Port-Said University
Faculty of Nursing
Nursing Administration Department

Academic year: 2020/2021	**Administration in Nursing**
Fourth year\ 2nd Term	**Final exam : Degree (100 marks)**
Time allowed: 3 hours **Date 22/6/2021**	**Examiners: Prof. Sanaa abd-Elazeem** **Dr. Noura El-gharieb**

Question No. (1): (10 marks): Choose the correct answer:

1.	**Advantage of team method is :-**			
	a.	useful in emergency situation	b.	Continuity of communication
	c.	Reduction of time spent in performing non-nursing activities	d.	increase efficiency and speed
2.	**Integrated methods.**			
	a.	Democratic method	b.	Patient centered method
	c.	private method	d.	task method
3.	**Establish performance standard; Monitor performance and compare with standards are steps of** …….			
	a.	controlling process	b.	planning process
	c.	Directing process	d.	None of the above
4.	**A performance standard depends on all the following factors except …..**			
	a.	Good communications	b.	Employees expectations
	c.	Nature of work the employees done	d.	Employees experience
5.	**It refers to the size of the difference between actual performance and the standard to be met.**			
	a.	Expectations principle	b.	Variance
	c.	Exception	d.	None of the above
6.	**Modern Methods of Performance Appraisal all of the items except**			
	a.	Assessment Centre Method	b.	360-Degree Feedback.
	c.	Psychological Appraisals.	d.	Forced distribution
7.	**Traditional staffing calculation done based on**			
	a.	Patients condition	b.	Equation
	c.	Nurses number	d.	Number of beds
8.	**Job specifications referred to**7-b			

	a.	Job development element	b.	Qualifications
	c.	Job analysis element	d.	Job recruiting element
9.	**Panel of expert to take decision on table**			
	a.	Delphi technique	b.	Survey technique
	c.	Brain storming group technique	d.	Nominal group technique
10.	**Decentralized schedule**			
	a.	Done by head nurse	b.	Done by staff
	c.	Done by hospital medical director	d.	Done by nurse service director

Question No. (2): (20 marks): Read the following statements and put (T) for true statement and (F) for false statement, and correct the wrong answer

1.	Hallo effect is overemphasize a positive event underrated total performance	F
2.	Judgment purposes for Administrative decision is determining training and development needs for nurses.	F
3.	Informal evaluation should be conducted according to hospital policy	T
4.	The function method help in developing leadership skills	F
5.	A modification to team nursing is care pairs of patient care delivery.	T
6.	Leniency/ strictness error is rater tends to assign extreme ratings of either excellent	T
7.	Case method is client focused and outcome oriented.	F
8.	Demands considerable time of the manager is disadvantage of paired comparison	T
9.	Advantages of graphic rating scale is a relatively easy to use and low cost.	T
10.	Management by objectives approach regularly, but more than once a year,	T
11.	Case method is client focused and outcome oriented.	F
12.	Associated nurse carries out the nursing care planned by the primary nurse when she is not on duty.	T
13.	Continuing education includes under and post graduate studies	F

14.	Job specification is one element of job analysis	F
15.	Staffing is extension to management concept	T

Question No. (3): complete the following statements (20 marks):-

1- Principles of Assignment:
-1. Made by the first line manager (head nurse or charge nurse).
2. Based on nursing needs of each patient and approximate time required to care for him.
3. Planned from week to week rather than from day to day to assure continuity of care.
4. The capabilities of staff, skill level, and their experience are considered.
5. Take into account all indirect and direct unit activities.
6. Geographical location of the unit and the assigned duties are considered to save nurse's time and effort.
7. Each task must be the responsibility of one nurse

2- Disadvantage of task method:
- Unclear line of responsibility and accountability function centered method
- No communication,
- No satisfactions
- Some tasks may missed
- Monotony on doing one task
- Un-fragmented care

3- Alternative methods: -
- Case management.
- Critical pathways.
- Practice partnerships.
- Differentiated practice.
- Patient centered care.
- Clinical microsystems.

4- Performance appraisal can be done by:
- Supervisors who rate subordinates.
- Subordinates who rate supervisors.
- Peers who rate each other.
- A combination of raters, supervisors and subordinates each other.

5- Guideline of writing records are :

-Clear

- Use Ink in writing

- Don't erase or use corrector

- Must be signed

-Use Identified abbreviations

Question No. (4): Differentiate between (30 marks) : -

1-Block and cyclical schedule

- **1- Block Scheduling.**

Means that the work schedule for a unit is planned in a " block" of week, i.e. days to be worked by staff are blocked together.

