute innovation to their work.

The changes required for the 1990s will be great: they will demand a whole new philosophy requiring abolishment of annual ratings, merit systems and performance appraisals. They will require the abolishment of grades in school from toddlers on up through university.

We have been taught in North America to believe that I can win only if you lose an equal amount, and so-called business strategy is too often merely strategy to choke a competitor. This must end.

We need government agencies that take the responsibility to help the management of companies to cooperate, and not merely frighten them out of the kinds of cooperation that could help industry to compete in the world's markets.

We must, in the years ahead if we wish to survive, change to the principle of win, win. Compete, sure, but in the framework of cooperation first so everybody wins.

Helaine Messer