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Development of a pay for performance reward system in a health care organization

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The Development of a Pay for Performance Reward System in a Health Care Organization

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CHAPTER I

INTRODUCTION

The administrative staff at Columbus Hospital has received numerous complaints from tenured staff over the past two years. Staff members have verbalized dissatisfaction to their immediate supervisors and have written complaints to the Vice President of Human Resources and to the Chief Executive Officer (CEO) regarding the tenure program. The program has been accused of unfavorable discrimination against long-term employees. Newer employees essentially receive a larger percentage increase in pay than the longer-termed employees for an equal number of hours of service. The complaints have led to an investigation of all employee benefits and methods of distributing the benefits.

This paper discusses the present compensation system at Columbus Hospital and alternative pay and benefit packages. The alternatives are analyzed and recommendations are presented.

Columbus Hospital is a 198-bed acute health care facility located in Great Falls, Montana. Founded by the Sisters of Providence in 1892, Columbus Hospital was so

named in commemoration of the 400th anniversary of the discovery of America. The hospital functions under the auspices of the Saint Ignatius Province with headquarters in Spokane, Washington. As a Catholic affiliation, the hospital is a not-for-profit business.

Traditionally, the Sisters' mission was to provide Christian, compassionate care for others through high-quality patient care, education, research, and sound administrative and financial policies. This key objective continues today as the focus of employment at Columbus. The philosophy of the hospital states that the employees

> will make efforts at the personal and institutional level to bring about respect, peace and justice for all persons regardless of race, creed, age, sex, social status, or ethnic background.[1]

One of the key objectives states:

> Columbus Hospital provides our employees equitable compensation and opportunities for professional and personal growth based on their continuing contribution to the achievement of hospital objectives.[2]

Columbus Hospital is considered a medium-sized hospital compared to others in the state. The largest medical complex is Saint Vincent's Hospital in Billings, possessing 278 acute care beds.[3] The range of hospital size is vast, as bed capacity is as low as nine in Big Sandy.[4] Great Falls has three medical facilities: Columbus Hospital, Montana Deaconess Medical Center, and the Malmstrom Air Force Base Hospital. Health care competition is, therefore, provided to the community and the clients that it serves. None of the employees at

Montana Deaconess Medical Center or Columbus are unionized. Union awareness is strong, however, as nurses in some hospitals in Billings and Missoula, two prominent cities in Montana, are unionized. Of the 8,000 nurses currently licensed in Montana in 1989, the Montana Nurses Association quotes a state union membership of 1,100. In addition, a national nurses union is available.

Great Falls is located in west-central Montana, just east of the Rocky Mountains and equi-distant from Glacier and Yellowstone National Parks to the north and south respectively. Its population as of a 1986 census is 57,310. This city, therefore, constitutes the second largest city in Montana. The inhabitants of the entire state number approximately 805,000.[5] Due to the lack of large numbers of people in one area, the routine trade area for Great Falls reaches a 100-mile radius to the north, south, and east, and 50 miles to the west. With few health care facilities that are able to own high-technological equipment in this sparsely-populated area, customers can be forced to travel long distances to seek specialized health care. A helicopter medical transport system is utilized by Columbus Hospital to enable emergency patients to expeditiously seek the hospital's medical and nursing services.

Great Falls is home to Malmstrom Air Force Base, a large government facility responsible for manning and maintaining the numerous missile sites around the area.

The 9,200 people and subsequent income to the community that this Air Force Base provides are very significant. Plans to expand the services and population at Malmstrom have given Great Falls an economic boost that is much needed.

Great Falls has experienced a drop in employment in the last decade due to the closing of the Anaconda Company, "The Smelter." This was a manufacturing facility that smelted and refined copper until 1972. Over 2,000 employees were on the payroll at that time. In August of that year, production declined. Copper and zinc refining required fewer employees than copper smelting. Due to a drop in the demand for copper, the entire plant closed in September of 1980. With a loss of 510 jobs, income declined along with the tax base.[6]

Limitations of the Research

The primary research that was collected and evaluated is limited to the employees at Columbus Hospital at the time when the research was conducted. The results may not be representative of other health care facilities and service organizations. In addition, those employees who participated in interviews and surveys did so voluntarily. The limitations recognize that the data may be biased due to nonresponse error. No guarantee is made to ensure that those who did respond to the interviews and surveys are representative of those who did not respond.

Further potential for bias is also present. Although the collected data purposefully deleted the employee's name, anonymity cannot be absolutely guaranteed. Information was given to the respondents regarding the anticipated use of the data, and the people who would evaluate the data. The interviewers were not neutral, unbiased third-party members; they were fellow employees at the hospital. This could have influenced respondents' opinions and answers.

No attempt was made to determine similarity of respondents' opinions among health care facilities in other parts of the country, nor in health care facilities of different sizes within the same geographic area. The concern was only to determine the opinions of Columbus Hospital employees, given the benefit program and type of reimbursement system presently utilized. The conclusions and recommendations may not be appropriate for other service organizations.

The secondary research studied was selected from articles that primarily addressed performance pay systems not only in service organizations, but in health care organizations specifically. The results, therefore, may not be applicable in other types of organizations.

Organization of Remainder of Paper

Chapter 2 presents the current compensation system at Columbus Hospital. Details of the development of a task

force committee are explained.

The research and literature reviewed are discussed in Chapter 3. Advantages and disadvantages of a change in the present pay system are analyzed. Information shared with the committee from the programs at the Great Falls Gas Company and at Saint Vincent's Hospital are included. A summary of the pay programs of eleven hospitals of similar size around the state is given.

This information leads to the development of the normative model for Columbus Hospital in Chapter 4. Job description and performance evaluation tool revisions are discussed including an example of each tool before and after committee suggestions were implemented. Financial implications of the pay for performance system are reported. Market raises, cost-of-living allowances, and tenure considerations are evaluated for inclusion into or exclusion from the program for Columbus Hospital. Requirements for manager training with regard to the revised performance evaluation tool are recommended.

Chapter 5 gives conclusions and recommendations for Columbus Hospital based upon the research and discussion.

To summarize, Columbus Hospital is a competitive service organization in Great Falls, Montana. Among the hospital's objectives are to provide equitable compensation and opportunity for growth to its employees. The Great Falls area is presently in an economic upswing.

CHAPTER END NOTES

[1]Columbus Hospital, Employee Personnel Handbook (Great Falls, Montana, By the Author, 1982), p. ii.

[2]Ibid., p. 2.

[3]American Hospital Association, Guide to the Health Care Field (Chicago, Illinois: AHA, 1986), p. A151-A153.

[4]Ibid.

[5]Commercial Atlas and Marketing Guide, 120th edition (Chicago: Rand McNally and Co., 1989), p. 403.

[6]Great Falls Tribune, The Big Stack (Great Falls, Montana, By the Author, 1982), p. 56.

CHAPTER 2

PRESENT COMPENSATION SYSTEM AT COLUMBUS

Columbus Hospital practices a traditional step system based upon tenure for determination of employee monetary compensation. The longer employees work for the company, the higher the hourly rate. Rationale for this practice is simple: recruitment and orientation of new employees are expensive for the organization. Retention of experienced employees is the goal.

Columbus utilizes six steps to determine tenure. The steps are based upon completion of hours worked. The employee is automatically placed into a higher step with a subsequent base pay increase upon completing the specified hours. The step increase is independent of the employee's rating on the annual performance evaluation. The steps are broken down in Table 1.

TABLE 1

TENURE STEPS

Steps	Hours of Service
1	Entrance
2	1,040 completed hours of service
3	3,120 completed hours of service
4	5,200 completed hours of service
5	8,320 completed hours of service
6	12,480 completed hours of service

Wage increases by 5 percent between steps.

Longevity pay is given to those employees who have reached the top of the six-step pay scale due to serving the hospital in a full-time capacity for more than six years (12,480 hours). Under this pay plan, eligible employees receive an annual lump sum payment based upon years of service at Columbus Hospital. The amount of the payment for grouped-years is presented in Table 2. Employees can participate when they reach 10 years of service. Part-time employees are given a percentage of the amount paid to full-time employees according to the amount of hours worked. For example, employees working 32 hours per week are given 80 percent of the amount given full-time employees. Employees working 24 hours per week are given 60 percent of the amount given full-time employees.

TABLE 2

LONGEVITY BONUS PLAN

Years of Full-time Service	Amount Paid
10-14	$ 150
15-19	$ 300
20-24	$ 450
25 or more	$ 600

Of the 800 employees at Columbus Hospital in December of 1987, 300 (37.5 percent) were at the top of the six-step pay scale. The amount of the lump sum longevity pay is less than the amount of increase between tenure steps. To illustrate, employees starting at $10.00 per hour make a 5 percent increase in wages to $10.50 per hour for completing

1,040 hours of service. This translates to a $1,040/year raise. Employees working for 10 to 14 years receive a $150.00 lump sum bonus under the longevity bonus plan.

In addition to direct monetary compensation, Columbus Hospital offers a benefit package. Table 3 summarizes the availability of indirect compensation benefits.

TABLE 3

COLUMBUS HOSPITAL STANDARDIZED BENEFITS

	Available to:			
Benefit	Permanent Full-time Employees	Permanent Part-time Employees Working 48-79 hours per 2-week pay period	Permanent Part-time Employees Working Less than 48 hours per 2-week pay period	Permanent On-call Employees
Death Leave - up to 3 days	Yes	1/2 Benefits	None	None
Health Insurance	Yes	None	None	None
Holidays - 13 per year	Yes	1/2 Benefits	None	None
Jury Duty - Supplemental Pay	Yes	Yes	None	None
Life Insurance	Yes	Yes	Yes	None
Merit Increases	Yes	Yes	Yes	Yes
Retirement	Yes	Yes	Yes	Yes
Sick Leave - 12 per year	Yes	1/2 Benefits	None	None
Vacations - number of days according to tenure	Yes	1/2 Benefits	None	None
6% Premium Pay	No	Yes	Yes	Yes

Permanent On-call is defined as an employee who does not work any definite scheduled hours, but who is available to be called into work when needed by the hospital. Premium Pay is a method of further prorating benefits. Part-time and on-call employees receive an additional 6 percent of base pay in lieu of the standardized benefits that are not given. Employees who are considered probationary and/or temporary receive no indirect compensation. Probationary employees are those who have worked at Columbus Hospital for less than three months, despite number of hours worked in a pay period. Temporary

employees are those who are hired only for a specific, temporary period of time.

Standardized benefits include the Social Security Program, a Retirement Income Plan, a Tax-Deferred Annuity Program, and a Leave of Absence Program. In addition to these benefits, market raises and cost-of-living allowances are also provided by Columbus Hospital. These are classified under General Increases and are evaluated at least yearly to ensure that employees receive a competitive rate of pay. An evaluation is conducted utilizing wage and salary surveys of comparable jobs within the community and other areas of recruitment. Market raises have been granted to registered nurses and physical therapists, for example, within the past year due to supply and demand determinations.

Merit Pay is an incentive program provided for Columbus Hospital employees based upon employee performance. Many authors use the terms "merit increases" and "pay for performance" interchangeably in their writings. The criteria for merit pay at Columbus Hospital, however, is very strict. The amount of supervisory time and documentation required act as deterrents against utilizing this incentive plan. When questioned, the majority of employees were not aware that the hospital offers merit pay compensation. Interviews showed that, when instructed about the requirements to attain merit pay, the

overwhelming perception is that it is impossible to achieve. The Supervisory Manual states to the manager:

> It should be remembered that merit increases are normally rare and action by a supervisor/department manager should only be initiated in cases where outstanding performance is readily identifiable.[1]

Criteria to request merit pay for the employee include the following:

At least 50 percent of the employee's evaluations must have an overall evaluation rating of outstanding. The available ratings include, in order of increasing merit: unsatisfactory, improvement needed, competent, superior, and outstanding. No more than the last five annual evaluations will be considered when determining the 50 percent status.