Block scheduling is done for 4-8 weeks at a time. It can be calculated easily and has flexibility in that the next block of time does not necessarily need to follow the pattern of the preceding block, This type of scheduling does not provide for maximum level of care seven days a week.

This type of scheduling does not provide for maximum level of care seven days a week .e.g..

X : days worked.

O: days off in the week

- **2- Cyclic time scheduling Schedule patterns are set for a certain number of weeks and are repeated (every two, four, six, or more weeks as desired) within the given cyclical period.**

- **Taking in consideration the need of proper number and mixes of personnel, continuity of care.**

Advantages.

1- Personnel know their schedules in advance and consequently can plan their personal lives and social activities.

2- There is a decrease in preoccupation with staffing, time for scheduling, time for maintenance of schedule, and conflict over preferred days off.

2- **3- Staff is treated more fairly by equitable distribution of popular and unpopular days on duty.**
4-The scheduling of appropriate number and category mix of personnel is simplified.
5- It helps establish stable work groups and decreases floating thus promoting team spirit and continuity of care.
Disadvantages.
* **Decrease in the flexibility of staffing**.

2-Skill training and leadership, management training

This program is directed towards equipping a selected group of employees for growing responsibilities and new positions in nursing.

Leadership and Management Development Program may be offered to:-
* Personnel in any supervisory capacity who have had insufficient preparation in the necessary skills
* Potentially capable personnel before they are assigned to management position.

Objectives:

1- Spread leadership and management competency among personnel (decentralized leadership)

2- Increased delegation of authority, developing professional accountability.

3- promote good morale among administrative personnel, which in turn influence staff morale.
3- Reduce costly turnover in top position.
4- Assist the individual to project her/his personality into the job using desirable concept of leadership and management.

6- Broaden selection possibility for promotion.

7- Meet the employee's needs for preparation for advancement when unable to obtain this through formal education

3-Job description and job analysis

FOR BASIS COMPARISON	JOB ANALYSIS	JOB DESCRIPTION
Meaning	A deep research on a particular job to ascertain every small details about it, is known as Job Analysis.	A Analysis. comprehensive job summary depicting the job contents in short but in an exhaustive manner.
What is it?	Process	Statement
Concept	A process of determining all the necessary requirements and aspects of a job.	A concise job. statement of what a job demands.
Incorporates	Tasks, responsibilities, skill, abilities, working conditions and adaptabilities of a certain job.	Duties and . Responsibilities, authority, purpose and scope of a specific job.
Mode	Oral or Written	Written
Advantage	Helpful in Recruitment and Selection of manpower	Helpful in ascertaining whether an applicant is eligible as per the set standards.

Question no (5) Give short account on (20 marks) 5 marks for each one

1-Centralized schedule

Use one individual or a computer to do the staffing and scheduling duties for all the units. It is usually used in small hospitals.

Advantage :

- **This type of staffing is fairer to all employees.**
- **There is balance distribution among the hospital unite.**
- **The first level manager is freed to complete other management functions.**

Adjustment could be done more easy in case of emergency or understaffing functions.

- **This method is more cost effective**

Disadvantage:

- Centralized Staffing does not provide as much flexibility for the worker.
- It does not account for a worker's desires or special needs.
- Manager may be less responsive to personnel budget.

-Professional qualifications. body of knowledge and skills, required by the nurse as a professional to provide the needed nursing service,

-Experience. Needed years of experience required for a certain job, it differ according to job title, and the organization

-Personal qualifications, as a leader qualities.