Of the six areas evaluated as input into the overall rating, no improvement needed ratings are allowed.

The following procedure is then required:

1. The employee's Department Manager must recommend by memorandum addressed to the Administrator that an employee is qualified for a merit increase. The recommendation must contain sufficient information and justification outlining why this particular employee deserves a merit increase.

2. The memorandum will be initially forwarded by the Department Manager to the Personnel Director for review and recommendation to the memorandum and forward it to the Administrator who will be responsible for the final decision.

3. The Department Manager will be notified of the Administrator's final decision. A copy will be routed to Personnel for filing. Approved requests will be filed in the employee's personnel record. Disapproved requests will be filed in a general file.

4. If approved, the increase will be effective the beginning of the first pay period after the date of the Administrator's written approval. The amount of the merit increase will be 5% of the employee's present day rate.

5. The increase will remain in effect until revoked by memorandum to the Personnel Director from the Department Manager. The memorandum will include appropriate comments that substantiate the loss of the merit increase. Department Managers must remember that any employee with a merit raise who receives an overall rating that is less than "outstanding" on any evaluation, must have their merit raise revoked by memorandum.

6. An employee who has a merit increase and is promoted, demoted, or transfers to another department will again become eligible for consideration for a merit increase after completing a three-month reclassification period.[2]

The Human Resources Department indicates that in 1988, 15-20 employees, which represents 1.87-2.50 percent of the 800 employees at Columbus Hospital, received merit pay. Lack of knowledge of the ability to enhance one's pay through improved performance coupled with the perception of inability to achieve the requirements makes this benefit less than optimal.

Dissatisfaction about the present compensation system has been verbalized by many employees who feel that their contribution is more than that of some of their coworkers. Many employees believe that just because a person has worked longer at Columbus, that does not necessarily make the person worth more money. Many of these discussions among employees take place in informal settings, such as the cafeteria. The topic had been presented to several immediate supervisors by their staff members during

counseling and evaluation settings. The conversations overheard in informal settings and those presented one-on-one by staff members to their supervisors comprised a topic for discussion at a supervisor's meeting in the Spring of 1988. Approximately 90 percent of the supervisors present at the meeting were aware of employee dissatisfaction with the present tenure system. It was surmised that, although wages are to be confidential, many employees share this information with one another. In addition, it was the belief of the group that this is not a new dissatisfaction. Several causes which could be responsible for the recent surge of complaints were discussed. Among these causes are a change in staffing patterns initiated one year ago to increase productivity, increased awareness on the part of the employee due to increased publications being made available, and a heightened awareness of wages due to shortages of personnel in some health care areas. Gilles reports that "all workers are concerned with the relationship between their wages and work output."[3] Livy concurs that employees expect to be paid a wage commensurate with the work they perform.[4]

Financial Status of Present System

Service organizations are labor intensive. Columbus Hospital's payroll accounts for 48.6 percent of its annual budget. In 1988, the annual pay raises given for step

increases amounted to $175,000. Two-hundred eighty employees (35 percent of the 800 employees) were raised to the next higher step. The average annual pay increase was $625.00 per person. The amount paid for merit bonuses was approximately $16,380 in 1988, representing an average bonus of $936.00 per person. As labor costs are of major concern to this service organization, the impact of a change in method of determining employee compensation needs to be carefully planned.

Biannual surveys by the U. S. Chamber of Commerce indicate that supplementary benefits amount to about 37 percent of the employer's payroll.[5] Benefits are, therefore, not an insignificant part of the compensation package. This translates to approximately $5.6 million per year paid by Columbus Hospital for indirect compensation. The benefit program offered by Columbus is commensurate with the programs of other hospitals in the area. Employees have not verbalized dissatisfaction with the package offered. Although this is a very significant financial concern, major changes have not been deemed immediately necessary.

The tenure and step programs have been carefully studied since the hospital administration was made aware of employee dissatisfaction. On the surface, a "quick fix" would be to simply increase the number of steps in the program, maintaining the same percentage increase between steps and/or to increase the lump sum payments for

longevity bonuses. Financial analysis performed by Columbus Hospital accountants reveals a substantial increase in labor costs for both of these options.

Committee Development

A volunteer committee of employee representatives from each area of the hospital was solicited by the administration in September, 1987. The one objective of the committee was to determine if a pay-for-performance reward system was desirable for Columbus' employees. Eighteen employees volunteered to participate in the committee. The following departments were represented: Nursing Service (including float pool, Intensive Care Unit, Coronary Care Unit, Pediatrics, Staffing Coordinator, Medical Department, and Emergency Department), Biomedical Department, Pathology (Laboratory), Respiratory Department, Plant Engineering, Materiels Management, Medical Records, Educational Services, and Medical Transcription.

This activity of developing a task force made up of employees to assist in decision-making is representative of Columbus' approach to human resource management. It is the administration's belief that those decisions that directly affect employees ideally should include a great deal of employee input. Given legal regulations and time constraints, this is not always possible. Explanation is given to employees when this is the case.

The members of the task force gathered initially with Columbus Hospital's CEO and the Vice President of Human Resources. Background and information were provided to the members regarding the present pay plan, its development, and the concerns about the longevity and tenure components. Procedures for pay changes that include cost-of-living allowances and market raises were described. A target date of January, 1989, was given for recommendations that the task force members decided to implement, if any. Procedure and agenda of following meetings were left to the discretion of the members. The CEO and Vice President would be available for counsel at any time throughout the process.

The committee chose a chairperson and a vice-chairperson, and set dates for monthly meetings. Suggestions were made regarding information that the committee required to make the decision. It was decided that the following activities were required:

1. Perform a literature review.
2. Devise employee surveys.
3. Initiate and engage in employee interviews related to the pay system.
4. Document employee input.

Subsequent monthly meetings included approval of formats written for employee input, appropriate methods for distribution and retrieval of surveys, distribution and discussion of literary research, and discussion of survey and interview results.

Appropriate representatives were invited to the meetings to share insight into perceived effects of a change in the pay program upon their areas of interest. For example, a member of the Recruitment and Retention Committee attended a Pay for Performance meeting to share pertinent information on the potential outcomes of the pay system upon recruitment of new employees into the organization and retention of employees. A representative of the Nursing Career Ladder Committee was invited to give the Pay for Performance Task Force members insight into the impact of the pay system upon the career ladder for nurses.

Survey and interview data were considered individually and results were tallied by hand. Concerns and ideas presented to the committee were pigeon-holed by a subset of committee members and then presented to the entire committee. Formal regression analysis and sophisticated analytical tabulation were not performed. The committee was convinced that these activities would not improve the quality of the decision. Survey results were separated according to the department that the employee worked in and the number of years of service that the employee had completed.

The task force reported that non-professional departments, such as Housekeeping, were adamantly opposed to changing to a performance pay system. On the other hand, departments made up of primarily professional people, the

Nursing Service Department for example, were excited and anxious to try the pay system.

The second most striking result was in relation to those employees who presently received a significant amount of longevity pay in comparison to recently-hired employees. Although part of the rationale to consider a revised pay program was due to dissatisfaction with the lump-sum tenure bonuses, long-term employees were reluctant to try the performance pay system and give up the bonuses.

These concerns then lead to discussion of grand-fathering tenure for the first year or two of the program, rather than starting at skill level entry pay to determine performance increases.

In March of 1988, the task force, having considered all of the information, drafted a memorandum to hospital administration. The memorandum, provided in appendix 1 reiterated the goal of the Pay for Performance Task Force, explained the research done, and suggested that Columbus adopt this program. Stipulations for implementation were given including: 1) objective, behaviorally-based job descriptions, and performance evaluations; and 2) education for supervisors and department heads regarding the development of the job descriptions and evaluations.

CHAPTER END NOTES

[1]Columbus Hospital, Supervisory Manual (Great Falls, Montana, By the Author, 1986), p. 47.

[2]Ibid., p. 48

[3]Dee Ann Gilles, Nursing Management: A Systems Approach (Philadelphia: W. B. Saunders Co., 1982), p. 133.

[4]Bryan Livy, Job Evaluation: A Critical Review (London: George Allen and Unwin, 1975), p. 78.

[5]Thomas O. Kirkpatrick, Supervision (Boston: Kent Publishing Co., 1987), p. 356.

CHAPTER 3

REVIEW OF LITERATURE

Discussion of a Pay for Performance Reward System

Information was reviewed from sources that address pay for performance in health care settings as well as in other businesses. Most of the hospital-specific articles speak to a "catching up" philosophy, as most companies that have instituted pay for performance are non-health care businesses. Hospitals have been forced to be operated as businesses relatively recently. Cost containment prior to this business approach was unnecessary, as all of the costs incurred by the hospital were automatically passed to the consumer without question.

A government initiated diagnostic-related grouping (DRG) system of health care reimbursement generally ended this manner of billing in October, 1983. Briefly, the DRG system works like this: The hospital is paid a specific amount of money for a patient who has a specific disease process or treatment, no matter the patient's length of stay nor costs incurred. The amount paid to the hospital has reportedly been determined by a nationwide survey of the average amount required to care for the specific

problem. For example, the hospital that admits a patient who is suffering a heart attack will be paid $5,242. The average length of stay for this illness is determined to be 9.1 days. Therefore, if the patient is dismissed after only 8 days, the hospital has made a profit. If, on the other hand, the patient requires a cardiac catheterization procedure ($2,000), a pacemaker ($3,000-$10,000), cardiac rehabilitation ($800), and/or an extended length of stay due to, for example, lack of nursing home beds available, the hospital, nevertheless, gets the standardized $5,242 as reimbursement. It is not at the hospital's discretion as to what treatment or length of stay the patient will be provided. These decisions are made by the patient's personal physician who is not employed by Columbus Hospital. At the same time, physicians are becoming more and more concerned about premature hospital dismissal. This results in the hospital's lack of control over some costs.

The DRG system was initially restricted to those cases of Medicare and Medicaid reimbursement, as this was a government program. Since its initiation, however, virtually every third-party payer has adopted the program. Financial reimbursement from insurance companies is now very similar to the DRG reimbursement.

Events such as this have forced health care institutions to become businesses - very sensitive to cost containment and newly aware of such things as productivity

indices. The literature reflects this new business attitude that hospitals have been forced to adopt.

> Hospitals that will have the edge on their competitors in coping with the changing economic environment in health care are putting in pay-for-performance systems for all their employees . . .[1];

> The times are forcing health care institutions to strive for more effective use of their human resources and develop better wage and salary systems.[2]

Opinions of the pay-for-performance type of monetary reward vary greatly. For every article that advocates this reward system, it is possible to find one that rejects it. The rationale for adopting the program has been researched from several different angles. Although somewhat overlapping, the major considerations of pay for performance and its effects can be categorized into the following areas: 1) job satisfaction; 2) productivity and profitability; and 3) job description and performance evaluation revision.

The literature studied relating to job satisfaction and employee motivation in health care facilities centered upon the nurse employee. Comparatively little is written about other hospital employees as nursing service personnel account for at least 50 percent of an institution's employees and subsequent payroll.

Job satisfaction and resulting motivation are two of the strongest advocates for a pay-for-performance reward system. "Salary, benefits, positive evaluations, and promotion form part of the reality of practice and

influence performance. Rewards, then, are a crucial issue in motivation."[3]

Barros lists benefits of a pay-for-performance system specifically targeting the job satisfaction issue:

1. The employee receives recognition for accomplishments, and support for good performance.
2. The employee enjoys improved communication with supervisors.
3. The employee finds areas for improvement and training more easily identifiable.
4. The employee can better set goals and develop plans for future personal development.
5. The employee is held accountable for his/her own performance.[4]

Kanter states that "Every year, routine company surveys show fewer employees willing to say that traditional pay practices are fair."[5] The perception of equity and fairness have been shown to directly affect job satisfaction and motivation. A pay-for-performance system is viewed as equitable - not from a standpoint of equal pay for same job descriptions, but rather equal pay for equal quality of job performance. Fairness translates to getting appropriate monetary reimbursement for the duties performed. In addition, it incorporates the belief that everyone is playing by the same rules. Supervisor attitude and judgment are minimized. Objective performance is stressed.

This philosophy increases the responsibility of managers determining the performance evaluations. "The

prevailing styles by which leaders manage their [people] heavily influence the degree and quality of motivation."[6] Many organizations have run into snags putting performance pay into practice. Some problems are unavoidable, like employee jealousy. "Others stem from indecisive or poorly-trained managers . . . singling out exceptional employees . . . can undercut overall morale."[7] Manager training is, therefore, crucial for the pay system to suceed.

Another author states that "Improving job satisfaction is often mistakenly looked upon as the panacea for the ailments of the organization."[8] Top administration is, therefore, required to assess whether increasing job satisfaction through means such as performance pay will solve the problem presented.

Benefits of performance pay upon productivity are closely related to job satisfaction and motivation. Most management and supervisory text books link an increase in job satisfaction with a direct increase in productivity. Consequently, managers are taught techniques to improve corporate life. The revolution of McGregor's Theory X and Theory Y, and Ouchi's Theory Z has been ultimately assessed from a financial outcome angle. The emphasis is on the self-fulfilling prophecy of managers expecting better work, workers providing better work, and organizations ultimately doing better financially. According to Laron and Brown, however,

> When considering job satisfaction, it is tempting to conclude that . . . increased satisfaction will increase performance or output . . . This simplistic model is inadequate to explain the relationships involved in job satisfaction.[9]

Performance pay has long been utilized in the manufacturing sector, commonly known as piece-work. The more work an employee accomplishes, the more money the employee is paid. The bottom line here is obviously productivity. A problem arises in customer-service organizations, however. "Many managers have trouble answering the basic question, how do you measure performance?"[10]

A health care institution's productivity cannot be relied upon to provide accurate employee compensation based upon the employee's performance. The employee may be functioning at 130 percent of the standard, but that does not guarantee that the institution's income will reflect the level of work. Managers again would need to take on added responsibility to create and/or update standards of performance that truly reflect a positive outcome for the institution. The manager reaps a benefit of performance pay, though, by being able to focus employee attention on operational and strategic planning priorities. This can move the manager and the employee closer to attainment of established goals. This activity then improves and expands future organizational objectives to complement the goals of the employee.[11] As the employee is able to find areas for improvement and training more easily identified, management can develop the appropriate programs to satisfy

the needs without having to direct additional time and energy into a needs assessment tool. This effectively increases the manager's productivity. Performance pay is also capable of introducing flexibility and mobility into jobs, thereby lowering costs of employee cross-training and orientation. Employer participation in development activities should improve clinical performance and subsequent productivity. These linkages are more readily achieved if there is a direct relationship between the performance appraisal system and the reward system.[12]

Pure cost issues reveal both risks and benefits for the employee and the organization entertaining the feasibility of a pay-for-performance system. The employee is putting his pay at risk. Several performance pay options are available that affect the degree at risk. An example of the most severe degree is the pure commission pay. On the other end of the spectrum are programs that establish a skill level base pay and include a subtle tenure element and cost-of-living pay increases. "Maslow's heirarchy of needs has been frequently applied to nursing managers and staff personnel."[13] Seybolt studied nursing administrators and found their perceived needs in this descending order of priority: social needs, security needs, esteem needs, autonomy needs, and self-actualization needs.[14] The administration considering performance pay is wise to consider the basic risk to the employee.

Administration's cost concern is double-edged.

> Facing challenges from competitors with lower labor costs, companies in fields from airlines to autos are seeking ways to reduce the fixed cost of labor by increasing the variable component of pay. One way to do this is to make pay more contingent on performance. . .[15]

There needs to be a limit on the variable portion, however, that the company can accept. This limit in itself can be a demotivator. If outstanding performance will earn the employee a 2 percent increase in pay, the employee may determine that it's not worth the effort. The institution needs to balance a potential increase in payroll costs with an increase in revenue that more than compensates. This financial problem escalates. "Surveys show that roughly 80 percent of American workers believe they are better than the norm."[16] Coworker harmony can turn into bitterness. An example comes from the Apollo Middle School near Fort Lauderdale. Large performance bonuses were given to some over others. "Because of hard feelings generated by the pay, the relationship between the faculty and staff has never been the same."[17] Dudley Biggs, Chairman of PSM Consultants, believes that the cost to the organization of performance pay is justifiable. He relates that to motivate and reward employees for outstanding performance in meeting objectives, ". . . incentive compensation is paid only after the objectives have been achieved and is, therefore, a small and reasonable cost of management."[18] Management time to document the performance is also a cost

issue. "These systems take more time and care to administer once they're in place," says Ed Gubmans.

> You're asking managers to spend more time and do a better job on setting clear job expectations for employees, to do better day-to-day coaching, and to do a more accurate job of performance appraisal.[19]

The in-depth management training required is of financial concern to most businesses. Job descriptions and performance evaluations may need to be completely rewritten to coincide with the objective nature inherent in a performance pay system.

Finally, one of the prerequisites to a performance pay system is appropriately-written job descriptions and objective performance evaluations.[20] Job expectations that are clearly defined are an initial benefit to the employee of a performance pay system.[21] Larson and Brown studied job satisfaction of nurse employees. "The most striking result of our study was that all . . . satisfaction variables were significantly predicted by respondents' job expectations . . ."[22] Departmental and organizational standards must reflect not only the goals of the institution, but must also begin to define the job expectation of each employee. The quality as well as the quantity of work performance must be communicated to the employees and well understood by the manager. Education of the standards, goals, and expectations of one's work will only improve the synergistic outcome of the entire organization. This knowledge allows management to focus

employee attention upon operational and strategic planning priorities. It is not unusual for a particular employee or department to do well only at a comparatively greater expense to the entire organization.

> Vroom's Expectancy Theory of Motivation concludes that a person will work more conscientiously where there is a high degree of certainty that a given outcome will occur, and when the outcome itself is desirable to the person.[23]

It is assumed that an increase in pay is desirable. The required education and communication to initiate a performance pay system is in itself a cost issue for the institution. The time and energy that may be required to define standards and rewrite job descriptions and performance evaluations can be staggering. The cost of bypassing this important step, however, has been shown to be greater than the expense of completing the necessary paperwork.

> The failure of incentive compensation systems almost always can be traced to the absence of specific objectives and performance standards against which performance can be accurately measured . . .[24]

Providing 100 percent objectivity in work performance is all but impossible. In a service organization, the quality of service rendered frequently has a subjective component. "In an effort to make decisions look objective, managers sometimes make [a] dangerous mistake: trying to quantify things that shouldn't be."[25] Consultant Carl Thor of the American Productivity and Quality Center specializes in jobs that are difficult to measure. He concedes that

businesses "sometimes look at factors that may not be terribly relevant simply because they're easier to measure."[26] But the difference between a merit pay system, in which employees' raises are determined according to their supervisor's judgments about performance, and a pay-for-performance system, where rewards on top of base pay are given based upon specific contributions according to company priorities,[27] needs to be made. The link between performance and pay has to be clearly established.

The style and wording of the performance appraisal is critical. Education of managers who give evaluations is crucial. It is

> common in American companies to see supervisors trying to give all their employees high ratings so they can buy employee cooperation and 'look good' as managers. Companies have had to force 'grading on a curve' in order to get any differentiation.[28]

Many risks and benefits are apparent when considering a change in the pay system to pay for performance. Those presented deal with employee satisfaction/motivation, cost, and requirements of the standards, job descriptions, and performance evaluations.

Programs at Two Regional Service Organizations

The Board of Directors at the Great Falls Gas Company started their pay-for-performance program on officers of the company in 1982. The program utilizes specific performance objectives which are tied to the portion of the pay which is at risk, ranging from 6 to 16 percent. Three

basic criteria have been identified as requirements for the success of their program:

1. The specific goals or objectives must be measurable;

2. There must be agreement between the employee and supervisor on the goals;

3. There must be good communication between the employee, supervisor, and top management as to how these objectives can be reached, and what the payout will be if the objectives are met. Also, the employee must be frequently appraised as to how they are progressing toward goal achievement.

In fiscal year 1988, the Gas Company extended the pay-for-performance program to first-line supervisors. These supervisors control about two-thirds of the total work force. The performance objectives for each officer and supervisor are individualized. The performance pay for the supervisors comes out of the 3 percent of the total salary budget for fiscal year 1988. The company reduced their budget estimates for base salary to their officer level group in order to have dollars available for the pay-for-performance program for first-line supervisors. Time frames were placed on each objectives.

The major objectives for the entire company were shared with the supervisors. The supervisors and officers, along with their immediate supervisors, determined specific objectives. If all of the specific objectives are achieved, then the president will achieve his overall goals. Examples of a Customer Service Supervisor and Distribution Foreman are provided in appendix 2.

The traditional expected annual raises were eliminated. Each manager and supervisor were trained on ways to conduct more effective performance appraisals. An ongoing program was developed to include managers in the training process to develop skills in communication, delegation, reward-discipline, time management, and other areas as needed. The company set measurable objectives relating to the provision of more challenging and rewarding work for each employee. Percentages of total available points are earned by the manager or supervisor if the specific objective is met. For example, 5 percent is earned if absenteeism is reduced by 20 percent compared to the previous fiscal year. The entire plan is provided in appendix 2.

The program at the Great Falls Gas Company has met with a fair degree of success as reported by Larry Geske, President. The pilot project, utilizing the officers for a five-year period, provided the needed revisions for the program to be utilized, with minimum change, for the first-line supervisors. Supervisor motivation is evident, knowledge about company goals is present, and additional labor costs have not increased.

St. Vincent's Hospital in Billings, Montana, utilizes a performance pay system which includes an employee self appraisal. Supervisors assist the employee with guidelines to complete this form. The five major objectives of the

self appraisal are given to the employee in preparation for the appraisal interview:

1. Reach an agreement on the performance of the employee.
2. Identify strengths.
3. Identify performance areas that need to be improved.
4. Agree on a performance improvement plan.
5. Agree on expectations for the next appraisal period.

The employee is given a 2- to 3-week period to complete the self appraisal.

Management staff have been provided verbal and written instruction and education regarding preparation and conduction of the interview. Examples of information given are:

- Plan the conclusion: for instance, review what was accomplished in the interview, the developmental plan, etc., and set the agenda for the next meeting.
- Avoid inappropriate topics: stick to the objectives being evaluated.
- Encourage the employee to talk.
- Listen and don't interrupt.
- Avoid confrontation and argument.
- Focus on performance, not personality.
- Focus on the future, not the past.
- Conclude on a positive note.

Performance results are determined utilizing function ratings related to planning, implementation, and results. The performance objectives are classified according to maintenance or developmental activities. A five-point rating scale is utilized to determine performance. Table 4, taken from St. Vincent's personnel book, defines the scale.

TABLE 4

RATINGS FOR PERFORMANCE

RATING KEY	RATING FACTOR
Outstanding	5
Superior	4
Fully Satisfactory	3
Marginally Satisfactory	2
Unsatisfactory	1

DEFINITIONS:

Outstanding (Far exceeds expectations) 5
The employee constantly and consistently performs far above standards established for the performance objective being evaluated. Obvious evidence shows performance is distinguished when compared to vast majority of peers. Virtually flawless.

Superior (Exceeds expectations) 4
The employee almost always performs above established standards for performance objective being evaluated. Obvious evidence shows performance is usually better than expected and stands above that of his/her peers.

Fully Satisfactory (Meets all expectations) 3
The employee always meets and on occasion may exceed standards established for the performance objective being evaluated. Evidence shows that the employee accomplishes all tasks and responsibilities involved with the performance objective in a consistent manner. Errors/problems are few.