If managerial position, needed. In details according to the applications

3- Reports

NTRODUCTION
All professional persons need to be accountable for the performance of their duties to the public. ¬ Since nursing has been considered as profession, nurses need to record their work on completion. ¬ Records are a practical and indispensable aid to the doctor, nurse and paramedical personnel in giving the best possible service to the clients. ¬ Report summarizes the services of the person or personnel and of the agency.
- RECORDS ¬ A record is a permanent written communication that documents information relevant to a client's health care management. ¬ A record is a clinical, scientific, administrative and legal document relating to the nursing care given to the individual family or community. ¬ Reports are oral or written exchanges of information shared between caregivers or workers in a number of ways. ¬ A report is the summary of the services of person or personnel and of the agency.
-Records are a practical and indispensable aid to doctor, nurse and paramedical personnel in giving the best possible service to their clients. ¬ Recorded facts have value and scientific accuracy for more than mere impression of memory and there are guidelines for better administration of health services.
¬ Supply data that are essential for programme planning and evaluation. ¬ Provide the practitioner with data required for the application of professional services for the improvement of family's health. ¬ Tools of communication between health workers, the family & other development personnel ¬ Effective health records show the health problem in the family and other factors that affect health. ¬ Indicates plans for future. ¬ Help in the research for improvement of nursing care.
¬ Nurses should develop their own method of expression and form in record writing. ¬ Written clearly, appropriately and adequately. ¬ Contain facts based on observation, conversation and action. ¬ Select relevant facts and the recording should be neat, complete and uniform ¬ Valuable legal documents and so it should be handled carefully, and accounted for. ¬ Records should be written immediately after an interview. ¬ Records are confidential documents. ¬ Accurately dated, timed and signed ¬ Not include abbreviations, jargon, meaningless phrases
For the Individual and Family ¬ Records serve to document the history of the client. ¬ Records assist in the continuity of care. ¬ Records serve as evidence to support or to manage or face the legal questions that arise. ¬ Records serve to recognize the health needs and can be used as a research and teaching tool.
For the Doctor ¬ Serves as guide for diagnosis, treatment, follow up and evaluation of services. ¬ Indicate progress and continuity of care. ¬ Help self evaluation of medical practice. ¬ Protect the doctor in case of legal issues. Records may be used for teaching and research.
- For the Nurse ¬ Provide with documentation of services rendered, i.e. shows health condition of the client. ¬ Provide data essential for planning and evaluation of services for further improvement. ¬ Serve as a guide

for professional growth. ¬ Enable to judge the quality and quantity of work done. ¬ Serve as communication tool between staff and other members involved in care. ¬ Indicate plans for the future.

- For Authorities ¬ Provide the management with statistical information necessary for decision in regard to utilization of resources, planning for administrative control and future references. ¬ Help the supervisor evaluate the services rendered, teaching done and a person's action and reactions.

Cumulative or continuing records ¬ This is found to be time saving, economical and also it is helpful to review the total history of an individual and evaluate the progress of a long period.

Family records ¬ All records, which relate to members of family, should be placed in a single family folder. Gives the picture of the total services and helps to give effective, economic service to the family as a whole. ¬ Separate record forms may be needed for different types of service such as TB, maternity etc. all such individual records which relate to members of one family should be placed in a single family folder.
.Forms, case cards and Registers. ¬ Family record ¬ Eligible couple and child register ¬ Sterilization and IUD register ¬ MCH Card/ register ¬ Child Card/ register ¬ Birth and death register ¬ Sub centers/PHC/clinic register ¬ Stock & Issue register ¬ Reports of blood test of Malaria and Filaria ¬ Malaria parasite positive case register and others
.Diaries – Diary of (M and F) Diary of HA (M and F) 3.Return- Monthly report of HW (M and F) Complication report of Monthly report In addition, each organization should maintain: i. Cumulative records ii. Family records

The patient's clinical record ¬ Records of nurses' observations – Nurses' Notes ¬ Records of orders carried out ¬ Records of treatment ¬ Records of admission and discharge ¬ Records of equipment loss and replacement (inventory) ¬ Records of personnel performance.

The Head Nurse's Responsibility for the Clinical Record Protection from loss The head nurse is responsible for safeguarding the patient's record from loss or destruction. No individual sheet is separated from the complete record unless, as with the doctor's order sheet, it is kept in a special place where its safety is guarded. Safeguarding its content The hospital administration usually has a procedure with which the head nurse should be familiar for handling legal matter of this kind. Patient has the right to insist that his record be confidential.

- Completeness Compile records with complete identifying data on each page in the form approved by the hospital. The two parts of the record for which the nursing service is universally wholly responsible are the vital sign, graphic sheet and nurses' observation or nurses' notes. Responsibility for nurses' notes The form for nurses' notes which has been established by the hospital should be used by all nurses.

¬ What information is essential to record? ¬ What useful purposes will it serve? ¬ Is the information obtained in other way or is it recorded elsewhere? ¬ Can two records be combined? ¬ Can it be easily filled? ¬ Is the form uniform throughout the hospital?

- ¬ Get into the habit of using factual, consistent, accurate, objective and unambiguous patient information ¬ Use your senses to record what you did. ¬ Ensure there is a reasoned rationale (evidence) for any decision recorded. ¬ Ensure notes are accurately dated, timed, and signed, with the name printed alongside the entry. ¬ Write the notes, where possible, with the involvement and understanding of the patient or care taker. ¬ Errors should be corrected by putting a single line through the incorrect statement and signing and dating it.