Marginally Satisfactory (Usually meets expectations) 2
The employee meets standards established for the performance objective most of the time, but almost

never exceeds those standards. Evidence shows that the employee usually accomplishes tasks and responsibilities required by the performance objective. Some errors may occur occasionally and the employee may need more assistance that others in performing necessary tasks. Performance for the objective being evaluated compares with some peers, but may fall below the performance of many coworkers. Developmental plans may be necessary to assist the employee in developing skills necessary to meet minimum standards.

Unsatisfactory (Does not meet expectations) 1
The employee almost never meets the standards established for the performance objective being evaluated. Evidence shows that serious problems exist with the employee's performance in this area. Counseling/coaching has been initiated and developmental plans are necessary. Performance falls far short of standards and does not compare favorably with the majority of coworkers.

The rating factors are then totalled and the performance objectives are grand-totalled to determine the overall performance rating for the employee. This overall rating determines the percent increase in pay that the employee has earned. Table 5, taken from St. Vincent's personnel book, gives the percent increase in wage for each rating.

Performance appraisal examples for a departmental manager and a "typical" employee are provided in appendix 3. Cost of living allowances and market raises are separate from St. Vincent's performance pay increases. The benefit package includes all of the items offered by the Columbus Hospital package except for the longevity bonus. This is a notable exception as it relates to one of the aspects of employee dissatisfaction at Columbus.

TABLE 5

PAY FOR PERFORMANCE MATRIX

FORM I	FORM II	RATING	% OF BASE SALARY	LUMP SUM MERIT%
40.5 - 45.0	13.5 - 15.0	Outstanding (Far Exceeds Expectations)	4%	2-3%
32.19- 40.49	10.73- 13.49	Superior (Exceeds Expectations)	3%	1-2%
22.68- 32.18	7.56- 10.72	Fully Satisfactory (Meets all Expectations)	3%	0
9.18- 22.67	3.06- 7.55	Marginally Satisfactory (Usually Meets Expectations)	1-2%	0
3.0 - 9.17	1.0 - 3.05	Unsatisfactory (Does not Meet Expectations	0	

Evaluation of health care facilities throughout Montana reveals the following data shown in Table 6.

These data show that most unionized hospitals do not practice a performance pay system. In fact, most hospitals in Montana do not utilize any system other than the traditional step system which includes a tenure program. With the exception of one hospital, a pay for performance-type system negates a tenure increase system. Specific information is not available regarding employee satisfaction to deletion of tenure bonus when performance pay was instituted.

TABLE 6

MONTANA HOSPITALS' PAY PROGRAMS

Hospital	Number Acute Care Beds	Unionized Employees	Tenure Program	Pay for Performance Appraisal System
Community Hospital-Anaconda	43	Yes	Yes	No
Deaconess Medical Center-Billings	253	Yes	Yes	No
St. Vincent's Hospital & Health Center - Billings	278	No	No	Yes
Bozeman Deaconess Bozeman	72	Yes	Yes	No
St. James Community Hospital - Butte	274	Yes	Yes	No
Veteran's Administration Hospital - Fort Harrison	150	Yes	Yes	Yes
Montana Deaconess Medical Center - Great Falls	272	No	Yes	No
Northern Montana Hospital - Havre	120	No	Yes	No
Kalispell Regional Hospital	107	No	Yes	No
Veteran's Administration Center-Miles City	91	No	Yes	No
Missoula Community Hospital	125	Yes	Yes	No

Source: American Hospital Association

CHAPTER END NOTES

[1]Ed Gubman, "Pay for Performance is Credo of Cutting Edge," Hospitals, April 16, 1985, p. 64.

[2]Annamarie Barros, "Setting Up a System of Pay for Performance," Medical Library Observer, November, 1986, p. 39.

[3]Bette Case, "Excellent Performance," Nursing Management, December, 1983, p. 45.

[4]Barros, p. 41.

[5]Rosabeth Moss Kanter, "The Attack on Pay," Harvard Business Review, March/April, 1987, p. 61.

[6]Case, p. 46.

[7]Newsweek, "Grading Merit Pay," November 14, 1988, p. 45.

[8]Elaine Larson and Marie Annette Brown, "Job Satisfaction," The Journal of Nursing Administration, January, 1984, p. 31.

[9]Ibid., p. 32.

[10]Newsweek, p. 46.

[11]Barros, p. 41.

[12]Lynda P. Nauright, "Toward a Comprehensive Personnel System: Job Description Development," Nursing Management, July, 1987, p. 46.

[13]Case, p. 46.

[14]Ibid.

[15]Kantor, p. 76.

[16]Newsweek, p. 45.

[17]Ibid.

[18]Dudley P. Biggs, "Incentive Pay Plans Boost Managers' Performance," Health Progress, March, 1987, p. 61.

[19]Gubman, p. 64.

[20]Barros, p. 41.

[21]Kantor, p. 78.

[22]Larson, p. 36.

[23]Kirkpatrick, p. 327.

[24]Biggs, p. 61.

[25]Newsweek, p. 46.

[26]Ibid.

[27]Kanter, pp. 78-79.

[28]Ibid.

Chapter 4

NORMATIVE MODEL FOR COLUMBUS HOSPITAL

Job Description and Performance Evaluation Revisions

The literature made evident the requirement of an objective performance evaluation to decrease the employee risk of wage determination by subjective employer favoritism. Once the decision by the committee was communicated to administration, the tasks of implementation were placed upon another group of people and the ad hoc committee was dissolved.

Given the results of the hospital-wide surveys which revealed that a greater percentage of professional employees favored the performance pay system, administration decided to choose a subset of professional employees to pilot the program for a one-year period of time. The nursing services department, made up of over 50 percent professional people (registered nurses) volunteered to pilot the program on the RN staff members.

Nursing managers and supervisors were appointed to the committee and were asked to obtain volunteer RN staff members to join and assist with input. The committee

membership resulted in eleven managers and supervisors and six RN staff people.

Revision of the RN performance evaluation tool was the priority, however, it was quickly determined that the RN job description needed to reflect the evaluation, so this form was revised and updated first. Much discussion ensued relating to nursing skill and knowledge requirements for general and specialty areas. Nursing practice has become nearly as specialized and divided as medical practice in recent years. For example, an RN who has worked in labor and delivery very competently for ten years may not be safe in the care of an acute cardiac patient. Although basic anatomy and physiology knowledge is present, the techniques and equipment in specialized areas have changed dramatically and continue to change constantly. The discussion revolved around a potential need of an RN job description for each unit and nursing area in the hospital. Although requirements for quality of work would be more specific given individual unit/area job descriptions, transferring of nurses from one area to another would not only be more difficult, but stressful on the employee. In addition, Columbus Hospital, like most other hospitals, employs float nurses. These people work many different units depending upon the staffing need of the unit on that particular shift. It is possible for the float nurse to work five different areas in any five-day week, having been trained in all areas. It was deemed as

unfair by the committee to expect a float nurse to answer to five separate job descriptions.

The committee members worked separately and then as a group to devise a generic form that would satisfy the needs of all nursing areas. Criteria-based job description information was heavily utilized.[1] One registered nurse job description was developed incorporating hospital policies and procedures, legal and ethical requirements. The former RN job description is provided in appendix 4 in addition to the revised form.

With a functional registered nurse job description in place, the committee turned to the task of developing an objective performance evaluation. The job description served as the basis of evaluation. This sounds obvious, however, former tools did not associate the two directly. To illustrate, a previous evaluation form is provided in appendix 5. This form was utilized for nurses, secretaries, laundry personnel, housekeepers, kitchen workers, and all other employees at the hospital. Indeed, with the exception of the nursing service department, it continues to be the format for evaluation of all other personnel in the hospital. The evaluating supervisor utilizes the job description when determining performance, however, the two documents are very separate.

The committee determined that restating the job description on the performance evaluation promoted objectivity. The description is restated, verbatim, as the

acceptable/satisfactory level of performance. Definitions of lower and higher ratings are specifically given on the form to promote employee understanding of behaviors and their subsequent ratings. An employee is clearly able to identify behaviors that would achieve a superior rating for future goal setting. The inclusion of these behaviors not only adds to the objective nature of the form, but assists the supervisor with suggestions to improve employee performance. It is not uncommon for an employee to leave an evaluation session unable to verbalize specific behaviors that would cause an improvement in performance and future evaluations. An area for goals for the upcoming, usually annual, evaluation period is also provided.

Each attribute in the job description and the performance evaluation was then weighted according to importance. "Professional decorum," for example, is rated on a scale from zero to ten, while "completes additional duties" is only given a possible weight from zero to two. The rating that the employee receives is divided by the total possible rating to achieve a percentage. All attributes may not be applicable to all nursing areas. For example, an operating room nurse is not responsible for devising and writing a patient plan of care. This attribute is then deleted, and the rating is divided by the total possible applicable number.

The resulting percentage places the employee into one of the following five categories of performance: outstanding, superior, acceptable/satisfactory, needs improvement, or unsatisfactory. The performance evaluation tool is provided in appendix 6.

Financial Implications of New Evaluation System

Determination of percent increases for performance ratings was made with the assistance of the Vice President of Human Resources and the Vice President of Accounting. The 1989 projected amount for tenure pay was utilized as a basis for the amount of money available for performance pay increases for the same year.

Consideration was given regarding employee incentive to achieve a higher ranking depending upon the percentage spread for one rating to another. A spread of 0 to 3 percent provides the RN with the potential of increasing annual wage by approximately $750.00 if an outstanding rating is achieved. The spread between steps averages $250.00 per year. This amount which satisfied the budgetary constraints was believed to fulfill employee incentive to achieve higher rankings. Table 7 reveals the percent pay increases for each performance rating.

TABLE 7

PERCENT INCREASE IN PAY DETERMINED BY PERFORMANCE RATING

Outstanding	= 3 percent
Superior	= 2 percent
Satisfactory	= 1 percent
Needs Improvement	= 0 percent
Unsatisfactory	= 0 percent

The step system was discussed to determine its inclusion into or exclusion from the pay-for-performance program. Consideration was given to a first-year grandfathering possibility. It was felt that the rationale for the tenure step system was not negated by a performance pay-type compensation, so the decision to continue the step system, based upon hours of service completed, was upheld and will continue in addition to pay for performance. The rationale for the step system is based upon recruitment and orientation costs to the hospital. The financial implications of continuing the step system were considered separately, however, the figures initially used already included the step increases so budgetary constraints were satisfied.

An estimated curve was developed for financial purposes in an attempt to anticipate the number of employees who would achieve each ranking. Previous performance evaluations and supervisor forecasts revealed that of the 144 RNs on the staff, 3 percent (5) would achieve a rating of outstanding, 10 percent (14) would achieve a rating of superior, 82 percent (118) would

achieve a rating of satisfactory, and 5 percent (7) would achieve a rating of needs improvement. Unsatisfactory ratings were not included as these employees would be counseled up to a higher rating or counseled out of the institution. The cumulative percentage of the pay for performance increases were within the financial constraints imposed by administration.

Market Raises, COLA, and Tenure Considerations

Market raise evaluation is conducted at least annually to ensure that employees within a specific job description receive a competitive rate of pay. The evaluation utilizes wage and salary surveys of comparable jobs within the same community and in other areas of recruitment. Supply and demand of certain personnel with specific job duties dictate the availability and the amount of the market raise. In January of 1989, for example, RNs were noted to be in greater demand than supply as evidenced by available openings for RNs throughout the hospital. The RNs were, therefore, given a 5 percent increase in pay to promote both recruitment and retention. Market raises are separate from performance pay and will continue to be evaluated separately.

Cost-of-living allowances are similar to market raises, but are not job specific. Once the wage and salary evaluations are completed, a number of economic factors are considered and a decision is made by administration to

grant or not to grant a general increase. If a general increase is granted, the amount of the general increase is determined and applied to the step system pay plan. This allowance is also separate from performance pay and will continue to be determined separately.

Tenure or longevity pay, as discussed in Chapter 2, required much consideration to determine inclusion into or exclusion from the performance pay system. Thirty-seven and one-half percent of the employees in December of 1987 were candidates and received longevity bonuses. Research of eleven regional health care facilities reveals that, with one exception, those organizations that practice longevity bonus plans do not have performance pay and those that pay for performance do not give longevity bonus. Given that the six-step tenure plan is to be continued with the performance pay plan, another tenure plan is redundant and therefore is omitted. The financial implications support this decision. For example, an RN who has completed 15 years of service for the hospital would receive a lump sum of $300 per year in addition to the Step 6 base pay. Given performance pay without longevity pay, the same RN who achieved a satisfactory rating on the performance evaluation would receive an annual increase of $270.00. For a superior rating, the same RN would receive an annual increase of $540.00. While maintaining incentive to achieve a higher rating, the resultant increases are not outside the amount already allotted for pay increases.

To avoid a drastic increase in payroll expenses at one time of year, the RN evaluations and subsequent increases in wage were staggered throughout the calender year. To illustrate, rather than giving all RN evaluations in January, the annual appraisals will be due on the employee's anniversary date of hire into the organization.

Discussion of omission or inclusion of merit pay was postponed by the nursing pilot committee. It was learned that none of the recipients of merit pay at this time are in the Nursing Services Department. This issue will be addressed if the performance pay system is adopted by those departments that employ merit pay recipients.

Management Training for Performance Evaluation

As the literature supports, management training is deemed necessary to utilize the behaviorally-based performance evaluation tool. Two primary reasons are evident to necessitate training: 1) the evaluation must be as objective as possible; 2) over- and under-rating carry financial implications.

Managers and supervisors were given written information to assist them in objectively determining employees' performance.[2] Examples of revising subjective statements into objective behaviorally-based comments were provided. The procedure for performance evaluation determination encourages peer input and is required to be approved by the manager and the vice president of the

department before it is given to the employee. These people ensure that the information is representative of the employee performance and is stated objectively. This also provides an opportunity for supervisor-manager learning and problem-solving in regard to employee behavior.

As the performance ratings hold financial implications for the hospital, education was provided to the evaluators to minimize over-rating and under-rating of behaviors. Background was given that included rationale for consistently over-rating employees. Examples of appraisal errors that were provided for education purposes included the halo effect, the constant error, the recency error, ambiguity, control tendency, and personal bias. Education was given in supervisory groups and reiterated and discussed on a one-to-one basis with each supervisor by the manager and/or vice present. An open door policy between supervisors and managers remains for any problems or questions encountered in performance evaluation.

CHAPTER END NOTES

[1]Union Memorial Hospital, Inc., Criteria-Based Job Descriptions (Monroe, North Carolina, 1983), pp. 4-14.

[2]Joyce M. Alt and Gary R. Houston, Nursing Career Ladders (Rockville, Maryland: Aspen Publications, Inc., 1986), pp. 1-32.

Chapter 5

CONCLUSIONS AND RECOMMENDATIONS

A one-year trial study for the pay for performance system is currently in progress. The system is being piloted on registered nurses. Most registered nurses who have received evaluations thus far verbalize that objectivity is apparent. Some supervisors have noted an increase in time spent to write the evaluations. They stated that this may be due to the different form rather than the tool itself. Experience utilizing the new form may return the time factor to the original amount. The revised job description and evaluation tool have been shared with prospective nurse employees. The verbalized perceptions, as indicated by the interviewing supervisors, are positive. Many of the prospective employees stated that expectations of job performance are clearer than those at other organizations.

An evaluation of the system will be made toward the end of the one-year trial, and revisions will be incorporated. Supervisory, employee, and accountant input will be utilized to revise or decide to delete the pay system. If the performance pay system is approved, the system will be expanded to include licensed practical

nurses, nurse assistants, and ward secretaries on nursing units. Job descriptions and performance evaluations for these employees will be rewritten. With the exception of the nurse administrators, the entire nursing department will be utilizing the pay for performance system by the beginning of the second year.

The intent of the nursing department administration, should the pay system be approved by nursing service, is to act as preceptors to the supervisory staff of other departments in the hospital. Nursing service plans to assist the department heads of the housekeeping, laundry, food service, and accounting departments to communicate with the employees of those departments. Information regarding perceived benefits, satisfaction and dissatisfaction of the proposed change in the pay system is needed. The nursing department will provide the employees of the other departments with examples and information to assist them in the decision to adopt or reject the plan. Department heads will be helped with the development of behaviorally-based job descriptions and objective performance evaluations.

Financial analysis of the one-year pilot project and impact on future labor costs need to be carefully studied. Departments planning to adopt performance pay need to evaluate the financial implications when determining percentage increases, as the nursing departments' percentages may not be applicable to all areas.

Recommendations for future pay structure changes include a closer study of the need for the six-step plan. Rationale to keep the step system lies heavily on the costs of recruitment and orientation of new employees. These costs are significant, so tenure is recognized in an attempt to minimize turnover. Two or three steps may satisfy the intent.

In conclusion, the Columbus Hospital administration, acting upon employee dissatisfaction with the pay structure, developed a performance pay program. The program is based upon research done by an ad hoc committee of employees. Nursing administrators volunteered to pilot the program on registered nurses for a one-year trial. Job descriptions and performance evaluations were revised to promote objectivity. The program will be evaluated at the end of the trial period and, if accepted, will be expanded to include other departments of the hospital.

Whether this change in compensation satisfies the needs of the employees and subsequently decreases dissatisfaction with the tenure program has yet to be determined. As statistical data was not obtained from the piloted employees, measurements of satisfaction will be difficult. It is therefore recommended that information be obtained before and after initiation of the program into other departments in an effort to objectively measure satisfaction.

Appendix 1

Memo From Pay for Performance Task Force

MEMORANDUM

TO: William J. Downer, Jr., President

FROM: Jan Ammerman, 4 East Supervisor

RE: Pay for Performance System

DATE: March 28, 1988

The Pay for Performance Task Force was developed to entertain the feasibility of this type of merit system. After analysis of employee questionnaires, surveys, conversations, and literature research, this task force has come to the conclusion that a Pay for Performance reward system is not only feasible, but desirable for the employees at Columbus.

Stipulations to the Pay for Performance system implementation include the following:

1. Objective, behaviorally-based job descriptions, and performance evaluations.

2. Education for supervisors/department heads regarding development and usage of #1.

We recommend that if these stipulations are not met, the Pay for Performance system not be implemented.

This task force has completed the first step of its mission. We need your decision to go ahead with the program or to dissolve this ad hoc committee. Please communicate your decision on Pay for Performance to me before our next scheduled meeting on April 21, 1988.

Tenure and merit program analysis and suggestions will be dependent upon Administration's decision regarding this recommendation.

Please contact me for any questions, background or rationale to support this recommendation.

JA/dc

cc: Richard Mink, Assistant Vice Pres., Human Resource

Appendix 2

Great Falls Gas Company Pay for Performance Plan

SUPERVISOR - FISCAL 1988 - INCENTIVE PLAN

CUSTOMER SERVICEMEN SUPERVISOR

75% of the incentive bonus will be based on specific objectives. 25% of the incentive bonus will be based on the company's overall performance. (R.O.E.).

Listed below are two objectives designed to increase productivity, which in turn should reduce unit costs substantially.

A percentage weighting will be applied to each objective with stepped graduations. Each plateau of the objective achieved above the minimum requirement will initiate a proportional payment, up to the total bonus amount provided.

40% 1. A direct relationship to the bottom line will be observed through reduced lost and unaccounted for gas, by removing a greater number of inaccurate meters from the field each year.

METER CHANGE OUT OBJECTIVE

BONUS	
1/5	Minimum requirement to qualify - 250 points per year per man.
2/5	Increase of 10 points per man per year to 260 points per year per man.
3/5	Increase of 25 points per man per year to 275 points per year per man.
4/5	Increase of 50 points per man per year to 300 points per year per man.
5/5	Increase of 100 points per man per year to 350 points per year per man.

50% 2. Concentration of higher quality service in less time per call will allow additional time for other fill-in work.

UNIT COST PER SERVICE CALL

IMPROVED QUALITY AND MAINTAIN SAFETY

BETTER MANPOWER UTILIZATION

0 Minimum - Maintained 57 minutes per call.

$\frac{1}{5}$ 20% reduction to 45 minutes per call.

$\frac{2}{5}$ 30% reduction to 40 minutes per call.

$\frac{3}{5}$ 40% reduction to 35 minutes per call.

$\frac{4}{5}$ 45% reduction to 30 minutes per call.

$\frac{5}{5}$ 50% reduction to 25 minutes per call.

10% 3. Increased sales by Marketing leads.

100% if 25 leads convert to new appliance sales.

50% if 15 leads convert to new appliance sales.

35% if 10 leads convert to new appliance sales.

SUPERVISOR - FISCAL 1988 - INCENTIVE PLAN

DISTRIBUTION FOREMAN

75% of the incentive bonus will be based on specific objectives. 25% of the incentive plan will be based upon the company's overall performance (R.O.E.).

1. 10% of bonus will be achieved when a typed detailed construction report for main renewals is prioritized and time table with estimated starting dates has been submitted on or before April 1, 1988.

40% 2. Reduction of temporary laborer payroll costs. By scheduling temporary employee hiring to coincide with peak work load periods.

	REDUCTION	Raw Salary's Cost
100%	30%	$15,000
50%	20%	$10,500
25%	10%	$ 5,500
10%	5%	$ 2,700

15% 3. Reduce regular payroll costs by improved productivity and planning.

50% This goal will be satisfied when the next day's scheduled work is distributed to the crews prior to 4:30 p.m.

50% Also provide fill-in work log for personnel when assigned jobs have been completed ahead of schedule or have been cancelled, and you are not available. Copy of log submitted to superintendent monthly indicating fill jobs, completion dates, and signatures.

15% 4. Reduce overall service line installation costs by reducing the average payroll unit cost per service as calculated from the Year to Date Data Processing Payroll Account Report.

REDUCTION OF AVERAGE PAYROLL UNIT COSTS

5%	$ 2.00
10%	5.00
15%	10.00

10% 5. Reduce 380 account installation average unit cost per service stub.

REDUCTION OF AVERAGE PAYROLL UNIT COST

5%	$ 1.00
10%	3.00

10% 6. Increased sales by marketing leads.

100% if 6 leads convert to new gas appliance sales.

50% if 3 leads convert to new gas appliance sales.

35% if 2 leads convert to new gas appliance sales.

Appendix 3

St. Vincent's Performance Plan

Saint Vincent
HOSPITAL AND HEALTH CENTER

P.O. BOX 35200
Billings, Montana 59107-5200
406-657-7000

PERFORMANCE PLAN

AND REVIEW

MANAGEMENT — SUPERVISORY

FORM

NAME: Iva Smile	EMPLOYEE NUMBER: 007	HIRE DATE: 1-22-82
DEPARTMENT: Typical	POSITION BEING REVIEWED: Department Manager	LENGTH OF TIME IN POSITION: 5¼ years
REVIEW PERIOD: From 9-1986	To 9-1987	
DATE REVIEWED: FIRST QUARTER: 12/6/86	SECOND QUARTER: 3/9/87	THIRD QUARTER: 6/7/87 ANNUAL: 9/5/87

REVIEW PREPARED BY:	TITLE:	DATE:
U. Better Shapeup	Division Vice President	9/5/87
I HAVE SUPERVISED THIS EMPLOYEE SINCE: 4/5/1983		
REVIEWED BY:	TITLE:	DATE:
Eye M. Fine	Executive Vice President	9/11/87

INSTRUCTIONS:

1. Be sure to complete all calculations necessary on pages 2 and 3.
2. If a performance objective listed on page 2 is not ready for review at the time of the annual appraisal, and it is not the fault of the employee being reviewed, it should be removed from this appraisal and included in the performance objectives for the next review period.
3. Appraisals are to be completed no later than three weeks from the date of receipt from personnel.
4. When completed, quarterly review forms should be attached to this form.