¬ Follow the SMART model (Specific, Measurable, Achievable, Realistic and Time-based) or similar when planning care ¬ Write up notes as soon as possible after an event and, by law, within 24 hours, making clear any subsequent alterations or additions ¬ Do not include jargon, meaningless phrases (for example 'slept well'), offensive subjective statements. ¬ It must be clear what was originally written and why it was changed, therefore correction fluids should not be used. ¬ The NMC's position on abbreviations is that they should not be used (NMC, 2002c).e.g. 'PT' could mean patient, physiotherapist or part time; 'BD' could mean twice or brought in dead.

- Reports can be compiled daily, weekly, monthly, quarterly and annually. Report summarizes the services of the nurse and/ or the agency. Reports may be in the form of an analysis of some aspect of a service.

These are based on records and registers and so it is relevant for the nurses to maintain the records regarding their daily case load, service load and activities.

¬ Good reports save duplication of effort and eliminate the need for investigation to learn the facts in a situation. ¬ Full reports often save embarrassment due to ignorance of situation. ¬ Patients receive better care when reports are thorough and give all pertinent data. ¬ Complete reports give a sense of security which comes from knowing all factors in the situation. ¬ It helps in efficient management of the ward. ¬ Reports should be made promptly if they are to serve their purpose well. ¬ A good report is clear, complete, concise. ¬ If it is written all pertinent, identifying data are include – the date and time, the people concerned, the situation, the signature of the person making the report. ¬ It is clearly stated and well organized for easy understanding. ¬ No extraneous material is included. ¬ Good oral reports are clearly expressed and presented in an interesting manner. Important points are emphasized.

¬ Oral reports : Oral reports are given when the information is for immediate use and not for permanency. E.g. it is made by the nurse who is assigned to patient care, to another nurse who is planning to relieve her.

¬ Written reports : Reports are to be written when the information to be used by several personnel, which is more or less of permanent value, e.g. day and night reports, census, interdepartmental reports, needed according to situation, events and conditions.

1. Change- of- shift reports or 24 hours report ¬ Provide only essential background information about client (name, age sex, diagnosis and medical history) but do not review all routine care procedures or task. ¬ Identify clients' nursing diagnosis or health care problems and other related causes ¬ Describe objective measurements or observations about clients' condition and response to health problems. Stress recent change, but do not use critical comment about clients' behavior
2. ¬ Share significant information about family members, as it relates to clients' problems. ¬ Continuously review ongoing discharge plan. Do not engage in gossip. ¬ Describe instructions given in teaching plan and clients' response.
3. SAMPLE OF AN CHANGE- OF- SHIFT REPORT OR 24 HOURS REPORT WARD: NUMBER OF BEDS: DATE: Bed NO. Name & Age Diagnosis Morning Shift Evening Shift Night Shift Final Census Signature

Transfer reports A transfer reports involve communication of information about clients from the nurse on sending unit to the nurse on the receiving unit. Nurse should include the following information. ¬ Client's name, age, primary doctor, and medical diagnosis. ¬ Summary of medical progress up to the time of transfer. ¬ Current health status- physical and psychosocial. ¬ Current nursing diagnosis or problems and care plan. ¬ Any critical assessment or interventions to be completed shortly. ¬ Needs for any special equipments etc.

. Incident reports ¬ The nurse who witnessed the incident or who found the client at the time of incident should file the report. ¬ The nurse describes in concise what happened specifically objective terms, etc. ¬ The nurse does not interpret or attempt to explain the cause of the incident. ¬ The nurse describes objectively the clients, conditions when the incident was discovered. ¬ Any measures taken by the nurse, other nurses, or doctors at the time of the incident are reported. ¬ No nurse is blamed in an incident report ¬ The report is submitted as soon as possible. ¬ The nurse should never make photocopy of the incident report.

. Census report This is a report compiled daily for the number of patients. Very often it is done at midnight and the norms are collected by the night supervisor. The report will show the total number of patients, the number of admissions, discharges, transfers, births and deaths. The nurses should remember that a single mistake in the census figures made buy one of the nurses make the census report of the entire institution incorrect.

.Birth and death report The nurses are responsible for sending the birth and death reports to governmental authorities for registration within the specified time. 6. Anecdotal report An anecdote is brief account of some incident. Incident reports and reports on accidents, mistakes and complaints are legal in nature. A written record concerning some observation about a person or about her work is called an anecdote note.