...subscribing to the philosophy and policies of the Sisters of Charity of Leavenworth

A-6-87 (11/86)

RATING KEY	RATING FACTORS
OUTSTANDING	5
SUPERIOR	4
FULLY SATISFACTORY	3
MARGINALLY SATISFACTORY	2
UNSATISFACTORY	1

DEFINITIONS: TYPE OF OBJECTIVE

M = MAINTENANCE: needs to be accomplished to keep the institution/department in its existing state.

D = DEVELOPMENTAL: needs to be accomplished for the institution/department/individual to progress.

PART A: performance results

	PERFORMANCE OBJECTIVES: Major items for which the appraisee is accountable.	TYPE OF OBJECTIVE	** FUNCTIONS RATINGS ENTER APPROPRIATE RATING FACTOR			RATING FACTOR TOTALS	
			PLANNING	IMPLEMENTATION	RESULTS		
1	Informs the President weekly of the hospital financial operating results by means of a written report.	M	3	3	3	9	
2	Meets 90% of guest relations and M.D. objectives identified in operational plan.	M	3	2	2	7	*A
3	Increase all M-DAX quality scores to a minimum of 70 in all categories or an increase of 2% over last year's scores, whichever is lower.	M	3	3	3	9	
4	Department budgets will be prepared on schedule and monitored bi-weekly. Department expenses will be kept within budget limits.	M	4	4	5	13	*B
5	A plan for increasing revenue/decreasing expenses 4% will be developed by Nov. 1, 1987, and implemented by March 1, 1988.	D	4	5	5	14	*C
6	Staff P P + R forms will be completed within one week of their due date.	M	3	2	2	7	*D
7	PMIs will be conducted monthly with all staff members.	M	3	1	1	5	*E
8	Complete 20 hours of continuing education, and attend one state wide or national conference.	D	3	3	3	9	
8	← TOTAL I				TOTAL II →	73	

**FUNCTION DEFINITIONS:

PLANNING: Plans objectives and activities ahead; anticipates contingencies; thoroughly researches a problem and proposes a solution in terms of the ultimate or relevant consequences involved and develops practical alternate solutions.

IMPLEMENTATION: Makes effective and efficient use of people, time, materials and equipment; constructively uses the skills and knowledge of subordinates; interfaces and blends his/her efforts well with others in order to achieve an integrated and harmonious team effort; conducts his/her activities within the scope of assigned responsibilities and authority.

RESULTS: Has full knowledge and accepts responsibility for operations under individual jurisdiction; monitors outcomes for compliance with established goals and procedures and takes appropriate corrective measures when necessary; is profit and service oriented and maintains highest levels of service and/or performance with the resources available; achieves results which are beneficial to the hospital and are the outcome of actions planned and implemented by the individual.

PERFORMANCE RESULTS RATING..... (divide Total II by Total I)	9.12
CAPABILITY FACTORS RATING..... (divide Total III by 80)	2.75

RATING KEY	RATING FACTORS
FULLY SATISFACTORY	3
SATISFACTORY IN MOST AREAS (underline areas needing improvement)	2
UNSATISFCTORY (explain reasons and include a development plan)	1

PART B: capability factors

ITEM	DEFINITION	RATING FACTOR	
JOB KNOWLEDGE	Applies knowledge and skills in every aspect of responsibility; keeps informed on current developments to insure completion of all responsibilities/operations; complies with all regulations as well as hospital programs, policies and objectives.	3	
LEADERSHIP	Development of subordinates' managerial and technical skills; stimulates and guides subordinates so they will work together toward common objectives; discovers and utilizes peoples' capabilities; awards recognition for good work; has the respect of subordinates and peers.	2	* F
JUDGEMENT	Consistently demonstrates the ability to accurately estimate situations and reach sound and workable solutions; uses sound reasoning; differentiates between relevant and irrelevant, significant and insignificant.	3	
INITIATIVE	Acts independently without specific instructions in a self-confident and constructive manner; works to improve self and job; evidences enthusiasm.	3	
INTEGRITY	Practices honesty, fairness and moral vigor in character and in action; informs superiors of negative as well as positive aspects concerning his/her responsibilities; accepts responsibility for unfavorable as well as favorable projects.	3	
PERFORMANCE PLANNING AND REVIEW	Performance appraisals and developmental plans for employees are completed by their due date, and are reviewed with the employee; annual appraisals are returned to personnel within three weeks of receipt.	2.5	* G
TIME UTILIZATION	Uses time well; does not waste time; rarely misses deadlines; operations under his/her control are most always on time; handles extra time demands in stride; is punctual.	3	
INTER-PERSONAL RELATIONS	Good social skills and uses them effectively with superiors, peers, subordinates, and guests; adapts and is responsive to people's needs; is sincere; open to constructive criticism.	2.5	* H
	TOTAL III ➡	22	

PERFORMANCE RESULTS RATING.	9.12
CAPABILITY FACTORS RATING...	2.75
OVERALL RATING...	25.08

(To obtain overall rating, multiply the performance results rating by the capability factors rating)

Iva Smile
P P + R Form
addendum: Comments
date:

Performance Results

A. Iva was able to meet only 85% of these objectives. She did not fully carry out the plans she had made.

B. Iva had a very good plan, put it into effect, and was able to keep department expenses 5% under budget limits.

C. Iva worked with marketing to create a plan for increasing revenue, and was able to increase department revenue by 7.5%.

D. Iva had set up a schedule to meet this objective, but was only able to meet this objective with 75% of her staff. She was never more than three weeks late.

E. Iva scheduled regular PMIs with her staff. However, after a few months, she no longer followed through on her schedule, and PMIs were regularly missed with her staff.

Capability Factors

F. Iva works well alone, but does not utilize the capabilities of her staff, thus creating extra work for herself, causing her to miss some deadlines.

G. 25% of her P P + R forms were turned in after their due date. Since they were only 2 weeks late, I gave her a 2.5 rating.

H. Iva is seen as distant to her subordinates. She is not as friendly or available as they would like. This is reflected in attitude toward doing regular PMIs.

DEVELOPMENTAL PLAN:

By October 15, 1987, Iva will have met with Terry Radcliffe to set up training to improve communication with her staff. This training will be completed by Dec. 1, 1987.

By October 15, 1987, Iva will have met with Terry Radcliffe to set up training for time management and delegation skills. This training will be completed by Feb. 1, 1988.

Saint
Vincent
HOSPITAL AND HEALTH CENTER

P.O. BOX 35200
Billings, Montana 59107-5200
406-657-7000

PERFORMANCE PLAN AND REVIEW
MANAGEMENT — SUPERVISORY
Quarterly Review

NAME:	EMPLOYEE NUMBER:	DATE OF REVIEW:
Iva Smile	3333	5-24-86
REVIEWED BY:		**DEPARTMENT:**
U. Better Shapeup		Typical

A. ACCOMPLISHMENTS OF THE PAST THREE MONTHS:

- expenses have kept within budget limits
- two department meetings were held, one containing an inservice
- revenues have been increased by 4.5%
- department goals for the year are on schedule

B. COMMENTS:

- you still need to seek more employee input
- your personal training/reading has fallen behind

C. GOALS AND OBJECTIVES FOR THE NEXT THREE MONTHS: (NOTE: add any new objectives to page 2 of the annual performance plan.)

- set up a department inservice on guest relations
- a department meeting will be held each month
- continue to implement department goals for the year
- make special efforts to complete performance objective #7 from your P,P and R form.

D. COMMENTS OF REVIEWER:

E. COMMENTS OF EMPLOYEE:

SIGNED: Employee: _____ Date: _____

Reviewer: _____ Date: _____

NOTE: Attach this form to the Performance Plan and Review Form.

A-6-66 (11/86)

SAMPLE

STAFF FORM II

RATING KEY	RATING FACTORS
OUSTANDING	5
SUPERIOR	4
FULLY SATISFACTORY	3
MARGINALLY SATISFACTORY	2
UNSATISFACTORY	1

PERFORMANCE RESULT RATING: 3.55

(divide total II by total I)

PART A: performance results

	PERFORMANCE OBJECTIVES: major items for which the employee is accountable	RATING FACTOR	
1	Maintain sanitation of equipment and work area at all times, to meet the department standard, achieving 90% on the checklist which is completed on a weekly basis.	4	*A
2	Properly identifies all patients before drawing their blood, using laboratory procedure.	3	
3	Provides a clean, safe, and orderly environment for patients, evidenced by a 90% rating on quarterly patient environmental check list	2	*B
4	Food is delivered to Rimrock on time, according to job description, with adequate amount to feed all patients, as evidenced by a maximum of four valid complaints per quarter.	5	*C
5	Properly prepares the Operating Room for the next case, maintaining department turnover schedule 90% of the time.	3	
6	Daily Floor Care: sweeps, mops, wet washes and vacuums floors assigned achieving a level of 90% on periodic checks.	4	*D
7	Key punches all information as required by supervisor within 24 hours.	3	
8	Files all patient accounts transferred to the file room from the business office and credit and collection in proper areas specified by the supervisor/lead within one day (week)	3	
9	Responds to all requests for repairs within four hours.	5	*E
10			
	← TOTAL I / TOTAL II →	32	

A - achieved 94% average on checklists
B - achieved 80% average on checklist
C - No complaints for quarter & 3 letters of appreciation received
D - achieved 95% average
E - achieved 1 hour response average

CAPABILITY RATING	2.75

(Divide total III by 8)

RATING KEY	RATING FACTORS
FULLY SATISFACTORY	3
SATISFACTORY IN MOST AREAS (underline areas needing improvement)	2
UNSATISFACTORY (explain reasons and include a development plan)	1

PART B: capability factors

ITEM	DEFINITION	RATING FACTOR	
APTITUDE	Knows job techniques; makes efforts to learn more; acts reflect sound judgement.	3	
INITIATIVE	Acts independently without specific instructions; is self confident; works to improve self and job; makes constructive suggestions.	2	#1
QUALITY OF WORK	Workmanship acceptable; applies knowledge and skills well; accurate and reliable in work; errors rare; exhibits pride in work; follows policies and procedures.	3	
INTEGRITY	Practices honesty, fairness and moral vigor in character and in action; accepts responsibility for unpleasant as well as pleasant tasks.	3	
TIME UTILIZATION	Uses time well; fast worker; does not waste time; rarely misses deadlines; handles extra time demands in stride; is punctual.	3	
RELATIONSHIPS WITH OTHERS	Tactful and kind to peers, superiors, subordinates, guests and physicians; adapts and is responsive to people's needs; good social skills; is sincere; open to constructive criticism.	3	
ATTITUDE	Cheerful; cooperative; supportive of hospital goals and objectives; inspires others positively; enthusiastic; responds positively to change.	3	
ATTENDANCE	Regular in attendance; does not abuse sick leave; adjusts to work needs; attends required meetings; calls when unavoidably absent or detained.	2	#2
	TOTAL III ➡	22	

PERFORMANCE RESULTS RATING..	3.55
CAPABILITY RATING	2.75
OVERALL RATING...	9.76

To obtain overall rating, multiply the performance result rating by the capability rating.

COMMENTS ON CAPABILITY FACTORS:

1. Rather than make constructive suggestions, — often ridicules dept policy + other workers.
2. — attends only 25% of department meetings + inservices.

Appendix 4

Registered Nurse Job Descriptions

(FORMER REGISTERED NURSE JOB DESCRIPTION)

COLUMBUS HOSPITAL
JOB DESCRIPTION

Position Name: Registered Nurse I

Department: Nursing Service

Date of Last Review: September 1983 Approved by: _____

Title of Immediate Supervisor: Nursing Supervisor

BASIC FUNCTION:

Renders professional nursing care to patients within an assigned unit of a hospital in support of medical care as directed by medical staff and pursuant to objectives and policies of the hospital. The Registered Nurse I is responsible for the direct comprehensive nursing care of the patient. The Registered Nurse I bears a legal responsibility for the activities of nonprofessional personnel for the performance of those functions specifically delegated to them. The Registered Nurse I defines the total nursing needs of the patient and is responsible for seeing that they are fulfilled.

The graduate nurse functioning under a temporary permit or a registered nurse will function within the confines of this job description. The graduate nurse or registered nurse with no prior experience will be under close supervision of their supervisor and assistant director for at least the three-month probationary period.

RESPONSIBILITIES:

Assumes responsibility for professional growth and development through membership and participation in professional and civic organizations, and through a program of reading and study. Performs related work as required.

BEHAVIORS:

1. NURSING PROCESS

   A. Assessment

      1. Takes nursing histories from patients and/or others that identify common variables affecting care and serve as guides for the development of individual nursing care plans that:

         a) provide baseline data pertaining to activities of daily living.

b) reflect the physiological condition of the patient.
c) reflect the psychosocial needs of the patient.
d) reflect the perceptions of the patient and/or family of his health problem(s) and his expectations of the present hospitalization.
e) provide information needed to begin discharge planning.

2. Identifies common recurrent patient problems, symptoms, and behavioral changes in relation to:
a) standards of care.
b) individual patient needs.

3. Obtains and reviews available data obtained by other members of the health team (medical history, physical examination, medical care plan, social worker's reports, and community referrals.

B. Planning

1. Writes a nursing care plan using the assessment data, that:
a) integrates the medical care plan.
b) establishes realistic immediate long-term and short-term goals.
c) shows evidence of understanding principles underlying nursing intervention.

2. Involves the patient and/or family in developing the nurse care plan.

3. Plans patient care with other members of the health team.

4. Identifies immediate and long-term consequences of nursing activity.

5. Understands the legal consequences of nursing actions.

6. Revises the initial nursing care plan to the changing needs of the patient.

C. Implementation

1. Sets priorities and gives nursing care based on the nursing care plan.

2. Implements the medical care plan as delegated.

3. Assigns aspects of care to selected members of the nursing team.

4. Coordinates the activities of other disciplines to implement the individual patient care plan.

D. Evaluation

1. Evaluates the response of the patient to his care plan.

2. Evaluates the response of the patient to nursing intervention.

3. Revises the nursing care plan to meet changing needs of the patient.

4. Evaluates the goals of the patient care plan.

5. Collaborates with other disciplines to revise the patient care plan according to changing needs of the patient.

II. TEACHING

A. Patient/Family

1. Communicates a rationale for nursing intervention to the patient and/or family.

2. Collaborates with patient and/or family to identify individual informational needs and to assess learning readiness.

3. Uses teaching strategies to meet individual informational needs that involve the patient and/or his family or other supporting people.

4. Communicates referral to other members of the health team to meet specific learning needs of the patient and/or family.

5. Validates the teaching plan by consulting with other staff nurses.

6. Writes the teaching plan as part of the nursing care plan.

7. Implements and/or assists others to implement the planned teaching strategies.

8. Evaluates and revises the teaching strategies in relation to the patient and/or family.

B. Staff and Students

1. Serves as a positive role model for professional nursing students.

2. Contributes to the learning experiences of professional nursing students in cooperation with other Registered Nurse members of the team and the clinical instructor.

3. Assists auxiliary personnel on the nursing team to identify their needs for learning basic nursing tasks.

4. Participates in teaching, guiding, and evaluating the performance of auxiliary personnel.

5. Communicates the rationale for nursing intervention to staff and students.

III. COMMUNICATION

A. Patient and Family

1. Applies effective interviewing skills to elicit information from patient and/or family that is necessary to plan, implement, and evaluate nursing care.

2. Communicates accurate information about the nursing care plan to the patient and/or family.

3. Applies basic verbal and nonverbal communication skills to identify and reduce anxiety in the patient and/or family.

4. Identifies and reports verbal and nonverbal communication problems of patient and/or family.

B. Staff

1. Interacts effectively with other team members to keep them informed of changes in the condition of the patient.

2. Interacts effectively with other team members to keep them informed of changes in the patient care plan.

3. Records pertinent information clearly and accurately.

4. Reports pertinent information to the appropriate person.

5. Participates in patient care conferences.

IV. EVALUATION

A. Staff

1. Participates effectively in evaluation procedures by providing data for assessment of clinical performance.

2. Participates effectively in evaluation of standards of care.

3. Participates effectively in identification of unsafe patient care practices and assumes responsibility for intervention.

B. Other

1. Participates effectively in evaluation of environmental safety.

2. Participates effectively in evaluation and revision of nursing procedures and equipment needed for patient care.

C. Self

1. Participates in formal self-evaluation by identifying areas of strength and limitation.

2. Seeks supervision of own actions.

3. Plans and participates in educational programs and workshops to increase professional competence and to meet personal needs and goals.

4. Understands the legal consequences of nursing actions.

EMPLOYMENT SPECIFICATIONS:

Graduation from an accredited school of nursing. Current licensure to practice as a registered nurse in Montana.

Must be physically and mentally capable of performing all essential tasks and duties involved in the job.

** Is eligible for Registered Nurse 2 Clinical Advancement Program.

(REVISED REGISTERED NURSE JOB DESCRIPTION)

COLUMBUS HOSPITAL
JOB DESCRIPTION

Position Name: Registered Nurse I

Department: Nursing Service

Date of Last Review: 5/88 Approved by: _____

Title of Immediate Supervisor: Nursing Unit Supervisor

JOB DESCRIPTION:

Assesses, plans, implements, and evaluates the total nursing care rendered to assigned patients. Initiates patient and significant others' teaching. Provides leadership in coordinating ancillary, medical, and other patient care services in maintaining standards for the high quality, safe, appropriate, and cost effective care given to patients in the clinical setting.

QUALIFICATIONS:

A graduate from an accredited nursing program who is currently licensed to practice professional nursing in the state of Montana.

Physically and mentally capable of performing all tasks and functions of the position.

ORGANIZATIONAL RELATIONSHIPS:

Reports directly to the assigned unit supervisor. Supervises LPNs, patient aides, and other unit personnel.

JOB FUNCTIONS:

1. Demonstrates knowledge and acceptance of Columbus Hospital's mission and philosophy through compassionate, constructive, and courteous communications with and behavior towards medical staff, visitors, patients, volunteers, and other hospital employees.

2. Utilizes the nursing process in order to guarantee that high-quality, safe, and appropriate care is given to assigned patients.

   A. Assessment:
      1) Collects pertinent and complete patient history on all assigned patients upon admission.

2) Utilizes observational and other assessment skills to assess patients' health status.
3) Obtains additional health data from other members of the patient care team.

B. Planning:
1) Integrates findings into the development of a written patient care plan upon admission.
2) Creates an appropriate plan of care that notes desired outcomes, goals, and appropriate interventions to reach desired goals.

C. Implementation:
1) Adheres to unit standards of care in performing all tasks and duties as assigned in the plan of care by maintaining a high level of expertise in Nursing Service and unit-specific nursing skills.
2) Delegates tasks as appropriate and provides supervision to ensure high-quality patient outcomes.
3) Communicates incomplete tasks to oncoming shift in order to facilitate completion.

D. Evaluation:
1) Documents pertinent information regarding intervention and patient outcomes in the medical record.
2) Reports critical outcomes to the appropriate staff in a timely fashion.
3) Updates the care plan as needed to reflect changes in patient status.

3. Patient Education:

A. Assesses patient and/or significant others' educational needs as part of the nursing process.
B. Integrates learning needs into the plan of care.
C. Documents in the record and alters the plan of care based on the achievement of patient educational goals.
D. Utilizes other resources within the hospital or community in order to facilitate patient education.

4. Staff Education:
A. Accepts responsibility for supervision and learning needs of floats, orientees, and student nurses.
B. Conducts regular patient care or educational conferences as requested by the unit supervisor.

5. Communication:
A. Utilizes high-quality and professional verbal skills in communicating with peers, medical staff, families, patients, and supervisors.

B. Utilizes high-quality and professional written skills with approved approved terminology and abbreviations in order to document clearly and concisely.

6. Research:
   A. Participates in utilizing published literature and current research in the review and revision of unit standards of care.
   B. Participates in the pilot of new patient care equipment and supplies.

7. Takes the responsibility for continuing professional development and education.
   A. Regularly attends unit meetings and mandatory in-services as well as educational programs.
   B. Identifies own learning needs and communicates same to supervisor.
   C. Participates in appropriate professional organizations.

8. Professional Decorum:
   A. Adheres to the Nursing Service dress code.
   B. Conducts self as a professional person in interactions with members of the health care team, patients, and significant others.
   C. Conducts self as a member of the health team and accept responsibility as part of a unit.

9. Productivity, Efficiency, and Safety
   A. Reports for duty as scheduled.
   B. Reports on time as scheduled.
   C. Completes duties in a timely fashion.
   D. Consistently exhibits a positive attitude and sense of teamwork in providing patient care.
   E. Practices safe nursing care by anticipating potential staff, visitor, and patient safety problems and implementing preventative measures.

10. Successfully achieves and maintains goals negotiatated with unit supervisor.

11. Accepts and complete additional duties as assigned.

Appendix 5

Personnel Performance Evaluation Tool

Employee Name

Personnel Performance Evaluation

Date _____

PLEASE RETURN TO HUMAN RESOURCES

BY _____

Annual ☐
Probation ☐
Other _____

RATE EACH FACTOR — OUTSTANDING · SUPERIOR · COMPETENT · IMPROVEMENT NEEDED · UNSATISFACTORY

Checking items OPTIONAL with department
◆ Strong ✓ Standard – Weak

1. QUANTITY ☐☐☐☐☐
- ☐ Amount of work performed
- ☐ Organization of work
- ☐ Completion of work on schedule

2. QUALITY ☐☐☐☐☐
- ☐ Accuracy
- ☐ Neatness of work product
- ☐ Thoroughness
- ☐ Reporting and/or recording of work

3. WORK HABITS ☐☐☐☐☐
- ☐ Attendance ☐ Punctuality
- ☐ Application to duties
- ☐ Observance of rules and regulations
- ☐ Compliance with work instructions
- ☐ Orderliness in work
- ☐ Efficient use of equipment and supplies
- ☐ Acceptance of supervision

4. GUEST RELATIONS ☐☐☐☐☐
- ☐ Use of basic guest relations with public/co-workers.
- ☐ Creating a positive telephone impression.
- ☐ Interaction with hostile or depressed persons.
- ☐ Creating a supportive climate for public/co-workers.

5. PERSONAL ATTRIBUTES ☐☐☐☐☐
- ☐ Personal appearance
- ☐ Integrity
- ☐ Initiative
- ☐ Adaptability

6. TECHNICAL COMPETENCY ☐☐☐☐☐
- ☐ Job knowledge
- ☐ Willingness to learn

7. SUPERVISORY ABILITY (only for supervisors) ☐☐☐☐☐
- ☐ Planning and assigning
- ☐ Training and instructing
- ☐ Disciplinary control
- ☐ Evaluating performance
- ☐ Leadership
- ☐ Making decisions
- ☐ Fairness and impartiality
- ☐ Approachability

Use COMMENTS space to describe employee's strengths and weaknesses. Give examples of work well done and plans for improving performance.

(Factor ratings of Unsatisfactory, Improvement Needed, or Outstanding must be substantiated by comments.)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

(Continue COMMENTS on reverse side)

SIGNATURES OF REPORTING OFFICERS

This report is based on my observation and/or knowledge. It represents my best judgment of the employee's performance.

RATER _____ DATE _____

I concur in and approve this report.

DEPT. HEAD _____ DATE _____

HUMAN RESOURCES _____ DATE _____

OVER-ALL EVALUATION

UNSATISFACTORY	IMPROVEMENT NEEDED	COMPETENT	SUPERIOR	OUTSTANDING

EMPLOYEE REVIEW

This evaluation has been reviewed with me and I understand my ratings. I have been counseled on areas that need improvement and on how I can improve my performance.