SAMPLE OF AN ACCIDENT REPORT Name: Age: Address: Bed no. Ward no. : C.R.No.: Date & time of accident: Description of how the accident occurred: Safety precautions: Condition of the patient before and after the accident: Doctor's examination findings: Treatment ordered: witness to accident: Signature of the doctor: Signature of the nurse Unit: Date of report:

.Before anything can be written clearly, it must be clear in one's own mind. 2.Reports, lacking facts, may be biased or worthless. 3.Conciseness, accuracy and completeness are essential to good reports. 4.It is better to write several reports than one when there is more than one main subject upon which to report

Use terminology in keeping with the nature of reports: ¬ Short, simple, commonly used words for nontechnical reports. ¬ Scientific terms when issuing reports to professional personnel. ¬ Specific rather than general words ¬ Use a single meaningful term rather than phrases. 6.Observes mechanics of good writing. ¬ Use goods sentences and paragraphs ¬ Observe margins

Spell properly; avoid abbreviation except in clinical charting. ¬ Use correct pronoun ¬ Don't forget punctuation ¬ Be neat 8.Write report in a conversational manner. 9.Date reports 10.If report is typed by someone else, check it before signing it.

The patient has a right to inspect and copy the record after being discharged ¬ Failure to record significant patient information on the medical record makes a nurse guilty of negligence. ¬ Medical record must be accurate to provide a sound basis for care planning. ¬ Errors in nursing charting must be corrected promptly in a manner that leaves no doubts about the facts. ¬ In reporting information about criminal acts obtained during patient care, the nurse must reveal such information only to the police, because it is considered a privileged communication.

FACT Information about clients and their care must be functional. A record should contain descriptive, objective information about what a nurse sees, hears, feels and smells. ACCURACY A client record must be reliable. Information must be accurate so that health team members have confidence in it. COMPLETENESS The information within a recorded entry or a report should be complete, containing concise and thorough information about a client care or any event or happening taking place in the jurisdiction of manger.

CURRENTNESS Delays in recording or reporting can result in serious omissions and untimely delays for medical care or action legally, a late entry in a chart may be interpreted on negligence. ORGANIZATION The nurse or nurse manager communicates information in a logical format or order. Health team members understand information better when it is given in the order in which it is occurred. CONFIDENTIALITY Nurses are legally and ethically obligated to keen information about client's illnesses and treatments confidential.

Maintaining good quality records and reports has both immediate and long-term benefits for staff.. In the long term it protects individuals and teams from accusations of poor record-keeping, and the resulting drop in morale. It also ensures that the professional and legal standing of nurses are not undermined by absent or incomplete records, if they are called to account at a hearing. Computer-Assisted Charting

Disadvantages Sophisticated security system needed to prevent unauthorized personnel from accessing records Initial costs are considerable Implementation can take a long time Significant cost and time to train staff to use the system >Computer downtime can create problems of input, access, transfer of information

Case Management System Charting

A method of organizing patient care through an episode of illness so clinical outcomes are achieved within an expected time frame and at a predictable cost >A clinical pathway or interdisciplinary care plan takes the place of the nursing care plan . Accuracy in Charting Be specific and definite in using words or phrases that convey the meaning you wish expressed >Words that have ambiguous meanings and slang should not be used in charting

Brevity in Charting Sentences not necessary Articles (a, an, the) may be omitted

The word "patient" omitted when subject of sentence Abbreviations, acronyms, symbols acceptable to the agency used to save time and space

Choose which behaviors and observations are noteworthy

Legibility and Completeness in Charting If writing not legible, misperceptions can occur >Completeness is more important than brevity (see Boxes 7-1 through 7-3 for charting guidelines)

Record information about the patient's needs and problems and specify nursing care given for those needs or problems

The Kardex
Not a part of the permanent medical record A quick reference for current information about the patient and ordered treatments >Usually consists of a folded card for each patient in a holder that can be quickly flipped from one patient to another
Information on the Kardex Room number, patient name, age, sex, admitting diagnosis, physician's name Date of surgery Type of diet ordered Scheduled tests or procedures Level of activity permitted Notations on tubes, machines, other equipment in use Nursing orders for assistive or comfort measures
List of medications prescribed by name IV fluids ordered

4-Barriers of decision-making

1-Inadequate fact finding

2-Time constrains

3- Fail to follow systematic process of decision making

4-Fear of Failure

5-Resistance to change.

6-Lack of experience

With our Best Wishes

Prof Sanaa Ghandour
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