EMPLOYEE'S SIGNATURE _____ DATE _____

Appendix 6

Pay for Performance Evaluation Tool

PAY FOR PERFORMANCE EVALUATION TOOL

EMPLOYEE NAME: _____

EMPLOYEE NUMBER: _____

ADJ HIRE/RECLASS DATE: _____

DATE OF EVALUATION: _____

PURPOSE OF EVALUATION |___| ANNUAL
|___| PROBATIONARY
|___| OTHER

NURSING UNIT: _____

REGISTERED NURSE I PERFORMANCE EVALUATION

Directions: Circle the appropriate number below the description that most closely describes the employee's consistent behavior. Transfer those numbers to the Performance Index worksheet to establish the final Performance Index.

# 1	Behavior and/or communication with peers, patients, physicians, and others is perceived as nonconstructive, rude, inappropriate, noncompassionate or derogatory.	Demonstrates knowledge and acceptance of Columbus Hospital's mission and philosophy through compassionate communications with, and constructive, courteous behavior toward medical staff, visitors, patients, volunteers, and other hospital employees.	Demonstrates exemplary compassionate constructive and courteous behavior at all times. Is considered a role model by peers and other staff. May have written commendations from others regarding communication skills.
	Comments:		
	Points: (circle one) 0 1 2 3	4 5 6 7	8 9 10
#2A	Assessments are not always completely accurate or timely. Documentation is not always concise or complete.	Utilizes the nursing process in order to guarantee that high-quality, safe, and appropriate care is given to assigned patients. Assessment: 1) Collects pertinent and complete patient history on all assigned patients within 4 hrs. of admission. 2) Utilizes observational and other assessment skills to assess patients' health status. 3) Obtains additional health data from other members of the patient care team.	Assessments are consistently thorough, pertinent and timely. Utilizing percussion, palpation, auscultation and inspection skills. Histories include patient as well as S/O if possible. Health data from other resources (lab, old records, allied health personnel, etc.) is thorough and complete.
	Comments:		
N/A	Points: (circle one) 0 1 2 3	4 5 6 7	8 9 10

#2B	Care plans are not always initiated upon admission and/or are incomplete or inconsistent with problems identified in the patient assessment.	Planning: 1) Integrates findings into the development of a written Patient Care Plan upon admission. 2) Creates an appropriate plan of care that notes desired outcomes, goals and appropriate interventions to reach desired goals	Care plans are initiated consistently upon patient admission. Care plans are consistently individualized to the patient specific needs and not just standardized to the patients' medical diagnosis.
	Comments:		
N/A	Points: (circle one) 0 1 2 3	4 5 6 7	8 9 10
#2C	Does not assume responsibility for knowing and practicing nursing practice standards. Fails to use proper delegation and supervision skills in order to ensure high-quality care. Leaves tasks incomplete or fails to pass such information to supervisor, charge nurse or oncoming staff.	Implementation: 1) Adheres to unit standards of care in performing all tasks and duties as assigned in the plan of care by maintaining a high level of expertise in Nursing Service and unit-specific nursing skills. 2) Delegates tasks as appropriate and provides supervision to ensure high-quality patient outcomes. 3) Communicates incomplete tasks to oncoming shift in order to facilitate completion.	Assists in setting practice standards through literature search, attendance at educational meetings or participation in professional organizations. Information procured is shared with professional supervisory staff. Is an outstanding resource for new employees, floats and students in training for unit-specific skills. Consistently utilizes correct delegation and supervision skills in order to complete tasks to ensure highest quality care.
	Comments.		
	Points: (circle one) 0 1 2 3	4 5 6 7	8 9 10

#20	Documentation is either unclear incomplete or unduly lengthy. Fails to report critical outcomes or changes in condition. Plan of care is not always reflected in the documentation or not altered due to patient change in status.	Evaluation: 1) Documents pertinent information regarding intervention and patient outcomes in the medical record. 2) Reports critical outcomes to the appropriate staff in a timely fashion. 3) Updates the care plan as needed to reflect changes in patient status.	Documentation in the medical record is always clear, concise and complete, and reflects the written plan of care. Verbal reports to physician or supervisory staff are timely and complete. Care plans are reviewed and appropriately revised prior to a change in responsibility for care.
	Comments.		
	Points: (circle one) 0 1 2 3	4 5 6 7	8 9 10
#3	Fails to recognize patient and/or S/O educational needs in assessment. Fails to incorporate these in patient care plan. Fails to document educational status in the medical record. Is either unaware of or fails to utilize other educational resources in order to accomplish educational goals.	Patient education: 1) Assesses patient and/or significant others' educational needs as part of the nursing process. 2) Integrates learning needs into the plan of care. 3) Documents in the record and alters the plan of care based on the achievement of patient educational goals. 4) Utilizes other resources within the hospital or community in order to facilitate patient education.	Gives top priority to patient and/or S/O educational needs. Plan for meeting these needs is developed, documented, carried out, evaluated and revised as necessary. Is aware of educational resources and consistently utilizes them in order to assure high quality and consistent educational information.
	Comments.		
N/A	Points: (circle one) 0 1 2 3	4 5 6 7	8 9 10

#4	Reluctantly assume staff education responsibility. Does not conduct or participate in patient care conferences.	Staff educaiton: 1) Accepts responsibility for supervision and learning needs of floats, orientees, and student nurses. 2) Conducts regular patient care or educational conferences as requested by the unit superviser.	Acts as a preceptor as requested. Participates in evaluating staff education needs and is a resource for implementing the plan to meet those needs. Patient care conferences are complete, well documented and utilized to review or revise the patient care plan.
	Comments. Points: (circle one) 0 1 2 3 4 5		
#5	Written and verbal skills are poor, unclear, or not professional.	Communication: 1) Utilizes high-quality and professional verbal skills in communicating with peers, medical staff, families, patients, and supervisors. 2) Utilizes high-quality and professional written skills with approved terminology and abbreviations in order to document clearly and concisely.	Written as well as verbal skills are clear, concise, constructive and professional at all times.
	Comments. Points: (circle one) 0 1 2 3 4 5		
#6	Does not evidence behavior that reflects current nursing knowledge. Reluctantly participates, if at all, in product review.	Research: 1) Participates in utilizing published literature and current research in the review and revision of unit standards of care. 2) Participates in the pilot of new patient care equipment and supplies.	Assists in implementing research projects. Enthusiastically searches for better, more efficient or more cost-effective ways to render care. A change agent.
	Comments. Points: (circle one) 0 1 2 3 4 5		

REGISTERED NURSE I PERFORMANCE EVALUATION

#7	Fails to attend mandatory inservices and at least 50% of unit meetings. Does not exhibit behavior that shows personal responsibility for own professional growth.	Takes the responsibility for continuing professional development and education. 1) Regularly attends unit meetings and mandatory in-services as well as educational programs. 2) Identifies own learning needs and communicates same. 3) Participates in appropriate professional organizations.	Actively pursuing higher education or certification. Attends inservices, workshops or seminars to increase knowledge and skills and shares information with peers as requested. Identifies learning needs with recommendations to meet those needs. Active in appropriate professional organization.
	Comments. Points: (circle one) 0 1	2 3	4 5
#8	Resorts to appearance, conduct and behavior unbecoming a professional when under stress.	Professional decorum: 1) Adheres to the Nursing Service dress code. 2) Conducts self as a professional person in interactions with members of the health care team, patients, and significant others. 3) Conducts self as a member of the health team and accept responsibility as part of a unit.	Is an example of a professional nurse in conduct, appearance, behavior and communication. Unflappable even in times of high stress and frustration.
	Comments. Points: (circle one) 0 1 2 3	4 5 6 7	8 9 10

REGISTERED NURSE I PERFORMANCE EVALUATION

#9	Absents exceed 3-5 periods per year for full-time, or 1-3/yr for part-time employee. Tardiness exceeds 1/month. Overtime exceeds 1% of time worked unless requested to stay to meet staffing needs. Has more than acceptance errors in care, medication errors or employee incidents.	Productivity, Efficiency, and Safety: 1) Reports on time as scheduled. 2) Reports for duty as scheduled. 3) Completes duties in timely fashion. 4) Consistently exhibits a positive attitude and sense of teamwork in providing patient care. 5) Practices safe nursing care by anticipating potential staff, visitor, and patient safety problems and implementing preventative measures.	Rarely, if ever, absent, tardy or overtime. Not only a member of the team, but an informal leader in establishing enthusiasm and a sense of team work. Rarely has medication errors, errors in patient cases or employee incidents that were avoidable by practicing good safety standards.
	Comments. Points: (circle one) 0 1 2 3	4 5 6 7	8 9 10
#10	Fails to achieve goals or to maintain achievement of goals.	Successfully achieves and maintains goals negotiated with unit supervisor.	Takes an active role in setting professional goals and attains, maintains, and may exceed goals set.
	Comments. Points: (circle one) 0 1	2 3	4 5
#11	Fails to complete additional duties as assigned.	Accepts and completes additional duties as assigned.	
	Comments. Points: (circle one) 0 1	2	

REGISTERED NURSE I PERFORMANCE EVALUATION

GOALS FOR UPCOMING EVALUATION PERIOD:

I have read and understand the above documentation.

DATE	EMPLOYEE SIGNATURE
DATE	SUPERVISOR (RATER'S) SIGNATURE
DATE	DIRECTOR'S SIGNATURE

COMMENTS:

13/PE

BIBLIOGRAPHY

Articles

Barros, A. "Setting up a System of Pay for Performance." Medical Laboratory Observer, November, 1986, pp. 39-45.

Behrend, Barbara J; Fince, Debra A; Emerick, Carol Ann M; and Scoble, Kathleen. "Articulating Professional Nursing Practice Behaviors." Journal of Nursing Administration, February, 1986, pp. 20-24.

Biggs, Dudley P. "Incentive Pay Plans Boost Manager's Performance." Health Progress, March, 1987, pp. 60-62.

Broekenshire, Anne and Hattstaedt, Mary Jane O'Hara. "Revising Job Descriptions: A Consensus Approach." Supervisor Nurse, March, 1980, pp. 16-20.

Bushardt, Stephen C. and Fowler, Aubrey R., Jr. "Performance Evaluation Alternatives," Journal of Nursing Administration, October, 1988, pp. 40-44.

Case, Bette B. "Excellent Performance," Nursing Management, December, 1983, pp. 45-48.

Garcia, L. S. "Creating Job Standards for a Merit Pay Plan." Medical Laboratory Observer, October, 1988, pp. 30-36.

Gubman, Ed. "'Pay for Performance' is Credo of Cutting Edge for Hospitals." Hospitals, April 16, 1985, p. 64.

Ignatavicius, Donna and Griffith, Jeff. "Job Analysis: The Basis of Effective Appraisal." Journal of Nursing Administration, July/August, 1982, pp. 37-41.

Kanter, Rosabeth Moss. "The Attack on Pay." Harvard Business Review, March/April, 1987, pp. 60-67.

_____. "The Revolution in Compensation." Personnel, January, 1987, pp. 76-82.

Larson, Elaine; Lee, Pat Chikamoto; Brown, Marie; and Shorr, Judy. "Job Satisfaction." Journal of Nursing Administration, January, 1984, pp. 31-38.

Nauright, Linda P. "Toward a Comprehensive Personnel System: Job Description Development - Part I." Nursing Management, May, 1987, pp. 54-56.

_____. "Toward a Comprehensive Personnel System: Job Description Development - Part II." Nursing Management, June, 1987, pp. 33-48.

_____. "Toward a Comprehensive Personnel System: Job Description Development - Part III." Nursing Management, July, 1987, pp. 44-48.

Stankard, Martin. "Paying for Productivity: A Concept Revisited." Compensation and Benefits Management, Summer, 1987, pp. 187-191.

Vestal, Katherine W. "Financial Considerations for Career Ladder Programs." Nursing Administration Quarterly, Fall, 1984, pp. 1-8.

Waldman, Steven. "Grading Merit Pay." Newsweek, November 14, 1988, pp. 45-46.